Welcome from the Chair
Professor Hannah Dahlen

As Chairperson for the 11th International Normal Labour and Birth Conference (NLBC) I am thrilled to welcome you to Sydney in 2016 to participate in one of the best midwifery conferences in the world.

This conference will be hosted by the School of Nursing and Midwifery, Western Sydney University in association with the Australian College of Midwives. The NLBC conference was founded by Professor Soo Downe from UCLAN and it has grown in reputation over the past 11 years. Every second year it leaves its lovely home in Grange-over-Sands in the English Lake District and goes to another country. The conference has now been held in Canada, China, Brazil, and in 2016 we will host it in Sydney.

I have been going to the International Normal Labour and Birth Conference since 2010 and have persistently advocated for Australia to be a host, as I know how many wonderful researchers and passionate midwives, doctors and consumers we have working for normal birth in this country. We will have a wonderful line up of speakers including 10 keynote speakers (midwives, obstetricians, lawyers, scientists and consumers), 100 oral presentations, 70 posters and nine workshops.

The conference will be held at Waterview located in Bicentennial Park, Sydney Olympic Park. The conference will address social, cultural, physiological, psychological, emotional and spiritual aspects of labour and birth. It will examine new developments in the current evidence based on the nature of and cultures around birth, and on associated processes and outcomes of labour and birth. Papers will cover primary and secondary research, methodological debates, and new philosophies and constructs in this area. Don’t miss this amazing event. I look forward to seeing you Down Under!

Welcome from the Australian College of Midwives President, Professor Caroline Homer

As President of the Australian College of Midwives, I am delighted to welcome you to the 11th International Normal Labour and Birth Conference.

For the first time this important conference will be held in Australia and hosted by the School of Nursing and Midwifery, University of Western Sydney and the Australian College of Midwives. I was fortunate to attend one of the first Normal Labour and Birth Conference held in the beautiful Grange-over-Sands in Cumbria, England.

It was also like being at the Oscars of the Midwifery World as many of the amazing midwives that I had only ever read were there and sharing their wisdom, research and stories. It was also a lot of fun and I have fond memories of sitting on the lawn at the lovely venue. I have watched this fabulous event mature and develop over time and it is now the premier international conference about labour and birth and a must for all who work alongside women giving birth.

I am therefore, absolutely thrilled that the 11th Conference will be held ‘down under’ in beautiful Sydney at a gorgeous time of the year – our spring and we are really pleased to be in partnership with the team at Western Sydney University. I encourage you to start making plans to head to Sydney! I look forward to seeing you in Sydney in October 2016.
Welcome from conference series founder (NLBC), Professor Soo Downe

When we held the first event in the UK in 2001, we did not dare to dream that we might see the day when over 500 delegates would come from all around the world, to catch up with the latest in the fascinating and rapidly expanding world of normal birth research and practice. The organisers have done an outstanding job in creating a wonderful programme of scientific, practical and social activities. I look forward to spending the next three days together, and to contributing, learning, and enjoying what promises to be a very memorable event.

Since that first event the conference has now become an annual event, held in different locations around the world in even dated years, and in the UK in odd-dated years.

This event in Sydney follows Brazil in 2014; China in 2012; and Canada in 2010. Future events will be held in the USA (2018) and India (2020). More details about the Conference Series, and about members of the Conference Series group and the Conference Scientific Committee will soon be found on the Normal Birth Conference Series website which is under development.

Professor Soo Downe

THANKS TO OUR GOLD SPONSOR

Western Sydney University, ACM and ULAN would like to offer our heartfelt thanks to NSW Health’s Nursing and Midwifery Office for their invaluable support of the Normal Labour and Birth Conference 2016.
Keynote speakers

PROFESSOR EUGENE DECLERCQ

Eugene Declercq is the Professor of Community Health Sciences and Assistant Dean for DrPH Education at the Boston University School of Public Health and professor on the faculty of Obstetrics and Gynecology at the Boston University School of Medicine. He has served as lead author of national reports on women’s experiences in childbirth and in the postpartum period entitled Listening to Mothers I, II & III and New Mothers Speak Out and is the founder of the website birthbythenumbers.org. He is one of the Principal Investigators for the Massachusetts Outcomes Study of Assisted Reproductive Technologies (MOSART), an NIH funded study of infant and maternal outcomes associated with assisted reproductive technologies.

He was awarded the 2013 Martha May Eliot award from the American Public Health Association for service to maternal and child health in the U.S.

KERSTIN UVNÄS MOBERG

Kerstin Uvnäs Moberg is an MD, PhD from the Karolinska Institutet in Stockholm and a full professor of physiology at the University of Agriculture. She has published more than 450 peer reviewed original and review papers and supervised more than 30 PhD students. She spent her first 10 years as a scientist within the field of gastrointestinal physiology with a particular interest in the endocrine system of the gastrointestinal tract and the role of the vagal nerve.

In the beginning of the 1980’s her research focus shifted to the physiology and psychology of oxytocin based on animal experiments and clinical studies. The role of sensory stimulation such as touch, warmth and stroking, for the release of oxytocin was studied in animal experiments. The role of oxytocin during labor, skin-to-skin contact, lactation and other types of relationships was studied in clinical studies.

Recent research topics include the role of oxytocin in human animal interactions and the role of human animal interactions on wellbeing and health and also the beneficial role of oxytocin in menopause.

She has published several books, e.g. the oxytocin factor and the hormone of closeness and oxytocin the biological guide to motherhood.

DR SARAH BUCKLEY

Dr Sarah Buckley is a qualified GP with training in GP obstetrics, and is currently a full-time writer and lecturer on pregnancy, birth and parenting. She is the author of the internationally best-selling book Gentle Birth. Gentle Mothering and is also the mother of four children.

Sarah has a special interest in hormonal physiology and was commissioned by Childbirth Connection (US) to write a scientific report on this topic. Hormonal Physiology of Childbearing was published in January 2015 by Childbirth Connection, now a program of the National Partnership for Women and Families, with support from DONA International and Lamaze International. This report has been described as “...one of the most revolutionary and influential publications on maternity and newborn care ever issued.”

Sarah is committed to the best possible outcomes for mothers, babies, fathers and families in relation to hormonal physiology in childbearing and is currently also pursuing a PhD on this topic.
Keynote speakers (continued)

**PROFESSOR CAROLINE HOMER**

Caroline Homer is the President of the Australian College of Midwives. She was the first President to be publicly elected, has been an active member of Australian College of Midwives for more than 18 years and has served on many national and state-based committees.

In her day job, she is the Director of the Centre for Midwifery, Child and Family Health, Director of Midwifery Studies and the Associate Dean for International and Development in the Faculty of Health at the University of Technology Sydney.

She has led research into the development and implementation of innovative models of midwifery care and the translation of research into clinical practice and holds ARC and NHMRC grants. She has been involved in the development and evaluation of midwifery and maternity services in Australia and in a number of other countries in the Asia Pacific region, including Papua New Guinea, Samoa and Timor Leste.

She was an author in the Lancet Series of Midwifery and the 2014 State of the World’s Midwifery Report.

**PROFESSOR ALEC WELSH**

Professor Welsh is a subspecialist in Maternal-Fetal Medicine (MFM) with Masters and PhD degrees in Digital Imaging and Fetal Imaging.

He is an active clinician in both obstetrics and maternal-fetal medicine, and is a strong believer in collaboration between midwives and obstetricians in maternity care.

He runs a Fetal Imaging Research team of ten at University New South Wales and coordinates the Perinatal Academic Group at Royal Hospital for Women.

He helped to establish the NSW Fetal Therapy Centre at the Royal Hospital for Women and performs laser therapy for twin-twin-transfusion syndrome as well as all other fetal procedures. Within the fetal medicine and fetal imaging research community, Professor Welsh has multiple collaborations including research groups of the Universities of Oxford, Sao Paolo, Michigan & Baylor College of Medicine. He has approximately 75 peer-reviewed publications.

**PROFESSOR MARALYN FOUREUR**

Maralyn Foureur has been a midwife for 40 years and academic for the past 20, and is Professor of Midwifery at the University of Technology Sydney (UTS). She is one of an inspiring team of midwives who prepare graduates to competently and compassionately care for women during pregnancy, childbirth and early parenting. In 1984 Maralyn set up the first independent midwifery practice in Australia with visiting rights to maternity hospitals in Newcastle, NSW.

This was the inspiration for one of the first randomised controlled trials of continuity of midwifery care (under her previous surname Rowley); a study that now forms part of the Cochrane systematic review of this model of care. With a record of 100 publications and more than $5 million in research grants, Maralyn is regarded as a world leader in researching birth unit design and its impact on childbearing women and families and the quality and safety of maternity care provided by midwives. Her research findings have been translated into the design of several new Australian maternity units in Sydney, Canberra and Townsville and she is currently part of a team of researchers in Denmark undertaking a randomised controlled trial in this area.

“My lifetime research has contributed knowledge to understanding how relationship based care and an optimally-designed birth unit provide the best environment for labour and birth to unfold.”
Sheena Byrom OBE

Sheena Byrom is a practising midwife, and worked within the NHS for more than 35 years. Sheena was one of the UK’s first consultant midwives, and as a head of midwifery successfully helped to lead the development of three birth centres in East Lancashire. Sheena is a Board member of the Royal College of Midwives (RCM), a member of the RCM’s Better Births initiative, Patron of StudentMidwife.Net and Chair of the Iolanthe Midwifery Trust. Currently Sheena is working as a midwifery expert at North Cumbria University Hospitals NHS Trust, and is one of the project leads for a new exciting development, the Midwifery Unit Network.

Sheena’s midwifery memoirs, Catching Babies, is a Sunday Times bestseller, and her absolute passion is promoting normal physiological birth, and a positive childbirth experience for all women. Her latest book, The Roar Behind the Silence: why kindness, compassion and respect matter in maternity care is jointly edited with Soo Downe, and together they hope the book will used as a resource to promote positive childbirth throughout the world. Sheena was awarded an OBE in 2011 for services to midwifery, and was made a Fellow of the Royal College of Midwives in 2015. Sheena actively lobbies for maternity service improvements through several social media channels. Sheena is currently a midwife consultant, and lectures nationally and internationally on midwifery and childbirth related topics. Her personal and midwifery related website is sheenabyrom.com

Professor Sally Tracy

Sally Tracy is the Professor of Midwifery at the University of Sydney and conjoint Professor, School of Women’s and Children’s Health, Faculty of Medicine, University of New South Wales.

She leads the Midwifery and Women’s Health Research Unit based at the Royal Hospital for Women.

Her research projects funded by the NHMRC include the randomised controlled trial of caseload midwifery care, the M@NGO trial; the EMU study, evaluating midwifery led units in New Zealand and Australia; and more recently the amniotic fluid lactate study and the Birth on Country partnership grant with the University of Queensland.

Professor Sue Kildea

Sue Kildea holds a clinical chair in midwifery and is a joint appointment between the Mater Health Services Brisbane and the University of Queensland.

She has clinical, management, policy, education and research experience across both acute and primary health care settings.

Sue is a strong collaborative researcher and many of her research projects aim to make a difference to the lives of Aboriginal and Torres Strait Islander families.

Together with a Senior Elder from Maningrida in Arnhem Land she was a joint recipient of the UTS Human Rights Award for contribution to advancing reconciliation between Indigenous and non-Indigenous Australians (2004). Sue is a strong proponent of normal birth and returning birth to the rural, remote and primary care setting.
Andrew Bisits has been in full time obstetrics since 1984. Andrew is currently the medical co director of maternity services at the Royal Hospital for Women in Randwick Sydney a tertiary maternity service where 4100 babies are born each year.

He did his training in Newcastle, NSW, Australia and worked there for 23 years. During that time he developed a strong interest in models of maternity care that supported normal birth, hence the focus on midwifery teams, primary midwifery and midwifery group practices.

He has had a clinical, research and didactic interest in any area of obstetrics which minimises interventions and maximises the possibility of a safe and normal birth.

Since the planning of the term breech trial he has looked at various ways of maintaining the capacity to offer vaginal breech birth where appropriate. A large part of this has involved looking at ways to increase the possibility of physiological breech birth.

Andrew has research interests in statistics particularly the area of formal causal inference using observational data. He is a keen teacher.

Bashi Hazard is an Australian lawyer and the principal of B W Law, a legal practice directed at assisting women and children in Australia, and Board Director of Human Rights in Childbirth (HRiC). Bashi has represented families and individuals in coronial inquests, statutory investigations and in commercial litigation. She has also worked on healthcare policy and human rights based fact-finding reports both in Australia and internationally.

Bashi’s background is in competition and consumer law, developed while working for several years with Allens in Sydney, immediately after graduating with first class honours in Law and Economics from the University of Sydney. Bashi has written and spoken on issues relating to competition and trade practices law, legal professional privilege, the human and constitutional rights of free speech, and women and reproductive rights, particularly in relation the human right to bodily integrity and informed consent.

Bashi is mother to 3 amazing young children, teaches ethics to primary school aged children and grows orchids.

Leona McGrath is a very proud Aboriginal woman from Queensland, a proud descendent of the Woopaburra and Ku Ku Yalanji peoples. Leona is a midwife, artist, mother to three beautiful children and one gorgeous grandson. She is the Senior Advisor for the NSW Aboriginal Nursing & Midwifery Strategy. The Strategy provides financial support to Aboriginal people to undertake nursing & midwifery degrees.

Leona is the Chair of the Australian College of Midwives Aboriginal & Torres Strait Islander Advisory Committee and also the co-Chair of the Rhodanthe Lipsett Indigenous Charitable Midwifery Trust Fund. Leona’s passion lies with increasing the Aboriginal & Torres Strait Islander Midwifery workforce which will contribute to better health outcomes for Aboriginal & Torres Strait Islander women, babies and the overall community.
I’m Jacqui Cross, and I have the great privilege to be the Chief Nursing and Midwifery Officer within NSW Health. We’re delighted to be a gold sponsor of Normal Labour and Birth 2016.

This is in part because one of my ambitions within this role relates to supporting midwives across a range of areas, and in particular how I can support midwives to protect, promote and support normal birth.

One thing that I most admire about midwives is your strong expressive voice and your advocacy for midwifery and the woman-centred care you provide, including your passion in articulating the positive difference you make to women and their families every day.

The NSW Health policy “Towards Normal Birth” has fully embraced the necessary shift towards physiological birth, aiming to increase the vaginal birth rate in NSW and decrease the rate of caesarean sections through reducing intervention and focusing on enabling positive birth experiences. This work also sits within a broader scope that requires us to address the needs of culturally and linguistically diverse communities and the care this group of women and families require.

I am particularly proud to be working with midwives such as Leona McGrath, and others like her, who show exceptional leadership in providing culturally safe midwifery care, and who support both our current and future Aboriginal and Torres Strait Islander midwives and students. One of my priority areas is to focus on ways to support midwives and nurses in their practice, to assist in creating a culture of lifelong learning and to explore opportunities to strengthen their practice and specialisation opportunities. Another equally important priority is to explore how we can nurture and support our midwifery students, as midwives of the future, through strengthening the relationship with experienced midwives so that knowledge and expertise can be shared.

Midwives also need to be supported to practice midwifery to their full potential and scope of practice, in an environment that supports them, whilst supporting a woman’s choice regarding their birth. Ultimately women need to be in the centre of care, with care provided that supports their choice, with birth occurring in a culturally safe and appropriate environment with a known midwife. We are fortunate in NSW to have examples where exceptional care has been provided to women. The stories told by women when nominating midwives for our recent Excellent in Nursing and Midwifery Awards gives me great pride and confidence in the profession of midwifery.

I hope you have a productive and inspiring time at NLBC, and I look forward to both working with and supporting the passionate, driven, midwifery profession within NSW.

Jacqui Cross
CNMO
NSW Government Health
Nursing & Midwifery Office
Thank you to our sponsors
Provider attitudes and birth place: negotiating divergence in philosophy, scope and practice.

Saraswathi Vedam

Background
The US Birth Place Mapping Study examines the effects of place of birth on maternal/newborn outcomes and how experience and access to options for physiologic birth care are affected by integration of midwives into health care systems. A multidisciplinary task force created a 50 state database that tracks regulations, conditions for practice, and availability of licensed providers across birth settings in the United States. We developed and validated state-by-state “report card”, ranking states on the regulatory conditions for midwives who offer care across home, birth centers and hospitals; and linking scores to rates of physiologic birth. Aim 1. To analyze the status of access to midwives across birth settings (e.g. formal licensure, insurance coverage, scope & place of practice) in each state. 2. To analyze integration scores for each state (e.g. ranked by best conditions for practice and interprofessional collaboration across settings). 3. To compare integration scores with CDC and MANAStats data on markers of physiologic birth (e.g. cesarean, induction, vaginal birth, VBAC, etc.) in each state. 4. To compare regulation and integration of midwives with rates of physiologic birth outcomes in different regions Method We populated the database with published regulatory data and developed a scoring system to highlight barriers that affect integration of midwives into local maternity care systems. Higher state scores indicate more favorable practice conditions and increased access to midwives in all settings. However, because of discrepancies between publicly available information about midwifery regulation and licensure, and the realities of how statutes are interpreted or actioned, the team decided to validate the data that informs the scoring system so that it describes the actual context of practice. To do so we verified the ‘on the ground’ relevance, importance, and realities of integration through a 50 state survey of 74 regulatory and practice experts.
This included over 100 questions about midwifery integration. Results We present our results through 4 interactive maps: 1. Each state in the US displayed by access to regulated midwives 2. Actual integration of midwives and impact of local interpretations of regulations according to 4 color-coded categories 3. Illustrated rates of birth place (home, birth center, hospital) for each state 4. Illustrated rates of physiologic birth for each state conclusion. These graphics interact visually with each other; we have linked perinatal outcomes, physiologic birth, and choice of birth place in states where providers and care are well integrated, compared to states where disarticulation exists. The graphics are supplemented with a summary of results (including a description of the scoring system and a summary of the key markers of integration of each type of midwife). In addition, we plan to highlight ‘model states’ (i.e., highest rates of integration of providers across birth settings)

Bio of presenter

Saraswathi Vedam is a midwifery professor in the Faculty of Medicine and Chair of the Birth Place Lab, at University of British Columbia. She has been in active clinical practice for 30 years. She serves as Senior Advisor to the MANA Division of Research, Executive Interim Board Member, Canadian Association of Midwifery Educators, and Founding Chair of the historic Home Birth Consensus Summits. Her scholarly work includes a development of scales to measure attitudes to planned home birth among maternity care providers, and Changing Childbirth in BC, a community-based participatory provincial study on womens preferences for model of care and decision-making during pregnancy. This study resulted in the development of two new scales to measure Mothers Autonomy in Decision Making (MADM) and experience of respectful care, the MOR index (Mothers on Respect). In 2010, she chaired the 5th International Normal Labour and Birth Research conference in Vancouver.

Authors and Affiliations

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Quinn Metcalfe, RM, MS, Birth and Beyond Faculty Practice
Laura Schummers, PhD candidate, Department of Epidemiology, Harvard School of Public Health
Offering 'real' choice of place of birth

Tracey Cooper

Background

This initiative uses the evidence from the Birthplace study and the recommendations from the NICE Intrapartum guideline (2014) to promote birth without intervention in a freestanding birth centre and development of an alongside birth centre in the UK. Chorley Birth Centre (CBC) and Preston Birth Centre (PBC) are example of how this evidence has been used to maximum effect to change the experiences of women, their families and improve the working lives of midwives. Its impact is being used both nationally and internationally as an example of using evidence to provide excellence in midwifery practice.

Chorley Birth Centre (CBC) was under threat of closure and required rejuvenation and there was a need to develop an alongside birth centre, to reduce unnecessary interventions. Through using the evidence to change current thinking about birth settings with key organisational members CBCs future was turned around and there was agreement to develop a new alongside birth centre at the Trust’s main site in Preston. The Consultant Midwife led a bid for improving birth environments funded by the DOH, receiving £754,000 and using a neighbouring successful maternity service as an example of good practice the refurbishment of CBC and development of PBC took place.

Maternity user surveys revealed overwhelming support. The responses showed that there was a strong desire for partners to be more involved.

Women with uncomplicated pregnancies are offered birth at Home, CBC, PBC, OU as a choice. A 24 hour stay is offered, which facilitates partners staying to bond as a family. Nature therapy at both sites is used to promote relaxation.

Development of CBC and PBC increases wellbeing: it promotes normal birth; reduces interventions; includes partners in the birthing process; provides a healthier start for babies; and women are able to resume a normal lifestyle more quickly.

Outcomes:

**HOME:** 2%

**CBC:**

279 births Jan-Dec 2014 (112 prior reopening), therefore a 150% increase in women
using it.

80% of women use water at some point in labour
60% of women give birth in water
75% Breastfeeding initiation rate

**PBC:**

400 births since opening 12th Nov- Dec 2014
80% of women use water at some point in labour
60% of women give birth in water
75% Breastfeeding initiation rate

Births at Home, CBC, PBC represents 25% of the total births at the Trust.

Evidence shows CBC and PBC provides excellent satisfaction for women, their families and greater job satisfaction for midwives. The women and their families who have used it are advocates for both birth centres. CBC has been used by the World Health Organization as only one of 4 case studies in the UK included as an example of good practice in Europe. CBC has been used as an example of good practice by NICE to help implement the new Intrapartum guideline. This will help increase generalisability at national and international level.

**Bio of presenter**

Dr Tracey Cooper PhD, BSc(Hons), Dip(Mid Studies), RM, RGN, EN(G). Tracey has 25 years midwifery experience. She is a Consultant Midwife in Normal Midwifery and a Supervisor of Midwives. She was a member of NICE IPC guideline group and NICE Quality Standards for Intrapartum Care.
Qualitative findings from The Birthplace in Australia study: Midwives’ experiences of providing homebirth.

Rebecca Coddington

Background

International evidence supports planned homebirth as being safe for women with low risk pregnancies when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place. For low risk women, homebirth is recognised as significantly increasing their chance of achieving a normal birth, with lower rates of caesarean section and obstetric intervention when compared with hospital births. Despite this evidence, the issue of homebirth remains contentious.

In Australia, there are significant barriers for women who wish to access homebirth with only 0.4% of women achieving a planned homebirth in 2012. Currently, there are two ways in which women may access homebirth models of care; through a publicly-funded homebirth program attached to a public hospital or through engaging the services of a private practice midwife (PPM).

Aim

To describe the different models of homebirth midwifery care available in Australia and explore the perspectives of both publicly-funded and PPMs regarding the barriers and facilitators to providing homebirth.

Method

The presentation is a collaborative project derived from two PhD studies attached to The Birthplace in Australia project, a national study examining the safety of births planned at home, in birth centres and in hospitals. Both studies employed a qualitative approach using Constructivist Grounded Theory. One study explored the experiences of midwives working in publicly-funded homebirth models and the other examined the interactions and processes involved in the transfer of women to hospital after planning a homebirth.

Findings

Publicly-funded and PPMs face different challenges. For the past 15 years, PPMs providing homebirth care in Australia have been unfunded and uninsured. Many found the experience of transferring women to hospital difficult. Midwives working in publicly-funded homebirth models also report difficulties overcoming negative attitudes towards homebirth from obstetric and other allied health professionals as well
as a general lack of understanding from both the public and other health professionals about how the model works.

An example of a highly successful publicly-funded homebirth program will be given along with instances of PPMs managing successful homebirth transfers.

Conclusion

Homebirth has the potential to be an important strategy in improving rates of normal birth for low risk women. Despite international evidence reporting the safety of homebirth for low risk women, there are still many challenges faced by midwives providing homebirth in Australia.

For the safety and wellbeing of mothers and babies and the satisfaction of midwives, safe, reliable and respectful maternity care needs to be available. In order to increase access to homebirth services for low risk women in Australia who seek it, negative attitudes and a lack of understanding of homebirth models need to be addressed.

Bio of presenter

Rebecca Coddington is an Australian midwife and researcher currently completing her PhD at the University of Technology Sydney. She has worked on a number of qualitative research projects and currently works as a childbirth educator, professional birth support person and tutor for Indigenous midwifery students. She is passionate about improving women’s experience of birth with a particular interest in homebirth and the cultural and political influences on maternity care systems.

Deborah Fox is an Australian midwife, researcher and casual academic, currently completing her PhD at The Centre for Midwifery, Child and Family Health at the University of Technology Sydney (UTS). Her doctoral study has been funded by UTS, the Nurses Memorial Centre and the Australian College of Midwives. In Singapore, she established the country’s first caseload midwifery model in collaboration with obstetric colleagues at The National University Hospital.

Authors and Affiliations

Authors
Rebecca Coddington, Deborah Fox, Caroline Homer, Athena Sheehan and Christine Catling.

Affiliations
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Athena Sheehan
School of Nursing and Midwifery, Western Sydney University
Birthplace in Australia: Qualitative perspectives on intrapartum transfer from planned homebirth to hospital

Deborah Fox

Background
The qualitative PhD study from which this presentation is derived is attached to the Birthplace in Australia project, which is examining the safety of births planned at home, in birth centres and hospitals; providing important evidence on the safety of childbearing in different settings in Australia. Recent evidence supports the safety of planned homebirth for low risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place.

Despite the low rates of homebirth in Australia and many other developed countries, there remains a demand for homebirth services. Smooth processes for transfer to hospital are a crucial element of the provision of safe homebirth services. The majority of transfers are non-urgent, with few emergency transfers of low risk women. A number of studies have demonstrated a trend for larger proportions of primiparous women to be transferred than multiparous women.

Aim
Much is known about rates of transfer internationally, but little is known about the experiences of the women and caregivers involved. The aim of this presentation is to explore the processes and interactions that took place in the birthing rooms of women who had been transferred from a planned homebirth to hospital during the intrapartum period.

Method
Semi structured interviews were conducted with women, midwives and obstetricians, about their experiences of homebirth transfers. The Constructivist Grounded Theory approach enabled the conceptualization of the social interactions and processes that emerged from the data.

Bio of presenter
Deborah Fox is an Australian midwife, researcher and casual academic, currently completing her PhD at The Centre for Midwifery, Child and Family Health at the University of Technology Sydney (UTS). Her doctoral study has been funded by scholarships awarded to her by UTS, the Nurses Memorial Centre and the Australian College of Midwives. Deborah is a passionate advocate for the promotion of normal birth and is focussed upon researching ways in which midwives and obstetricians may collaborate to ensure the health and well-being of women experiencing risk factors or complications. In Singapore, she worked as a midwife and childbirth educator for five years; and established the country’s first caseload midwifery model in collaboration with obstetric colleagues at The National University Hospital. At the Royal Womens Hospital in Melbourne she is currently involved in piloting a continuity of carer model that integrates care, education and peer support for women during pregnancy.

Authors and Affiliations

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Outcomes of planned home births vs hospital births in four Nordic countries 2008-2013

Helena Lindgren

Background

The prevalence of planned homebirths in the Nordic countries vary from 0.6 to 18/1000 births. The Nordic countries are similar with regard to cultural context, public health conditions and overall tax-paid equal access to health care. Two studies have reported safe conditions for the planned homebirths in Sweden and Norway but studies were small. The aim of the present study was to compare outcomes in women who planned, and were selected to, home birth at the onset of labour with low-risk women who gave birth in the hospital in four Nordic countries.

Material and methods

Data from 3068 women who planned, and were selected to, home birth in 2008-2013 were collected prospectively and the outcome was compared with 15000 planned hospital births in Denmark, Iceland, Norway and Sweden. The following variables were analyzed: maternal: age, single parent status, smoking habits, BMI, parity, epidural analgesia, dystocia, mode of delivery, maternal position during delivery, episiotomy, anal sphincter tears and postpartum haemorrhage. Neonatal: weight, apgar scores, transfer to NICU, perinatal death. Transfers from home to hospital during labour or after the birth were also registered and the analysis performed according to intention-to-treat.

Results

The characteristics of the women choosing home birth will be described. The above maternal and neonatal outcomes will be presented and discussed.

Bio of presenter

Helena Lindgren holds a position as senior lecturer and is also an associate professor specializing in reproductive and perinatal health. She has a PhD in medical science. She has extensive experience from teaching at midwifery programs and master program in care sciences.

Her research focus has mainly been on different birth settings. Medical outcome and mothers experiences of home birth have been investigated both in a Swedish context and internationally. The role of the midwife in different settings has been studied with qualitative and quantitative methods. As a principal investigator she runs two different programs: 1) Birth settings for women with an expected normal birth and 2) Prevention of interventions in normal labor and birth. The prevalence and risk factors for perineal
trauma in childbirth is in focus for one research project -MIMA Midwives management in second stage of labor.

Authors and Affiliations

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School of Health Sciences, Department of Midwifery, University of Iceland

Faculty of Health Sciences, Oslo and Akershus University College of Applied Sciences
Are current guidelines for Group B Streptococcus (GBS) prophylaxis causing iatrogenic microbial and epigenetic harm for minimal short-term gain?

Kate Braye

Background: Intrapartum antibiotic prophylaxis (IAP) is given to women to lessen the risk of early onset GBS disease (EOGBSD) but selecting the appropriate candidates for prophylaxis continues to be a contentious issue both in Australia and around the world. GBS infection remains a major cause of neonatal morbidity and mortality however large numbers of well women are being exposed to antibiotics in order to prevent a condition, which although serious, is rare and treatable. During labour, and probably also in utero, the infant will be exposed to a range of organisms, both commensal (known collectively as the microbiome) and occasionally pathogenic. Neonatal GBS colonisation has been perceived as pathogenic and in need of intervention, which leads to medicalisation of labour and birth. Two main strategies have been used to reduce neonatal GBS colonisation and therefore disease; a risk based approach or universal screening (US) of all pregnant women in the third trimester. IAP, or more rarely a chlorhexidine (CHX) vaginal douche is then offered to women deemed to be at risk of passing the GBS bacteria on to their baby. Two recent systematic reviews suggest the evidence for both IAP and CHX is of poor quality. Further, there is emerging evidence that the overuse of antibiotics is having effects on the microbial and epigenomic balance of mother and baby. With this information in mind we undertook three integrative literature reviews, asking the question, are current guidelines for Group B Streptococcus (GBS) prophylaxis causing iatrogenic microbial and epigenetic harm for minimal short-term gain?

Aims:

1. To examine new developments concerning maternal and neonatal GBS colonisation and EOGBSD

2. To explore the impact of intrapartum prophylaxis methods on the maternal and fetal microbiome and epigenome
3. To raise issues for debate to better inform the GBS narrative.

Methods: Three integrative reviews of the literature have been undertaken. A review of the evidence for offering IAP, a review of the evidence for CHX vaginal douche for GBS prophylaxis, and the benefit/risk ratio of these modalities with particular focus on the microbiome.

Results: Our integrative literature reviews show poor evidence for IAP and CHX. Further, evidence of harm on the microbiome after antibiotics are given to mother and/or child is emerging.

Conclusion: In the light of the overuse of antibiotics world wide, the medical prophylaxis of well women and babies to reduce the likelihood of EOGBSD is a topical issue for midwives. The short-term approach of reducing GBS bacterial load and lessening the risk of a serious and rare disease with large doses of antibiotics must be weighed against the emerging evidence of long-term health sequelae. This presentation will increase our understanding of the issues that need to be addressed to change the narrative around GBS prophylaxis and its consequences.

Bio of presenter

Kate has more than 30 years midwifery experience. In the early 2000’s Kate became a Lactation Consultant and gained a Master of Midwifery.

She is a facilitator for ALSO (Advanced Life Saving in Obstetrics), BaBE (Becoming a Breech Expert) and CRANA (Council of Remote Area Nurses Association). Kate has worked for 7 years with BMGP (Belmont Midwifery Group Practice) and is currently spreading the love at the high acuity John Hunter Delivery Suite. She is a PhD candidate at UTS.

Authors and Affiliations

Braye, K. RN,RM PhD candidate
Foureur, M. Professor of Midwifery, UTS
Measuring progress in labour without the use of vaginal examination: Can midwives verbalisation of events in labour reveal tacit cues to reliably indicate progress in order to inform the design of a labour observation tool?

Elizabeth Whitney

Midwives care for women in normal labour. Since the 1950’s there has been an emphasis on measuring progress in labour. Vaginal examination (VE) is the accepted gold standard and is employed to assess cervical dilatation which is then plotted against time on a Partogram (labour chart).

The invasive nature of VE, its potential towards infection and evidence demonstrating its inaccuracy; combined with a global concern regarding the economic sustainability of medical intervention in childbirth, has prompted scrutiny of labour management.

Recent Cochrane Review found insufficient evidence to support the use of both VE and Partogram, resulting in a recommendation for further investigation into observational approaches to measuring progress in labour.

It is recognised that midwives use other observational and tacit cues to assess labour progress. A reliance on the biomedical approach to childbirth has meant that these midwifery skills have been undervalued, are rarely recorded on the partogram and remain at the margins of practice.

This research aims to uncover midwives tacit knowledge, in order to identify cues which can be used to demonstrate labour progress and inform the design of a new labour observation tool. Couched in the Radical Critical Paradigm and taking a Post-Positivist, Feminist stance Critical Action Research will be employed to uncover midwives tacit knowledge about labour progress.

Action Research is participatory and democratic, whilst simultaneously contributing to scientific knowledge and practice development. The approach will use research as a vehicle for critical expression to challenge ingrained ideologies which influence the way that midwives and women perceive labour, whilst employing emancipatory approaches to develop and change practice.

Exploring the direct experience of midwives in practice, care of the woman will continue through the usual process. ‘Thinking aloud’, midwives will tell their experience of events as they unfold in the labour room, which will be audio recorded.

Concurrent audio recordings will be transcribed, analysed and compared against standard Partogram measures, to identify cues which may indicate labour progress. The researcher and midwife will meet to review the audio transcript and Partogram.
This process will be audio recorded and aims to check the authenticity of the transcript whilst providing retrospective data. Women's views about labour progress and the impact of the midwife thinking aloud will also be sought through a postnatal smartphone questionnaire.

The resulting data will be thematically analysed and used to inform the design of a labour observation tool, which can be used as an alternative to vaginal examination and tested across diverse practice settings.

This paper will explore and discuss the research methodology and reveal the initial data emerging from the study.

Bio of presenter

Liz Whitney is an experienced midwife and midwifery lecturer at the University of Bradford. This research is being undertaken as part of doctoral studies.
Evaluation of a retrospective diary for peri-conceptual and mid-pregnancy drinking: Scottish cross-sectional study

Andrew Symon

Background
Increasing alcohol consumption, including hazardous consumption among women, is a social and cultural phenomenon in many societies. Identifying a history of hazardous or irregular drinking patterns is essential: heavy pre-pregnancy drinking is strongly associated with unplanned pregnancies and with continued drinking during pregnancy, even after pregnancy diagnosis. Alcohol can cause teratogenic effects and has a clear association with maternal anxiety and depression. Abstinence in pregnancy is recommended in many countries but alcohol assessments during pregnancy vary widely, reflecting geographical and cultural variations. Some UK midwives lack confidence when using standard tools. Routine practices often focus only on current drinking (if any) and may not capture significant alcohol history.

Aim
To assess peri-conceptual and mid-pregnancy drinking, and evaluate the level of agreement between a week-long retrospective diary (RD) and the current standard alcohol questionnaires used for pregnant women in two Scottish health board areas.

Method
Cross-sectional study (n=510) comparing alcohol consumption in the peri-conceptual and mid-pregnancy periods as assessed by retrospective diary and the Alcohol Use Disorders Identification Test (AUDIT) and its 3-item version AUDIT-C. Women were recruited at three mid-pregnancy ultrasound scan clinics. A sub-sample (n=30) provided hair for alcohol metabolite analysis. The abbreviated Depression-Anxiety-Stress Scale (DASS-21) was used to assess maternal wellbeing.

Results
The response rate was 73.8%. The RD correlated moderately well with the AUDIT and AUDIT-C but identified significantly higher peri-conceptual alcohol consumption levels, particularly regarding heavy episodic drinking (median 6.8 units on drinking days; range 0.4 63.8). Additional peri-conceptual consumption on special occasions and holidays ranged from one to 125 units per week. Reported intake fell sharply following pregnancy diagnosis, but the RD still identified higher levels than the standard tools.

RD correlations with DASS-21 sub-scales were weak. Biomarker analysis identified hazardous peri-conceptual drinking. Modelling of RD and AUDIT / AUDIT-C found significant linear and quadratic components peri-conceptually, but a much weaker relationship during pregnancy.
Conclusions
The retrospective diary identified higher consumption levels compared with standard tools, especially regarding peri-conceptual heavy episodic drinking. Routine clinical practice methods may not capture potentially harmful or irregular drinking patterns. Given the association between pre-pregnancy and antenatal drinking, and alcohol's known teratogenic effects and association with markers of reduced maternal wellbeing, the RD is a useful low-tech tool to gather information on peri-conceptual and mid-pregnancy drinking.

Bio of presenter
Andrew Symon has worked in both Scotland and Kenya as a midwife. A return to clinical midwifery after taking a Social Policy and Law degree (1992) was followed by a PhD in 1997 (both degrees at Edinburgh University). He has published two books based on this research, and edited two more on clinical risk management. He is Senior Lecturer in the School of Nursing & Midwifery, University of Dundee, Scotland, and is programme lead for the MSc Maternal and Infant Health and the MSc Health Studies (Research). He has published widely on his research interests and collaborations which include models of midwifery care, quality of life assessment, and nutrition and alcohol issues during and after pregnancy. He is convenor of the McTempo collaboration (Models of Care: The Effects on Maternal and Perinatal Outcomes). He writes children’s fiction in his spare time.

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Using Foucault’s theory of Heterotopia to explain how change in English labour ward midwives use of birthing pools was achieved

Kim Russell

The aim of this action research study was to increase midwives use of portable birthing pools (in standard labour rooms) to women in normal labour. Over the course of the study the number of waterbirths increased from 25 to 115 and birthing pool use became accepted by midwives as part of normal birth practice. However increased use of birthing pools led to challenges from obstetricians about the safety of pool use.

Foucault’s theory of heterotopia asserts that when subjugated discourses with different values and beliefs become visible to a dominant discourse that this leads to increased policing of spatial divisions. The aim of this presentation is to discuss how the increased use of birthing pools led to change in the organisational midwifery labour ward culture.

Methods
Data from interviews and focus groups with labour ward midwives and managers were analysed using Foucauldian discourse analysis to identify discursive strategies and construct dominant and subjugated labour ward midwifery discourses.

Findings
Four focus groups (n=14) and 17 semi-structured interviews were used to collect data over four research phases. Discourse analysis revealed the presence of a dominant biomedical and subjugated being discourse within womans and midwifery discourses. The dominant biomedical midwifery discourse met the needs of the institution and gave midwives a clear identity and status. The subjugated being within womans discourse was associated with one-to-one care and the delivery of the midwifery model of care and waterbirth practice. The ‘being with woman’ midwifery discourse enabled waterbirth midwives to be physically and emotionally present and provide individualised care. Thus, the being with woman discourse gave midwives the power to act differently to institutional norms of biomedicine and birth.

Conclusion
As the number of waterbirth practitioners increased the subjugated being with womans discourse became more visible by obstetricians. Portable birthing pools situated in surveillance rooms created a space recognisably different from the labour spaces occupied by biomedicine.

Increased use of birthing pools led to heterotopic clashes between the biomedical and midwifery discourses e.g. doctors questioned the safety of waterbirths and believed the practice should be restricted. In order to reduce clashes steps were taken by the
organisation to make birthing pools less visible to dominant labour ward discourse by requiring waterbirth midwives to wear theatre clothing, standardising pool use and purchasing mirrors and stools to monitor labour progress more effectively. Overtime modifying midwives dress and behaviour to fit with the quasi-technical construct of biomedicine led to the normalisation of birthing pool use. The findings of this study suggest that refashioning the being with womans discourse enabled labour ward midwives to promote birthing pools on labour ward.

Bio of presenter

Kim Russell is currently the Head of Midwifery Education at the University of Nottingham. She trained as a midwife at Worcester Royal Infirmary and worked as a clinical midwife for fourteen years before moving into Higher Education to teach on the first Midwifery degree programme at the University of Worcester in 2000. She is a National Teaching Fellow of the Higher Education Academy, a member of the Doctoral Midwife Research Society, National Association of Educators in Practice (NAEP) and past member of the Royal College of Midwives Education and Research Committees. Her PhD research used action research to identify barriers to waterbirth practice and help clinicians develop interventions to improve the low rate on one consultant led unit. Kim’s passion and drive to engage in learning and teaching innovation and research is underpinned by a desire to inspire others to find ways to lead the delivery of high quality midwifery care.

Authors and Affiliations

Nottingham University
The culture of midwifery in Australia

Christine Catling

Background

There are no current accurate data on the state of the future Australian midwifery workforce, although there is a projected shortfall of over 24,000 registered nurses in NSW by 2025. This is likely to include midwives. Given midwives are the largest group of maternity service providers, this workforce shortfall will likely have a negative impact on the care, wellbeing and safety of childbearing women and their families. Because of this, it is vital to examine factors within the maternity workplace that have a bearing on retention and attrition of staff. As well as staffing factors, workplace cultures also have a bearing on birth practices. There is a paucity of literature that examines the embedded social and cultural norms in institutions and how they affect birth. What we do know is that outdated hospital protocols, an insufficient workforce, a lack of continuity of care and a technocratic philosophy towards birth lead to a less satisfied workforce, higher medical intervention rates and a de-humanized approach.

Aim

The outcomes of this study will include new knowledge of the relationship between the workplace and attrition/retention of midwives; and the ability to improve workplace cultures to retain staff. It will illuminate how cultures restrict or support midwifery practice, induce fear or empower midwives to work to their full scope. Further work aims to examine how workplace culture affects birth practices and outcomes.

Method

Three focus groups of midwives will be held (in Sydney, Canberra and Melbourne) with questions based on the SCARF framework (Status, Certainty, Autonomy, Relatedness and Fairness). This aims to determine the main factors apparent within a maternity workplace culture. Following analysis of the focus groups, a national maternity workplace survey (with questions informed by the focus groups) will be sent online to all members of the Australian College of Midwives (approximately 5,500 in 2015). Data will be analysed thematically and quantitatively.

Results

The results of the national survey will be shared at the conference. The results will provide new knowledge of the Australian workplace culture. Maternity managers and organisations will be interested in how the overall culture affects engagement, functionality and productivity at work, and the implications for staff turnover.
Conclusion

The conclusions to this study will be drawn once the results are analysed. These will be presented at the conference.

Bio of presenter

Christine, a midwife for 23 years, is a lecturer in midwifery within the Faculty of Health and in 2015 was the inaugural research fellow with the WHO Collaborating Centre at UTS. Previous roles include those of Research Assistant, Clinical Midwifery Consultant at St George Hospital (where she worked in policy development), clinical midwife and Antenatal Educator. She coordinates the National Publicly-funded Homebirth Consortium and supports Higher Research Degree students within the Centre for Midwifery, Child and Family Health. Her published work comprises papers on normal birth after caesarean section, simulation based learning, and maternal and neonatal outcomes from publicly-funded homebirth models, amongst others. Her PhD explored the influences on women who chose a publicly-funded home birth. Current research projects include those on health system strengthening in Papua New Guinea, vaginal breech birth, and examining the maternity workplace culture in Australia.

Authors and Affiliations

Dr Christine Catling, University of Technology Sydney
Mothers, maternity workers and social media

Sheena Byrom

Social media is here to stay. The use of social media has tripled since 2007, and whilst this surge inevitably includes health professionals, many are fearful and wary to engage.

The continual expansion of social media technology has maximised opportunity for individuals to be visible, accessible, and connected. This includes maternity care workers enabling them to gain and share knowledge, to build supportive networks, and to innovate. By using social media maternity workers can access influential leaders and experts at the touch of a button, as there are no hierarchies in cyberspace. Women using maternity services are also using social media for information and support, and often use technology such as smartphone apps to guide them through their pregnancy, childbirth and parenting. Social media connects mothers and maternity care workers, with an ever-increasing ability to seek and receive feedback about care. Drones are being utilized in developing countries, to enable much needed connectivity and information transfer via the internet Facebook (https://info.internet.org/en/), increasing the global reach. Online blogging and digital sharing is competing with written academic articles for disseminating research and opinion, and making them more accessible. But there needs to be caution, and some health care workers lack insight of the importance of professional integrity.

This workshop will review and explore the opportunities social media presents to maternity care workers and those they serve. An overview of the range of social media platforms available will be explored, in addition to how social media is being used as an important aspect of health promotion and health care.

The session will offer a practical guide on how best to access, utilise and maximise social media avenues for learning from conferences, lobbying for change, professional development and practice, and relationship building. It will include examples of how social media has acted as a change agent in health care arenas, and where the digital space has offered a platform for innovation and engagement. The workshop will also highlight the importance of modelling positive behaviours online, and how to stay safe.
Delegate requirements:

Prior to attending delegates will need to sign up to Twitter https://mobile.twitter.com/home, and if using a mobile device, to download the app.
Management of the third stage of labour: What does this mean to you?

Lesley Dixon and Elaine Gray

Active management of the third stage of labour has been promoted by many clinicians as a prophylaxis against post-partum hemorrhage. Yet there are various definitions and ways of ‘doing’ an active third stage depending on the country, the hospital or clinician. The International Confederation of Midwives (ICM) and the Federation of International Gynecologists and Obstetricians in a joint statement defined an active third stage as having three components which were: the administration of an uterotonic with the anterior shoulder at birth or immediately following the birth of the baby, the immediate clamping and cutting of the cord and the use of controlled cord traction to expel the placenta. This way of managing the third stage has been recommended in practice guidelines and has become a routine practice for many midwives.

The World Health Organization has examined the contribution of each of the components of active management in their recommendations for the prevention and treatment of post-partum hemorrhage. Of the three defined components of active management only the administration of an uterotonic has moderate evidence to support its use. The use of controlled cord traction was examined (through a randomized controlled trial) with results indicating an average reduction in blood loss of 11mls and an average reduction in time to placental birth of 6 minutes. This suggests that controlled cord traction has minimal impact in the reduction of postpartum hemorrhage. The practice of immediately clamping and cutting the cord has been reviewed and there is now sufficient evidence to support a delay in cord clamping following the birth of the baby. Benefits include reduced iron deficiency anaemia for infants at four months of age. The optimal use of an uterotonic as a prophylaxis or treatment has yet to be resolved.

Physiological placental birth (expectant management) is a way of supporting the birth of the placenta by optimizing the woman’s own physiology. In that women are supported to have skin to skin contact with the newborn, a uterotonic is not administered (unless there is heavy blood loss at which time it is administered as a treatment), the cord is not clamped and cut until it has stopped pulsating or after the placenta has been expelled and maternal effort is used to expel the placenta. Data from New Zealand midwives demonstrated that for low risk women supporting a physiological third stage following a physiological labour and birth resulted in lower post-partum hemorrhage rates than actively managed third stage care.
Care during the third stage is at a crucial stage of evolution. Midwives now have evidence to challenge the routine practices that have been recommended for placental birth. With so few components of active management having evidence to support their use midwives need to consider what defines active management in 2016.

Aim of the workshop

An exploration of how midwives support placental birth in a way that is beneficial for both mother and baby.

Workshop objectives

- To explore how midwives can bridge the theory practice gap when supporting women during the third stage of labour.
- To review the latest understanding of the physiology and the evidence for the different components of third stage care.
- To determine what elements of third stage care are considered important for midwives as they seek to reduce the rate of post-partum hemorrhage.
- To identify and explore similarities and consider possible differences between midwives internationally when supporting women during the third stage of labour.

Teaching/learning strategies/audience participation

The workshop has been designed to explore evidence informed midwifery practice and how midwives utilise this evidence to aid their decision-making process and therefore support their practice. Adult learning principles will be incorporated throughout the workshop with the overarching principle of creating an atmosphere where midwives can discuss the topics openly and share their own experiences to enhance self-directed learning. The interactive workshop is cognitive of the different context of practice and place of practice of participants therefore acknowledging the individual midwife's place of practice. A variety of teaching and learning strategies will include experiential methods, formal presentations and group work (dependent on the size of the audience). There will be a strong emphasis on self-directed learning and reflective approaches to the topic. Narratives will be utilised as teaching tools to enhance learning through story telling. Application of theory to practice will be achieved by utilising problem-based learning through the use of scenario based activities.

Resources/ room layout/numbers of participants

Teaching tools have been designed to incorporate the group within activities and interactive teaching and learning methods will be used. These will include a variety of visual aids and Power Point presentations as well as discussion and storytelling to enhance learning opportunities. Midwives build expertise and knowledge through working with women, this workshop will provide an opportunity for us to learn from each other as we define the important elements which ensure safe care during the third stage of labour.
LESLEY DIXON; PhD, M.Mid. BA (Hons) RM

Lesley is a practicing midwife and the Principle Midwifery Advisor for Research and Publications at the New Zealand College of Midwives. In this role she provides advice to midwives, reviews research and its impact on practice, and also leads, co-ordinates and supports midwifery research projects. Lesley has over 30 years’ experience as a registered midwife and has worked in a range of clinical settings.

ELAINE GRAY: M.Mid ,Diploma in Adult Teaching and Learning, RM, RN,

Elaine is a practising midwife and Principle Midwifery Advisor for Continuing Education at the College of Midwives. She has a wealth of experience as an educator within the maternity services. From her extensive clinical experience she has been able to develop post registration midwifery education in a range of settings and currently delivers education programmes nationally. Elaine has been instrumental in developing many of the workshops provided by the College
What matters to women who have given birth in Norway: Findings from the Babies Born Better Survey (B3 – Survey)

Tine Schauer Eri

Background

The health and wellbeing of women and families worldwide are threatened by rising rates of clinical interventions in childbirth and focus on pathology. There are both maternal and professional concerns about the increasing use of interventions during labour, and thus a need for adjustments to promote optimal care. A shift in perspective in maternity care planning, evaluation and research towards salutogenesis is suggested as a way to meet the challenges of increasing clinical intervention and thus rising healthcare costs in Europe. Cost Action IS1405, addresses these issues and the main objective is to improve maternal and infant wellbeing and the economic sustainability of European maternity services. The B3-survey is a part of COST Action IS1405; developed to explore womens experiences and views concerning care during labour and birth in Europe and worldwide. User involvement is an important challenge in childbirth care systems. Modern clinical practice recognises that people are not merely passive recipients of advice and procedures from health professionals, but active, informed participants in effective care, who choose for themselves how healthcare is implemented and provided. The survey is translated into 22 languages. 37608 women from 30 countries have responded so far, more than 8000 of them in Norway.

Aim

The aim of the B3-survey is to explore womens experiences with maternity care in Europe. The aim of our study is to give an account of Norwegian womens description of the care they received in the place they gave birth.

Method

The study is based on data from more than 8000 self-recruited women, who gave birth in Norway during 2010-2015. They responded to a web based survey about experiences with maternity care in their most recent birth. The survey was promoted via Facebook, Twitter and through editorial articles on the survey, with a link to the survey in relevant online newspapers and maternity-related websites in Norway. The survey has both open-ended and fixed questions.
Data from two open-ended questions were coded with a framework designed for the B3-study, and were subsequently subjected to descriptive analysis. The two questions were: What were the three best things about the care you received? If you had the power to make three changes in the care you had, what would those be? The framework was previously tested on the data from the first 343 respondents in Norway.

Results

The framework was used to code the expressions into themes and sub-themes. The main themes were: Atmosphere, attitudes, relations and feelings / Specific interventions and scenarios / Involved actors / Setting, organisation, premises and catering / General comments. The results are to be announced at the conference.

Conclusion

To be announced at the conference.

Bio of presenter

The Authors represent the Norwegian team in the B3-study, and are members of COST Action IS-1405. They are all midwives, Three of them are working in education and research, and one is working as a clinical midwife.

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Women’s perception of safety during labour and birth: An integrative review

Margaret McCormick

Background

Safety during childbirth is a complex, multidimensional, yet ill-defined concept. Research suggests ‘not feeling safe’ can contribute to the development of a range of poor outcomes for women and their babies, and increasingly for health care providers to complaints and litigation. For this reason, providing a contemporary understanding of what ‘feeling safe’ actually means for women, during labour and birth, is fundamental to improving organisational strategies aimed to achieving positive health outcomes for women and their babies.

Aim

To explore how safety is understood and experienced by women during labour and birth and to consider how women’s perceptions of the concept, match or diverge with those of organisations providing their care. The review will aim to answer three core questions:

- How is safety defined by women and what influences their perception of safety?
- How is safety defined for organisations and how is it operationalised?
- Does women’s understanding and experience of safety match or diverge to that of organisations?

Method

Cooper’s integrative literature review methodology was utilised. Four data bases were searched: MEDLINE, PsycINFO, CINAHL and Embase from 2005 to 2015. Inclusion criteria were: (1) qualitative and quantitative studies from peer reviewed journals, (2) systematic and integrative reviews which included a critical appraisal (3) publication in English, (4) a focus on women’s perception of their safety, during labour and birth.

Results

Forty nine papers, from 17 different countries met the inclusion criteria. The authors used a range of approaches and methods. The majority of articles came from the United States (25%), followed by the United Kingdom (19%). Eleven articles (22%) defined safety, with seven (64%) defining safety from an organisational view and four (36%) from the women’s perspective.

The analysis highlights women define safety during childbirth, as a holistic and multidimensional concept. Safety for women means their physiological, psychological,
social, cultural and spiritual needs are actively considered by health care providers. Key factors influencing women’s perception of safety are: the professionalism of the individuals caring for them, availability of hospital resources if complications occur, clear communication with health professionals, and having a sense of control and autonomy.

In comparison, the organisation’s definition of safety has a strong focus on the prevention of injury to patients, from the care which is intended to help them. It is operationalised in hospitals by clinical governance, policy and educational strategies. However, the gap in the organisational view reveals the lack of collaboration with women when defining and implementing safety initiatives.

Conclusion

This integrative review highlights a lack of shared understanding when defining safety, during labour and birth. This has significant implications for both women and organisations. Broadening the organisation perspective of safety, to include the women’s view is essential. It will provide not only valuable insights, but possible solutions, to understanding and improving the safety of women during childbirth.

Bio of presenter

I am an experienced midwife with an extensive knowledge in midwifery education and midwifery leadership. In my current role as a midwifery educator at a large metropolitan hospital in Melbourne, Australia, I develop and facilitate professional education to the multi-professional team, with a strong interest in improving women’s safety during childbirth. Currently, I am undertaking my PhD at the University of Melbourne. The title of my thesis is An evaluation of the influences on women’s perception of safety during labour and birth. In Australia, the women’s voice - in the safety domain - has been overshadowed, by maternity care providers focusing on implementing risk management strategies to minimize litigation. It is aimed this thesis will provide a contemporary understanding of what safe means for women during labour and birth, and in partnership with women, develop and evaluate an intervention to inform pregnant women of an organisation strategy, aimed to improve their safety.

Authors and Affiliations

Margaret McCormick: The University of Melbourne & Western Health.
Associate Professor Marie Gerdtz: The University of Melbourne.
Dr Wendy Pollock: The University of Melbourne.
Are Women interested in Acupressure to increase spontaneous onset of labour?

Lyndall Mollart

Background
Many women would like to avoid medical or surgical interventions in childbirth; a desire that may contribute towards the popularity of complementary and alternative medicine/therapies (CAM). Women who are post-dates may benefit from acupressure techniques that influence uterine activity and may potentially reduce medical intervention.

Aim
This Australian feasibility study aimed to determine; the willingness of women experiencing a post-date pregnancy to participate in a randomised controlled trial (RCT) of acupressure and compliance with the study protocol.

Method
Following ethical approval, a two-armed feasibility randomised controlled trial (RCT) was conducted in two outer metropolitan public hospitals in New South Wales, Australia (Australia and New Zealand Clinical Trials Register (ANZCTR): 12613000145707). Eligible healthy primigravid women experiencing a singleton cephalic pregnancy at 40 weeks +/- 2 days gestation were assessed as eligible to participate and were provided with study information. After providing written consent, women were randomised into standard care or standard care and acupressure intervention. The intervention group received verbal and written instructions on the self-administration of three acupoints (Spleen 6, Large Intestine 4, and Gall Bladder 21) to be used second hourly each day until spontaneous or induced labour began. Staff providing clinical care were blinded to group allocation unless the participant disclosed study participation.

Assessment of feasibility included determining recruitment rate, acceptability of CAM, and acupressure protocol compliance via participant surveys. The primary clinical outcome was spontaneous onset of labour.

Results
From the 67 women eligible, 11 women (16.4%) declined as they were already using or
wanted to use acupressure and 12 were uninterested or gave no reason, thus 44 women (65.6%) agreed to participate and were randomised.

In the intervention group there was a high compliance with the acupressure protocol (83%) and the use of the three acupoints (94%). Most women (79.3%) used self-help and CAM strategies including nipple stimulation (38%), reflexology (24%), acupuncture (14%), evening primrose oil (17%), raspberry leaf tea (14%), sexual intercourse (14%) and one woman used fruit dates. There was a clinical but not a statistically significant difference in rate of spontaneous onset of labour (50% acupressure vs 41% control).

Conclusion
This feasibility study revealed that most women found it acceptable to be randomised to receive the intervention. Many pregnant women are interested in the use of CAM, and acupressure in particular, for the initiation of labour. Further study is warranted on midwives knowledge and recommendations on self-help and CAM strategies for women experiencing a post-date pregnancy.

Bio of presenter
Lyndall Mollart is currently completing her PhD in the use of complementary therapies, specifically Acupressure for women experiencing a post-date pregnancy with a feasibility RCT and a Australian National survey of midwives. Lyndall is a Clinical Midwifery Consultant with a diverse portfolio including policy development, research, education, and implementing evidence based change to clinical practice. Professor Maralyn Foureur is a leading Australian midwifery researcher with an international reputation for pioneering research into innovative models of maternity care. Her initial research studying outcomes for midwifery continuity of care was the first randomised controlled trial in this area and is included in World Health Organisation documents and the Cochrane Database of Systematic Reviews.

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Hearing stories of birth in pregnancy: a hermeneutic phenomenological study of women's experiences across two generations

Lesley Kay

Background and study aim
This qualitative study considered how women from two different generations came to understand birth in the context of their own experience but also in the milieu of other women's stories. The aim was to determine how pregnant women hear and understand stories and portrayals of birth and in so doing reveal how the telling of such stories shapes and constructs the meaning of birth for the pregnant woman.

Methodology and method
The research utilised a hermeneutic phenomenological approach underpinned by the philosophies of Heidegger and Gadamer. Twenty participants were purposively selected, recruited and interviewed. In phase one ten women who were expecting their first baby in 2013 were recruited in order to explore how they understood birth prior to the event and in the light of other women's stories.

The second phase of the study evolved from the first. In phase two interviews with an older cohort of women were undertaken to determine whether women from a different era were more able to translate knowledge into meaning. This was based on the belief that information and therefore knowledge was mediated by personal contact and not through virtual technologies as described by the previous generation of women.

Findings
Five central and interrelated interpretive findings emerged: for the women birthing in 2013 the birth stories heard had a significant role to play in the women's understanding and expectations of birth. The norm as portrayed in the circulated stories was one which perpetuated what one participant described as the drama of birth; the modern landscape of birth created and perpetuated fear of childbirth for many. The stories the women heard did not necessarily help them to become knowers and gain wisdom about birthing; the women birthing in the present day were overloaded with information amassed in an attempt to manage their anxieties about birth as well as to fit the role of the informed patient and demonstrate their competency as mothers; the cultural and spiritual significance of birth was not communicated in the stories shared; many of the women felt secure in the system of birth as constructed, portrayed and...
sustained in the stories widely circulated.

Conclusions
The data revealed that the lifeworld of birth being sustained in stories was one of product and process, concentrating on the stages and progression of labour and the birth of a healthy baby. The thesis revealed that the information gleaned from birth stories did not in fact create meaningful knowledge and understanding about birth for these pregnant women.

The work highlights a need for further research to qualify the relationship between what women see and hear about birth and their expectation and consequent experience of birth. Further it demonstrates that women should be given help and guidance to unpack and understand negative stories and portrayals of birth to mitigate the damaging effects of expectant fear.

Bio of presenter
Lesley Kay is a Senior Lecturer of Midwifery at Kingston University and St. Georges University of London. Lesley spends half her time facilitating student education and half her time facilitating research. For most of her clinical career Lesley worked as a team leader in a Community setting (latterly working out of Cambridge University Hospitals NHS Foundation Trust) moving to work in education at Anglia Ruskin University in 2009. Lesley’s PhD study (which is the basis of her presentation) was undertaken at the University of Central Lancashire under the supervision of Professor Soo Downe. Lesley’s previous research looked at Midwifery leadership in a Community setting and utilised an ethnographic methodology. Alongside her role at the University Lesley works as a Panellist on the Fitness to Practice Panels of the Conduct and Competence Committee at the Nursing and Midwifery Council.

Authors and Affiliations
Lesley Kay Senior Lecturer in Midwifery at Kingston University and St. George’s University of London
The longitudinal analysis of care during labour: The midwifery perspective

Methychild Gross

Background

Since the end of the 90’s there has been an increase in studies on labour progression. Leah Albers and colleagues were pioneering in this field which had been previously investigated by Emanuel Friedman. More recently, a couple of studies reevaluated the labour curve and its modeling. Interest in labour duration is evident, however knowledge about process-oriented care in labour including the onset of labour and the cascade and timing of interventions is often lacking.

Aim

The aim of this paper is to describe core issues of the longitudinal analysis of interventions during labour.

Methods

Most of the results are from the database of the ProGeb-Study (n=3963), which investigated process-oriented care in 47 units in Lower Saxony. We applied descriptive and multivariable time-to-event analyses.

Results

Onset of labour was self-diagnosed by regular (64.3%) or irregular (22.8%) contractions, watery fluid loss (26%), and/or a bloody show (11%). Both nulli- and multiparae self-diagnosed the onset of labour with median 4 and 2.5 hours before the midwives. Multiparae had slightly longer median time intervals between the onset of labour and the beginning of care by the midwife than nulliparae.

The median time interval between labour onset and the initiation of water immersion and massage was between three and four hours; that before the initiation of vertical positioning was 1.8 hours. The intervention cascade in nulliparae most often started with epidural analgesia (27.8%). In multiparae, amniotomy was most often the first intervention (33.6 %), and spontaneous birth most often followed (80.0%).
hours after onset of labour, 20.0% of multiparae had an amniotomy. In multiparae, amniotomy was associated with an initial 6.6-fold acceleration. In nulliparae, epidural analgesia was associated with a shorter first stage when administered between 7 and 11 hours after labour onset. The later it was performed, the less likely was spontaneous birth and the more likely an operative vaginal birth in nulliparae or a caesarean section in multiparae. The start of oxytocin augmentation was associated with acceleration towards both full dilatation and caesarean section during first stage. During second stage oxytocin was associated with an increased risk of operative vaginal birth. The later oxytocin augmentation started, the more likely it was that spontaneous birth would be delayed in multiparous women.

Conclusion

The longitudinal analysis of patterns of care helps to understand the association between the timing of interventions and outcomes in first and subsequent labours. This has the potential to inform evidence based care during labour.

Bio of presenter

Mechthild M. Gross holds a degree in nursing and midwifery, a Masters degree in psychology, a PhD, and a postdoctoral thesis (Habilitation). Since 2015 she has been professor of midwifery at Hannover Medical School. Since 2009, she has been the head of the European Master of Science in Midwifery at Hannover Medical School. At present she is the principal investigator for the German part of the OptiBIRTH-study: Improving the organisation of maternal health service delivery, and optimising childbirth, by increasing vaginal birth after caesarean section through enhanced women-centred care in Germany. Prof Gross was the vice chair and German representative on the Management Committee of the COST Action IS0907 Childbirth cultures, concerns and consequences. She is the German representative on the Management Committee of the current COST Action IS1405 (2014-18) [http://www.cost.eu/COST_Actions/isch/Actions/IS1405?management].

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Interventions in labour: The established ‘normal’ in spontaneous vaginal birth?

Mervi Jokinen

Background

Maternity policies in England have supported women’s choice of birth settings with most recent national guidelines recommending that low risk women should consider giving birth outside acute hospital setting. One consequence of this policy direction is that hospital labour and birth may become synonymous with the need for more intensive surveillance and treatment resulting in over-use of intervention. Regular scrutiny of births recorded as normal is one way of tracking trends in this area and the Trent study collected data of interventions in normal births in England (Downe et al 2001). Fourteen years later, the Royal College of Midwives (RCM) commissioned a repeat of this survey to identify current trends.

Aim

To describe the nature and prevalence of interventions in labour and birth for all births recorded as normal, spontaneous or physiological, for women and babies defined as both high and low risk at labour onset.

Method

A cross-sectional prevalence survey of hospital births over 5 continuous weeks spanning six months was carried out in 2014. A representative sample of 52 units in England was selected and data collection was undertaken prospectively or retrospectively, depending on Trust choice. The survey was adapted from the questionnaire used for the Trent study and outcomes of the pilot carried out in 5 Trusts in the North West of England. All completed surveys were scanned directly using SNAP software and 10% were checked for accuracy by hand. Simple descriptive statistics (using SPSS v.20) were used to explore the data.

Results

Seven Trusts of varying size and configuration with good geographical distribution participated in England. Out of reported 3063 births, 2385 (78%) women experienced at least one of the nine interventions highlighted in the survey. Overall, 2009 (65.5%) births were recorded as being normal and just over two thirds of these were associated with intervention (66.2%). The most frequently used was cardiotocography (CTG) (38%) and the least frequent were fetal blood sampling and antibiotics during labour (both 3%). At labour onset the health status of the woman was recorded as high risk (with complications) in 642 instances, 39% of these women gave birth normally without the interventions of interest.
Conclusion

This study indicates that, despite government policies supporting normal labour and birth, rates of physiological labour and birth in English hospital settings continue to be very low, and that they may even be falling, especially among healthy women and babies. However, it also demonstrates that women and babies with complications at the onset of labour can be supported to experience a labour and birth with minimal interventions, which supports the objectives of RCM Better Births.

Bio of presenter

Mervi Jokinen MSc (Dist), PG Cert, BSc (Hons), RM, SRN

Practice and Standards Professional Adviser; Royal College of Midwives UK

President European Midwives Association (EMA)

Mervi is a professional adviser in the Royal College of Midwives (RCM). One of the many aspects of this role is the development of national midwifery/maternity guidelines and standards, internal within the RCM and external in collaboration with other stakeholders. Mervi is committed to normality in childbirth and believes that midwifery practice issues should be at the centre of all initiatives to improve maternity services. Aiming to support midwives in offering women more choice in birth options, she has developed a portfolio of publications, including a book on home birth practice, RCM Birth Centre Standards and Birth Centre Resource: a practical guide. As EMA President, she has a strategic lead in maximising the representation and influence of EMA in the EU, promoting women’s general and reproductive health.

Authors and Affiliations

Mervi Jokinen Royal College of Midwives UK
Birth preferences and attitudes of the next generation of Western Australian maternity care consumers

Kathrin Stoll

Background

Australian caesarean birth rates have exceeded 30% in most states and are approaching 45%, on average, in private hospitals. Australian midwifery practice occurs almost exclusively in hospitals; less than 3% of women deliver at home or in birthing centres. It is unclear whether current practices, i.e., hospital-based, high intervention birth reflect preferences of the next generation of maternity care consumers.

Aim

Examination of young adults’ attitudes toward childbirth including preferences for type of maternity care provider and place of birth, fear of childbirth scores, birth preferences and reasons for preferences.

Methods

A cross-sectional online study was conducted with 760 Western Australian students attending one tertiary institution. Students were eligible to participate if they were less than 40 years of age and did not currently have children but confirmed their intention to become parents. To assess associations or comparison of means, bivariable analyses were used. Factors associated with birth preferences were assessed with binary logistic regression analysis.

Results

More students who preferred midwives (35.8%) had vaginal birth intentions, contested statements that birth is unpredictable and risky, and valued patient-provider relationships. More students who preferred obstetricians (21.8%) expressed concerns about childbirth safety, feared birth, held favourable views towards obstetric technology, and expressed concerns about the impact of pregnancy and birth on the female body. One in 8 students preferred out-of-hospital birth settings. Furthermore, 15.6% of young adults indicated a preference for a caesarean birth (CB), even without obstetric indications; on the other hand 14.8% would prefer a vaginal birth without epidural anesthesia. The most common reasons why young adults would choose a CB
were fear of labour pain, to avoid damage to my (my partners) body, and to maintain vaginal integrity.

Students who had ever witnessed a human birth and students who felt confident in their knowledge about birth were twice as likely to have normal birth intentions. Elevated childbirth fear, but not elevated stress, anxiety or depression, significantly reduced the odds of reporting normal birth intentions among Australian students.

Conclusion

Findings revealed consumer demand for midwife-attended births at home and in birthing centers. Increasing access to midwifery care in all settings is a cost effective strategy to decrease obstetric interventions for low risk women and a desirable option for the next generation. Young adults reported fear levels that warrant attention prior to a future pregnancy. Although the majority would choose a vaginal birth, knowledge about benefits and risks for vaginal and caesarean births will facilitate decisions based on informed choice rather than inadequate knowledge or fear.

Bio of presenter

Kathrin Stoll is a PhD level researcher, with 15 years of experience. Kathrin holds federal and provincial postdoctoral salary awards. Her program of research focuses on clinical, psycho-social, and health systems factors that are associated with optimal maternal and newborn outcomes. Because of her interdisciplinary education and work experience (spanning the disciplines of psychology, sociology, epidemiology, nursing, family practice and midwifery) she has had the pleasure of working with clinicians, graduate students and fellow researchers from different disciplines. Kathrin has published over 30 papers and spent 5 years volunteering as co-editor of the Canadian Journal of Midwifery Research & Practice. She works closely with 2-4 midwifery undergraduate and graduate students every year, and enjoys mentoring them through the process of developing the research skills necessary to complete their capstone/thesis projects.

Authors and Affiliations

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The Complementary Therapies for Labour and Birth study: A randomised controlled trial of antenatal integrative medicine for pain management in labour

Kate Levett

Objective

To evaluate the effect of an antenatal integrative medicine education program, in addition to usual care, for nulliparous women on intrapartum epidural use.

Design

Open label, assessor blind, randomised controlled trial (RCT).

Setting

Two public hospitals in Sydney, Australia.

Population

176 nulliparous women with low-risk pregnancies, attending hospital-based antenatal clinics.

Methods and Intervention

Randomisation at 24-36 week gestation to the Complete Birth Study, a two-day integrative medicine antenatal education program, plus standard care, compared with standard care alone.

Main outcome measures

Rate of epidural use.

Secondary: onset of labour, augmentation, mode of birth, newborn outcomes.

Results

There was a significant difference in epidural use between the two groups: study group (23.9%) standard care (68.7%) (risk ratio (RR): 0.37 [95% C.I.: 0.25, 0.55], p=<0.001).
The study group participants reported a reduced rate of augmentation (RR=0.54 [95% C.I.: 0.38-0.77], p<0.0001); caesarean section (RR=0.52, [95% C.I.:0.31-0.87], p=0.017); length of second stage (MD= -0.32, [95% C.I.: -0.64, 0.002] p=0.05); any perineal trauma (0.88 [0.78-0.98] P=0.02); and resuscitation of the newborn (RR=0.47 [95% C.I.:0.25-0.87] p=<0.015).

There were no statistically significant differences found in spontaneous onset of labour, pethidine use, rate of post-partum haemorrhage (PPH), major perineal trauma (3rd and 4th degree tears), or admission to special care nursery/neonatal intensive care unit (SCN/NICU) (p=0.25).

Conclusion

The Complete Birth antenatal education program, which incorporates evidence-based complementary medicine (CM) techniques, acupressure, relaxation, massage and yoga techniques, significantly reduced epidural use and caesarean section. This study provides evidence for integrative medicine as an effective adjunct to antenatal education and contributes to the body of best practice evidence.

Bio of presenter

Kate Levett is a researcher, epidemiologist, educator and acupuncturist. She has recently completed her PhD at the National Institute for Complementary Medicine (NICM) at the Western Sydney University. Her thesis examined the use of complementary therapies for pain management in labour and birth. She is currently a Research Fellow and epidemiologist at the Sydney School of Medicine at the University of Notre Dame, where she collaborates with Auburn Hospital in the Department of Obstetrics investigating population health issues.

She is a qualified acupuncturist, and works mainly in the area of pregnancy and fertility, and womens health. As a qualified acupuncturist, epidemiologist, teacher, and birth educator she brings together skills and expertise across these fields. She will be discussing using Complementary therapies for labour and birth, and the application of these results in the clinical setting.

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Womens’ and prenatal care providers’ perceptions of prenatal influences on maternal confidence for physiologic labor and birth

Melissa Avery

Background

Little research shows care providers how to help women develop confidence for physiologic labor and birth during pregnancy. In the U.S., nearly 1 in 3 women experience cesarean; a quarter have induced labor, too many for a physiologic process. Our research is focused on understanding more about women’s prenatal confidence from the perspectives of women and prenatal care providers.

Methods

The aims of this study were to understand 1) women’s perceptions of care processes, support and information they receive during pregnancy that help them feel confident for labor and birth, and 2) prenatal providers’ beliefs about physiologic birth, and care components they believe enhance women’s confidence for labor and birth.

The research included two phases, Phase 1: focus groups and interviews with women who had given birth within six months; Phase 2: interviews with prenatal providers including midwives, family physicians and obstetricians. IRB approval was received from the University of Minnesota.

Phase 1
A culturally diverse sample postpartum women up to 6 months recruited from multiple sites in Minnesota, USA, participated in focus groups, reflecting on information during pregnancy that helped them feel confident for labor and birth, including their prenatal care. Women completed a survey with demographic questions and a place to record individual comments about prenatal care. Those who had a physiologic birth (term pregnancy, spontaneous labor, no epidural, vaginal birth) were invited to an individual interview. Nine focus groups and 16 interviews were conducted. Interviews focused on the woman’s beliefs and goals for labor and birth, care processes experienced during pregnancy that enhanced her confidence.

Phase 2
We are interviewing midwives, family physicians and obstetricians, asking about their beliefs regarding physiologic birth. They will complete an individual survey with demographics, provider type, and likelihood of recommending physiologic birth. Providers known to the research team will be contacted, others will be located by referral.
Results

Glaser’s (1978) constant comparative method is used to guide analysis of all data. Three levels of coding will identify themes. (Open Coding; Substantive Codes; Mutually Exclusive Categories).

Phase 1

Preliminary analysis of women’s focus groups and interviews supports emerging themes: Support from experiences of friends and family, Support from prenatal providers, Value of stories of other women, External helpful resources, Continuity of Carer, and Trust in the process of the body.

Phase 2

Interviews with midwives and physicians will be conducted through April; analysis will be complete by July, 2016.

Preliminary conclusions

Women desire information during pregnancy and a partnership with their care providers. Our goal is development and testing of an intervention to guide clinicians in prenatal care that is woman-centered, includes shared decision making and is evidence-based.

Bio of presenter

Melissa D. Avery, PhD, CNM, FACNM, FAAN is a Professor in the School of Nursing at the University of Minnesota, USA. She directs the University of Minnesota nurse-midwifery program and has 25 years full-scope clinical midwifery experience. Her current research is examining care practices during pregnancy to enhance maternal confidence for physiologic labor and birth, and examining the efficacy of exercise for preventing postpartum depression. Her past research has included exercise and gestational diabetes and vaginal birth after cesarean.

Dr. Avery has been a pioneer in distance education technologies, and is currently partnering with faculty colleagues to develop simulations for midwifery education including interprofessional opportunities. She was inducted into the University of Minnesota, Academic Health Center, Academy for the Scholarship of Teaching and Learning in 2009 and is a past President of the American College of Nurse-Midwives.

Authors and Affiliations

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Melissa A. Saftner, PhD, CNM, Clinical Associate Professor, University of Minnesota, USA
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Hurry up and wait: A pilot randomised controlled trial of two types of partograms for normal first stage labour management

Nigel Lee

Background

Principles of first stage labour progress, documentation and management, such as the use of alert and action lines, were established in the 1970s, based on research from the 1950s and continue to influence clinicians expectations of normal rates of cervical dilatation. Up to 45% of nulliparous women in spontaneous labour will receive oxytocic augmentation for labour dystocia, which remains the most common reason for a caesarean section. Recent research has proposed more contemporary criteria for diagnosing the active phase and measuring progress accounting for a slower, incremental rate of dilatation using a partograph with a stepped line as a visual prompt to indicate labour dystocia. However this new approach has not been tested in clinical practice. Furthermore previous trials have reported that women may be reluctant to participate in studies where there is a prospect of a longer labour, despite less intervention.

Aim

To compare a standard partogram with an Action line to a new design including a stepped Dystocia line.

Method

A pilot single blind randomised controlled trial (RCT) Primary outcomes included proportion of eligible women recruited and reasons for non-recruitment. Secondary outcomes included rates of intervention, mode of birth, maternal and neonatal outcomes.
Results

One hundred and forty nine women were assessed for eligibility, of which 99 (66%) were randomised, only nine (6%) declined to participate. The rates of augmentation (artificial rupture of membranes and/or oxytocic infusion) were significantly lower in the Dystocia line group compared to the Action line with a non-significant increase in spontaneous vaginal births. There was no difference in rates of other maternal and neonatal outcomes.

Conclusion

The findings suggest that recruitment to a larger RCT comparing new labour management guidelines to standard care would be achievable. The use of a dystocia line partograph, compared a partograph contacting an action line, may result in a fewer women being diagnosed with labour dystocia and a reduction in associated interventions.

Bio of presenter
Nigel is a midwifery lecturer and researcher with the School of Nursing Midwifery and Social Work at the University of Queensland. Nigel has been a part time clinical midwife on the Birth Suites of the Mater Mothers™ Hospital for about 12 years, whilst undertaking other roles in clinical education and research. He has worked in metropolitan and regional hospitals around Australia and the United Kingdom. He completed his PhD in 2013, researching sterile water injection techniques for the management of back pain in labour. His research in this field is ongoing with two multicentre trials underway.

Authors and Affiliations

Presenter: Nigel Lee  RM MMid PhD Lecturer/Researcher
School of Nursing, Midwifery and Social Work
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Nomenclature and a proposed approach for the diagnosis of labor dystocia

Nancy Lowe

Background

Slow or difficult labor (dystocia) is the most commonly diagnosed problem during childbirth and is the recorded reason for approximately half of all primary cesarean deliveries in the United States. The diagnosis of dystocia depends on the appropriate diagnosis of active labor. The term dystocia and the related multiple terms clinicians use to describe dystocia point to the lack of diagnostic precision from inadequately defined diagnostic criteria.

Aim

The purposes of this review were to 1) summarize definitions of dystocia specified by leading professional obstetric and midwifery organizations in English-speaking countries, 2) describe the use of the term dystocia in research, and 3) present guidelines for an evidence-based approach for the diagnosis of labor dystocia.

Methods

A search was conducted to identify definitions of dystocia or related terms of: 1) major midwifery and obstetric organizations from United Nations-member sovereign nations and international organizations and 2) published research from 2000 – 2013.

Results

From 46 midwifery and obstetric organizations, only 6 guidelines were identified with identifiable dystocia definitions and recommendations. In only 25 publications did researchers define dystocia-related terms with prospectively applicable non-ambiguous clinical parameters. Based on our review, we propose a 3-point approach to diagnose active labor onset and classify labor dystocia-related labor problems into well-defined, mutually exclusive categories. This approach can be used clinically and validated by researchers.

Conclusions

Our “Common Approach to the Diagnosis of Labor Dystocia” is based on a synthesis of existing professional guidelines and research. This approach is applicable to in-hospital care of laboring women in facilities with advanced fetal monitoring, labor augmentation, and operative capabilities. Our “Common Approach” is based on the three concepts of a point of active labor determination, a point of protraction diagnosis, and the earliest point of arrest diagnosis. In this presentation, we will describe our
approach in detail including the standardized diagnostic criteria. Further, we will highlight proposed outcomes including: 1) the consistent evaluation of labor progress, 2) improved communication among members of the healthcare team and the laboring woman and her family, 3) appropriate timing of intervention(s) to speed labor or facilitate birth, and 4) the promotion of the translation of evidence-based principles into clinical practice. Further, we propose that in the United States, adoption of our Common Approach to the Diagnosis of Labor Dystocia will ultimately decrease the rates of unnecessary intervention during labor (particularly oxytocin augmentation) and cesarean delivery, but also decrease costs of care and improve safety for childbearing women and their infants.

Bio of presenter

Dr. Nancy K. Lowe has a long and distinguished career as a nurse/nurse-midwife educator, clinician, and researcher. She is a professor at the College of Nursing University of Colorado, Anschutz Medical Campus in Aurora, CO, USA and previously was professor at Oregon Health & Science University and The Ohio State University. Dr. Lowe is an active researcher and scholar with over 60 peer-reviewed papers in medical, nursing, midwifery, and interdisciplinary scientific journals. Her current research focuses on the prevention of unnecessary cesarean delivery in nulliparous women at term gestation with one head-down, infant through the application of a scientifically generated partograph to aid clinician decision-making in collaboration with the laboring woman. Since 2001, she has been the Editor-in-Chief of the Journal of Obstetric, Gynecologic, & Neonatal Nursing (JOGNN). Dr. Lowe is a fellow in the American College of Nurse-Midwives and in the American Academy of Nursing.

Authors and Affiliations

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Jeremy L. Neal, PhD, CNM Assistant Professor, School of Nursing Vanderbilt University Nashville, TN USA
**Prevalence of a prolonged latent phase and labour outcome**: 
Review of birth records in a Swedish population

Karin Angeby

**Background**

Labour is traditionally divided into the first, second and third stage, subsequent the first stage is divided into a latent phase and an active phase (1). In Sweden the diagnostic code defines prolonged latent phase > 18 hours to cervix dilation 3 cm regardless of parity. Previous studies describe the prevalence of prolonged latent phase between 5%-6.5%.

**Aim**

To describe the prevalence of a prolonged latent phase, in women with spontaneous onset of labour and with the intention to give birth vaginally. Further to compare obstetric interventions and labour outcome in women with a latent phase < 18 or ≥ 18 hours.

**Methods**

Case control study from a middle-sized hospital, in the western part of Sweden. Birth records of intended vaginal births with spontaneous onset of labour and a gestational week ≥ 34 were included in the analysis. Background characteristics, obstetric interventions, labour and neonatal outcome were compared between records from women with < 18 hours latent phase and those with ≥ 18 hours.

**Results**

A prolonged latent phase ≥18 hours occurred in 23.5% of the birth records analyzed (n=1445) and was more common in primiparas. Both primiparous and multiparous women were more exposed to obstetric interventions, labour surveillances and pharmacological pain-relief. A prolonged latent phase was associated with an assisted birth.

**Conclusion**

The prevalence of a prolonged latent phase is more common than earlier reported. A prolonged latent phase was associated with obstetrical interventions, and assisted births.

**Bio of presenter**


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Oxytocin augmentation and cesarean delivery in nulliparous women following spontaneous labor onset based on ACOG/SMFM, Friedman, and NICE active labor determination strategies

Nancy Lowe

**Background:** Accurate diagnosis of active labor serves the purposes of providing a basis for identifying slow labor progress that might require intervention while also protecting women in earlier labor from being managed as though active labor had begun. However, the active labor diagnostic criterion that is best suited for clinical use remains unclear.

**Aim:** The purposes of this study were to determine what percentage of nulliparous women met each of three internationally recognized active labor determination criterion (American College of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine [ACOG/SMFM], Friedman, and the U.K.’s National Institute for Health and Care Excellence [NICE]) following admission to hospital and to describe oxytocin augmentation and primary cesarean rates across criterion groups.

**Methods:** A database of all births over a 5-year period at a large, academic hospital in the Midwest United States was developed. Nulliparous women carrying a single, term, vertex fetus with spontaneous labor onset were studied (n=2,573). Active labor determination criterion were applied retrospectively (1) ≥ 6 cm dilatation at admission, consistent with ACOG/SMFM guidelines; (2) ≥1.2 cm/hour leading to cervical dilatation ≥3 cm, consistent with Friedman criteria; (3) ≥0.5 cm/hour, on average, over a four hour time period leading to cervical dilatation ≥4 cm, consistent with NICE guidelines. Percentages were used to describe how many women met each active labor diagnosis criterion following admission. Generalized linear regression using a log-link function was used to estimate cesarean risk for each criterion.

**Results:** A greater percentage of nulliparous women met NICE active labor determination criterion following admission (47.7%, n=1227), as compared to ACOG/SMFM (10.1%, n=259) or Friedman (15.7%, n=402). Nulliparous women admitted in active labor per NICE criterion were more likely to receive oxytocin augmentation of labor (29.9%) than the Friedman (17.7%) or ACOG/SMFM (13.1%) active labor criterion groups. The cesarean rate was higher in the ACOG/SMFM active labor criterion group (9.7%) than in the Friedman (7.0%) or NICE (6.7%) active labor criterion groups. Cesarean delivery was significantly less likely among nulliparous women meeting NICE active labor criterion at admission, as compared to ACOG/SMFM criterion (OR 0.56 [0.36-0.89]). Nulliparous women admitted to hospital in pre-active labor compared to those in active labor were more likely to experience oxytocin augmentation across the 3
criteria and cesarean delivery using the Friedman (OR 1.81, 95% CI 1.12, 2.92) and NICE criteria (OR 2.84, 95% CI, 2.17, 3.70).

**Conclusions:** NICE guidelines provided the most inclusive active labor determination criterion for nulliparous women. Moreover, cesarean rates were lowest when NICE criterion was applied for active labor determination. The new active labor determination guidelines promoted by ACOG/SMFM in effort to decrease primary cesarean rates resulted in the highest primary cesarean rate in this study. Regardless of the active labor determination criterion applied, a majority of nulliparous women are admitted to labor units prior to active labor onset and this early admission is associated with increased rates of oxytocin augmentation and cesarean delivery.

Bio of presenter

Dr. Nancy K. Lowe has a long and distinguished career as a nurse/nurse-midwife educator, clinician, and researcher. She is a professor at the College of Nursing University of Colorado, Anschutz Medical Campus in Aurora, CO, USA and previously was professor at Oregon Health & Science University and The Ohio State University. Dr. Lowe is an active researcher and scholar with over 60 peer-reviewed papers in medical, nursing, midwifery, and interdisciplinary scientific journals. Her current research focuses on the prevention of unnecessary cesarean delivery in nulliparous women at term gestation with one head-down, infant through the application of a scientifically generated partograph to aid clinician decision-making in collaboration with the laboring woman. Since 2001, she has been the Editor-in-Chief of the Journal of Obstetric, Gynecologic, & Neonatal Nursing (JOGNN). Dr. Lowe is a fellow in the American College of Nurse-Midwives and in the American Academy of Nursing.

Nancy K. Lowe, PhD, CNM, FACNM, FAAN

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Denver, CO, USA

Jeremy L. Neal, PhD, CNM

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Hormonal Physiology of Childbearing

Sarah Buckley

How does the hormonal physiology of childbearing enhance efficiency and safety for mother and baby in labour and birth?

Can physiologic birth optimise longer-term outcomes by promoting breastfeeding and maternal-infant attachment?

How important are prelabour physiologic preparations for mother and baby, and what might be the impacts of pre-empting full physiologic readiness by induction or prelabour cesarean?

What additional impacts might epidural analgesia, synthetic oxytocin administration, and caesarean section have on these hormonal systems, and how can care-givers support mothers and babies to fill the “hormonal gaps” when these interventions are needed?

Dr Buckley will address these topics from her 2015 report *Hormonal Physiology of Childbearing*. This report provides substantial scientific evidence that normal labour and birth are essentially salutogenic, promoting positive health and wellbeing for mother and offspring, and also documents the growing evidence that common maternity care interventions can disturb hormonal processes, reduce their benefits, and create new short- and longer-term challenges.

“This report...will be retrospectively evaluated as one of the most revolutionary and influential publications on maternity and newborn care ever issued.” -HPoC Foreword

*Hormonal Physiology of Childbearing: Evidence and Implications for Women Babies and Maternity Care* is published by the National Partnership for Women and Families (US). [http://transform.childbirthconnection.org/reports/physiology/](http://transform.childbirthconnection.org/reports/physiology/)

Dr Buckley is a Keynote speaker and her Bio is located in the main program.
Acupressure: facilitating normal birth and partner involvement
Bernadette Leiser

Background
Many women would like to avoid pharmacological or invasive methods for initiating labour and pain management in labour and this may contribute towards the popularity of complementary and alternative medicines/therapies (CAM) and specially Acupressure. Acupressure is application of direct firm pressure on specific points along the acupuncture channels known as meridians where the ‘qi’ energy (pronounced chee) surfaces. The use of acupressure can be viewed from the medical model as promoting the release of endorphins, blocking the pain receptors to the brain, and stimulating the release of oxytocin.

Systematic reviews of randomised controlled trials have found acupressure to be a safe, non-invasive technique that can provide pain relief and shorter duration in labour (Smith et al 2011, Mollart et al 2015). Acupressure and/or moxibustion can assist in decreasing breech presentations at term.

Partners and support persons who have received self-help education in acupressure report “feeling of involved and useful, seeing themselves as being important and active in the birth rather than having only a bystander’s role”. Midwives are keen to learn a new clinical skill (acupressure) which have the potential to reduce medical interventions and facilitate normal birth and labour.

Aim
This workshop aims to provide midwives and student midwives with sufficient theory and practical skills to identify and use six acupressure points for the use in late pregnancy, labour and childbirth.

Method
The original 1 day workshop (developed b Debra Betts (NZ Nurse and Acupuncturist and taught by Bernadette and Lyndall) has been modified for the conference to a 2
hour workshop without losing integrity and value. The workshop consists of 50% theory (Powerpoint presentation) and 50% practical. For the practical session, a **maximum of 30 participants** will practice in pairs in a safe supervised environment to correctly identify and apply appropriate pressure to acupoints. For participants who are pregnant: they may participate in location of acupoints only – as many of the acupoints have a uterine contractibility action.

### Results

Participants will be able to-

- Recount the basic theory of meridians and acupressure points (acupoints)
- Discuss partner/support person role to support women in labour using acupressure
- Identify 6 acupoints for clinical conditions e.g. breech presentations, pain relief in labour, and retained placenta.
- Competently demonstrate acupoints: Gall Bladder 21; Bladder 60 & 67; Spleen 6; Kidney 1; Large Intestine 4.

### Conclusion

This workshop was conducted at the Australian College of Midwives National Conference in Tasmania in 2013 with overwhelming interest and positive feedback. The midwives who have attended the acupressure workshops believe this skill and information is crucial for midwives and vital this information is provided to women and their partners.

### Bio of presenter

Bernadette Leiser has been a Midwife for 40 years and has worked in various settings ranging from home birthing, birth centre, community team midwifery, Midwifery Group practice to being the Towards Normal Birth Midwife at her hospital.

Bernadette also holds diplomas in Medical Herbalism, Nutrition, Massage therapy, Aromatherapy, Reflexology, Reiki, Bowen therapy and Hypnobirthing.

She has introduced various CAM therapies into the hospital setting and has been involved in various research projects, the latest being the SWIFT trial on Sterile Water injections for low back pain in labour.

Her focus and passion have always been to keep birth normal. Currently, Bernadette works as a midwife, runs her private Natural Therapies practice and lectures at university and natural therapies colleges.

She teaches the Reflexology for midwives course and runs Acupressure workshops for midwives and student midwives.
Authors and Affiliations

Bernadette Leiser. Sole to Soul reflexology.
Lyndall Mollart. Sole to Soul reflexology.
Non medical factors influencing the practice of caesarean sections in Chile

Michelle Sadler

Background

The increase in the caesarean section rate in Chile has been progressive during the last 3 decades. In 1986 the country had 27.7% of caesarean sections; in 1994, 37.2%; 40.5% in 2004, and 49.3% in 2012 –with 40% in public and 72% in private health. This has happened despite government efforts and policies to promote vaginal birth since 2007. There is a growing recognition of the impact of non medical factors in this rise, but very little attention has been given to their understanding.

Aim

To identify the non medical factors which influence the rise in caesarean sections in Chile.

Method

A two year study was carried out (2014-2015) in public and private health, in the Metropolitan Region of Chile. The techniques used were: in depth interviews (50: pregnant and postpartum women, midwives, obstetricians); discussion groups (2 groups of midwives, 2 groups of women); survey (sample 400 women who had at least one caesarean section in the last 10 years).

Results

Different views of childbirth in women and medical staff (midwives and obstetricians) were identified, that range from a non-interventionist approach to a highly medicalized and interventionist one.

Despite the medicalized view is more hegemonic and present in the sample, there is consensus that a change of approach is needed in childbirth care, towards a more normal birth approach. The reasons identified for the high level of interventions and caesarean sections are: extreme medicalization of the process with high use of routine practices that are not evidence driven, shared culture of birth as a pathological and dangerous process that needs to be intervened and controlled by specialists, and a
shared idea that “Chilean” women have small pelvis and present more pathologies than other populations (there is no evidence to support this idea). The difference in c-sections across health systems is partly explained because of the lack of regulations and auditing in private health. It can also be said that whereas in public health the birth is majorly managed by midwives, in private health it is territory of obstetricians, who see more pathologies in the birth process and tend to over-medicalize it. There are economic factors involved: whereas in public health the midwife and doctor get a fixed salary for hours of work (independent of the quantity of procedures), in private the pay is per birth.

Conclusions

The study shows the persistence of a highly medicalized and interventionist approach to childbirth despite governmental efforts in the last decade to change this approach. Obstetric practices are not evidence driven, and most of women and families give total authority to medical staff, with little or no active questioning of the information received. There is a need to strengthen education about physiological birth and its benefits in the general population and in health professionals (university education and clinical practice); and to work on strategies to decrease the perverse economic incentives in private health.

Bio of supervisor

Michelle Sadler S. Social Anthropologist and Master in Gender Studies, University of Chile. MSc in Medical Anthropology, University of Oxford. Assistant Professor, Anthropology Department, University of Chile. Director Research topics: gender and health, sexual health, reproductive health, teenage pregnancy, masculinities and reproductive health, fatherhood, childbirth practices and cultures. Consultant for the Women´s Health Program, Ministry of Health, Government of Chile. Currently participates in the COST Action IS1405 BIRTH: Building Intrapartum Research Through Health - an interdisciplinary whole system approach to understanding and contextualising physiological labour and birth.

The study was funded by the Ministry of Health and the National Commission for Research on Science and Technology (Chile), though the FONIS Program (National Fund for the Study and Development of Health). The project ID is FONIS SA13I20259.

Authors and Affiliations

Pascale Pagola Davis

Michelle Sadler Spencer
**Women’s reasons for, and experiences of, choosing a homebirth following a caesarean section**

Hazel Keedle

**Background**
Caesarean section is rising in the developed world and vaginal birth after caesarean (VBAC) is declining. There are increased reports of women seeking a homebirth following a caesarean section (HBAC) in Australia but little is known about the reasons for this. This study aimed to explore women's reasons for and experiences of choosing a HBAC.

**Methods**
Twelve women participated in a semi-structured one-to-one interview. The interviews were digitally recorded, then transcribed verbatim. These data were analysed using thematic analysis.

**Results**
The overarching theme that emerged was ‘never happening again’. Women clearly articulated why it [caesarean section] was never happening again under the following sub themes: treated like a piece of meat, I was traumatised by it for years, you can smell the fear in the room, re-traumatised by the system. They also described how it [caesarean section] was never happening again under the sub themes: getting informed and gaining confidence, avoiding judgment through selective telling, preparing for birth, gathering support and all about safety but I came first. The women then identified the impact of their HBAC under the sub-themes I felt like superwoman and there is just no comparison.

**Conclusions**
Birth intervention may cause physical and emotional trauma that can have a significant impact on some women. Inflexible hospital systems and inflexible attitudes around policy and care led some women to seek other options. Women report that achieving a HBAC has benefits for the relationship with their baby. VBAC policies and practices in hospitals need to be flexible to enable women to negotiate the care that they wish to have.

**Implications for practice**
VBAC policies and practices in hospitals need to be flexible in order for women to be able to negotiate the care that they wish to have.

**Bio of presenter**
Hazel Keedle has recently completed a Masters Honours of Nursing at Western Sydney University. Her thesis was exploring women's reasons for and experiences of choosing a homebirth following a caesarean section. Hazel is now a full-time PhD candidate at Western Sydney University with an Australian Postgraduate Award scholarship. The
PhD thesis is focusing on the experience of women planning a VBAC in public hospitals in NSW.

Authors and Affiliations
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Professor Virginia Schmied, Western Sydney University, Parramatta, Australia,
Dr Elaine Burns, Western Sydney University, Parramatta, Australia,
Professor Hannah Dahlen, Western Sydney University, Parramatta, Australia
Who Owns the Baby? Skin-to-Skin Contact after a Caesarean Section

Jeni Stevens

Background

The World Health Organization and UNICEF recommend that mothers and newborns have skin-to-skin contact immediately after birth, including after a caesarean section if the mother is alert and responsive. Skin-to-skin contact is biologically normal, and is recommended to continue for at least one hour for all women or until after the first breastfeed. A Cochrane review showed evidence that skin-to-skin contact can potentially improve maternal and infant bonding, breastfeeding duration and that it keeps newborns physiologically stable. Immediate or early skin-to-skin contact after a caesarean section may also improve maternal and infant bonding, breastfeeding outcomes, keep newborns physiologically stable and it potentially reduces maternal pain and anxiety. After a normal birth, women are increasingly having immediate skin-to-skin contact. This paper explores whether the same WHO/UNICEF standard applies after a caesarean section.

Aim

To provide insight into mother infant practices following a caesarean section.

Method

Ethnographic methods (observations, video-recording, field notes and interviews) were used to study the interactions, in particular skin-to-skin contact, between 21 mothers and their newborn infants for up to two hours after having a caesarean section at one hospital site. Interviews were conducted with the same women at six weeks postpartum, with the aim to discover their satisfaction with their contact with their newborn at birth. Further interviews were conducted with hospital staff members to determine their perceptions and knowledge about skin-to-skin contact.

Results

Of the 21 mothers, 16 had SSC in the operating theatre and 14 had SSC in recovery. Women stated that the contact they had with their newborn immediately after a caesarean section was important to them. They want to own their baby.

However it was observed that organisational, environmental and cultural barriers facilitated midwives and paediatric doctors in adopting ownership of the baby after a
caesarean section. They decided what happened to the baby in the operating theatre. Despite this, a small number of midwives made strategic efforts to return ownership of the baby to the mother.

Conclusion
Mothers can own their baby in the operating theatre and recovery when midwives support the provision of skin-to-skin contact and keep mothers and babies together. Midwives can help facilitate skin-to-skin contact in the operating theatre and recovery by providing evidenced based education to the mother, by being the womans advocate, and by making small changes to the care they provide.

Bio of presenter
Jeni Stevens is a PhD Candidate from Western Sydney University. She is currently undertaking research on the Facilitators, Barriers and Implications of Immediate Skin-to-Skin Contact post a Caesarean Section and was a recipient of a University of Western Sydney scholarship. Jeni is also a mother of four sons, a Registered Midwife, Registered Nurse and a Lactation Consultant. Jeni has a passion to educate people, especially about breastfeeding. Jeni has previously completed research which focused on Midwives and Doulas perspectives of the role of a Doula in Australia.

Authors and Affiliations:
Jeni Stevens (Presenter) - Western Sydney University
Professor Hannah Dahlen - Western Sydney University
Professor Virginia Schmied - Western Sydney University
Dr Elaine Burns - Western Sydney University
Producing robust and compelling normal labor and birth science; the power of causal inference methods

Ellen Tilden

Background
Midwifery approaches to care of women during the childbearing cycle improves outcomes while decreasing costs. There is a need to (1) isolate specific components of midwifery care improving women’s health, and (2) rule out other potential explanations for these associations (e.g., self-selection bias). Given this, and increased interest in well-woman models of care, generating accurate research about normal labor and birth care and effectively communicating this science to those unfamiliar with normal labor and birth are urgent. As well, healthy women have strong preferences regarding maternity care and are at low risk for poor outcomes, important reasons why experimental study design is suboptimal for science in these areas. Observational study design with causal inference methods is likely the strongest approach for many normal labor and birth questions. Causal inference methods have become the norm in related fields (e.g., epidemiology, health services research), yet have gained only limited traction in midwifery research, where they may provide an important tool to produce meaningful normal labor and birth science of the highest quality.

Aims
i) Effectively describe causal inference methodological approaches that are most relevant to generating robust normal labor and birth science (theory and practical implementation)

ii) Highlight challenges encountered when using observational data for normal labor and birth science and approaches to overcome these challenges

iii) Clarify the methodological power of causal inference techniques to communicate normal labor and birth science to diverse audiences (funders, policymakers, other researchers), including those unfamiliar with midwifery

Method
We will detail three causal inference techniques relevant to the scientific study of normal labor and birth: propensity score analysis, g-computation, and directed acyclic graphs. For each, we employ a multi-format approach to explain the relevance, the conceptual background, and implementation.
Material will be conveyed in lecture format, using examples, and provide key citations and code (Stata and SAS).

Results
This tutorial workshop will provide participants with conceptual understanding and concrete skills to implement causal inference methodologies to advance the science of normal labor and birth.

Conclusion
With increased interest in normal labor and birth research, scientists within this arena must succeed in generating analysis that can produce both improved understanding of normal labor progress and birth as well as confidence in research findings across multiple audiences within and beyond midwifery circles. Causal inference techniques are gaining currency across fields of biomedical research and will be an important tool for successfully meeting opportunities to develop and disseminate normal labor and birth science. We seek to offer lucid and pragmatic information to normal labor and birth scientists.

BIO
Ellen Tilden, PhD, CNM, is an Assistant Professor in the School of Nursing at Oregon Health and Science University (OHSU) and a full-scope nurse-midwife with over a decade of clinical experience. Her research is inter-disciplinary, employing economics and causal inference tools, with the overarching research goal to define risk-appropriate care for healthy women and their children. Funding: NIH Office of Research on Women’s Health and NICHD (K-12 BIRCWH).

Authors and Affiliations
Ellen Tilden, PhD, CNM, Assistant Professor in the School of Nursing at Oregon Health and Science University (OHSU), Portland Oregon
Jonathan Snowden, Ph.D., is an Assistant Professor in the School of Public Health and Department of Obstetrics and Gynecology at OHSU
Agreement between data in the Netherlands Perinatal Registry and recollection of events by women in midwife-led care at the onset of labor

Lilian Peters

BACKGROUND: National perinatal datasets are frequently analyzed by researchers and healthcare professionals to answer research questions or to use the data for benchmarking. Until now it is unclear if the data entered by midwives in the Netherlands Perinatal Registry are in agreement with the self reported memories of women regarding their birth experiences.

AIM: The aim of the study was to assess the agreement on labor characteristics between the data of the Netherlands Perinatal Registry and the self reported childbirth experiences of women.

METHODS: Data of the Netherlands Perinatal Registry and the DELIVER study of the period 2009-2011 were analyzed. The data from the Netherlands Perinatal Registry comprised data on pregnancies, births and neonatal outcomes of births in the Netherlands. In the DELIVER study, a study that evaluated the quality, organization and accessibility of primary midwifery care in the Netherlands, the memories of the women regarding their birth experiences were collected.

From both datasets, low risk women were selected who were in midwife-led care at the onset of labor, and the following outcomes were compared: Data of birth interventions (i.e. instrumental delivery, emergency c-section, manual placenta removal, episiotomy) and data regarding planned and actual place of birth were collected (i.e. home birth/hospital). Cohen’s kappa measures were calculated to assess agreement between both datasets. Kappa’s were interpreted as follows: 0.81-1.00 (perfect), 0.61-0.80 (substantial), 0.41-0.60 (moderate), 0.21-0.40 (fair), 0-0.20 (slight).

PRELIMINARY RESULTS: Data of 2369 women were analyzed. Both datasets indicated that 45% of the women were nulliparous, 40% were between 30-34 years of age and 95% were of Dutch origin. Between the Netherlands Perinatal Registry and self-reported childbirth experiences moderate agreement was observed regarding a manual removal of the placenta (kappa 0.68). Perfect agreement between the datasets were observed regarding birth interventions (kappa ranged 0.90-0.99), and planned and actual place of birth (kappa ranged 0.84-0.91).

CONCLUSION: The data of the Netherlands Perinatal Registry and self-reported childbirth experiences of women regarding birth interventions, planned and actual place of birth showed perfect agreement which suggests limited recall bias of women regarding their birth experience and accuracy of the data of the Netherlands Perinatal Registry.
Bio of presenter

Lilian Peters PhD works as a postdoctoral researcher at the department of Midwifery Science at the VU University Medical Center Amsterdam (Netherlands). As an epidemiologist she is involved in several projects for which she analyses data of the Netherlands Perinatal Registry, the Birthplace cohort study (in collaboration with the University of Oxford, National Perinatal Epidemiology Unit), and The Swedish Medical Birth Register (in collaboration with University College Cork, Irish Centre for Fetal and Neonatal Translation Research).

Moreover, in collaboration with the study group Reproductive Origins of Adult Health and Disease (University Medical Center Groningen, Netherlands) she developed an add-on study in the LifeLines cohort study. The LifeLines-ROAHD study aims to identify which risk factors are associated with the various courses of conception, pregnancy, childbirth and health outcomes of mother and child. In the summer of 2016 the data of 36,000 women will be collected.

Lilian L. Peters PhD1, Marianne Prins RM MSc2, Ank de Jonge RM PhD1

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Intention, Identity and Responsibility: a grounded theory study concerning physiological breech birth skill acquisition

Shawn Walker

Background

Experience in vaginal breech birth is unusual in most parts of the developed world in the 21st century, and experience in physiological breech birth even more so. The literature indicates some expectant parents still desire care providers able and willing to support vaginal breech births, but little evidence concerning how maternity care professionals can adequately develop skill to meet this demand as safely as possible.

Aim

This on-going study aims to develop a middle-range theory on skill acquisition for physiological breech birth, for the purposes of guiding future research into how training programmes and service organisations can support professionals to enhance breech birth skills.

Method

In-depth interviews with obstetricians and midwives working in different locations and practice environments internationally were collected via Skype. The interview data have been analysed iteratively using grounded theory methodology. Each interview was coded line-by-line, and codes were reflected upon through the writing of copious memos, which influenced subsequent interviews and analysis. Correspondences and connections in the data were explored by organising them into categories, until the extensive list of codes and categories could be built up into related theoretical concepts and mapped to form an initial theoretical framework.
Stages of theoretical sampling and comparative analysis were used to probe and saturate this theoretical framework, to develop a working theory of a physiological breech birth learning journey.

Results

Common elements in these practitioners learning journeys included: physiological coherence and critical awareness, leading to intention, identity and responsibility. The journey begins with a strong foundation in normality, characterised by a sense of coherence concerning the physiological processes of birth. At some point, a triggering experience prompts the practitioner to develop a critical awareness around mainstream breech practices. Following this, the practitioner develops an intention to learn physiological breech skills and sets down a path involving seeking out experts they perceive as genuine. The practitioner returns to the familiar practice environment having acquired a new identity associated with breech skill, which attracts further breech experiences. Finally, the practitioner becomes aware of their own ability to recognise and compare patterns among their experiences, a mark of expertise, and the responsibility such expertise entails. These elements continue to be explored through the final stages of theoretical sampling.

Conclusion

Awareness of the learning journey undertaken by those who have acquired skill and experience with physiological breech birth may provide some insight into how maternity service providers and training programmes can enable more professionals to acquire these elusive skills.

Bio of presenter

Shawn is a midwife who has worked in all midwifery settings, in the US and the UK: home, freestanding and alongside birth centres, and hospital labour wards. In response to local women’s demands for more choice and continuity in breech services, Shawn worked with her multi-disciplinary colleagues to develop the Heads Up Clinic, which was shortlisted for a Royal College of Midwives Excellence in Maternity Care Award in 2013, and where she worked as a Breech Specialist Midwife until January 2014. She has published numerous professional articles about breech practice and service organisation, and blogs at breechbirth.org.uk.

Authors and Affiliations
Shawn Walker
Midwife, St Mary’s Hospital, London
PhD Candidate, City University London
A decision-making model regarding birth choices following a previous caesarean delivery

Shu-Wen

Background

A previous cesarean delivery (CD) ranks as the top reason for repeat cesarean delivery (RCD) rates but little is known about women's decisions regarding birth choices.

Aim

To understand women's decision-making processes and influences and develop a decision-making model regarding birth choice following a previous CD.

Methods

A qualitative approach with theoretical sampling was applied. Eleven obstetricians and 21 women were recruited from a maternity unit of a medical centre in northern Taiwan. Data collection included in-depth interviews, observation and field notes. The constant comparative analytic method was employed for data analysis.

Results

A decision-making model regarding birth choices consists of four components: influences, processes, outcomes and reflection. At the antepartum stage, both pregnant women's and obstetricians' decisions are influenced by internal and external factors. Internal factors influencing pregnant women's decisions include previous birth experience, fear of vaginal birth, evaluation of modes of birth and current pregnancy situation (e.g. foetal presentation and size). External factors comprise of information resources (including obstetricians' recommendations, the experience of significant others, and the internet) and types of health insurance (National Health Insurance and private insurance). Internal factors influencing obstetricians included attitudes towards VBAC and their confidence in performing VBAC. External factors influencing obstetricians included the National Health Insurance policy on reimbursement, hospital policy regarding VBAC, the system of the designated obstetricians, medical malpractice and women's choice.

The decision-making processes or strategies used by participants varied slightly. Cultural Theory, the Theory of Planned Behavior, and Shared Decision-Making help explain these decision-making processes and strategies. The decision-making process used by pregnant women included searching information, respecting professional judgment, evaluating alternatives, and making a decision. Obstetricians decision-
making strategies included inquiring about women’s intentions, informing women of alternatives, interpreting risks and benefits, and letting women decide for themselves.

The final decision regarding mode of birth is highly flexible and can be changed in accordance with the development of pregnancy. Obstetricians either adopted defensive medicine by recommending RCD or they shared decision-making and respected women’s decisions. After birth, women reflected on the birth in three areas including reflection on birth choices, reflection on factors influencing their decisions and reflection on outcomes of decisions.

Conclusion

The decision-making model regarding mode of birth was generated from participants interviews, which has potential to assist midwives to develop a greater understanding of the choices and influences on women’s decisions regarding birth choices.

Authors and Affiliations

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Support for vaginal breech birth at term: Findings from the UK “Think Breech” a mixed methods study

Mary Sheridan

Background
Breech presentation occurs in 3-4% of singleton term pregnancies. Caesarean section has become the globally preferred birth mode for term breech babies. However, guidance recommends External Cephalic Version (ECV) should be offered for all uncomplicated term breech presentations. Studies have shown up to 30% of singleton term breech pregnancies may be undiagnosed, limiting the number of women who can be offered ECV. When ECV is declined or unsuccessful or breech presentation is diagnosed in labour, vaginal breech birth should be considered as an option.

Aim
To identify support for evidence-based (EB) management of singleton term breech pregnancies in the UK and extent to which EB recommendations were implemented.

Method
A three phase mixed methods study was completed. Phase 1 involved a cross sectional survey of adherence to EB guidance for term breech diagnosis and management. Phase 2 involved case studies at three UK units identified as implementing optimal breech management using a term breech index (TBI) developed from phase 1 to explore how best-practice was sustained. Phase 3 aimed to design, implement and pilot a quality improvement (QI) intervention to improve identification and management of term breech pregnancies at two NHS maternity units identified from phase 1.

Results
The phase 1 survey was completed of all 172 UK maternity services and responses received from 72% of units. Findings included details of management options for women when breech presentation was diagnosed in labour including vaginal breech birth and caesarean section.

Phase 2 involved case studies at three UK units identified as implementing EB breech management in line with guidance (i.e. with a high TBI from phase 1). Several common themes to support EB term breech management were identified, including support for vaginal breech birth if ECV was declined or unsuccessful and a culture of EB practice across the unit.

The phase 3 QI intervention pilot study was planned at two units with a low TBI score. As significant barriers to QI implementation were apparent from the outset at both units, the focus for phase 3 was revised into an examination of organisational factors impacting on EB practice.
Pre and post intervention interviews with 7 women, 14 clinicians and 5 NHS managers identified barriers and perceived facilitators to change, highlighting several important issues including impact of external and internal financial and policy drivers on maternity service planning and provision, and how high priority areas for service change were
identified.

Conclusion
The study findings highlight the potential for all units to recommend a pathway of care for women with a singleton term breech pregnancy, including ECV, vaginal breech birth and caesarean section in line with the evidence. However, all relevant stakeholders have to agree on the priority for, and approaches to, implementation of the service change.

Bio of presenter
Mary has been a midwife for 28 years and currently has a part-time clinical role at Guys and St. Thomas NHS Foundation Trust, London, UK undertaking Examination of the newborn. Mary was awarded a National Institute of Health Research (NIHR) Clinical Doctoral Fellowship in 2009 and her research project aimed to improve the detection and management of breech presentation and developmental dysplasia of the hip. Her doctoral studies are supervised by Professor Debra Bick, Professor Glenn Robert and Professor Susan Bewley, Kings College London.

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Searching for autonomy: An international quantitative survey of womens expectations and experiences surrounding planned vaginal breech birth

Karol Petrovska

Background
Internationally, vaginal breech birth (VBB) is a rare occurrence with a limited number of facilities supporting this birth option. Despite the limited support for VBB in maternity facilities, some women continue to request it as an option for birth. Little is known about how women make this decision and what factors may influence their choices of mode of birth. Women who plan a VBB are often highly motivated and, after having done their own research, choose to navigate the health system to find a clinician who is willing to assist them to birth their baby vaginally.

Aim
The aim of this study was to explore the experiences of women, at an international level, who had planned a VBB and increase understanding as to how to best support women with a breech presenting baby in their birth choices.

Methods
An international cross sectional online survey was conducted between April 2014 - January 2015. The survey consisted of questions regarding womens experiences in seeking a VBB. The survey was distributed online via closed membership Facebook groups that have a consumer focus on VBB.

Results
There were 204 responses to the survey. Most (44.3%) of the participants were between 31 and 35 years of age and were from the United States or Australia. A large proportion (76.3%) of the women had tertiary education. Only half of the respondents who had a VBB (63.4%) strongly agreed or agreed that they were satisfied with the information they received, with a similar number of women stating detailed statistics on the safety and risk of VBB that helped them make a decision regarding mode of birth. Additionally only half of the respondents felt either supported, or very much supported, by their care provider. Many of the women (74.5%) accessed social media and the internet to assist them in making their decision but were unsure about the reliability of information found online. Less than half (42.3%) felt supported by their families in their decision-making process.
Conclusion
Demand for VBB exists in many countries that currently have limited support for this birth option. Information regarding VBB should be tailored to the woman's needs, values and personal context so that she is able to make an informed decision about her care and feel supported throughout pregnancy and birth. Reconfiguring attitudes to VBB in maternity services may be challenging, however facilitating access to VBB options for women recognises that the woman's autonomy and values remain central to her pregnancy and birth experience.

Bio of presenter
Karol Petrovska is currently enrolled in a PhD course at the University of Technology, Sydney and is studying the impact of social discourse on the choices women make for breech birth. She has a background in Occupational Therapy and Journalism. Karol had a vaginal breech birth with her second daughter in March 2012 after originally planning a homebirth. Her first daughter was born in water in 2010. Karol is passionate about promoting normal birth and increasing access to evidence based information for women so they are able to make informed choices for labour and birth. She currently works at the Office of Kids & Families as a Senior Policy Analyst in the Maternal and Newborn Unit.
Embracing the traditional male leadership in Uganda to improve birth outcomes

Marg Docking

Background
The most urgent challenge for midwives in the developing world to reduce maternal complications, is to overcome myths and misunderstandings about pregnancy and birth. My own heartbreaking experiences in Uganda led me to develop a model of community midwifery education based on train-the-trainer workshops. With critical thinking and empowered decision making at the core, I launched Wise Choices For Life Inc. (WCFL) pilot program in Uganda.

I saw first-hand, how cultural traditions and spiritual beliefs around pregnancy-impacted peoples perception, understanding and behavior. It grieved me that hospital based education was not providing the solution to the maternal mortality rate as it does in the developed world.

A clinical approach to midwifery education in male dominated societies will not affect behavioral change, unless it reaches the critical mass of male, non-medical, decision makers.

Aim
To empower youth with knowledge and life skills about birth, to reduce the prevalence of birth complications associated with unplanned pregnancies.

Method
By realigning our educational efforts to cater for the traditional gender roles we could reach men, normally excluded from the conversation about midwifery. This necessitates a change from hospital-based to community-based education.

The Wise Choices For Life model trains non-medical community leaders about puberty, sex, conception, pregnancy, birth, family planning and the environment. By combining a medically sound curriculum with traditional forms of communication (drama, debate, song and dance) WCFL empowers leaders to confidently and sensitively explain the consequences of risky behavior and correct generally accepted myths.

The training includes the safe space to discuss myths about obstructed labour, fistula, hemorrhage and infection.

Results
Our workshops led by national, accredited WCFL trainers, engage in a full spectrum of society. With endorsement from the Ugandan Ministry of Health, the Church of Uganda and the Christian University the workshops include, civil, religious leaders, parents and teachers.
Many are for the first time discussing and debating taboo topics in a safe public space. Ugandans, are engaging with the medical world and being challenged to question their default position on these topics.

The hope and freedom this brings to many has been truly powerful to witness.

Conclusion

Midwifery education in developing countries must adapt to work within the social, cultural and spiritual contexts. Traditional hospital-based midwifery education will not reach the critical mass nor the spectrum of society required to affect change on a societal level.

By delivering midwifery education in a respectful and relevant way without compromising quality we can reach those traditionally excluded from the conversation. Midwifery education can then, fulfill its role to bridge the gap between how things are, and how they could be.

Bio of presenter

My experiences in midwifery from remote and rural Australia made me question why some communities are safer for mothers to give birth and others around the globe, so dangerous. After experiencing the joy of safe birth myself, I set off for Uganda. Here the answers were so complex and the tragedy so overwhelming I was almost paralyzed into doing nothing.

I was struck by the slow impact of change as mothers were birthing at a far greater rate than midwives were being trained.

I tried a new approach with a train the trainer workshops in basic midwifery to male and female, non medical and religious leaders.

Returning to Australia I completed a certificate in sexual health and family planning, then set up a not for Profit called ‘Wise Choices For Life’

Accredited teams of Ugandans now train in five regions.

It’s been a hard journey of love but has taken a shift in the way I think midwifery education needs to spread. Hospital knowledge does not change behaviour in the community.

Authors and Affiliations

Marg Docking

Director, Wise Choices For Life Inc
Using Evidence for Transformational Change

Tracey Cooper

This initiative uses the evidence from the Birthplace study and NICE guidance to promote birth without intervention in a freestanding birth centre. Chorley Birth Centre (CBC) and alongside Birth Centre, Preston Birth Centre (PBC). This is an example of how this evidence has been used to maximum effect to change the experiences of women, their families and improve the working lives of midwives. The Birth Centres are an integral part of the community, supported by the families locally. Its impact is being used both nationally and internationally as an example of using evidence to provide excellence in midwifery practice.

Chorley Birth Centre (CBC) was under threat of closure and required rejuvenation and no birth centre in Preston. Through using the evidence from the Birthplace study and NICE recommendations to change current thinking about the Birth Centre and development of maternity services with key organisational members the future was turned around. The Consultant Midwife led a bid for improving birth environments funded by the DOH, receiving £754,000 and using a neighbouring successful maternity service as an example of good practice the refurbishment of CBC was supported and development of an alongside birth centre at Preston.

Maternity user surveys revealed overwhelming support for CBC and development of PBC from members of the Trusts Public and Patient Involvement Group, local women and the local NCT groups. The responses showed that there was a strong desire for partners to be more involved with the birth and felt that there is a need for facilities to be improved to accommodate an overnight stay for partners. The respondents concluded that they would recommend CBC to friends and relatives if it were updated and support a new birth centre in Preston.

Women with uncomplicated pregnancies are offered birth at home and both birth centres as a choice. A 24 hour stay was implemented to facilitate partners staying to bond as a family. A new operational guide provides clarity for all in the organisation. Evaluation is performed by reviewing on a monthly basis: all cases, including transfers;
comments from families; and normal birth rates.

The birth centres increase wellbeing: it promotes normal birth; reduces interventions; includes partners in the birthing process; provides a healthier start for babies; and women are able to resume a normal lifestyle more quickly.

Bio of presenter
Tracey has 25 years midwifery experience, working in all areas of midwifery and birth settings. She has held both management and Consultant Midwife roles. She is currently a Consultant Midwife in Normal Midwifery and a Supervisor of Midwives for Lancashire Teaching Hospitals NHS Foundation Trust.

Tracey contributes to guidance and professional policy locally and nationally. She was a member of the update group for the newly updated NICE Intrapartum guideline (2014), a Midwifery Advisor to the NICE Safe Staffing Advisory Committee (2015) and the NICE Quality Standards for Intrapartum Care (current). She is a CQC Specialist Advisor and a member of the BJM Editorial Board.

Tracey gained her PhD in 2011 at UCLAN, looking at Women and Midwives Perceptions of the Midwives Role. Tracey has a special interest in the effect of interventions on long term health of women and babies, place of birth, keeping the first birth normal and supporting all women have the best birth
Translation of normal labour and birth research: The implementation of a statewide normal birth guideline

Lyndel Gray

Background
Within maternity care, clinicians, consumers and policy makers have recognised the need to address high intervention and caesarean section rates for women and their babies. In 2010, the majority of Queensland women (90.8%) birthed term babies, with 33.6% born by caesarean section. Clinical practice guidelines are one strategy to safely decrease intervention rates. In 2010 Queensland Centre for Mothers and Babies reported a perceived inconsistency in ideas and opinions of different clinical staff working within the same facility and the dismissal by some staff of clinical guidelines. The report recommended facilities should be supported to develop protocols based on evidence.

Queensland Health is committed to the provision of best practice, offering contemporary maternity care and implementing woman centred care. It was recognised a statewide normal birth clinical guideline was fundamental in translating the available evidence and providing a resource for maternity clinicians. The guideline needed to respect the broad parameters of normal and maintain women at the centre of their care within a safe multidisciplinary framework, which supports care by the appropriate clinician at the right time and within a respectful culture.

Aim
Develop and facilitate the uptake of a contemporary guideline to protect, promote and support normal birth through woman centred, collaborative care.

Method
A statewide guideline was developed using a rigorous method that involved engaging multidisciplinary working party which included consumers.

Systematic literature reviews, statewide consultation on draft documents, and endorsement through key Queensland Health governing bodies was undertaken. The guideline was published in 2012.

Implementation strategies included engaging a large working party and involving statewide consultation, a parliamentary launch, education via statewide videoconferencing, online education and knowledge assessments linking the document into other statewide documents and pathways, provision of auditable standards and an implementation checklist. The checklist was aligned with the National (Australian) Safety and Quality Health Service Standards and can be customised for local use.
Results
Whilst recent perinatal data collection statistics have not been published in Queensland which may provide evidence of practice change, there is evidence the guideline is well established across Queensland. Responses to a facility survey (n=29) which included self-assessment of guideline implementation displayed awareness, distribution, education and practice improvement initiatives were well-established in more than 20 facilities. Individual online knowledge assessments have been attempted over 500 times.

Conclusion
The statewide clinical guideline is available and is amongst the most highly utilised Queensland clinical guidelines providing clinicians with evidence informed guidance to promote and protect normal birth.

Bio of presenter
Lyndel Gray RN RM BSc Grad Dips(Child Health, Business Management, Commerce) MN MIntEc&Fin

Lyndel is a Clinical Nurse Consultant and Midwife with Queensland Clinical Guidelines (QCG). QCG has gained recognition locally and internationally for producing evidence-based, peer-reviewed, multi-disciplinary, practical, and economical clinical guidelines. With extensive maternity and neonatal clinical, teaching, and management experience within the private and public sectors in Australia and also overseas, Lyndel was the primary project officer in the development of the Queensland Normal Birth guideline.

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Barriers to sustainability in midwifery practice

Lorna Davies

The acknowledgement that sustainability is a key health related issue is being increasingly recognised. The probable impact of human influence on the climate system is clearly stated in the Synthesis Report of the Fifth Assessment Report from the Intergovernmental Panel on Climate Change. It has been argued that we are more likely to consider issues relating to sustainability when we feel a sense of personal ownership. Professional identity has been acknowledged as a factor that might lead individuals to a greater sense of engagement with the concept of sustainability. This idea prompted me to embark on a doctoral study with the aim of establishing what understanding midwives in New Zealand have of sustainability and to explore whether collective involvement in activity relating to sustainability might lead to change in practical and philosophical aspects of practice for those participating.

Using Participatory Action Research (PAR), I set out to elicit the views of three groups of midwives using a series of focus groups over the period of a year. The midwives appeared to be interested in the broad subject of sustainability. They engaged willingly in discussion and considered at length the broader conceptual elements of economic, social and environmental sustainability. However, the action component of PAR did not significantly engage the midwives and during analysis of the data, it became apparent that the main focus of the midwives was the sustainability of their professional identity rather than saving the planet. Further in-depth analysis was to reveal a number of hurdles that the midwives identified as impacting on their professional role and identity. These included both inter and intra-professional relationships, risk management, media surveillance and intergenerational conflict. Although there was a cursory acknowledgement of an association between professional sustainability and the broader tenets, for much of the time this was not viewed as tenable or even relevant by the midwives.

Using Actor Network Theory as a theoretical framework I followed the actors to analyse the relational aspects of midwifery with the other actors in the networks of birth and maternity care. I hoped that this would provide some answers as to why the issue of professional identity that I had originally imagined would provide a cornerstone on which to support the values of sustainability within midwifery practice, had assumed a role that militated against it. In so doing, I discovered that the confusion and dissonance of the midwives could be attributed to the competing paradigms of sustainability and the hegemony of neoliberalism. It would seem that the same things that were preventing the midwives from engaging with environmental, social and economic sustainability were those that challenged their professional sustainability.
Bio of presenter

Lorna Davies, RN, RM, BSc (Hons), PGCEA, MA, PhD Candidate is a UK qualified midwife who has worked in midwifery education for the last two decades. She has published extensively in midwifery journals and texts and has edited and co-edited four midwifery titles in recent years including Sustainability, Midwifery and Birth. She is particularly interested in viewing midwifery and childbirth through the lens of sustainability and is presently undertaking a doctoral thesis exploring this area. Lorna is currently a principal Lecturer in Midwifery at Christchurch Polytechnic Institute of Technology in New Zealand and a part time educator for the New Zealand College of Midwives. She also carries a small caseload as a self-employed midwife and is a childbirth educator with her own company, Opti-mum which has a focus on mindfulness and childbirth. She lives in Christchurch with her husband and has three grown-up children.

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Lorna Davies

PhD Candidate University of Canterbury, New Zealand

Principal Lecturer in Midwifery, CPIT, Christchurch, New Zealand.
The barriers and facilitators of introducing evidence-based practices around the use of episiotomy in Jordan

Suha Hussein

Aim

In this presentation, we will examine the facilitators and barriers to evidence-based episiotomy practice in Jordan and the strategies that may be effective in introducing evidence-based practice.

Background

The practice of episiotomy is frequently undertaken during birth in many parts of the world, including several countries in the Middle East and Eastern Europe, with no scientific evidence of its benefits. Evidence supports the restrictive use of episiotomy and this is reflected in policy statements and clinical practice recommendations internationally. In recent years, various strategies have been adopted internationally with a view to shifting opinion and reducing the rate of episiotomy.

Methods

The study was conducted in a major maternity hospital in Irbid, Jordan and comprised: a retrospective file review of 300 births, face-to-face, in-depth semi-structured interviews with 15 staff (10 midwives and five key stakeholders managers and doctors). A feedback and discussion session was conducted in the last phase of the study. Here the findings were presented to staff and strategies to reduce the episiotomy rate in the hospital were discussed. Data were analysed using descriptive statistics and thematic analysis.

Results

The episiotomy rate was 41.4% overall (91% of primiparous women and 24% of multiparous women). Six major themes emerged from the analysis: Policy: written but invisible and unwritten and assumed; the safest way; doctors set the rules; midwives swimming with the tide; uncooperative and uninformed women and the way forward. It was evident that doctors directed maternity care practices and dictated policy in the maternity unit. Midwives, while at times doubting the spoken policy, were reluctant to modify practices or try to implement change.

They did not want to rock the boat, believing it was better for them to keep the peace with doctors and senior staff. Midwives and doctors alike appeared to blame birthing women for not taking part in decision-making processes in relation to the administration of episiotomy: they described birthing women as uncooperative and lacking in knowledge related to labour and birth. Suggestions for change included: running educational programs for staff and women. Some emphasised that managers
needed to be leaders to facilitate change and to offer support to midwives to practise in a different way.

Conclusions

Despite the promising suggestions for change, it was nonetheless apparent that effecting change would be difficult without also addressing the power relationship between midwives and doctors.

Bio of presenter

Suha Hussein is a midwife and has practiced for five years in Jordan. She completed her Masters Honours at Western Sydney University in 2014. Suha is planning to undertake her doctoral studies on Jordanian women's experiences and perceptions of maternity care and birth interventions.

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Margie Duff, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University
An overview of child-birth in Iran: Who does the maternity care system serve?

Maryam Bazargan

Over the last 30 years, medicalised birth models for healthy pregnant women have become the dominant care model in Iran, with the second highest rate of Caesarean Section (CS) in the world, with only Brazil having more. In 2008, the rate of CS was >40% in public hospitals and >90% in private hospitals. Some reports indicate the rate of CS is as high as 80% in some public hospitals in 2009 and 73% in a centre with 5982 annual births in 2014. Lack of a transparent system for public reporting of health information made it impossible to access recent childbirth data in Iran.

Policies that have been adopted in Iran’s maternity system in the last few decades, has changed the birth culture dramatically. These policies mainly focused on training medical specialists, while the role of midwives in maternal care has been mostly neglected with maldistribution of personnel (30 obstetricians vs 15 midwives per 1000 births), especially midwives. Due to fee for service model and absence of clear guidelines and transparency at organizational level, obstetricians have gained the power as Andrea Robertson (2006) mentioned in her diary:

Physicians are all-powerful, completely dictating the management of every birth and seemingly oblivious to evidence on care, midwifery skills, the mothers wishes, or anything else that might impact their practice.

These expensive policy changes in the maternity care system have created a fear of normal child-birth among the women and an increased CS rate which is a source of high income for obstetricians. In this system there is no suitable education for pregnant women (midwives are marginalised and obstetricians do not have time to educate women for normal birth), there is lack of support for women (due to shortage of midwifery staff or presence of a family member at birth), mothers and their families needs are neglected, and human rights do not exist. Therefore, not only the professional, but also the women in Iran believe that CS is safer than normal birth and in reality the system serves obstetricians not the women.

Although, the need for change in child-birth in Iran is urgent, altering the professional attitude toward birth will not be an easy task, since money is powerful incentive. However, reorienting and relocating mainstream maternity services within a primary health care paradigm for healthy woman and babies should be the main focus of government policy in Iran. Could implementation of some midwifery lead care models, eg. Midwifery Group Practise (MGP), accompanied by introduction of maternity
guidelines to Iran’s health system initiate behavioural change in clinicians and control
the CS epidemic in Iran?

This presentation considers the evidence to support this, in addition to how respecting
women’s rights at childbirth and understanding women centered care, appears to be
another fundamental aspect to bring back women’s trust on her own body and her
ability for normal birth.

Bio of presenter
Maryam completed a Bachelor of Midwifery at Tabriz University of Medical Sciences, a
Masters of Physiology at Tehran University of Medical Science and a PhD in Pharmacy
(Pharmacology) on Drug Disposition in Feto Maternal Unit at University of South
Australia, School of Pharmacy and Medical Sciences.
Maryam has held academic status in Flinders University School of Nursing and
Midwifery since 2015.

Roslyn Donnellan-Fernandez
Roz is a practising registered Midwife and Lactation Consultant. She was Women’s &
Children’s Hospital Foundation Midwifery Fellow 2008 - 2011. Roz is qualified in general
and mental health nursing and has held academic status in Flinders University School of
Nursing & Midwifery since 2008. She undertakes teaching, curriculum development and
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Midwifery Unit Network - Building capacity and confidence through dissemination and social media networking

Mary Newburn

Theme: Policy and practice relating to physiological childbirth

Background

Following publication of the Birthplace in England research and NICE Intrapartum Care guideline, three innovative UK midwives set up an online network (website, Twitter and Facebook) to promote and support midwifery units. They invited a service user advocate with an interest in evidence-based care, women’s rights and birth centres to join them. Units managed by midwives, providing midwifery care for women who meet nationally agreed criteria for eligibility, provide excellent opportunities for women to experience physiological birth, with good clinical outcomes for babies and for women. Women also report feeling psychosocial safety in the midwifery unit/birth centre environment. Yet, midwifery units, particularly those which are not alongside an obstetric unit, often face financial and other threats. In some parts of the world there is no pre-existing culture or history of midwifery-led units.

Midwifery Unit Network (MUNet), established by Sheena Byrom, Lucia Rocca-Ihenaco and Felipe Castro Cardona with Mary Newburn, facilitates networking, disseminates evidence and demonstrates leadership. MUNet was set up at very low cost by volunteers. Using the network as a platform for influencing and development. LRI has been awarded a knowledge mobilisation fellowship in England by the National Institute for Health Research; LRI/FCC are building partnerships with midwives in mainland Europe.

Aims

The workshop will share the philosophy and practice of MUNet. The model will be critically appraised; delegates will be asked to consider how the existing network could be developed further and whether they would like to participate or create an affiliated MUNet in their own country.
Methods

The workshop will be participative. Delegates are encouraged to visit the website before attending and to join the Twitter and Facebook groups. The facilitators (MN and SB) will arrange small group activities in which delegates present their strategic needs in relation to physiological birth and midwifery units, and question each other. MN and SB will introduce MUNet, talking about the strengths of MUNet, social media (SoMe), next steps and lessons learned.

Results

From a small start, a website and social media network has been grown, providing a platform for gaining funding, influencing policy, SoMe activity, academic support at City University, London, fellowship shortlisting and a planned European partnership programme. Collaboration between a small group of committed midwives, experienced as managers, consultant midwives and PhD research, with an experienced service user has been positive.

Conclusion

Midwifery networks of interest build confidence and potential capacity for more physiological birth. They provide a basis for formalising midwifery knowledge and influence. MUNet needs to engage with more UK and mainland European midwives. The MUNet model can be learned from and adapted in Australasia and other parts of the world, and the workshop will provide MUNet with new ideas and renewed motivation.

Bio of presenter

Mary Newburn has four sons and two granddaughters. She has been involved with the NCT since her first two babies were born in the 1970s.

Mary read Sociology at the London School of Economics and has an MSc in Public Health: Health Services Research. Her work at the NCT over 26 years included antenatal education, policy research, influencing and campaigning, advocating for women and encouraging local advocates in the maternity services, disseminating research findings and editing the CPD journal. Topics worked on include antenatal screening, improving access to information and support for expectant and new mothers and fathers, caesarean births, normal birth – developing a consensus with the Royal College of Midwives and Royal College of Obstetricians, home births, postnatal care, continuity of midwifery carer and birth centres. Mary is now a freelance health researcher and consultant in public and parent involvement.
Understanding how caseload works: Can theory help?

Michelle Newton

Background
Interventions such as the introduction of a new model of care are multi-faceted and often complex. Caseload midwifery is a complex intervention and has many ingredients. The challenges of defining and researching complex interventions have been well documented, including the difficulty of identifying causal relationships between aspects of the intervention and outcome. Theoretical frameworks in research can enable analysis of elements of complex interventions shown to have beneficial outcomes, eg. increases in normal birth associated with caseload midwifery.

Aim
We used Normalization Process Theory (NPT) to explore the introduction of caseload at two hospitals in Victoria, Australia. NPT uses four constructs to understand the work of a new intervention: coherence (what is involved in the work of implementation); cognitive participation (who does the work required for the implementation); collective action (the operational work required to organise a new practice); and reflexive monitoring (formal and informal evaluations).

Method
Midwives working in caseload and standard care were surveyed prior to and two years after the implementation of caseload, and caseload midwives and key stakeholders participated in in-depth interviews, with NPT concepts embedded in the data collection tools. Results draw on all data sources and use NPT as a framework to further consider which aspects of caseload midwifery care contributed to positive outcomes.

Results
Survey responses were 49% (150/309) at baseline and 44% (155/349) at two years and 40 in-depth interviews were conducted. Two of the constructs were strongly reflected in the findings; coherence (how caseload was understood) and collective action (how caseload work was enacted), and these in turn were reflected in midwives decisions about their suitability for caseload work (reflexive monitoring).

Both coherence and collective action were evident in how participants explained the positive clinical outcomes associated with the model; proposing that positive outcomes were a result of a commitment to normal birth, providing individualised care specific to physical and psychosocial needs, and being able to work throughout the continuum.
Through the establishment of relationships with women, there was an investment past the here and now, which facilitated ongoing exchange of information and engagement in active decision making with women. Providing care across the continuum also provided opportunities for midwives to see consequences of their care. The capacity to have a positive influence on outcomes was associated with caseload midwives professional satisfaction.

Conclusion
NPT has provided an opportunity to explore issues from a range of perspectives, and a way of explaining and understanding the factors that have facilitated or constrained normalisation of caseload at two different sites, including reasoning for improved outcomes for women and babies.

Bio of presenter
Michelle Newton has a clinical and education background in midwifery. Currently she is Course Co-ordinator of the Bachelor of Nursing and Midwifery (double degree) at La Trobe University. She has extensive experience in clinical midwifery, hospital and university-based midwifery education and in midwifery curriculum design. She also has expertise in the implementation and evaluation of midwifery-led models of care and in primary health care initiatives.

Michelle’s PhD was an exploration of midwives and key stakeholders experiences of primary midwife-led care, a model of care where women receive care from a known midwife throughout pregnancy, birth and early parenting and her continued research has focused on the sustainability of caseload midwifery models from a workforce and implementation perspective. Michelle is the current Vice-President of the Australian College of Midwives.

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2. School of Nursing and Midwifery, La Trobe University
3. The Royal Women’s Hospital
4. Australian Catholic University
Caseload midwifery in Australia: What access do women have?

Kate Dawson

Background

In Australia, various reviews of maternity services have recommended continuity of care for women having a baby. Caseload midwifery, where women receive care from a known midwife during pregnancy, birth and the postnatal period, is associated with fewer childbirth interventions; increased maternal satisfaction; and lower burnout and higher satisfaction for caseload midwives. Little is known about the availability of caseload across Australia and the factors that influence its implementation.

Aim

The aim of this study was to evaluate the barriers and enablers to the introduction, expansion and sustainability of caseload midwifery in public maternity services in Australia.

Method

A national cross-sectional of public maternity providers, including separate surveys of: (a) maternity managers and (b) midwives. Various aspects of caseload were explored including its access and availability; manager’s views, experiences and intentions regarding the model in the future; the structure and functioning of existing models; and the views of midwives in relation to caseload work.

Results

Managers from 149/235 hospitals (63%) and 545/3800 midwives (14%) responded. Of these hospitals, 31% had a caseload model, and a further 15% were considering implementing it. Overall, including all responding hospitals, an estimated 8% of women received caseload care. Of the hospitals with a caseload model, the majority offer a low risk only model. Most hospitals had unmet consumer demand, and half were planning on expanding the model. The main barriers to implementation related to availability of seed funding and organisational support.

Conclusions

Caseload midwifery care is increasingly being offered as a model of maternity care in public hospitals in Australia. Despite strong consumer demand, only an estimated 8% of women in public hospitals have access to caseload care. Further research should explore the factors that can contribute to maternity services capacity to grow and sustain a caseload model of care.
Bio of presenter

Kate Dawson is a midwifery academic from La Trobe University coordinating the Graduate diploma in Midwifery the teaching into both the double degree in Midwifery and Nursing and also the Graduate diploma pathway. She is currently a PhD candidate with Judith Lumley Centre at Latrobe University, working on the project she is about to present. Kate has worked in midwifery for more than 10 years working across a range of models of care including family birth centre, caseload midwifery and in private practice.

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Opinions of professionals about integrating midwife-led and obstetrician-led care in the Netherlands

Hilde Perdok-van Oostveen

Objective

The current division between midwife-led and obstetrician-led care creates fragmentation in maternity care in the Netherlands. This study aims to gain insight into the level of consensus among maternity care professionals about facilitators and barriers related to integration of midwife-led and obstetrician-led care. Integration could result in more personal continuity of care for women who are referred during labour. This may lead to better birth experiences, fewer interventions and better outcomes for both mother and baby.

Design

A descriptive study using a questionnaire survey of 300 primary care midwives, 100 clinical midwives and 942 obstetricians.

Setting the Netherlands in 2013

Participants 131 (response 44%) primary care midwives, 51 (response 51%) clinical midwives and 242 (response 25%) obstetricians completed the questionnaire.

Findings

There was consensus about the clinical midwife caring for labouring women at moderate risk of complications. Although primary care midwives themselves were willing to expand their tasks there was no consensus among respondents on the tasks and responsibilities of the primary care midwife. Professionals agreed on the importance of good collaboration between professionals who should work together as a team. Respondents also agreed that there are conflicting interests related to the payment structure, which are a potential barrier for integrating maternity care. Key conclusions. This study shows that professionals are positive regarding an integrated maternity care system but primary care midwives, clinical midwives and obstetricians have different opinions about the specifications and implementation of this system.

Implication for practice Our findings are in accordance with earlier research, showing that it is too early to design a blueprint for an integrated maternity care model in the Netherlands. To bring about change in a maternity care system, an implementation strategy should be chosen that accounts for differences in interests and opinions between professionals.
Bio of presenter
Hilde Perdok is junior midwife researcher at the Department of Midwifery Science, AVAG and the EMGO+ Institute for Health and Care Research, VU University Medical Centre, Amsterdam, The Netherlands. H.perdok@vumc.nl

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Hilde Perdok is junior midwife researcher at the Department of Midwifery Science, AVAG and the EMGO+ Institute for Health and Care Research, VU University Medical Centre, Amsterdam, The Netherlands. H.perdok@vumc.nl
What are the experiences of New Graduate Midwives working in Midwifery Continuity of Care Models

Allison Cummins

Background
Midwifery continuity of care has been shown to be beneficial to women through reducing obstetric interventions and other maternal and neonatal morbidity. In Australia, numerous government reports recognise the importance of midwifery models of care that provide continuity. New graduate midwives, should have the opportunity to work in these models of care. Historically, new graduates have been required to have a number of years experience before they are able to work in continuity of care although a small number have been able to move into these models.

Purpose/Objective
To explore the experiences of the new graduate midwives who have worked in midwifery continuity of care, in particular how new graduate midwives are supported and how they make a difference through professionalism.

Method
A qualitative descriptive study was undertaken framed by the concept of continuity of care. Purposive sampling recruited newly graduated midwives working in a midwifery continuity of care model n=13. Data were collected via semi-structured interviews. Thematic analysis was used to capture important concepts in relation to the research question.

Key Findings
The new graduate midwives valued the relationship with the women and with the group of midwives they worked alongside. Sub themes include developing trusting relationships, consolidating skills, support by the group and feeling prepared to work in midwifery continuity of care from their degree. All of these factors led to the participants feeling as though they were becoming a real midwife.

Discussion
This study demonstrates that new graduate midwives value working in midwifery continuity of care. The participants reported having more confidence to practice when they have a relationship with the woman, as occurs in these models.

Bio of presenter
Allison Cummins coordinates the Graduate Diploma in Midwifery and teaches both in the undergraduate and post graduate midwifery programs. Allison has developed
teaching and learning grants including the one touch midwifery app for smartphones and other online and workshop projects.

Allison’s research interest includes the introduction and support for midwifery continuity of care models, where a known and trusted midwife provides care to a mother during pregnancy, birth and the early parenting period.

Allison has been a practising midwife for over 20 years working with women in home and hospital settings. She continues to work as a midwife at Sydney’s Royal Prince Alfred Hospital on a casual basis, her practice complements her teaching role.

Authors and Affiliations

Allison Cummins
Associate Professor Elizabeth Denney-Wilson
Professor Caroline Homer
Swedish women’s interest in models of midwifery care. “Time to consider the system?”

Ingegerd Hildingsson

Background

Sweden has an international reputation for offering high quality maternity care, although models that provide continuity of care are rare. The aim was to explore women's interest in models of care such as continuity with the same midwife, homebirth and birth center care.

Methods

A prospective longitudinal survey where 758 women's interest in models such as having the same midwife throughout antenatal, intrapartum and postpartum care, homebirth with a known midwife, and birth center care were investigated.

Results

Approximately 50% wanted continuity of care with the same midwife throughout pregnancy, birth and the postpartum period. Few participants were interested in birth centre care or home birth. Fear of giving birth was associated with a preference for continuity with midwife.

Conclusions

Continuity with the same midwife could be of certain importance to women with childbirth fear. Models that offer continuity of care with one or two midwives are safe, cost-effective and enhance the chance of having a normal birth, a positive birth experience and possibly reduce fear of birth. The evidence is now overwhelming that all women should have maternity care delivered in this way.

Bio of presenter

Ingegerd Hildingsson is a midwife and works as a professor at Mid Sweden University and Uppsala University, within the midwifery programs. She has more than 100 scientific publications, is one of the leading researchers in midwifery in Sweden and is still working on the Labour ward. Areas of research are mainly in the field of childbirth fear, caesarean section, homebirth and models of care.

She has been the supervisor of 8 PhD students finalising their PhD exams and is currently supervising 12 PhD students with projects in different areas, mainly in the field of midwifery,
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Margareta Johansson, RM, PhD, Karolinska Institutet, Department of Clinical Science and Education, Sadersjukhuset, Stockholm Sweden
Implementing and scaling up sustainable continuity models of care: A workshop on practical application and theoretical underpinnings from implementation science

Jane Sandall

Background

There is strong international evidence that continuity models of midwifery care improve outcomes, increases women’s satisfaction and sense of control, decreases anxiety in both a general population and in those with complex social needs, and provides economic benefits. However, moving to wide scale up has proved difficult and unsustainable in a range of countries.

Aim

We will draw on the field of implementation science research to help explain how and why some scale ups succeed while others do not, and provide an introduction to how theories and methods from Implementation Science can inform evaluation of scale up of new models of care.

Methods

This workshop will use practical, case-study examples of implementing continuity models of midwife care to illustrate the application of implementation and improvement science theoretical frameworks, methodologies for example, logic models, evaluability and fidelity assessment tools into maternity services research within both Australian and UK contexts.

Results

The workshop will be relevant to those with an interest in evaluation of the implementation of models of care and assessment of measurable change to their services, and to those implementing new models of care.

Participants will explore the potential barriers and facilitators to implementation and gain knowledge of methods and tools from implementation science that can be used to plan and evaluate scale up of new models of care.
Conclusion

Workshop participants will

- have an appreciation of the quick-wins and difficulties that emerged from the research and implementation of continuity models of care.
- have an understanding of the main theories and methodologies related to implementing and evaluating scale up of new models of care.

Bio of presenter

Jane Sandalls research focuses on the impact of the implementation of service delivery interventions to improve quality of care.

Authors and Affiliations

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Prof. Helen McLachlan, Judith Lumley Centre and School of Nursing and Midwifery, La Trobe University, Melbourne

Dr. Michelle Newton, Judith Lumley Centre and School of Nursing and Midwifery, La Trobe University, Melbourne

Prof. Sally Tracey, University of Sydney

Mrs. Hannah Rayment-Jones, Faculty of Nursing and Midwifery, Kings College London
Cognitive Apprenticeship in a Midwifery Led Unit. The teaching and learning experience of midwifery mentors and student midwives

Sarah Norris

My previous presentation at the Normal Labour and Birth Conference 2015, discussed the first part of the findings of my ethnographic study and introduced how the concept of the Community of Practice emerged from the findings, and how the midwives in a midwifery led unit, through their shared endeavour, participated in the reification of knowledge and practice through the fundamental principles of an Implicit Constitution.

In this presentation I introduce the second part of the findings concerning the socially situated learning of student midwives within the Implicit Constitution, and the particular nature of the relationship with their mentor in this practice setting through Cognitive Apprenticeship.

The findings of the study reflect the diverse nature of student midwives experience of mentorship and learning in practice. Understanding the complexity of their learning experience is of prime importance in devising strategies to maximise their knowledge and skill acquisition.

I will present how the concept of legitimate peripheral participation links with the community of practice, and propose that, through a praxis of Cognitive Apprenticeship students can be supported to understand the meaning of the practices within the community, enabling them to participate and learn. The findings of the study reveal, that much of the midwives knowledge in the midwifery led setting is tacit, and their decision making implicit. The proposed praxis of Cognitive Apprenticeship is adapted for use in the midwifery led setting. Its primary function is to support mentors in sharing their knowledge and practices and has pedagogical implications for teaching complex knowledge, enabling mentors to make their invisible thinking visible to students.

The relationship of Cognitive Apprenticeship is dynamic, requiring the equal commitment between mentor and student. This duality encourages the students to participate in practice and interpret the meaning of its implicit aspects. The student is
therefore supported in developing the cognitive and metacognitive skills essential for the independent thinking required in preparation for qualification.

I will present the adapted framework of Cognitive Apprenticeship, illustrating how it emerged from the findings of the study through the use of data extracts. I will give a reflective account that maps the descriptors of the framework to the data in order to confirm its authenticity in the context of the findings. I will then propose how the framework should be used in pre-registration midwifery education and mentorship preparation as a resource to bring structure and equity to student midwives learning in order to enhance their experience.

Bio of presenter
My career spans 40 years in Healthcare, the last 20 years as a Midwife. I have practised across hospital and community settings in my role as a Midwife. During this time I became a passionate supporter of normal birth and midwifery led care. I have been a Midwifery lecturer for the last 14 years, of both preregistration and post registration students, and it has been a privilege to be involved in the education of student midwives as they develop their knowledge and skills to become independent thinking practitioners of the future. I work with a fantastic team of Midwives at Swansea University, South Wales, UK and it is the success of our Community of Practice as a team that we are able to offer the exciting and innovative programme of education enjoyed by our Midwifery students. The ethnographic study I conducted for my PhD explored the teaching and learning experiences of midwifery mentors and student midwives in a midwifery led unit in South Wales.

Authors and Affiliations
Sarah Norris. RM(dip)., BSc (hons)., MA,. PGCtHE
Senior Lecturer in Midwifery; College of Human & Health Sciences
Swansea University
South Wales, UK.
Walking with a foot in each world: Students’ experiences of dealing with the divide between theory and practice

Meg Hitchick

Background
Anecdotes from midwives and students identify frustration that midwifery in hospitals is often determined by hospital policies that may be outdated, and not reflective of new, high-quality evidence. It is well-recognised that emerging evidence-based recommendations may take years to become standard practice in these settings. Students, on the other hand, are consistently exposed to high-quality research and evidence that contradicts the often-accepted mode of practice, particularly in hospital-based midwifery.

This sense of frustration at the theory-practice gap is not uncommon among career midwives. It can be argued that the effect is most potent among students, as the intense exposure to new evidence comes at a time when they are highly vulnerable in the clinical setting, and the least equipped to promote organisational change. Anecdotally, midwifery students report that the constant compromise between theory that promotes normal birth, and practice that seems to diverge from this, is one of the more frustrating and discouraging aspects of their student experience.

Aim
To explore students experiences of assimilating their knowledge of evidence-based recommendations for normal birth with the contradictory practices they are exposed to in hospital settings in Australia. These experiences may be used to encourage leaders in health care settings to consider ways in which midwifery students can be useful in bringing about change that promotes normal birth, and in turn, to better support training midwives in their transition to practice.

Method
Midwifery students practicing in hospital settings are invited to share their experiences of, and reflections about the divide between current theory and current practice. Written and transcribed quotes from the students are grouped by the key themes, and examined in light of research on midwifery clinical learning, with a particular focus on reflective practice.

Results
Students confirm the existence of the theory-practice divide and report a wide range of strategies for dealing with this. Students describe being uncertain as to the effectiveness of their strategies, and identify themes of powerlessness, frustration, compromise, anxiety and self-preservation.

As such, although students may hold strong convictions on evidence-based practice for normal birth, they may be highly unlikely to take risks on attempting to apply their current learning about normal birth in practicum settings.
Conclusion
In order to survive entry to the profession, students must evolve ways of coping with the research-practice disconnect, and they must discover strategies that allow them to develop authentic practice that is acceptable to their environment. The quality of students adaptations to bridging this gap is of paramount importance in informing the kind of practitioners and midwives they will become. Leaders can create clinical environments to support this process.

Bio of presenter
Students in the Bachelor of Midwifery from Western Sydney University, and University of Newcastle.

Authors and Affiliations
Meg Hitchick, Amy Tang (Western Sydney University) and Sherrie Finnie (University of Newcastle)
Mapping access to physiologic labour and birth across birth settings

Saraswathi Vedam

Background
The US Birth Place Mapping Study examines the effects of place of birth on maternal/newborn outcomes and how experience and access to options for physiologic birth care are affected by integration of midwives into health care systems. A multidisciplinary task force created a 50 state database that tracks regulations, conditions for practice, and availability of licensed providers across birth settings in the United States. We developed and validated state-by-state report card ranking states on the regulatory conditions for midwives who offer care across home, birth centers and hospitals; and linking scores to rates of physiologic birth.

Aim
1. To analyze the status of access to midwives across birth settings (e.g. formal licensure, insurance coverage, scope and place of practice) in each state.
2. To analyze integration scores for each state (e.g. ranked by best conditions for practice and interprofessional collaboration across settings).
3. To compare integration scores with CDC and MANAStats data on markers of physiologic birth (e.g. cesarean, induction, vaginal birth, VBAC, etc.) in each state.
4. To compare regulation and integration of midwives with rates of physiologic birth outcomes in different regions

Method
We populated the database with published regulatory data and developed a scoring system to highlight barriers that affect integration of midwives into local maternity care systems. Higher state scores indicate more favorable practice conditions and increased access to midwives in all settings. However, because of discrepancies between publicly available information about midwifery regulation and licensure, and the realities of how statutes are interpreted or actioned, the team decided to validate the data that informs the scoring system so that it describes the actual context of practice. To do so we verified the on the ground relevance, importance, and realities of integration through a 50 state survey of 74 regulatory and practice experts. This included over 100 questions about midwifery integration.

Results
We present our results through 4 interactive maps:

1. Each state in the US displayed by access to regulated midwives
2. Actual integration of midwives and impact of local interpretations of regulations according to 4 color-coded categories

3. Illustrated rates of birth place (home, birth center, hospital) for each state

4. Illustrated rates of physiologic birth for each state

Conclusion

These graphics interact visually with each other; we have linked perinatal outcomes, physiologic birth, and choice of birth place in states where providers and care are well integrated, compared to states where disarticulation exists. The graphics are supplemented with a summary of results (including a description of the scoring system and a summary of the key markers of integration of each type of midwife). In addition, we plan to highlight model states (i.e., highest rates of integration of providers across birth settings)

Bio of presenter

Saraswathi Vedam is a midwifery professor in the Faculty of Medicine and Chair of the Birth Place Lab, at University of British Columbia. She has been in active clinical practice for 30 years. She serves as Senior Advisor to the MANA Division of Research, Executive Interim Board Member, Canadian Association of Midwifery Educators, and Founding Chair of the historic Home Birth Consensus Summits. Her scholarly work includes a development of scales to measure attitudes to planned home birth among maternity care providers, and Changing Childbirth in BC, a community-based participatory provincial study on women’s preferences for model of care and decision-making during pregnancy. This study resulted in the development of two new scales to measure Mothers Autonomy in Decision Making (MADM) and experience of respectful care, the MOR index (Mothers on Respect). In 2010, she chaired the 5th International Normal Labour and Birth Research conference in Vancouver.

Authors and Affiliations

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Dr. Eugene Declercq, Professor and Assistant Dean, School of Public Health, Boston University

Hon. Hermine Hayes-Klein, Human Rights in Childbirth

Rebecca Spence, Esq

Dr. Kathrin Stoll, University of British Columbia School of Population and Public Health

Emma Butt, Attorney and Midwifery Student, University of British Columbia

Tara Gaston, Esq., MPH Candidate (Maternal & Child Health), Gillings School of Public Health

Dr. Renee Cramer, Associate Professor and Chair of Law, Politics, and Society, Drake University
Which women are actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey

Maggie Redshaw

Background

Pregnancy and the early postnatal period are critical and stressful times in the lives of women and their families. NICE recommends that a general discussion regarding mental health and wellbeing take place with all women both at the first contact in pregnancy and in the early postnatal period.

Aims

To find out which women are asked about their mood and mental health during pregnancy and in the postnatal period, who is offered treatment, and who takes up the offer and receives support, advice, and/or treatment.

Methods

This study used secondary analysis of data from a national maternity survey carried out in 2014 in England which asked about care in pregnancy, labour and birth, and the postnatal period and individual characteristics, including sociodemographic details. Women were asked about discussions with healthcare providers and if they have been asked about their mental health during pregnancy and afterwards, about any offers and uptake of treatment and support in addition to their past emotional and mental health history.

Results

Usable returns were received from 4578 women. During pregnancy most (82%) of women were asked about their emotional and mental health in pregnancy and in the postnatal period. A total of 21% disclosed mental health problems antenatally of whom 36% reported being offered treatment. More women (90%) reported being asked about their mental health in the postnatal period. The study showed that White women, those living in less deprived areas, those who had received more education were more likely to be asked about their mental health, more likely to be offered treatment, and more likely to receive support than other women.

Those who had the opportunity to build a trusting relationship with their midwife were also more likely to be asked about their mental health.
Conclusions

The results of this study suggest that the inverse care law may be operating in maternal mental health. Those women most likely to be in need of support and treatment are least likely to be offered it. Continuity of care and carer could facilitate the building of trusting relationships and equity of access to mental health services.

Bio of presenter
Senior researcher and psychologist working with a multi professional group in the UK Department of Health funded Policy Research Unit in Maternal Health and Care, with links to maternity care research in Queensland at UQ.

Authors and Affiliations

Maggie Redshaw, Associate Professor, PRUMHC, National Perinatal Epidemiology, University of Oxford

Jane Henderson, Senior Health Services Researcher and Midwife, PRUMHC, National Perinatal Epidemiology, University of Oxford
Relationships: The key to safe, high quality maternity care

Lesley Page

Aim

Using current evidence to make the argument for continuity of relationship between those women and their families using maternity services and a midwife or small number of midwives, set in an effective model of care including caseload and team midwifery. To outline possible causal mechanisms between relational continuity and safe high quality maternity care, improved outcomes and experience, and cost effectiveness. To outline barriers and propose solutions or facilitators to bring the evidence and policy into practice. To provide exemplars of different models that provide relationship based continuity, to illustrate approaches and process of implementation, organisation and operation. To agree on approaches to scaling up and spread of models that support continuity of relationship.

Methods

Consideration of evidence, current policy, concepts and experience related to organisational development of models that provide relationship based continuity and agreement of definition. This was followed by intense collaborative enquiry in a framework of implementation science, between a multi-disciplinary group of practitioners, leaders and academics including users of maternity services at the first Sheila Kitzinger Symposium Green Templeton College Oxford University.

Results

The evidence for the scale up of continuity of carer was considered to be compelling and it was recommended that the model should be extended to more services and more women particularly to more vulnerable women. Drawing on implementation theory and critical experience from practice, barriers to scale up and solutions or facilitators were identified.

Conclusion

Scale up and spread of relationship based continuity is key to ensuring the health of women and babies, a better experience, reducing inequalities in outcomes and more cost effective care. Models of care that provide continuity of relationship and are appropriately organised and supported provide the potential for more satisfying work experience and learning opportunities for midwives and student midwives. It is
essential that models implemented are based on effective work patterns and practices, with adequate resources, and support professional autonomy and flexibility, and have appropriate management and organisational support. There are a number of alternative models that work for childbearing women and midwives and staff, and that will work in different contexts.

Evidence informed strategies and the use of experience of successful development are critical for influencing policy, commissioning and scale up of models that provide continuity of relationship. Exemplars of development and different models of care help in disseminating key information.

Bio of presenter

Professor Lesley Page is President of the Royal College of Midwives and visiting professor KCL and adjunct professor at UTS and Griffith University. Lesley received the International Alumni Award University of Technology Sydney in 2013 and was conferred with an Honorary DSc by University of West London in November 2013. In 2014 she was made a Commander of the British Empire (CBE). Her work has integrated practice, management leadership policy development and research.

Author and Affiliations

Lesley Page RCM KCL UTS Griffith University
Jane Sandall KCL
Kirstie Coxon KCL
Nicola Mackintosh KCL
Hannah Rayment-Jones KCL
Women turning the tide: How a rural birthing service was saved

Sally Cusack

Introduction

I am the mother of two children, aged 10 and 7, my first born in standard public hospital maternity care setting. My second child was born at home under the care of a private midwife - two very different experiences.

As a result of my contrasting birth experiences, I have developed a personal interest in how our society’s views of birth impacts on mother’s and babies’ outcomes in birth. For the past 5½ years I have been volunteering with Maternity Choices Australia, a national volunteer run organisation that advocates for women-centred care that is based on best evidence.

Today I will be speaking about the experience of achieving the seemingly impossible task of saving a rural birth service at Murwillumbah Hospital from closure. Over the last 20 years, scores of these low risk services around the country have been closed without ever being reopened, forcing women to travel further to larger hospitals, usually without continuity of midwifery care available.

What happened at Murwillumbah?

In the last week of May this year the women receiving their ante-natal care from the Tweed Valley Birthing Service at Murwillumbah District Hospital were shocked to be told that as of Friday that week, birthing would have to cease there. The women were told that instead they would have to go to The Tweed Hospital to give birth. Ante-natal and postnatal care was still available from the same midwives at the TVBS and these midwives would remain as the women’s primary carers for the birth, but they would have transfer to TTH for the birth.

For the past five years, the birthing services available at MDH were for normal risk women with the TVBS and elective caesarean births. Higher risk and emergency surgical birthing was transferred to TTH.

Having to transfer to TTH for the TVBS women meant a sudden and very different change of plan for those, not to mention the 30 km extra drive up the highway. If there is traffic, which happens often, this could mean a 50 minute drive. Many of the women who choose to birth at MDH do so to avoid this lengthy drive and the risk of birthing before arrival at hospital.
Birth of a Campaign

Rachel Bryant, a Murwillumbah mum who used the service last year, was shocked to learn of this and wanted to do something to stop the removal of this essential service. Word on the street was spreading. How could this happen? Women had always been able to give birth at MDH ever since it was built by its own community in the 1930’s. Local groups such as Rotary Club was up in arms.

[Remaining content to cover the work done by Rachel, me and the local community to get the service reinstated in just 5 months].

Bio of presenter
Mother of two children, 7 and 10 years, with the benefit of two very different birth experiences: the first in standard hospital maternity care, and the second with private midwifery care in the home.

Since becoming a mother I have been the primary carer of my children and have focused my interests on pregnancy, birthing, parenting and education. This has lead me to work in a diverse range of roles, all voluntarily, such as maternity services consumer advocate with Maternity Choices Australia and radio presenter with my local community radio station.

Through my voluntary work, I have developed an interest in providing a forum for women and families to share their stories of family life, mostly through our radio show. I am also interested in working with our legal and policy frameworks to enable families to get the optimum levels of service that exist in these frameworks but are not always apparent to the general community.

Sally Cusack, NSW President, Maternity Choices Australia
Service User involvement: Women changing services

Mary Newburn

Background

In UK maternity services, maternity services liaison committees (MSLCs) were introduced after a parliamentary enquiry. They have provided a means for women to influence local services, including keeping home birth on the agenda, getting better support for breastfeeding women, looking for ways to reduce caesarean rates, planning midwifery-led birth centres, reviewing provision of mental health services.

The Health and Social Care Act 2012 changed structures for planning and delivering maternity services. From 1 April 2013, clinical commissioning groups were set up to determine the strategic objectives of NHS maternity services in England and in the upheaval many areas MSLCs were pushed out, losing their small budgets. Many of the new commissioners knew nothing of the history of MSLCs. Instead of seeing this method of involving and engaging with the public as a valuable foundation from which to grow, the MSLCs model was seen as tired; failing to deliver.

Aim

In 2014, as Strategic Ambassador for NCT, I was tasked with facilitating implementation of the NICE Intrapartum Care Guideline which says that midwives and doctors should explain to all pregnant women that they can choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit) and ‘low risk’ multiparous women should be told that ‘planning to give birth at home or in a midwifery units is particularly suitable for them because the rate of interventions is lower and the outcomes for the baby is no different compared with an obstetric unit’. The same message should be giving to nulliparous women about midwifery units births, and that if they plan for a home birth ‘there is a small increase in the risk of an adverse outcome for the baby’. I felt that local women would be key in getting this on the agenda locally and aimed to make links with remaining MSLCs and support MSLCs to get back on their feet.

Method

NCT networks and social media were used to build an engaged and supported community of MSLCs. With a grant from Department of Health (DH) we completed a mapping survey of MSLCs, and held two VOICES training days for MSLC service user reps.

Results
Prompted by support and encouragement, one MSLC leader (a childbirth activist) set up a new Facebook page for ‘MSLC leaders’ which now has 169 members, one for most of the maternity services in England. NCT published a practical guide on good practice and troubleshooting. I was commissioned by DH to revise their document *Maternity Services Liaison Committees Guidelines for working effectively*. This includes guidance of paying service user reps who take on the demanding role of chairing the MSLC, which is includes midwifery and obstetric clinical leads, something that women felt was important.

Conclusions

MSLCs are a useful mechanism for public engagement and for woman to influence services, including improving opportunities for physiological birth.

Bio of presenter

Mary Newburn has four sons and two granddaughters. She has been involved with the NCT since her first two babies were born in the 1970s.

Mary read Sociology at the London School of Economics and has an MSc in Public Health: Health Services Research. Her work at the NCT over 26 years included antenatal education, policy research, influencing and campaigning, advocating for women and encouraging local advocates in the maternity services, disseminating research findings and editing the CPD journal. Topics worked on include antenatal screening, improving access to information and support for expectant and new mothers and fathers, caesarean births, normal birth – developing a consensus with the Royal College of Midwives and Royal College of Obstetricians, home births, postnatal care, continuity of midwifery carer and birth centres. Mary is now a freelance health researcher and consultant in public and parent involvement.

Author and Affiliations

Mary Newburn, freelance health researcher and consultant in public and parent involvement. Affiliated to NCT, UK’s largest pregnancy and parenting charity, Kings College London, City University, NHS England, Midwifery Unit Network, MSLC leaders and South West London Maternity Network. Received honorary professorship from University of West London.
Quality maternal and newborn care and the contribution of midwifery: Establishing research priorities

Holly Powell Kennedy

Background

Establishing research priorities is critical to guide health systems and research funders in wise use of limited resources. Substantial research investment in maternal and infant health has resulted in notable improvements in morbidity and mortality, yet in many settings poor outcomes persist. Prior research has identified benefits of midwifery to healthcare delivery and outcomes yet the practice of midwifery is rarely studied.

Aim

The purpose of the priority setting exercise was to identify future research activities to improve quality of maternal and newborn care and to examine the role of midwifery in its provision. The ultimate goal is to improve the survival, health, and well-being of childbearing women, infants, and families.

Method

Methodology developed by the Child Health and Nutrition Research Initiative (CHNRI) was adapted and used for this priority setting exercise, to enable systematic listing and transparent scoring of competing research options. Steps included a) selecting the study team, b) specifying context and scope, c) systematic identification and refinement of research options (the study team examined the evidence that informed the 2014 Lancet series on midwifery to identify knowledge gaps for future research), d) identification of useful, important, and relevant scoring criteria, e) pre-scoring of research options, f) identification of stakeholders/technical experts, g) scoring research options against final criteria, and h) calculation of overall priority score and rank assignment. The top research priorities were mapped to the evidence-informed Quality Maternal Newborn Framework identified in the Lancet series on midwifery.

Results

The top research priorities for midwifery have been identified through this exercise and are currently in review for publication. This presentation will present strategies to act upon the research priorities and implications for global maternal and newborn health.

Discussion
Identifying research priorities is the first step in addressing how to effectively develop new knowledge to address quality maternal and newborn health care and the role of midwifery in providing that care. The research priorities identified demand asking different questions and employment of different methods of inquiry. The potential significance and impact of this new knowledge requires substantial investment in research programs that address not only issues related to clinical care in pregnancy and childbirth, but also the full scope of maternity and newborn care involving community as well as facility based practice. Thus, development of research capacity is needed to ensure that those conducting the studies within their communities have the requisite knowledge and skills.

**Conclusion**

This systematic and transparent research prioritization exercise started with identification of existing evidence and gaps in knowledge. Importantly, this new knowledge could contribute to achieving the sustainable development goal of healthy lives and well-being for all people. Investment in these priorities has the potential to assist women, infants and families to survive and thrive. It would be transformative for families and communities, science, and innovation.

Bio of speaker

Professor Holly Powell Kennedy is the immediate Past President of the American College of Nurse-Midwives. She is currently the Helen Varney Professor of Midwifery and Executive Deputy Dean at the Yale University School of Nursing. Her program of research focuses on understanding the impact of specific models of care during the childbearing year. She completed a Fulbright Distinguished Fellowship at King's College London where she examined the capacity of tertiary birth settings to support women in normal birth. She is the lead author on a follow up study from the Lancet Series on Midwifery to identify future research priorities.

Holly Powell Kennedy, PhD, CNM, FACNM, FAAN
Pain dynamics and physiological birth
Rhea Dempsey

Background

My understanding and articulation of a theory of Pain Dynamics, their impact on birth outcome and practice implications, has been shaped by insights into the psychological challenge of physical achievement that I gained as a physical education and outdoor adventure teacher. These insights have been further shaped during my almost 40 years as a birth educator, doula and counsellor with a particular interest in birth debriefing.

Pain Dynamics describe the interplay between a birthing woman, her caregivers and support team when she experiences a Crisis of Confidence. Crises of Confidence in birthing are akin to the experience of hitting a pain barrier in other high intensity physical activities. In the birthing domain Crises of Confidence often lead to the use of medical pain relief with consequent disturbance of the physiological birth process.

Aim

To increase potential for normal physiological birth by understanding the impact of Pain Dynamics.

Method

This workshop will focus on discussing and sharing information and stories relating to concepts, which underpin Pain Dynamics

- Circles of Influence impacting the birthing woman’s experience of pain in labour: cultural circle, circle of family & friends, circle of birthplace culture, circle of known support.
- Normalizing predictable Crises of Confidence
- Crises of Confidence versus Transition
- Birthing woman’s Pain Type
- Midwives attitudes to labour pain
- Impact of ‘Birth Territory’ on the experience of pain
- Core concepts of support
- Physiological pain as a pathway to birth hormones
Siren’s song of the epidural

Results

Developing strategies for practical application of the theory of Pain Dynamics and its underlying concepts: during midwives’ conversations with pregnant women, in birth education settings, in the birth space and in postnatal discussions.

Conclusion

Understanding Pain Dynamics offers midwives a framework for realistic discussions with pregnant/birthing women about the impact of Pain Dynamics on birth outcome. Understanding these impacts may encourage women to make wise choices regarding place of birth, continuity models, appropriate support for working with pain and so increase their potential for normal physiological birth.

Bio of presenter

Independent Birth Educator/Attendant/Counsellor/Author

Rhea’s understanding of birth has been gained during almost 40 years working with pregnant women, partners, midwives and medical practitioners in home and hospital settings.

Rhea is a highly sought after speaker, educator and birth attendant with experience at over 1000 births. She is respected as one of Australia’s foremost thinkers on the topic of working with pain in childbirth and its connection to normal physiological birth—themes explored in her book ‘Birth with Confidence: savvy choices for normal birth’.

She is the mother of adult daughters and grandmother to three delicious grandchildren.
Sterile Water Injections for pain in labour

Nigel Lee

Background

Access to safe and effective analgesia in labour is arguably a human right for women internationally; however there are significant challenges in achieving this aim with regard to access to suitable pharmacological agents and technologies. Common non-pharmacological alternatives such as water immersion, acupuncture and transcutaneous nerve stimulation may also be unavailable or impractical. Sterile water injections (SWI) presents an innovative, low technology alternative for the relief of pain in labour, in particular back pain. Apart from the brief but significant discomfort associated with the procedure, it is free from side effects for mother and baby, inexpensive and suitable for many maternity care settings.

Aim

The workshop is designed to assist participants in acquiring the theoretical and practical knowledge needed to practice and propagate the procedure. The workshop will also assist in addressing the challenges faced when introducing new practices. The session is suitable to all levels of midwifery practitioners and will be limited to 30 participants.

Methods

The workshop will be presented by midwives with clinical and research experience in the use of SWI and consist of a presentation (20 minutes) that will outline the evidence supporting the procedure, issues arising out of the research and review the underlying physiology. The greater part of the workshop (55 minutes) will be used for the practical session. The procedure of SWI does not involve skills that are outside the normal scope of midwifery practice and is therefore suitable to demonstrate and teach within a workshop setting.

Participants will have the opportunity to practice determining the correct anatomical locations and depth for the injections. Participants may wish to practice the procedure on themselves or each other in small groups; this approach has proven safe, popular
and effective in previous workshops. Equipment required to practice the injections including simulation injection pads and personal protective equipment such as gloves and sharps disposal will be provided. For demonstration and teaching purposes normal saline is used as this is virtually painless (normal saline does not cause the same injection pain as sterile water).

The discussion group (15 minutes) will focus on strategies for using and introducing SWI in different practice settings and include issues regarding changing practice and introducing the procedure to women and clinicians.

Conclusions

Severe back pain in labour presents a challenge for both birthing women and their midwives and may present a catalyst for increased analgesia and intervention. Sterile water injections provide an effective, non-pharmacological analgesic which is adaptable to any birth environment. The greater availability and use of SWI would contribute to supporting birthing women and normal birth through assisting to meet the challenge for safe, low technology and low cost analgesia.

Bio of presenter

The facilitators for this workshop; Nigel Lee, Bernadette Leiser, Yvonne Halter-Wehrli and Lena Martensson are all midwives who have clinical and research experience with the use of sterile water injections for relieving pain in labour. Their experience encompasses a number of techniques and settings for the use of the procedure. They are all investigators on the SWIFT trial, which is currently being undertaken at four hospitals across Sydney and the Central Coast. As the number of injections required to initiate the analgesic effect is not known, the SWIFT trial is a randomised controlled trial to determine if two sterile water injections will provide the same pain relief as four.

Authors and Affiliations

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Traumatic childbirth: women’s descriptions of care provider actions and interactions

Rachel Reed

Rachel Reed is a Lecturer in Midwifery at the University of the Sunshine Coast. She has practiced midwifery in a range of models and settings in the United Kingdom and Australia.

Background

A traumatic birth experience is associated with postpartum mental health disorders such as PTSD, and difficulties in mother-baby bonding. The actions and interactions of care providers can have a significant influence on women’s experience of birth trauma. In order to inform care that promotes optimal emotional and psychological outcomes, care providers need to understand the causes of childbirth trauma from the perspective of women.

Aim

The aim of this study was to capture women’s descriptions of their traumatic childbirth.

Method

Data was gathered via an online survey of 748 women who experienced a traumatic birth. The women responded in their own words to the question describe the birth trauma experience, and what you found traumatisin.

Thematic analysis of the data was carried out using a six stage process described by Braun and Clarke (2006). Ethical approval for the study was gained via the University of the Sunshine Coast Human Research Ethics Committee (USC Ethics Approval No. 125...
Results
The majority of participants (66.7%) described care provider actions and interactions as the traumatic element of their birth experience. Three themes were identified from the data: I was invisible and my consent and I was violated.

Conclusion
Women’s descriptions of traumatic childbirth revealed that the actions and interactions of care providers contributed to their experience of trauma.

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Post-traumatic Stress in Australian Midwives: Prevalence and Risk Factors

Julia Leinweber

Background

Women’s experiences of birth trauma have been linked to the development of Posttraumatic Stress Disorder (PTSD). Midwives caring for women may also be frequently exposed to traumatic birth events, placing them at risk of also developing post-traumatic stress. Posttraumatic stress can increase midwives perceptions of risk in practice and adversely affect their beliefs in the normality of childbirth. Little is known about specific risk factors for the development of posttraumatic stress among midwives.

Aim

To identify prevalence and risk factors for probable PTSD among Australian midwives.

Method

A national internet survey of midwives registered with the Australian College of Midwives was conducted. Trauma symptoms were assessed with the Post-traumatic Symptom Scale Self Report (PSS-SR). Probable PTSD was assessed as meeting DSM IV PTSD diagnostic criteria B, C and D (a score of at least ‘one’ on the four point frequency scale for a minimum of one intrusion, three avoidance and two arousal symptoms) and a total PSS-SR score. Personal, trauma event-related and environmental risk factors were assessed as possible predictors using multivariate analysis.

Results

707 surveys were completed. The prevalence of probable PTSD was 17% (n=102) (95% CI 14.2, 20.0). Multivariate analysis identified three factors independently associated with probable PTSD; (1) feelings of horror during the traumatic birth event witnessed (AOR=2.57, 95% CI 1.20, 5.51); (2) feelings of guilt associated with the traumatic birth event (AOR=2.14, 95% CI 1.12, 4.08) and (3) a personal history of a traumatic experience when giving birth (AOR=2.12, 95% CI 1.24, 3.64).

Conclusion

Almost one fifth of midwives in this sample met criteria for probable PTSD. Practice-related factors more than doubled the risk for probable PTSD: Post-traumatic stress in midwives should be acknowledged as occupational stress by health services and professional associations. Trauma informed care and practise (TICP), which
acknowledges the impact of trauma among women and their care providers and aims to reduce the incidence of traumatic birth events, are recommended.

Bio of presenter
Julia has practised as a midwife in Germany and Australia and is a lecturer for the European Master of Science in Midwifery Program at Hannover University (Germany). Julia has a long-standing professional and research interest in how witnessing trauma affects midwives and their relationship with women in their care. Today she is presenting some of the outcomes of her PhD research on traumatic stress in midwives.

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Counseling for childbirth-related fear: Evaluation and a national overview

Birgitta Larsson

Background

Childbirth-related fear is common and can cause psychological distress, increased risk of birth complications and a negative birth experience. A request for cesarean section is more occurring among women with childbirth-related fear. Women who report childbirth-related fear have been offered counseling by experienced midwives in most hospitals in Sweden for decades, but there is no evidence for its effectiveness. Furthermore, despite the national recommendations concerning counseling as the first choice treatment, information about the content of such counseling is sparse.

Aim

To get an overall picture of the counseling support in Sweden regarding comprehensiveness, content and organization and to investigate women’s experiences of attending existing counseling support for childbirth-related fear and the effect of this counseling over time.

Methods

One cross-sectional study. Questionnaires were sent to all obstetric clinics in Sweden (n=45), a total of 43 clinics responded. Descriptive and one-way ANOVA was used in the analysis. One longitudinal survey with selected sample of 936 women. Of these, 70 received counseling for childbirth-related fear. Data was collected by questionnaires in pregnancy week 18, 2 months and 1 year after birth. Comparisons were made between women with or without counseling. Crude and adjusted odds ratios were calculated.

Results

All obstetric clinics in Sweden offer midwife-led counseling but the time allocated for counseling ranged between 5.7 and 47.6 minutes per childbirth. Considerable disparities regarding treatment options and the midwives’ supplementary educations were shown. Women who received counseling reported higher fear 1 year after giving birth (OR 5.0), they had a more negative birth experience that did not change over time (OR 2.1) and they were more often delivered by planned cesarean section (OR 4.7) compared to women without counseling.

Also, they preferred cesarean section to a greater extent in the case of another birth (OR 12.0). However, 80% were satisfied with the given support.
Conclusion

The midwife-led counseling conducted at the different Swedish obstetric clinics show considerable disparities. Women with childbirth fear would benefit from care on equal terms irrespective of place of residence. Consequently, it would be valuable to develop a national healthcare program for childbirth fear. Although women were satisfied, the counseling had minor effect on childbirth fear, birth experiences and cesarean section rates.

Bio of presenter

Midwife since the late 1990s. I have mainly worked in labour and maternity wards but also with counselling for women with childbirth-related fear. Now I am also a PhD-student and my research area is support and treatment for women with childbirth-related fear.

Authors and Affiliations

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Higher prevalence of childbirth related fear in foreign born pregnant women - findings from a community sample in Sweden

Christine Rubertsson

BIO
Elin Termstrom, born in 1982. I’ve been a RM since 2010 and a doctoral student since 2013. The main focus of my research is Fear of birth, where we study both prevalence of fear but also how to treat women with fear of birth. I combine my doctoral studies with clinical work and teaching.

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Normalising birth: Australian midwives responses to obstetric emergencies

Rakime Elmir

Background

Pregnancy and birth is a normal physiological process, however in the rare event complications do arise even in the healthy low-risk woman. Obstetric emergencies, is a time-critical decision making event, requiring team communication and cooperation that can potentially make a difference between life and death to a woman and her baby. Facing a birth emergency or obstetric emergency can be a time of fear, apprehension and uncertainty for midwives. Many argue that as the risk of complications during pregnancy, birth and postpartum is low, both midwives and women should be supported to view birth in a positive light and midwives’ need to work with women to reduce the fear women may be holding. Some women do experience birth as traumatic and there is increasing research describing the effects of a traumatic birth on women, yet, there is little research on midwives experiences of obstetric emergencies.

Aim

To explore midwives perspectives and experiences of obstetric emergencies.

Method

This study was underpinned by a qualitative approach. Data were collected via telephone interviews with 15 Australian Midwives.

Results

One major theme that emerged from the analysis related to ‘normalising birth’. This theme reflects the philosophy that some midwives’ held onto during and following the emergency event. There was also consensus among the midwives’ regarding the need for education to prepare midwives for the event of obstetric emergencies and complications. Approaches to ensure these skills were transferred to junior and student midwives was also raised as crucial.

Conclusion

Witnessing and being actively involved in an obstetric emergency can affect the way midwives’ perceive birth and the birth process and may potentially affect their practice with women. Midwives require a model of institutional support following an obstetric emergency to assist them in coping with the aftermath effects of an unexpected birth emergency.
Bio of presenter

Dr Rakime Elmir is a midwife and a lecturer at Western Sydney University. She completed her PhD in 2012 looking at women’s experiences of severe postpartum haemorrhage and emergency hysterectomy. Following on from her doctoral work she has been involved in a number of studies around father’s experiences of traumatic birth and midwives experiences of obstetric emergencies. Rakime’s research interests include qualitative research methodology and methods, women’s health, and birth trauma.

Authors and Affiliations

RN, RM, Grad Cert Clinical Teaching, BN(Hons), PhD
Numbers needed to cheat: Sense and nonsense about the safety of births planned in primary care and out of hospital

Ank de Jonge

Background
Several studies have shown that births starting in primary care and/or out of hospital are not associated with higher rates of adverse maternal and perinatal outcomes compared to births that started in secondary care. However, these results are sometimes used to advocate out of hospital birth in situations where prerequisites for safe out of hospital births are not met. On the other hand, some people argue that these results show that primary care is unsafe because no adverse outcomes should ever occur in primary care if risk selection was adequate.

Both viewpoints suggest a misinterpretation of research data.

Aim
To clarify methodological issues that explain how opposing conclusions can be drawn using the same data on planned primary care births and planned out of hospital births.

Method
An overview will be given of methodological issues in published studies into the safety of planned primary care and planned out of hospital birth.

Results
Controversies about the interpretation of data on the safety of planned primary care births and planned out of hospital births are mostly based on the following methodological issues: 1. Are groups compared that are really comparable? 2. Do the numerator and denominator of rates of adverse outcomes come from the same population? 3. Do findings apply to a very specific group of women or newborns which can not be extrapolated to low risk women?

Studies show that births starting in primary care and out of hospital are often associated with adverse perinatal outcomes if these births are not well integrated into the maternity care system.

Most studies comparing planned births in primary versus secondary care and planned home versus planned hospital birth showed no increased rates of adverse maternal and
neonatal outcomes and lower rates of medical interventions, if these births are attended by licensed midwives and if there is a good risk selection and transportation and referral system.

Conclusion
Methodological issues can lead to misinterpretation of data on the safety of births in primary care. Births planned in primary care or out of hospital can have favourable maternal and neonatal outcomes coupled with low rates of medical interventions, provided safety conditions are met.

Bio of presenter
Ank de Jonge is an associate professor and coordinator of the department of Midwifery Science at VU University Medical Center, Amsterdam. She is also a primary care midwife in Amsterdam. Her main research areas are organisation of care, effectiveness of clinical interventions and birthing positions.

Authors and Affiliations
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Neonatal Outcomes with Hospital Waterbirth

Jennifer Vanderlaan

Background: Waterbirth is a low cost intervention to manage pain in labor, improve women's satisfaction and comfort, and support normal, physiologic birth while reducing the need for medical interventions and health care costs. A recent statement from the American Academy of Pediatrics and American Congress of Obstetricians and Gynecologists recommend against Waterbirth due to lack of evidence demonstrating neonatal safety. Prior reviews focus on the few randomized controlled trials, however multiple non-randomized controlled studies, clinical audits, and observational studies have yet to be synthesized.

Aim: To provide a systematic review and meta-analysis of neonatal outcomes for infants born underwater in hospitals compared to infants receiving standard hospital delivery care.

Method: A study protocol is registered with the International Prospective Register of Systematic Reviews CRD4201401587. A systematic literature search was conducted identifying peer-reviewed and grey literature. Studies were screened by two reviewers, a third reviewer provided assistance with disagreements. Eligibility criteria included studies of full-term neonates born underwater in a hospital with a conventional hospital delivery control group reporting any of the outcomes of interest. Meta-Analysis was conducted with effects pooled as log odds ratios using a fixed-effects inverse variance model, assessing heterogeneity with stratification.

Results: Initial search identified 488 studies. After screening, 32 studies met inclusion criteria and reported on unique data. Of those, 30 studies provided the statistics needed for inclusion in at least one analysis.

Six outcomes favored Waterbirth over conventional delivery: 1 minute APGAR (OR 0.63, CI 0.58-0.67, 14 studies), 5 Minute APGAR (OR 0.96, CI 0.95-0.97, 16 studies), Infection other than pneumonia (OR 0.70 CI 0.50-0.96, 10 studies), Respiratory Distress (OR 0.42, CI 0.24-0.74, 4 studies), Umbilical pH (OR 0.65, CI 0.61-0.70, 9 studies), and Neonatal Intensive Care Admission (OR 0.68, CI 0.53-0.83, 15 studies). Six outcomes were equivalent between Waterbirth and conventional delivery: Resuscitation (OR 0.75, CI 0.36-1.57, 5 studies), Pneumonia (OR 1.31, CI 0.19-9.03, 2 studies), Neonatal Hypothermia (OR 0.66, CI 0.38-1.14, 4 studies), Shoulder Dystocia (OR 0.82, CI 0.4-1.66, 3 studies), and Neonatal Death (OR 0.77, CI 0.13-4.50, 3 studies). Only one study reported cord avulsion.

In these preliminary results, heterogeneity for 1 Minute APGAR, Respiratory Distress, and Umbilical pH require further investigation.
Reasons for heterogeneity currently being investigated include use of different measures, use of different Waterbirth inclusion and exclusion criteria, familiarity of the facility with Waterbirth, and comparability of the control group. Potential bias has been identified as failure to report on discontinued water deliveries, inclusion of discontinued water deliveries in the control group, and methods of selection for control groups.

Conclusion: This study finds no evidence Waterbirth increases odds of poor neonatal outcomes, although assessment of heterogeneity is ongoing. Using pooled effects from 30 studies, the analysis of each outcome is either equivalent or favors Waterbirth. These findings support the conclusion that Waterbirth, as currently practiced in hospitals, is as safe as conventional delivery.

Bio of presenter

Jennifer Vanderlaan MSN MPH RN is a PhD candidate at Emory University Nell Hodgson School of Nursing where she researches the impact of health care systems on maternal and neonatal outcomes. She teaches courses in anatomy, physiology, and pathology. She is a 2015 Emerging Leader with the Association of Women’s Health and Neonatal Nurses, and recipient of the 2105 Health Policy Scholarship from the Georgia Nursing Leadership Coalition. She has 15 years’ experience in maternal health.

Priscilla Hall PhD RN CNM is faculty at Emory University Nell Hodgson Woodruff School of Nursing. She is the specialty coordinator for Women’s Health Nurse Practitioners, and she teaches courses in Women’s Health Issues, Evidence Based Practice and Health Care in the Caribbean. She was the recipient of the W. Newton Long Award from the American College of Nurse Midwives for research about women’s experiences of emotion and agency during childbirth. She has worked in maternal health for 30 years.

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Women’s experience of early labour: a mixed methods study

Jane Henderson

Background
Numerous studies have established that women who are admitted to hospital in early labour are at increased risk of a cascade of interventions leading to caesarean section. Women are therefore advised to stay at home until they are in active labour. However, diagnosis of active labour is notoriously difficult, especially for the woman herself, and many women report dissatisfaction with their care at this time.

Aims
To describe women's concerns about early labour and their experience, and to explore how early labour experience varies by age, ethnicity, and social circumstances.

Methods
This study used secondary analysis of a national maternity survey carried out in England in 2014. The survey, using postal or online questionnaires, asked about care and experience of pregnancy, labour and birth, and the postnatal period, and sociodemographic factors. The survey comprised mostly closed questions about care but free-text was also collected.

Results
The survey had a 47% response rate with usable responses from 4578 women. Compared to other women, those living in deprived areas, those from minority ethnic groups, young and primiparous women all reported worrying significantly more about not knowing when labour would start and about getting to the hospital in time. Overall, 63% of women contacted a midwife or the hospital at the very start of labour and 84% of them reported that they were given appropriate advice and support at this time. However, primiparous and young women were significantly less likely to consider the advice and support appropriate. Similarly, primiparous women and those living in deprived areas were significantly less likely to be asked to come into the hospital when they did contact a midwife in early labour. Open-text comments about care at this time suggest that some women, especially women in these groups, felt dismissed or not taken seriously when contacting the hospital at this time.
Conclusions

Primiparous women and those in more vulnerable circumstances experience greater worry about early labour and there is a lack of equity in how they are treated. All women need sensitive and responsive care reflecting their needs as individuals.

Bio of presenter

After graduating in Occupational Health and Safety at the University of Aston in Birmingham in 1983, Jane went to Australia to do an MSc in Occupationally Associated Male Infertility. She then moved to the Unit of Health Care Epidemiology in Oxford where she worked for 8 years before joining the NPEU in 1995. In 2006 Jane left the Unit to train in Midwifery at Oxford Brookes University; she re-joined the NPEU in 2011. Jane’s research interests include midwifery, multiple births, breastfeeding and women’s experiences of care.

Authors and Affiliations

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Maternal and newborn outcomes following waterbirth: The Midwives Alliance of North America statistics project, 2004 to 2009 cohort

Melissa Cheyney

Introduction
Data on the safety of waterbirth in the United States are lacking.

Methods
We used data from the Midwives Alliance of North America Statistics Project, birth years 2004 to 2009. We compared outcomes of neonates born underwater waterbirth (n = 6534), neonates not born underwater nonwaterbirth (n = 10,290), and neonates whose mothers intended a waterbirth but did not have one intended waterbirth (n = 1573). Neonatal outcomes included a 5-minute Apgar score of less than 7, neonatal hospital transfer, and hospitalization or neonatal intensive care unit (NICU) admission in the first 6 weeks. Maternal outcomes included genital tract trauma, postpartum hospital transfer, and hospitalization or infection (uterine, endometrial, perineal) in the first 6 weeks. We used logistic regression for all analyses, controlling for primiparity.

Results
Waterbirth neonates experienced fewer negative outcomes than nonwaterbirth neonates: the adjusted odds ratio (aOR) for hospital transfer was 0.46 (95% confidence interval [CI], 0.32-0.68; 0.001); the aOR for infant hospitalization in the first 6 weeks was 0.75 (95% CI, 0.63-0.88; .001); and the aOR for NICU admission was 0.59 (95% CI, 0.46-0.76; .001). By comparison, neonates in the intended waterbirth group experienced more negative outcomes than the nonwaterbirth group, although only 5-minute Apgar score was significant (aOR, 2.02; 95% CI, 1.40-2.93; 0.001). For women, waterbirth (compared to nonwaterbirth) was associated with fewer postpartum transfers (aOR, 0.65; 95% CI, 0.50-0.84; P = .001) and hospitalizations in the first 6 weeks (aOR, 0.72; 95% CI, 0.59-0.87; P = .001) but with an increased odds of genital tract trauma (aOR, 1.11; 95% CI, 1.04-1.18; P = .002). Waterbirth was not associated with maternal infection. Women in the intended waterbirth group had increased odds for all maternal outcomes compared to women in the nonwaterbirth group, although only genital tract trauma was significant (aOR, 1.67; 95% CI, 1.49-1.87; 0.001).

Discussion
Waterbirth confers no additional risk to neonates; however, waterbirth may be associated with increased risk of genital tract trauma for women.

Bio of presenter
Melissa Cheyney PhD CPM LDM is Associate Professor of Clinical Medical Anthropology at Oregon State University (OSU) with additional appointments in Public Health and Women Gender and Sexuality Studies. She is also a Certified Professional Midwife in active practice, and the Chair of the Division of Research for the Midwives Alliance of North America where she directs the MANA Statistics Project. She is the author of an ethnography entitled Born at Home (2010, Wadsworth Press) along with several, peer-reviewed articles that examine the cultural beliefs and clinical outcomes associated with midwife-led birth at home. Dr. Cheyney is an award-winning teacher, and in 2014 was given Oregon State University's prestigious Scholarship Impact Award for her work in the International Reproductive Health Laboratory and with the MANA Statistics Project. She is the mother of a daughter born at home on International Day of the Midwife in 2009.

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Melissa Cheyney

Background: In the United States, the number of planned home vaginal births after cesarean (VBACs) has increased. This study describes the maternal and neonatal outcomes for women who planned a VBAC at home with midwives who were contributing data to the Midwives Alliance of North America Statistics Project 2.0 cohort during the years 2004-2009. Method: Two subsamples were created from the parent cohort: 12,092 multiparous women without a prior cesarean and 1,052 women with a prior cesarean. Descriptive statistics were calculated for maternal and neonatal outcomes for both groups. Sensitivity analyses comparing women with a prior vaginal birth and those who were at the lowest risk with various subgroups in the parent cohort were also conducted. Results: Women with a prior cesarean had a VBAC rate of 87 percent, although transfer rates were higher compared with women without a prior cesarean (18% vs 7%, p < 0.001). The most common indication for transfer was failure to progress. Women with a prior cesarean had higher proportions of blood loss, maternal postpartum infections, uterine rupture, and neonatal intensive care unit admissions than those without a prior cesarean. Five neonatal deaths (4.75/1,000) occurred in the prior cesarean group compared with 1.24/1,000 in multiparas without a history of cesarean (p = 0.015). Conclusion: Although there is a high likelihood of a vaginal birth at home, women planning a home VBAC should be counseled regarding maternal transfer rates and potential for increased risk to the newborn, particularly if uterine rupture occurs in the home setting.

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Provider-initiated late preterm births in Brazil: differences between public and private health sectors

Maria do Carmo Leal

Background
A large majority of the rise of prematurity worldwide is due to late preterm births. This increase may not solely be due to a change in obstetrical risk but also to an expansion of the range of medically indicated interventions, especially pre-labour caesarean section. This trend is a concern because late preterm births pose similar risks to overall prematurity and because of the multiple implications of caesarean section. In this study we aimed to describe the factors associated with provider-initiated late preterm birth as well as to verify differences between the public and private health sectors according to obstetric risk.

Methods
This is a sub-analysis of a national population-based survey of postpartum women named Birth in Brazil, performed between 2011 and 2012. We excluded stillbirths, women with unknown GA, multiple pregnancies, premature deliveries at 20 to 33 weeks gestation and deliveries at 37, 38 or 41 weeks gestation, totaling 10,443 full-term (39-40 weeks of gestation) and 1,785 late preterm (34-36 weeks gestation). We performed non-conditional multiple logistic regressions to assess risk factors and analyse differences.

Results
Provider-initiated births reached about 40% of late-preterm newborns. It was associated with previous preterm birth(s) and maternal pathologies in both public (adjOR 3.7; CI 2.5-5.5 and adjOR 6.3; CI 4.6-8.7) and private health sector (adjOR 4.5; CI 2.4-8.8 and adjOR 7.1; CI 5.3-9.5), and with maternal age 35 years in the public sector only (adjOR 1.7; CI 1.2-2.4).
Among late preterms, the higher risk of provider-initiated birth in the private sector, compared with the public sector, occurred for women of both low (adjOR 1.9; CI 1.1-3.3) and high obstetric risk (adjOR 2.4; CI 1.2-5.1).

Conclusion
The high proportion of provider-initiated late-preterm newborn suggests a considerable potential for reduction as such prematurity can be avoided, especially in women of low obstetric risk. To promote healthy births, it is advisable to introduce policies with incentives for the adoption of new models of birth care.

Bio of presenter
Maria do Carmo Leal is a Professor at the National School of Public Health (NSPH) Oswaldo Cruz Foundation (Fiocruz), Brazilian Ministry of Health and a Senior Researcher of the Brazilian National Council of Research. She is a Lead Researcher, who has led several investigations into Maternal and Child Health with emphasis in Epidemiology and program evaluation in her country. Her areas of scientific expertise also include Primary Health Care; Birth and Childbirth; Inequalities in Health; Maternal, Newborn and Child Mortality. During all Maria do Carmo Leal's career, she has worked as a Graduate Professor of Epidemiology in the NSPH/Fiocruz, where she was the Director of the NSPH, the Vice President of Education, Information and Communication of Fiocruz, and the Director of Fiocruz Press. She was also the coordinator of the National Epidemiology Commission of the Brazilian Association of Public Health, and she has received the Rio de Janeiro State Scientist Award three times.

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2. National Institute of Women, Children and Adolescents Health Fernandes Figueira, Oswaldo Cruz Foundation, Rio de Janeiro, RJ, Brazil.
Could the midwives of British Columbia benefit from a model of midwifery supervision?

Jane Wines

Background

Midwives are the promoters of normal birth. Midwives in British Columbia (BC) work in a medical system that is generally supportive of normal birth. BC midwives have a comprehensive schedule of conditions to consult or transfer care, but some institutions have restricted the scope of the midwife. Even greater effected are the women who choose alternative care plans (that do not follow local community standards). Autonomy of women starts with autonomy of the midwife. Clinical support mechanisms, such as supervision, increase autonomy, and currently there is no such mechanism in BC.

Aims

To discover if midwives are able to work autonomously in a system with no organised clinical support. To discover if they want or need a clinical support system, such as that of clinical supervision.

Methods

Mixed methods were used to obtain quantitative and qualitative data. An online survey tool was used to assess the current experiences of midwives, followed by interviews to expand on the themes. The eligible population consisted of all 229 registered midwives in BC. They were sent links via an email list serve, run by the Midwives Association of BC (MABC), that all BC registered midwives must belong to. A literature review assessed the effectiveness of supervision as a way in which clinical support could be given.

Results

46% of BC midwives responded with completed surveys. Answers were rich in data and several themes identified. Midwives often practice within an atmosphere of fear or uncertainty when women choose to plan their care outside of community norms, even if still within the scope of midwifery practice in BC. Although most midwives can practice to their full scope most of the time, there is a significant influence exerted on the profession by medical colleagues. For example, if a woman wants to have a vaginal birth after caesarean or forgo routine interventions, midwives could risk retribution from their medical colleagues. Midwives have varying degrees of access to clinical support, but overwhelmingly indicated they would want, and use, a clinical support mechanism such as supervision. Supervision has been shown to improve professional visibility (5), safety of care, and autonomy of practice (6).
Conclusion

There should be a clinical support system, similar to clinical supervision, introduced to BC. Further research into the best model of supervision needs to be carried out, and a pilot project undertaken. Supervision would increase midwives autonomy, decrease attrition and burnout, and maximize womens chances of achieving a normal birth within a medical system.

Bio of presenter

Jane Wines obtained BSc in Midwifery at University of Surrey, Guildford, UK. In 2004 she immigrated with her family to British Columbia and set up a solo case holding midwifery practice. This has grown over the years and now is a 3 midwife practice with around 150 families served each year. She was the founding Head of Midwifery at Richmond General Hospital, and has been instrumental in increasing awareness of midwifery in the hospital and community. Having been clinical faculty for 10 years, in 2015 she was appointed as Lead, Clinical Faculty and Placement Support at the University of British Columbia. This involves finding clinical placements for all of BCs midwives and supporting and training preceptors. Currently she is a Masters candidate at the University of Central Lancashire.

Authors and Affiliations

The Maternity Care Classification System: a more accurate way of defining models of care than by name alone

Natasha Donnolley

Background

There is well-established evidence that outcomes for low-risk women and their babies are better in some models of maternity care compared to others. In particular, increased rates of normal birth, fewer interventions and greater satisfaction for women are achieved from particular midwifery-led continuity of carer models. The question remains, outside of a single research study, how do we know what the name or type of model of care means? How can models be defined so that women can make better-informed choices; so that outcomes in different types of models can be compared or evaluated; and evidence-based decisions about appropriate models of care for different groups of women can be made? What do ‘midwifery group practice’, ‘team midwifery’, ‘high risk maternity care’ and ‘shared care’ actually involve? How can we compare the outcomes from different models of care, if we do not have a standardised way to define and classify them?

The Maternity Care Classification System (MaCCS) is a world-first system to classify models of care and facilitate meaningful analysis and comparisons of maternal and perinatal outcomes in different models of care. The MaCCS classifies models of care based on their characteristics and then groups similar models into 11 Major Model Categories (MMC). The MMC provide a simple naming system using terminology that is generally recognised throughout the world, such as Midwifery Group Practice Caseload Care, Team Midwifery Care, Private Obstetrician (Specialist) Care and the like. An independent study of the MaCCS was undertaken as part of a PhD study at UNSW to determine whether the MaCCS was a valid tool to classify models of care.

Aim

The study aimed to examine the heterogeneity of models of care from within the same MMC to demonstrate the need for a classification system based on model characteristics rather than using model types/names.

Method

As part of a larger validation study, 69 public maternity services in one state in Australia completed a MaCCS survey to classify two models of care at each hospital. Participants answered a series of questions about the design of each of the models of care and assigned their models to a MMC. The data was analysed using a statistical software program to examine the variation in characteristics of models of care classified to the same MMC.
Results

There was substantial variation in how maternity care was structured and provided in models grouped into the same MMC. This included variation in the target groups of women, the extent of continuity of carer, the type and number of collaborative carers, the location of care, and for how long the care was provided.

Conclusions

This study found that within models of care of the same type (MMC) there was significant variation in some of the characteristics acknowledged in the literature to influence outcomes. Identifying models of care that facilitate normal birth and improved outcomes for women and babies will be less accurate if evaluation is based on the model category or name, rather than the characteristics of the model of care. The findings of this study and the eventual implementation of the MaCCS have implications for service design, evaluation of health outcomes and delivery of maternity care in Australia and abroad.

Bio of presenter

Natasha Donnolley is a Project Officer at the UNSW National Perinatal Epidemiology and Statistics Unit where she has been involved in a number of national maternal and perinatal morbidity and mortality reporting projects. Since 2012 her main focus has been developing a classification system for maternity models of care as part of the National Maternity Data Development Project. She is a certified Health Information Manager who has had a varied career in health, IT and politics. In addition to her professional responsibilities, Natasha has worked as a Consumer Advocate and Representative for maternal and perinatal health for the past 12 years including involvement in state, national and international committees. Natasha is a Director on the Boards of the Australian College of Midwives and the International Vasa Previa Foundation and is Co-Chair of the NSW Maternal and Newborn Advisory Group. Natasha is undertaking her PhD in the School of Women's and Children's Health at UNSW.

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The emotional well being of New Zealand midwives

Lesley Dixon

Background

Ensuring the psychological wellbeing of midwives is becoming increasingly recognised as an important strategy in maintaining a healthy workforce and retaining midwives within the profession. Midwives as a professional group are the main advocates for normal birth. In New Zealand (NZ) midwives can choose to be self-employed and work in the community providing continuity of care to a caseload of women (self-employed case loading) or can be employed to work within a maternity hospital environment (generally shiftwork). Some choose to work in both work settings (self-employed and employed by an organisation).

Aim

The overall aim of this study was to explore the emotional wellbeing of midwives in NZ. The first objective was to describe and compare the demographic and work related factors of midwives who were (a) self-employed, (b) employed by an organization or (c) both self-employed and employed. The second objective was to explore factors associated with burnout within each of the three groups

Method

Practising New Zealand midwives who were members of the New Zealand College of Midwives were invited to complete an online survey. The study package included demographic questions, the Depression, Anxiety and Stress Scale (DASS 21), the Copenhagen Burnout Inventory (CBI), Perceptions of Empowerment in Midwifery Scale (PEMS) and the Practice Environment Scale (PES).

Findings

A total of 1073 midwives responded (self-employed 44% n=473; employed 42% n=451; both self-employed and employed 14% n=146). Employed midwives worked fewer hours (Median 32hrs) than the other two groups (Median 40hrs and 36hrs respectively) but had significantly higher levels of work and personal related burnout as well as anxiety. Employed midwives also reported lower levels of autonomy, empowerment and professional recognition. Aspects of the work environment found to be associated with burnout (particularly for employed midwives) were inadequacy of resources, lack of management support, lack of professional recognition and development opportunities.
Conclusion

Working across the full scope of midwifery practice and proving continuity of care to women (in a caseload model) is protective in terms of emotional wellbeing regardless of whether the midwife is employed or self-employed. Continuity of care can support a supportive relationship and informed decision making with the midwife advocating for women to birth normally.

Bio of presenter

Lesley Dixon: Midwifery Advisor - Practice Advice and Research development  PhD, RM, RN, MA (Midwifery)
Lesley is a practising midwife and worked in England, Germany and New Zealand. Lesley has a good understanding of clinical practice issues, having worked both as self employed LMC midwife and in various employed positions. Lesley leads the College’s research programme.

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Andrea Gilkison, Programme Leader, Midwifery Department, Auckland University of Technology
Variation in healthy maternal and newborn birth outcomes in England: The influence of organisational, staffing and women’s background characteristics

Jane Sandall

Background
There is little evidence on the effect of maternity workforce and organisational factors on maternal and newborn outcomes. There is increasing concern that quality of care should include positive health outcomes in addition to morbidity and mortality, but few indicators available.

Aims
To assess how organisational and staffing factors interact with women’s characteristics, and affect variation in healthy maternal and newborn outcomes.

Method
Hospital Episode Statistics data from 143 NHS trusts in England in 2010-11 on 656,969 births. Ten outcome indicators were derived including 3 composite healthy mother and baby outcomes. Adjustments were made for mother’s characteristics, clinical risk factors (NICE guidance mapped to ICD-10 codes), organisational factors and maternity workforce staffing. Multilevel logistic regression models were fitted and based on the AUC were all in the range 0.70-0.80 (fair fit).

Results
There was wide variation after adjustment (1) healthy mother (without 2nd-4th degree tear/sutures/episiotomy, instrumental birth, maternal sepsis, anaesthetic complication. Returned home within 2 days, and not readmitted within 28 days) = 28% (range 18.8-41.4 %) (2) Healthy baby (weight 2.5-4.5 kg, gestational age 37, 42 weeks, live baby) = 85% (range 75%, 90.7 %), and (3) healthy mother/healthy baby dyad (in which both mother and the baby were healthy) = 25% (range 16.0% 38.5 %).

Staffing levels and organisational characteristics were not statistically related to any of the three healthy mother and healthy baby indicators. Clinical risk was the most important predictor of outcome followed by mother’s parity. Mothers and babies were more likely to achieve a healthy outcome with increasing parity, which had a more dominant effect upon the mother, and the effect of age was smaller. Ethnicity had a stronger effect upon the healthy mother outcome than the healthy baby outcome. Mothers from most deprived quintile were more likely to achieve a healthy mother outcome than mothers belonging to the least deprived quintile. This relationship was reversed, and less strong, for the healthy baby outcome.

Discussion
Wide variations in outcomes remain after adjustment for socio-demographic, clinical, and organisational factors. It is also necessary to understand how and why women from areas of social deprivation have better healthy mother outcomes and worse healthy

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baby outcomes.

Bio of presenter

Jane Sandall’s research focuses on the impact on health outcomes and users’ experiences of innovative service delivery models.

Susan Bewley is a clinical academic obstetrician with an interest on maternal morbidity. Debra Bick’s research focuses on the impact of pregnancy and birth on women’s physical and psychological health.

Graham Cookson’s interests lie in the economic analysis of public services and public policy, especially health policy.

Miranda Dodwell is trained as a childbirth educator, and is a researcher and maternity service user representative.

Kirstie Coxon’s research focuses on choice and place of birth. Rod Gibson is a data analyst/statistician with an interest in maternity care.

Trevor Murrell’s research interests focus on the health care workforce, and modelling of large data.

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Midwives management during the second stage of labor in relation to perineal injuries

Malin Edqvist

Background
It is reported that 77-86% of women sustain some degree of perineal trauma during childbirth. Injuries vary from small abrasions to severe perineal injuries such as obstetric anal sphincter injuries (OASIS). Researchers have mainly focused on OASIS, where known consequences for women are pain, dyspareunia and anal incontinence. Both short- and long-term symptoms have an impact on women’s daily lives and also alter the women’s understanding of their identity as sexual beings. Few studies have assessed risk factors for less severe perineal trauma such as second degree tears but the risk factors appear to be similar. There is a lack of knowledge regarding consequences after less severe injuries and whether these are preventable by midwifery care measures during the second stage of labor.

Aim
The objective of this study is to explore midwives management of the second stage of labor in relation to perineal and vaginal injuries (second degree tears) and to evaluate an intervention developed to prevent these injuries in nulliparous women.

Methods

Setting: Two labour wards in Stockholm (the capital city of Sweden) participated in the study.

Design: An experimental prospective cohort study. First a baseline measurement was conducted to document midwifery practices used during the second stage. Midwives working day shift in one ward performed the intervention and in the other ward midwives working night shift performed the intervention. Inclusion criteria: Nulliparous women considered as low risk, with a planned vaginal birth at term. Intervention: The intervention consists of 1) spontaneous pushing, 2) all birth positions except the semi-recumbent and the lithotomy position and 3) a slow delivery of the baby’s head, preferably the head is born in the end of a contraction or between contractions. Analysis: Descriptive statistics, bivariate analysis and logistic regression will be used to analyze the data.

Results
A total of 404 nulliparous women have been recruited to the baseline part of the study. Another 607 nulliparous women who met the inclusion criteria have been recruited to
the intervention study. Of the 607 women, 301 received the intervention and they will be compared to the 306 women who received standard care. Main outcome measures will be presented at the conference. Primary outcome: 1) Second degree tears 2) Second degree tears divided into three subgroups according to the extent of the tear. Secondary outcomes: 1) Obstetric anal sphincter injuries 2) Intact perineum 3) Blood loss at delivery.

Bio of presenter

Malin Edqvist is a registered midwife since 2003. She began her PhD studies in 2012 and her field of research is perineal injuries in childbirth in relation to different aspects of care and in different birth settings. She is a lecturer at the Midwifery program at the Karolinska Institute in Stockholm and also a member of a Swedish national advisory board on pelvic floor dysfunction related to pregnancy and childbirth.

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Assessing the barriers and facilitators of the implementation of delayed cord clamping: A qualitative synthesis

James Harris

Background

In 2015, the National Institute of Health and Care and Excellence (NICE) quality statement relating to delayed cord clamping (DCC) states: ‘women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat’.

Immediate cord clamping has previously been normal practice for midwives and obstetricians in the UK. The barriers and facilitators to changing maternity professional behaviour in relation to implementation of delayed umbilical cord clamping are currently unknown.

Aim

1. To assess the potential barriers and enablers for change for maternity healthcare professionals in implementing delayed umbilical cord clamping in a variety of birth settings and situations

2. To attempt to identify the evidence – practice gap within England, by identifying any relevant research related to delayed cord clamping

3. To identify any previously used implementation frameworks, models and theories that have been utilised and may be relevant for this particular health professional behaviour change.

Methods

A validated search strategy of 95 terms was applied to seven databases. Further citation, reference and hand searches were conducted. Grey literature was sourced via specialist databases. Quality assurance of search strategy was via expert consultation and inter-rater reliability of selection criteria checked. While an assessment of quality was undertaken, poor quality did not result in exclusion of the paper. Data were synthesised via the Framework Synthesis approach, using both a deductive (items from the Theoretical Domains Framework, (TDF)) and inductive approach (thematic analysis).

Results

The search identified eight studies that fit the inclusion criteria. Two studies were qualitative and the remaining six mixed-methods. The majority of the studies (n=6)
were US based. Key TDF domains that appear to act as a barrier or facilitator to DCC practice include knowledge, professional roles, beliefs about consequences and environmental context.

Both professional (midwives versus obstetricians) and contextual (perceived fetal wellbeing, place of birth) factors appear to impact DCC practice.

Conclusion

Due to the potential health and cost benefits of delayed cord clamping, a programme of research into the implementation of these guidelines is urgently needed. A theoretically informed complex intervention is urgently required to encourage health professional behaviour change. Initial evaluations of such an intervention will need to assess if specific interventions are required for differing professional groups and contexts.

Bio of presenter

James Harris is a lecturer in midwifery/post-doctoral fellow in implementation science evaluating the implementation of delayed cord clamping.

Caroline Hunter is a tutor in midwifery at King’s College London, with a research interest in clinical skills and the third stage of labour.

Nick Sevdalis is a professor of Implementation science & patient safety, and the head of the Centre for Implementation at Kings College London.

Jane Sandalls research focuses on the impact on health outcomes and users’ experiences of the implementation of solutions at a health system and service delivery level to improve quality and safety of care.

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Can twins have a normal birth?

Jeffrey Craig

This presentation will cover women's experiences in having twins and some of the research that our team has conducted with a cohort of mothers and their twin children.

Woman pregnant with twins experience a wide variety of experiences up to the time of delivery. Higher risk is conferred by a shared amnion and a shared placenta in up to one in five pregnancies but apart from mild prematurity and a higher likelihood of caesarean section, there are few differences compared to those expecting singletons. However, we have found that frequently, there is confusion about whether twins are identical or fraternal and there is no routine reporting of chorionicity (one or two placentae) and zygosity. We encourage accurate reporting of chorionicity, from ultrasounds and from examination of the placenta at birth.

For many years, researchers have been working with twins to tease apart the effects of nature (genetics) and nurture (environment) on human health and disease. We will present data from a study in which we have followed the progress of twins from mid gestation, which has led to some fascinating insights into the experience of twins in utero and beyond. The differences we have found within pairs of twins, including those that influence the epigenetic musicians that play the symphony of life on our genes, made us rethink what the normal in utero experience is for twins and the rest of us.

Bio of presenter

Associate Professor Craig leads the Early Life Epigenetics Research Group at the Murdoch Childrens Research Institute and is an Honorary Associate Professor within the Department of Paediatrics, University of Melbourne. He has established a number of longitudinal cohorts including the Peri/postnatal Epigenetic Twin cohort. Dr Craig is a passionate twin researcher and is Deputy Director of the Australian Twin Registry. His work focuses on epigenetic changes associated with early development and the link between environmental factors, development and disease, in particular cardiovascular and neurodevelopmental disorders. He is currently developing epigenetic biomarkers to integrate into disease risk models.

Authors and Affiliations

Jeffrey M Craig, Murdoch Childrens Research Institute, Royal Children's Hospital, Melbourne

Mark Umstad, Royal Women's Hospital, Melbourne
Continuity of midwifery carer moderates the effects of prenatal maternal stress on postnatal maternal wellbeing: The QF2011 Queensland Flood Study

Sue Kildea

Background
A number of studies have demonstrated that a severe independent stressor (such as a natural disaster) during pregnancy has negative effects on a range of maternal and infant outcomes. Partner support during pregnancy has been shown to protect against the negative effects of a severe stressor on women's postnatal mental health. When compared to standard care (SC) midwifery continuity of carer during pregnancy, birth and the postnatal period (MGP care) has been shown to significantly improve outcomes for mothers and infants with women reporting increased support. We hypothesised that MGP care, when compared to SC, would protect pregnant women from the impact of flood exposure on postnatal wellbeing.

Method
In 2011, we recruited women who had been exposed to the Queensland floods during pregnancy. A longitudinal study has followed the women and infants collecting data across a number of timeframes. Hierarchical linear regression models assessed risk factors (socio-economic status, other life events in pregnancy, and depression in pregnancy) and model of care interacts with flood exposure on postnatal maternal depression and anxiety.

Findings
Greater Edinburgh depression scores in early pregnancy, objective flood related hardship and subjective distress a woman experienced predicted higher depression and anxiety scores at six weeks and six months postnatally. For women who were flood affected, continuity of midwifery care through the MGP model was associated with lower depression and anxiety scores at six weeks postpartum, compared to women who received SC.

Implications
Maternal wellbeing following the birth of a child is critical for optimal family functioning and healthy child development. Research shows that mothers who are anxious or depressed in the post-partum period display compromised infant caregiving: they interact and respond less to their infants needs than healthy mothers. Further, infants of depressed mothers are shown to have difficult temperaments and high rates of emotional and behavioural problems in childhood. Our study found that MGP care was able to buffer the effects of stress in the context of a natural disaster.

Authors
Sue Kildea, Gabrielle Simcock, Aihua Liu, Adele Kahler, Sally Tracy, Marie-Paule Austin, David P. Laplante, Sue Kruske, Mark Tracy, Michael W. O'Hara, Suzanne King.

Bio of Presenter can be found in main program as a keynote speaker.
The relationship between early birth, caesarean section and maternal mental health and gastro-oesophageal reflux in infants admitted to hospital in the first 12 months following birth in NSW (2000-2011)

Hannah Dahlen

Background
Gastro-oesophageal reflux (GOR) is common in infants and is generally described as the effortless reflux of gastric contents into the oesophagus in an otherwise healthy infant. When the condition causes pathological symptoms and/or complications it is considered as gastro-oesophageal reflux disease (GORD). The progression from GOR to GORD is commonly misunderstood and difficult to treat and the terms GOR and GORD are often used interchangeably to describe infant reflux. It appears to be increasingly diagnosed and causes great distress in the first year of infancy, though the reason for this increase is unknown. In NSW residential parenting services support families with early parenting difficulties (e.g. sleep, settling and feeding difficulties). These services report a large number of babies admitted having been also given a label of GOR/GORD.

Aim
The aim of this study was to explore the maternal and infant characteristics, obstetric interventions, and reasons for clinical reporting of GOR/GORD in NSW in the first 12 months following birth (2000-2011).

Methods
A three phase, mixed method sequential design was used. Phase 1 included a linked data population based study (n=869 188 admitted babies). Phase 2 included a random audit of 326 medical records from admissions to residential parenting centres in NSW. Phase 3 included eight focus groups undertaken with 45 nurses and doctors working in residential parenting centres in NSW.

Results
There were a total of 1 156 020 admissions recorded of babies in the first year following birth, with 11 513 containing a diagnostic code for GOR/GORD. GOR/GORD was a diagnostic code for 1% of infants admitted to hospitals in the first 12 months following birth. Babies with GOR/GORD were also more likely to be admitted with other disorders such as feeding difficulties (9.8% vs 0.2%), sleep problems (10.2% vs 0.6%) and excessive crying (38.1% vs 0.6%). The mothers of babies admitted with a diagnostic code of GOR/GORD were more likely to be primiparous, Australian born, give birth in a private hospital, have a psychiatric condition, have a preterm or early term infant (37 or 38 weeks), have a caesarean section, have an admission of the baby to SCN/NICU and have a male infant. In the medical records review we found 36% of infants admitted to residential parenting centres in NSW (2013-2014) had been given a diagnosis of GOR/GORD. Focus group data revealed two themes:
It is over diagnosed and a medical label is a quick fix, but what else could be going on?

Conclusion

The fact that mothers with a mental health disorder are nearly five times as likely to have a baby admitted with GOR/GORD in the first year after birth should be of concern to clinicians. We propose a new way of approaching the GOR/GORD issue that considers the impact of early birth (immaturity), disturbance of the microbiome (caesarean section/antibiotics) and mental health (maternal anxiety in particular).

Bio of presenter

Hannah Dahlen is the Professor of Midwifery in the School of Nursing and Midwifery at Western Sydney University. She has been a midwife for 26 years and still practices.

Hannah has strong national and international research partnerships, has received 15 grants since 2000, including being CI on three NHMRC grants and an ARC Linkage grant and has had over 100 publications. She has spoken at over 100 national and international conferences and given invited keynote addresses at half of these.

Hannah is the National Media Spokesperson for Australian College of Midwives and has been interviewed in print, radio and TV numerous times and featured in three documentaries. Hannah is a past President of the Australian College of Midwives and received Life Membership in 2008 for outstanding contributions to the profession of Midwifery.

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Is there a human right to physiologic birth? The European Court of Human Rights and access to home birth

Zoe Miller-Vedam

Background

Access to normal physiologic birth and respectful maternity care is rare in many eastern European countries. Facing routine interventions, high rates of cesarean sections, and lack of respect for consent and autonomy in decision making, women have turned to home birth. Although home birth is legal in countries such as Hungary, the Czech Republic, Lithuania and Croatia, their national regulatory frameworks do allow medical professionals to attend home births. Recently, women have turned to human rights law to argue that these restrictions infringe upon their Right to Private and Family Life, as protected by Article 8 of the European Convention on Human Rights (‘the ECHR’).

Aim

To analyze all European Court of Human Rights (‘the Court’) decisions about planned home birth and consider the potential impact of these decisions on equitable access to physiologic birth care across Europe.

Methods

This is a critical review of all case law concerning access to home birth attended by qualified medical professionals that have been heard by the Court. A database search reveals that although the Court has considered related reproductive rights issues, it has only addressed access to home birth twice. Given the paucity of relevant case law, these two precedent setting cases, Dubska and Krejzova v the Czech Republic (‘Dubska’) and Ternovszky v. Hungary (‘Ternovszky’) were analyzed in depth from a human rights and feminist law perspective.

Results

Although in Ternovsky, the Court recognized that choice of birth place is part of the fundamental right to choose the circumstances in which to become a parent, their approach in Dubska, belies their commitment to uphold this principle. The Court’s reluctance to challenge the authority and existing medical framework of the respondent states, in the name of margin of appreciation, perpetuates a paradoxical legal standard where states claim to uphold autonomous medical decision making while restricting...
women’s choices and access to safe care. The Court’s decisions also demonstrate a flawed approach to examining global scientific evidence and a tendency to be swayed by arguments about competing rights and interests.

Conclusion

By restricting the ability of women to exert their human rights to privacy, bodily integrity and autonomy in healthcare decision making, the Court has severely undermined respect for and access to safe physiologic birth. This presentation will discuss the ECHR and the Court’s potential for protecting women’s access to physiologic birth, the Court’s reasoning in Ternovszky and Dubska, the treatment of global scientific evidence by the Court, and the impact of these decisions on women seeking physiologic birth. I will also discuss recent legal developments to Dubska and related upcoming cases that have been brought against Lithuania and Croatia.

Bio of presenter

Zoë Miller-Vedam has worked in human rights law and received her LLM in International Human Rights Law from the University of Leicester. Her research focuses on medical autonomy, reproductive rights, access to birth options and human rights in childbirth. Zoë is currently working on strategic planning and conference organization with Human Rights in Childbirth, a global NGO. She is also researching barriers faced by midwives in British Columbia who are seeking hospital privileges, in conjunction with the Midwives Association of British Columbia. She worked as an aide at the 2010 International Normal Labour and Birth Research Conference in Vancouver, Canada and attended the 2015 International Normal Labour and Birth Research Conference in Grange-over-Sands, UK.

Authors and Affiliations

Zoë Miller-Vedam, LLM.
When Legal Mechanisms Fail: Activism and the Uphill Battle for Reproductive Justice

Wendy Kline

“In a society that defines and regulates medicine by law,” argues Raymond DeVries, “midwives can achieve legitimate status only by accepting a place within medical statutes.” Yet what happens when midwives are not legally recognized? This talk examines moments in which the law has historically undermined collaborative structures between midwives and doctors. When U.S. midwives began to be arrested in increasing numbers in the 1970s, for example, they were forced to deny any reliance or connections between what they were doing and the practice of medicine, thereby weakening previously established connections and collaborations with supportive doctors. Not surprisingly, this legal process had profound long-term implications by polarizing different types of maternity care providers, thereby constraining efforts to work together to optimize maternal and infant health outcomes.

As one example, in 1974, lay midwife Kate Bowland was arrested for practicing medicine without a license. Decided in a court of law, there was little opportunity for nuance. The legal process proved unable to absorb the complexities of modern day midwifery, forcing the defense to argue that Bowland’s work was not in any way connected to medicine, thereby erasing valuable collaborative medical networks she had established in her practice. Drawing on the personal papers of Kate Bowland (including her diary during the time of her arrest and hearings) and other California midwives, along with legal proceedings, organizational records, correspondence, and media coverage, I use the Bowland “Bust” to illustrate the wider implications of the legal vulnerability of midwives and other maternity care providers historically and in the present day. Understanding how and why the law, in particular contexts, has served to exacerbate tensions between maternity care providers and reaffirm existing hierarchies can improve our abilities to confront these problems in the present.
Bio of presenter


Authors and Affiliations

Wendy Kline, Ph.D. Professor and Dema G. Seelye Chair in the History of Medicine, Purdue University
Pregnancy and birth care racial inequalities in Brazil

Silvana Granado

Introduction

Pregnancy and childbirth care racial inequalities remain in Brazil, despite recent improvement in perinatal health indicators in the country.

Objective

To verify if race associated with a variety of outcomes measuring access, adequacy and quality of prenatal and birth care.

Methods

This is a sub-analysis of a national population-based survey of postpartum women entitled Birth in Brazil, performed between 2011 and 2012. We used self-reported skin color according to the criteria of the Brazilian Institute of Geography and Statistics (IBGE, 2006). After excluding Asian (257) and indigenous (99) women, 23,533 women remained in the current analysis, among which 8,077 (34.3%) were white, 13,404 (57.0%) were brown and 2,051 (8.7%) were black. We used the propensity score as pairing technique and, for each comparison (white vs. brown; white vs. black; brown vs. black), we obtained samples of mothers with similar distribution by the covariates macro-region, socioeconomic status, maternal age, maternal education, source of payment of childbirth (public or private) and parity. We performed non-conditional binary and multinomial logistic regressions assessing race associated with outcomes.

Results

Compared to white, both black and brown color associated with inadequate prenatal care (OR 1.7, CI 1.4 -2.0), lack of binding to maternity care (OR 1.3, CI 1.1 -1.4), lack of companionship during labour and birth (OR 1.6, CI 1.4 -1.9), pilgrimage for birth care (OR 1.3, CI 1.1 -1.5) and dissatisfaction with the care received (OR 1.3, IC 1.0 -1.6). On the other hand, both black and brown color women were less likely to suffer from interventions during vaginal birth such as episiotomy and labor induction. We did not observe statistically significant differences between black and brown color women.

Conclusion

Racial inequalities were observed for all outcomes evaluated.

Bio of presenter

Epidemiologist with a degree in Nursing and Midwifery, Masters and PhD in Public Health from the National School of Public Health (1995 and 2001). Researcher holder in Public Health’s Department of Epidemiology and Quantitative Methods in Health,
National School of Public Health. Current coordinator of the Program of Graduate Studies in Epidemiology in Public Health from the National School of Public Health - ENSP / Fiocruz. Experience in research and teaching in public health area, subarea Epidemiology. Works in healthcare of women, children and adolescents, and Health Surveillance.

Authors and Affiliations

Maria do Carmo Leal
Silvana Granado Nogueira da Gama
Cleber Nascimento do Carmo
Vanessa Eufrauzino Pacheco
Ana Paula Esteves Pereira
Ricardo Ventura Santos
Supporting women’s autonomy: Lessons from one tertiary hospital

Rebecca Jenkinson

Background
All competent adults have the right to refuse medical treatment, and most (if not all) maternity care providers espouse respect for pregnant women’s autonomy. Especially in the context of growing medicalisation of birth and risk averseness, women may decline recommended or routine interventions in order to seek their preferred birth. However, news and social media accounts of pregnant women being required to accept recommended care, or punished for not doing so, are numerous, and respectful maternity care is increasingly viewed as a human rights issue.

In August 2010, one large urban tertiary hospital in Australia introduced Maternity Care Plans (MCPs) as a way of communicating and documenting women’s birth intentions when they declined recommended maternity care. The MCP policy recognises the women’s right to refuse any aspect of treatment and describes the hospital’s readiness to provide ongoing maternity care, including that which deviated from other local policies or clinical guidelines.

Aim
To identify factors that facilitate or impede supportive maternity care when pregnant women decline to follow professional advice.

Methods
A mixed methods design, incorporating descriptive statistical analysis of the clinical outcomes of women (n=52) with MCPs; content analysis of clinical documentation; and thematic analysis of in-depth, semi-structured interviews (n=30) with women, midwives and obstetricians.

Findings
Despite widespread espoused support for maternal autonomy, in practice women’s choices were bounded by midwives and obstetricians individual values systems. These boundaries were often unarticulated and variable, but when women’s refusals were perceived to be unreasonable, the women (and in some cases, the midwives caring for them) faced various forms of opposition.

Although the structured documentation and communication process appeared to reassure clinicians, and therefore facilitated women’s access to care, it did not entirely ameliorate the greater forces of power, paternalism and medical hegemony.

Recommendations for policy, practice, education and further research will be
presented.

Bio of presenter

Bec Jenkinson is a passionate maternity consumer advocate and critical friend of midwifery. She is a former state president and national vice president of Australia’s peak maternity consumer advocacy organisation, Maternity Coalition (now Maternity Choices Australia) and even once stood as an independent candidate in a federal election, campaigning on the single issue of maternity reform. Bec is the mother of three homeborn children and a PhD candidate, studying situations where pregnant women decline recommended maternity care, and in particular processes that might enable respectful care.

Authors and Affiliations

Bec Jenkinson.
School of Nursing and Midwifery and Mater Research Institute
The University of Queensland
The Circle of trust: New developments in midwifery theory for supporting normal birth

Elizabeth Newnham

Background

It is now recognised that broad, multi-perspective thinking is required to solve the complex issues that face humanity. Rising birth intervention rates are causing global concern, and rates of epidural analgesia uptake by women in labour are increasing. Epidural analgesia is a regular component of the cascade of intervention that commonly occurs in the hospital system, disrupting the process of normal birth.

Aim

The aim of this doctoral research was to investigate the personal, social, cultural and institutional influences on women making decisions about using epidural analgesia in labour. Focusing on epidural analgesia as the primary problem, it was understood that by investigating birth culture, other related insights would also be gained.

Methods

We utilised an ethnographic methodology and the study was set in an urban tertiary-level maternity hospital. Data were comprised of participant observation field notes, interviews with parturient women, and policy and practice documents. The research was underpinned by Critical Medical Anthropology and also drew on Foucauldian and Feminist theory, all of which acknowledge systems of power and informed our analytic approach.

Results

This presentation will focus on the Circle of trust: a concept developed through the integration and analysis of the research data and current midwifery and social theory. Despite cultural and institutional discourses of risk and intervention, women maintained a firm belief that their bodies knew how to give birth and described birth as a predominantly corporeal experience.

This finding contests current dichotomies of either natural or medicalised birth ideologies and refocuses attention to the individual bodies of birthing women. This dialectic the synthesis of natural versus medical into the corporeal gives new credence to the role that trust plays in birth. It also repositions the woman at the centre of the birth experience, disrupting historical midwifery/medical divides and initiating an alternative, contemporary birth discourse.
Conclusion

Old dichotomies of thought are being interrogated and innovatively re-envisioned to meet current complex problems. The Circle of trust builds on extant theory to provide fresh insight into the way we conceptualise birth and provides an emergent theoretical concept to accompany current empirical data, which is indicating a pressing need to re-envision maternity services.

Bio of presenter

Elizabeth Newnham has been working as a midwife since 2003, most recently as an academic. She has a degree in Politics and is interested in the effects of risk discourse and power on birthing practices. She recently submitted her doctoral thesis, which examined hospital birth culture and the various influences on women regarding the use of epidural analgesia in labour.

Authors and Affiliations

Elizabeth Newnham, University of South Australia
Dr. Lois McKellar, University of South Australia
Adj. Prof. Jan Pincombe, University of South Australia
From The Madonna to Brelfies: Representations of the breast and breastfeeding, and how the contemporary public performance of breastfeeding, acts as a form of cultural resistance

Laura Godfrey Isaacs

The sexualisation of breasts, with a corresponding diminishing respect for their biological function can be charted through art, media, pornography and the fashion industry, where the breast is constantly projected as youthful, sexual and available, at distinct odds with the nurturing, maternal breast.

The transition of the breast from a religious symbol, seen extensively up until the 16th century, with images of the nursing Virgin Mary, Maria Lactansà to its secularisation as an erotic symbol is clearly evident. Images of the breast, created from the 16th century, for the male gaze, predominate in nudes of this period, and consequently breastfeeding depictions are rare.

This artistic legacy, of the breast as a (hetero) sexual object, has been challenged by women artists particularly from the late 19th Century, with explorations of female subjectivity, and the domestic as a legitimate subject for Art, including both intimate portraits of mother’s breastfeeding and powerful public performances to challenge taboos against public breastfeeding. The contemporary phenomena of breastfeeding shaming has received attention recently, and triggered some powerful acts of cultural resistance by individual women organising Nurse-ins and posting brelfies on social media (selfies of themselves breastfeeding). Brelfies, have reached mass audiences through social media, which has encouraged a public conversation about breastfeeding in public, challenged negative cultural attitudes, and increased women’s autonomy, by promoting breastfeeding as a norm.

Aim
The aim of this presentation is to explore the history of cultural representations of the breast and breastfeeding in Western art and culture, and the implications on contemporary women’s breastfeeding behaviour, particularly in reference to women’s acts of cultural resistance to negative attitudes to breastfeeding through art, performative actions and images.

Method
A feminist art history and feminist media theory exploration of imagery related to
breasts and breastfeeding.

Results
Despite scientific research illustrating the positive health benefits of breastfeeding rates remain low in most Western countries. It is argued that art and media representations may contribute to this. The identified performative actions by artists, activists and individual women are arguably more influential than countless public health campaigns designed to exhort women to breastfeed, and suggest innovative ways in which negative cultural attitudes can be challenged, therefore supporting women in the practice of breastfeeding. Midwives’ increased cultural competency, and women’s activism could provide the key to encouraging and supporting women’s breastfeeding behaviour.

Conclusion
Traditional approaches to increasing initiation and sustained breastfeeding rates have had limited success. Consideration of the wider impact of culture, art and media may help practitioners to improve breastfeeding rates.

Bio of presenter
Laura Godfrey-Isaacs trained as a painter at Brighton University, University College London and as a Fulbright Scholar at The Pratt Institute, New York. She exhibited widely in the UK and Internationally, and worked as a feminist academic and activist, teaching at University of the Arts, London, The Royal College of Art and museums and galleries. In 1999 she set up a radical performance company, home live art, supported by the Arts Council of England, to produce performances, festivals and events for major arts organisation such as Tate and The National Theatre. In 2012 she started training in midwifery at Kings College London (KCL). She is a member of the Royal College of Midwives Student Forum, organising the Annual Student Conference, a member of the KCL Cultural Institutes Student Steering Group and curates the International Day of the Midwife at KCL. She aspires to bring her knowledge and experience in the arts together with midwifery, to bring fresh interdisciplinary perspectives

Authors and Affiliations
Laura Godfrey-Isaacs
King’s College London
Why Birth Matters: The impact of epidurals on newborn behaviour

Kajsa Brimdyr

Intrapartum drugs, including fentanyl administered via epidural, have been previously studied in relation to neonatal outcomes, especially breastfeeding, with conflicting results. We examined the normal neonatal behavior of suckling within the first hour after a vaginal birth while in skin-to-skin contact with mother in relation to these commonly used drugs. Suckling in the first hour after birth has been shown in other studies to increase desirable breastfeeding outcomes. Method: Prospective comparative design. Sixty-three low-risk mothers self-selected to labor with intrapartum analgesia/anesthesia or not. Video recordings of infants during the first hour after birth while being held skin-to-skin with their mother were coded and analyzed to ascertain whether or not they achieved Stage 8 (suckling) of Widstrom's 9 Stages of neonatal behavior during the first hour after birth. Results: A strong inverse correlation was found between the amount and duration of exposure to epidural fentanyl against the likelihood of achieving suckling during the first hour after a vaginal birth. Conclusions: Results suggest that intrapartum exposure to the drug fentanyl significantly decreased the likelihood of the baby sucking while skin to-skin with its mother during the first hour after birth.

This presentation includes video clips illustrating newborn behavior across the spectrum of fentanyl exposure. Although more than 80% of mothers in the United States intend to breastfeed, many have discontinued by 10 days postpartum. This research offers potential insight into why mothers are unable to meet their own breastfeeding goals, and has world wide implications as the use of fentanyl as an epidural anesthetic increases around the world.

Bio of presenter
Dr. Kajsa Brimdyr is an experienced ethnographer, researcher and international expert in the implementation of continuous, uninterrupted skin to skin in the first hour after birth. She is the Lead Ethnographic Researcher for Healthy Children Project, Inc., a non-profit, NGO agency as well as a Professor.

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- Karin Cadwell, PhD, Healthy Children Project, USA
- Raylene Phillip, MD, Loma Linda Medical Center, USA
- Ann-Marie Widstrom, Karolinska Institute, Sweden
- Kristin Svensson, Karolinska Hospital, Sweden
Why Birth Matters: The impact of synthetic oxytocin on newborn behavior
Kajsa Brimdyr

Rates of induction of labor in the United States have been increasing since the early 1990s to 22.8 percent, with synthetic oxytocin (synOT) alone trending toward being the most commonly used induction agent. This is true in spite of synOT receiving a Black Box warning (the strongest warning the FDA can give) that states Not for Elective Labor Induction: not indicated for elective labor induction since inadequate data to evaluate benefit versus risk; elective induction defined as labor initiation without medical indications. Once it has begun, labor is also often augmented by synOT. Hayes and Weinstein (2008) have called for standardization and uniformity of care in the use of oxytocin and report that synOT is often used in an unstructured manner and without a correct diagnosis of arrested labor. Intrapartum drugs, including synOT, have been previously studied in relation to neonatal outcomes, especially breastfeeding, with conflicting results. We examined the normal neonatal behavior of suckling within the first hour after a vaginal birth while in skin-to-skin contact with mother in relation to this commonly used drug. Suckling in the first hour after birth has been shown in other studies to increase desirable breastfeeding outcomes.

Method
Prospective comparative design. Sixty-three low-risk mothers self-selected to labor with intrapartum analgesia/anesthesia or not. Video recordings of infants during the first hour after birth while being held skin-to-skin with their mother were coded and analyzed to ascertain whether or not they achieved Stage 8 (suckling) of Widstrom’s 9 Stages of neonatal behavior during the first hour after birth.

Results
A strong inverse correlation was found between the amount and duration of exposure to synOT in labor against the likelihood of achieving suckling during the first hour after a vaginal birth.

Conclusions
Results suggest that intrapartum exposure to synOT significantly decreased the likelihood of the baby suckling while skin to-skin with its mother during the first hour after birth.
This presentation includes video clips illustrating newborn behavior across the spectrum of synOT exposure.
Although more than 80% of mothers in the United States intend to breastfeed, many have discontinued by 10 days postpartum. This research offers potential insight into why mothers are unable to meet their own breastfeeding goals, and has worldwide implications as the use of synOT for labor induction and augmentation increases around the world.

Bio of presenter
Dr. Kajsa Brimdyr is an experienced ethnographer, researcher and international expert in the implementation of continuous, uninterrupted skin to skin in the first hour after birth. She is the Lead Ethnographic Researcher for Healthy Children Project, Inc., a non-profit, NGO agency as well as a Professor.

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- Ann-Marie Widstrom, PhD, Karolinska Institute, Sweden
- Kristin Svensson, PhD, Karolinska Hospital, Sweden
Normalising breastfeeding: Midwifery language and practices during breastfeeding support

Elaine Burns

Background
In Australia, women have access to health professional support during the early establishment of breastfeeding. According to the National Infant feeding survey 96% of infants start life breastfeeding however the exclusive breastfeeding rates drop each month thereafter until at 5 months it has reached a low 15%. There are many factors influencing exclusive breastfeeding and one area that has been reported as undermining breastfeeding confidence is the conflicting advice provided by midwives and lactation consultants. In Australia the majority of women access a fragmented model of care provision where they meet a multitude of midwives across the pregnancy, birth and the postnatal journey. Increasingly continuity of care models are being offered and women report greater satisfaction with these models of care. In addition research has shown an increase in breastfeeding rates, at 6 weeks and 6 months after birth, if women have received continuity of midwifery care.

Aim
To explore the language and practices adopted by midwives when providing breastfeeding support, in the first week after birth, within two different models of care.

Method
Using ethnographic techniques, observational and audio recorded data were collected to explore interactions between breastfeeding women and midwives during the first week after birth.

Results
The results presented are a combination of two studies exploring health professional language and practices after birth (total 93 interactions). The majority of interactions, 69%, were observed in hospital settings and 31% were observed in women’s homes. The findings revealed a difference between the language and practices used by a majority of midwives in the fragmented model of care compared with those in the continuity model of care. In the hospital environment, midwives tended to approach breastfeeding with a focus on the transfer of nutrition, and the technical aspects of breastfeeding, rather than the relational.

Here the focus was on ensuring the baby maintained its blood sugar level during the first couple of days. By contrast the interactions observed in the continuity of care model, at the woman’s home, had a focus on the developing relationship between the mother and baby and normalising breastfeeding. The language and practices used in these interactions reflected genuine support for women during the early establishment of breastfeeding.

This paper will explore the differences in communication style between these models of care and will present exemplars of best practice communication and support.
Conclusion
Increasing access to relationship based care models, which encompass affirmative communication styles, and reflect genuine support, can have positive implications for establishing breastfeeding.

Bio of presenter

Dr Elaine Burns is a Registered Midwife and Lecturer at Western Sydney University. Elaine completed her doctoral studies in 2011 where she explored the language and practices of midwives, and lactation consultants, during interactions with women who were breastfeeding. Since then Elaine has been engaged in related research examining private midwifery and peer counsellor support for breastfeeding women, postnatal care provision and community support for mothers and babies.

Dr Virginia Schmied is Professor of Midwifery in the School of Nursing and Midwifery at Western Sydney University. She is a midwife whose work extends across clinical practice, education, research and consultancy. Virginia leads a program of research on transition to parenthood, perinatal mental health and infant feeding decisions with a particular focus on professional-client interactions and relationships, effective models to support vulnerable families across maternity and child and family health services.

Authors and Affiliations

Dr Elaine Burns - Western Sydney University
Professor Virginia Schmied - Western Sydney University
The impact of birth intervention on parenting experience and admission to residential early parenting centres in Australia in the first 12 months after birth

Cathrine Fowler

Aim: The aim of this study was to examine the physical, psychological and demographic characteristics, trends, service needs and co-admissions to other health services of women admitted to Early Parenting Centres (EPC) in NSW from 2000-2011. In this paper we examine the impact that birth interventions may have on women’s experience of parenting and their subsequent use of tertiary services such as Early Parenting Centres (EPC).

Background: Many mothers experience significant difficulties with early parenting, in particular with breastfeeding and settling an infant with dysregulated and persistent crying. In Australia there is a tiered system of health services (primary, secondary, tertiary) to support maternal and child health, including, non-psychiatric day stay and residential EPC such as Tresillian and Karitane. These organisations provide a range of services and evidence based interventions such as structured psycho-educational programs to enhance infant caretaking skills and assist adjustment to motherhood. In NSW approximately 3,400 women use the RPS services of Tresillian and Karitane each year, which is around 3.5% of the birthing population. The demand for these services is high. However we do not understand as yet if and how birth experiences may influence use of these tertiary referral parenting services.

Methods: This was a mixed methods study that used data linkage to report on the characteristics of all women admitted to EPC within the 12-month period following the birth In addition, 300 medical records were reviewed and focus groups with staff were undertaken.

Results: The analysis of linked data demonstrated that women with infants admitted to a EPC in the first 12 months following birth were more likely to have experienced a caesarean section or an instrumental birth. The analysis of 300 case files indicated that 51% of women admitted self-reported mental health disorder, 48% received a mental health diagnosis and 27% had an EPDS >12. The caesarean section rate in this case review sample was 37%. Reasons for referral to the EPC included sleep/settling issues (83%); feeding issues (6.3%) and parent support (10.7%). Mental health issues related to the birth experience were reported by 18.3% and 26% reported physical health issues related to birth and 7.3% reported Infant issues related to birth. The relationship between traumatic childbirth experiences and depression was also identified by staff during the focus groups.
Conclusion: The study findings suggest that around 20% of women admitted to EPC may be experiencing post-traumatic stress related to their birth. Links have been made between unsettled infants and specific maternal psychosocial risk factors such as a difficult birth experience, maternal mood and the maternal-infant relationship. While further work is needed, this is a significant issue with likely ongoing impact on the woman's health and well-being and that of her infant.

Bio of presenter

Cathrine Fowler is the Professor for the Tresillian Chair in Child and Family Health at the University of Technology, Sydney. As a child and family health nurse, with qualification in midwifery and adult education, she has gained extensive clinical and education experience working with families and their young children (0-5 years). Cathrine’s research and clinical practice interests focus on parental learning, working with families who are experiencing complex and challenging parenting situations and require additional support, and child and family health nursing professional issues.

Cathrine Fowler, Tresillian Chair of Child and Family Health Nursing, University of Technology, Sydney

Hannah Dahlen, Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University

Virginia Schmied  Professor of Midwifery, School of Nursing and Midwifery, Western Sydney University
How to write your Midwife story

Fiona McArthur


Background
The book Aussie Midwives is an anthology of Australian midwives that came out with Penguin Australia in March 2016. The stories are heartfelt and the very essence of why midwives love what they do. In collating the anthology, the experience made me wish more stories like these could be shared by others. The diverse settings in the book did nothing to hide the universal creed of dedicated midwives and the 11th International conference of Normal Labour and Birth epitomises that love of what we do. This conference highlights the constant striving to improve a woman's experience and outcomes during her pregnancy and mothering journey, it lifts the profile of midwives and midwifery, and of course, encourages new midwives to continue that journey. Midwives telling their stories is another way to complement this.

Aim
Midwives should be inspired to share their stories, to document the challenges they face so other midwives feel less alone, stronger and united, and perhaps just as importantly to allow the layman to see into the world of midwives and the families they care for. This presentation will demystify the roadblocks and help midwives see how they can begin to tell their stories.

Method
To outline simply the steps in creating a work of fiction or non-fiction. How to overcome the; where to start, word count needed, and the grammar gurus disapproval, that daunt new writers. I would propose the 500 words a day or Write a Book In 30 minutes strategy. The importance of story over literature when you want to inspire emotion. And where to find an editor. Highlight different ways to share midwifery knowledge, skill and experiences. From anthology stories, to self help books, to fiction with underlying messages, to magazine articles and blogs.

The PEP talk. Polishing the final manuscript. Explain about the emotional angst of putting your baby out there for others to read. Provide examples of publishing avenues paperback, POD, e-book, self publishing
Results
At the end of the presentation, every midwife in the room should have the basic tools to feel they could start writing about what they love, including a link to resources. She/he should be thinking about stories, the passion they want to share, and the fact that sharing those stories is fun and cathartic. Not quite - if it wasn't written down it didn't happen - but I would hope that some will go home and write it down.

Conclusion
I reminded a midwife recently she should be writing down her daily adventures because I can't wait for her book to be finished.

She said, you're so inspiring Fi, I need a little Fi boost every now and then. Ironic, when she was the one who has me holding my heart and covering my mouth with the situations she deals with.

I want to share that because I believe in the remarkable women and men out there who should share their stories. Let us lift the profile of midwifery

Bio of presenter
Fiona McArthur has worked as a rural midwife for thirty years, is married to a retired country paramedic, and is a mother and grandmother. She is a clinical midwifery educator, also involved with obstetric emergency and vaginal breech education for midwives and doctors with AMARE, as well as a published author in fiction and non-fiction. Fiona's love of writing has seen her sell over two million books in twelve languages. Living in northern New South Wales with her husband, Ian, Fiona loves that researching her books allows her to travel to remote places and meet remarkable people and her theme is the strength of women.
Exploration of Storytelling in antenatal care

Alison Teate

Background
Improved clinical outcomes are demonstrated with Midwifery Continuity of Care (MCOC). It is thought the catalyst for these improved outcomes may be the midwife-woman relationship, which is understood to grow in the antenatal period. We know antenatal care is a significant part of both standard maternity care (SMC) and MCOC. What we don’t know is what makes a midwife-woman relationship grow and be successful in improving clinical outcomes.

Aim
To explore the nature of midwife-woman interactions in the antenatal appointment and the perceptions and expectations of midwifery care from staff and women in two models of care, MCOC and SMC. Translate this knowledge into improved midwifery care.

Methods
Between 2012 and 2015 a feminist ethnographic study took place. National ethics approval was obtained. Analysis of transcribed audio and video data included thematic, descriptive and content approaches.

Results
Eighteen midwife-woman pairs, during a late pregnancy antenatal appointment, were observed and filmed at two hospital sites and in women’s homes. Six focus groups and two interviews with staff and 11 interviews with women were undertaken. Data analysis found that worry was a significant part of the antenatal appointment, which could be moderated by the factors time, environment and investment. When these factors were facilitative then a shared concept of hope transformed the worry. The factor of investment was linked to actions and intent of individual midwife and design of the model of care. The presence of investment in the midwife-woman interaction moderated the negative effects of time and environment and enabled connection through storytelling. Midwives used stories to reassure and to show compassion and understanding and women used stories to emphasise their knowledge and expertise or to uphold or defend issues that were important to them.

Conclusion
The density of shared storytelling in the antenatal appointment was influenced by time, environment and investment, which were facilitated by model of care and to some extent individual midwife. Shared storytelling was also identified as important to
womens experiences, as it engender compassion, enhanced healthcare messages, moderated worry and created shared hope.

These findings will assist in understanding what influences the nature of the midwife-woman interaction and to understand ways that maternity care can be improved.

Bio of presenter
Alison Teate is a PhD candidate at Western Sydney University and currently teaches Bachelor of Midwifery students at University of Canberra. Her past work includes establishing, supporting and researching in a variety of midwifery led models of care; Birth Centres; Publicly Funded Homebirth; and in new models of midwifery care.

Hannah Dahlen is a Professor of Midwifery and Higher Degree Research and has had national and international success with grants. She continues to work as a midwife and a strong profile in midwifery, including advocacy, research and leadership.

Professor Virginia Schmied is a leading Australian researcher in midwifery and child and family health. Her past experience extends across clinical practice, education, research and consultancy and she has worked in other tertiary institutions and as a senior manager in the public sector.

Nicky Leap has played a pivotal role in both midwifery research, education and practice in both the UK and Australia.

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Professor Hannah Dahlen, Western Sydney University
Professor Virginia Schmied, Western Sydney University
Adjunct Professor Nicky Leap, University of Technology, Sydney and Kings College London
“How we do it: Malabar Midwives a decade of caring for Aboriginal families”

Trudy Allende and Shea Caplice

It is essential and of the utmost importance that maternity health services for Aboriginal and Torres Strait Islander families are flexible, adaptive and responsive to individual preferences and the community. The Malabar model supports Aboriginal and Torres Strait Islander families throughout pregnancy birth and afterwards and has become a show case for Aboriginal Maternal and Infant Health in Australia.

When women have complex care and or support needs and there is a requirement for ongoing interventions from a variety of disciplines. Coordination of care is itself complex and is associated with the increased provision of safe, quality health care.

Now ten years on the question from colleagues is “How do we do it?” This presentation will describe the coordinated care approach that has been facilitated by the Malabar model for the past decade and explore a response to that question focussing on the innovative approaches that contribute to the success of the service.

Bio of presenters

**Trudy Allende**

Trudy is a proud Wonnarua woman, part of the Aboriginal community at La Perouse, Sydney and the mother of four children. Trudy is currently the Aboriginal Health Education Officer with the Malabar Community Midwifery Link Service and a committed and passionate Aboriginal Health worker. Trudy has led the inspiring Healthy Body Healthy Mind Camps for young kids in the La Perouse community and the Healthy Body Healthy Minds Gym group for new mothers. Trudy has worked with the Malabar team since 2008.

**Shea Caplice**

Shea has been a midwife for over 30 years. In addition to a homebirth practice Shea has been involved in setting up new midwifery models of care within the hospital system including birth centres, team midwifery and the first publicly funded homebirth service in NSW. Shea is currently the Midwifery Consultant with the Malabar Community Midwifery Link Service with the Royal Hospital for Women established in 2006. This model is a caseload midwifery model targeting the Aboriginal community and another first for NSW. In addition Shea is a film maker and the producer of many films relating to midwifery and birth. The Midwife Inside is her most recent production.

- The Midwife Inside – Film

Shea Caplice
The Midwife Inside is an innovative film project that includes interviews with three Australian midwives. The interviews are short and poignant with each midwife sharing their individual wisdom and essence in midwifery. There is an Indigenous midwife, a midwife who has been practising for 60 years and a homebirth midwife. The Midwife Inside is beautifully filmed and expresses the heart of midwifery that many midwives can relate to.

The interviews are short and could be presented as a series to be run one each day prior to the plenary sessions or run all together over about 25 minutes with a short intro. To celebrate Australian midwifery and acknowledge the wonderful profession it is.

Bio of presenter

Shea Caplice has been a midwife for over 30 years and has worked in all aspects of midwifery from homebirth to management. Shea has always been a strong and passionate proponent for normal birth. Shea is an experienced presenter that has spoken at conferences both nationally and internationally. Shea uses creative ways enhance her presentations and never fails to inform and entertain.

Authors and Affiliations

Shea Caplice
Independent film maker
Clinical Midwifery Consultant Royal Hospital for Women Sydney
Sustaining intelligent structured intermittent auscultation: Evaluating change

Robyn Maude

Background

The intelligent structured intermittent auscultation (ISIA) decision-making framework is an evidence-based fetal heart monitoring modality for low risk women. ISIA was developed as a knowledge translation innovation and introduced into practice in a study informed by the Knowledge-to-Action (KTA) process. The last phase of the action cycle of KTA is evaluating the sustainability of knowledge use, which activates a feedback loop that cycles through the action phases. The aim of this study was to evaluate the impact of the initial use of ISIA and the changes to practice that occurred.

Methods

Retrospective medical record review and focus groups with midwives five years after the introduction of ISIA.

Findings

The use of intermittent auscultation of the fetal heart during labour for low risk women has continued to increase, but non-clinically indicated admission CTG has paradoxically also increased. Documentation of fetal heart rate as a single number has also vastly improved while other aspects of admission assessment and on-going documentation (palpation, contraction strength and length, when and how long auscultation occurs and fetal movements) is inadequate. Barrier assessment reveals that the specific style of leadership in the unit was an important obstacle to the implementation of ISIA by midwives.

Conclusion

While some gains were made in the implementation of ISIA, some ground was also lost, and numerous barriers to the implementation of ISIA were observed. Sustaining change may require on-going education and the use of local champions to sustain knowledge transfer and continuous quality improvement.
Bio for presenter

Robyn is a Senior Lecturer and Director of Student Research at the Graduate School of Nursing, Midwifery and Health (GSNMH) at Victoria University of Wellington (VUW), New Zealand. Robyn continues to provide Lead Maternity Care (LMC) for a small caseload of women birthing in hospital and at home. Robyn’s research interests are largely clinically focused and concentrated on activities that promote and protect normal birth through developing an awareness of Knowledge Translation and Quality Improvement and their effects on clinical midwifery practice. Her current research interests include: Fetal heart rate monitoring and fetal movements; Water immersion and water birth; Medico-legal aspects of the provision of care; Knowledge translation, Knowledge-to-Action process; Quality improvement and clinical effectiveness; Continuity of midwifery care; Standards of midwifery practice; Models of midwifery; Midwifery Leadership, and the use of Probiotics in Pregnancy.

Authors and Affiliations

Robyn Maude
Graduate School of Nursing, Midwifery and Health
Victoria University of Wellington
New Zealand
Exploration of women’s and midwives’ ethical values in decision-making

Marianne Nieuwenhuijze

A respectful relationship between a woman and her midwife based on trust and understanding is an essential part of midwifery care. This enables a woman's active involvement in care, promotes self-care and supports her to make informed choices. Shared decision-making (SDM) is part of building this relationship. SDM is an essential component for the ethical delivery of midwifery care. Offering good, woman-centered care is only possible when a woman is given the opportunity to have an active say in what happens to her and her child.

However, SDM in midwifery care can be ethically challenging. One of ethical aspect that needs attention is the integration of ethical values in the decision-making process. This is a significant part of SDM. Values are important in a person's life and shape the looks upon oneself and one's existence. Many of the decisions in pregnancy and birth are personal, informed by individuals' situation and values; they are not merely fact-based or objective.

On the NLBC in Sydney, I will present the first study of my project on the ethical aspects of SDM. In this study we will explore the values that women and midwives bring to decisions in midwifery care. This study will include two complementary methods: focus groups and the Q-method.

In the focus groups we explore the ethical values of women, their partners and midwives (hospital-based and community-based). We will also explore the participants' understanding of the sources of their values. Focus groups will be organized, using purposive sampling to cover different cultural and ethnic background until saturation is reached. The audio-recordings will be transcribed verbatim and analyzed. Using a phenomenological approach, we will describe the lived conscious experiences with ethical values in midwifery care.

We will further explore the ethical values by asking women, their partners and midwives to do a Q-sort, in which participants will put around 40 statements on values related to SDM in their preferred order. These statements will be based on literature and findings from the focus groups. The Q-method combines qualitative and quantitative methods of investigation to allow a systematic study of subjectivity (Brown 1996). It seeks to discover how and why - rather than how many - people hold to certain beliefs, identifying aggregate viewpoints. A sample of 20 women, 20 partners of women and 20 midwives will be asked to conduct a Q-sort. Again, we will use purposeful sampling. The Q-sorts will be analyzed using factor analysis, creating typologies of values. These types can then be associated with characteristics of participants.
Ethical approval is obtained and data collection starts in February 2016. The results will be available for presentation in September 2016.

This study is part of a fellowship on the ethical aspects of SDM granted to me by Royal Dutch Organization of Midwives.

Bio of presenter
Marianne Nieuwenhuijze RM MPH PhD trained as a midwife in the Netherlands. After graduation, I worked as a practicing midwife for over 20 years, first in a hospital and later as an independent midwife in a community practice. Here I sparked my interest for evidence-based midwifery care. In 1999, I started as a lecturer at the midwifery education program of Zuyd University and became involved in the development of the Bachelor Sc midwifery program. A main area of interest is the integration of evidence-based practice and research in the curriculum. I was appointed head of the Research Centre for Midwifery Science in 2007 and recently became professor of Midwifery at Zuyd University.

I received my PhD in 2014. The title of my thesis was On speaking terms: choice and shared decision-making in maternity care. My interests in research are womens expectations, choices and decision-making in midwifery care, womens mental health, and the public health opportunities of midwifery care.

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Raymond de Vries PhD, professor midwifery science, CAPHRI, University Maastricht and professor of bioethics, University of Michigan, Ann Arbor, USA
Consumer attitudes about the role of monitoring and consent

Lisa Kane Low

A survey of women in the United States (US) who gave birth in 2005 found that 94% were monitored with electronic fetal monitoring (EFM). To a layperson, the routine use of EFM may seem beneficial, but the research literature confirms that routine EFM use, particularly for low risk women, offers almost no clinical benefit while increasing the risk for surgical interventions.

Thus one can argue that use of EFM is unethical without expressed consent by the healthy low risk woman, due to these increased risks. Yes rarely are women asked about their desires for use of EFM in the US. In order to examine women’s attitudes towards EFM and informed consent, we used Amazon’s Mechanical Turk (MTurk) to conduct a survey experiment. In November 2014 we posted our survey, targeted to women aged 18-50. Respondents were randomly assigned to view one of three different descriptions of EFM that included information about typical practice (i.e., consent is not obtained), benefit and risk to the patient, and practitioners’ reasons for monitoring. One scenario described it as being used to monitor the baby during labor and delivery, a second described it as being used to monitor the mother during labor and delivery, and the third described it as a general medical procedure (without reference to labor and delivery). The three descriptions were kept as similar as possible on all other dimensions. After reading the scenario, respondents were asked 1) how interested they would be in being monitored, 2) whether doctors and nurses should be required to obtain consent for monitoring, and 3) the reasons for their opinion. We also gathered information about gender, age, education, and parity (including history of any type of delivery and use of EFM).

Our sample included 597 women. The majority (67%) were under 35, 89% had at least some college education, and 48% had given birth; these demographics did not differ by scenario (N\text{General} = 201, N\text{Labor Mom} = 194, N\text{Labor Baby} = 202; all \( p \)'s > .31). Interest in being monitored was moderate (grand mean = 2.70, on a 5-point scale) and differed by scenario (\( F(2, 594) = 25.67, p < .001 \); see Fig. 3): there was increased interest when presented in the context of labor (as opposed to a non-specific, general medical situation) and when framed as monitoring the baby (as opposed to the mother).

Opinions about consent paralleled these findings. Despite the significant differences between the scenarios, (\( X^2(4) = 15.11, p = .004 \); see Fig 3), the vast majority of respondents believed that practitioners should obtain consent for monitoring. Among the women who thought practitioners should obtain consent, 54% said it was because they wanted to be informed about monitoring; another 45% said it was because they want to play a role in medical decision-making. These survey findings are consistent with the data from our consumer focus groups, where women reported feeling that...
they should have been asked about the type of fetal monitoring they desired, but they
were not. The use of informed consent in relationship to EFM should be standard of
care as well as increased use of IA for healthy low risk women.

Bio of speaker
Lisa Kane Low is an Associate Professor in the School of Nursing, Women’s Studies and
Department of Obstetrics and Gynecology at the University of Michigan and Associate
Dean for Practice and Professional Graduate Programs, which includes the midwifery
education program. Lisa is also the President of the American College of Nurse-
Midwives. Her research focus has been on care practices during labor to promote
optimal health outcomes and in particular support physiologic approaches to care and
the reduce the potential for cesarean births. Two areas of funded research focus have
included management of second stage labor and use of intermittent auscultation.
Are you listening to me? An exploration of the interactions between women and midwives when labour begins. A feminist participatory action research study

Helen Shallow

Background
I'd like you to imagine you are a head of midwifery

What would you do if you met a distraught new father who tells you how he and his wife called the maternity unit three times before they were allowed to go in and soon after arrival the baby was born with no signs of life?

What would you do if you heard a woman's harrowing account of how she dared not move around at home for fear of the baby being born, after the maternity unit told her they were temporarily closed?

In 2010 there were 750 reported cases in the UK of women turned away from their maternity units due to lack of staff or no beds and since then more maternity units have closed or merged to become larger units but with even less capacity.

In addition some women who report significant pain and fear are repeatedly sent home and told they are not in labour because the neck of the womb has not yet opened to 4cm and as one woman asked

why is it when you are in labour no one gives a shit. If you are 0-4 you are just a massive pain in the bum to everyone. Why is that?

Aims of my study, Methodology and Methods
The aim of my study was to explore these issues, raise awareness and propose solutions. I chose feminist participatory action research for its emancipatory potential and because it enabled me to work with mothers and midwives collaboratively. After a series of separate focus groups and interviews I brought both groups together to validate and discuss preliminary findings. This has not been done before.

Summary of Findings
After decades of scaremongering about childbirth many women lack confidence in their own potential and are denied midwifery care at this vulnerable time. Caught in this cycle are some women who know they are in labour and are advised to go home based on the 4 cm rule and it is these women who either arrive late in labour or give birth unintentionally at home who are denied the pain relief and support and fetal monitoring that we assured them of throughout pregnancy and this is a safety issue.

Compounding this are rapid changes in service provision, changes that women are ill prepared for and midwives find themselves acting as organisational gatekeepers to a restricted service rather than focussing on the expressed needs of women.
Burgeoning paperwork and reactionary checklists stifle the mother-midwife relationship and midwives are reluctant to involve women in decision making for fear of being overwhelmed. Decision making is affected by busyness and self-protective measures take priority over what is best for women.

Conclusion
The policy to encourage labouring women to stay at home for as long as possible without skilled midwifery support is flawed and increases risks to some mothers and babies.

Key Recommendations
Entry to Midwifery
Recommend a more rigorous selection process based on overtly feminist principles. Midwifery is a feminist issue.

Education
Recommend a radical re-think about exactly what we are t

Bio of presenter
I qualified as a midwife in Edinburgh in 1987. My two sons were then aged ten and seven. I practised in all areas of midwifery and worked in Botswana for two years. After attaining my Masters and PGCEA, in 1999/2000 I was seconded to a Health authority for a year where I undertook a feasibility study and wrote a report to set up a freestanding birth centre, post obstetric unit merger. My report informed others both nationally and internationally. I was a consultant midwife for over eleven years in two different Trusts. In my second post I set up a freestanding birth centre in Huddersfield, in time for the closure and move of the Huddersfield obstetric unit to Calderdale. The Birth Centre opened in August 2008 and was a successful and well-run service highly valued by the local community. My remit was leading on midwifery led care. I am convinced that in order to address the industrialised model of care prevalent in UK maternity we need to restore the mother midwife relationship. In 200

Authors and Affiliations
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Supervisors Professors Ruth Deery and Mavis Kirkham
Care in the first 30 minutes after birth: What do Australian women want maternity care providers to know?

Jenny A. Parratt

Background

Postpartum haemorrhage (PPH) rates have been rising in Western countries; most cases are caused by poor uterine contraction around placenta delivery. Oxytocin mediates uterine activity; it attaches to binding sites on myometrial muscle cells which prompt uterine contraction and retraction. Powerful ways to stimulate oxytocin release are mother/baby skin-to-skin contact (S2S) and breastfeeding (BF). S2S and BF within 30 minutes of birth, called Pronurturance, is associated with an almost 50% reduction in PPH rates. According to Pronurturance Plus theory, further reductions in PPH rates seem possible. Pronurturance Plus theory explains the mechanisms of how S2S and BF work, it also considers the effects of: the birthing environment; the midwife as a person; and the womans thoughts and feelings during third and fourth stages labour. What is missing is baseline data about womens experiences and preferences during these final stages of labour.

Aim

To understand womens preferences for care after the babys birth; ultimately to optimise caregiver practice, reduce PPH rates and improve womens satisfaction.

Participants

504 women who gave birth to a live baby in Australia in the 12 months prior to providing online responses to the qualitative question Do you have any recommendations or comments about your care in the first 30 minutes after birth that you would like midwives and doctors to know about?

Method

Ethical approval was granted. Consent was implied by participation; no identifying data was collected. We developed and piloted an online survey about the first 30 minutes after birth; most items produced quantitative data. The qualitative question of this paper was part of that survey. Recruitment, via womens networks and social media, occurred in the last quarter of 2015.

A total of 1318 women participated of which 504 (38.5%) answered the qualitative item. We used a feminist post-structural approach to qualitative data analysis and identified themes; interpretation was enhanced through feminist collaborative conversations.
Results

Early analysis indicates women's preference for S2S immediately after birth wherever possible, including operating theatres, recovery rooms and nurseries. BF in the first 30 minutes was preferred but needs to be promoted with clear, respectful and unpressured communication. Participants prefer midwives to prioritise quiet uninterrupted time for S2S and BF over routines; they want requests for delayed cord clamping respected. Preferences were moderated due to pain and newborn resuscitation. Intense grief and/or trauma was expressed by some women who missed out on S2S and BF.

Conclusion

Most women want uninterrupted S2S and BF for at least 30 minutes after birth; women and midwives would benefit from education about reducing interference at birth and Pronurturance Plus theory.

Bio of presenter

Jenny Parratt has been a midwife since 1982. For fourteen years Jenny practised privately attending homebirths in rural Victoria. In 2010 Jenny completed her PhD about women's changing embodied sense of self. She now develops curricula and teaches in postgraduate programs at Southern Cross University. Jennys research builds on and contributes to her ongoing professional goal to enable women to have the best possible childbearing experience. Jennys earliest research explored the childbearing experiences of women who were survivors of incest. Her more recent research has involved evaluation of team-based academic midwifery assignments and she was principal researcher validating an associated rubric. Jenny is an active reviewer for international journals and is an associate editor of Women and Birth. On a personal level, Jenny is mother to three adult children, she lives in rural Victoria with her partner and she is a keen cyclist, walker and gardener.

Authors and Affiliations

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Kathleen M Fahy PhD FACM, Professor of Midwifery, Southern Cross University; Editor-in-Chief of Women and Birth
Midwives views on partnership working with women and the factors that influence the provision of informed choice

Sally Boyle

Background
In the UK the concept of partnership working has been espoused within health and social care for a number of years. Models of partnership working have replaced the notion of midwives being with women due to the increased medicalization of childbirth. Most midwives in the UK work within the National Health Service (NHS), where implementing Government policy to personalise care, and to work in partnership with women, is particularly challenging. Maternity units are constrained by financial and organisational targets and there is a lack of evidence of the economic benefit of partnership caseload models. Midwives loss of autonomy to medical control has forced them to be with institution, resulting in the notion of supporting womens choices becoming little more than rhetoric.

Aim
The aim of this study was to determine how closely aligned the views of midwives were with the views of childbearing women in relation to what women want from the midwives who care for them?

Method
A qualitative study to determine the extent to which midwives felt that they worked in partnership with women and were able to offer them informed choice during childbirth. This was the second phase of a larger study, which built on the findings from the womens perspective. Focus groups were undertaken with midwives providing midwifery led care in two NHS maternity units in England following receipt of Ethical approval. The midwives were a purposive sample drawn from community and midwifery led birth centre practice settings. Vignettes were used as a vehicle to stimulate discussion, devised from interview quotes from the women and encapsulated the key themes identified from phase one of the study. Data was analysed using a thematic approach to interrogate the data and for categories to emerge.
Results
Midwives were under significant time pressure, impacting on their ability to provide women with holistic care or evidence based information against which to make informed choices. Staffing pressures resulted in women frequently not experiencing continuity of care and being less likely to disclose issues or concerns. Midwives identified time constraints were more critical when care was provided within the doctors surgery as opposed to clinics undertaken within birth centres. They acknowledged that midwives sometimes used their professional position to coerce women to accept the choices that the midwife perceived to be preferable.

Conclusion
Midwives were fully aware that they were not meeting women’s psychosocial needs during childbirth and suggested the following strategies to enhance care:

1. Introducing home visits towards the end of pregnancy to discuss birth plans and preparation for birth
2. Providing antenatal care in birth centres, enabling longer appointments to enhance psycho-social and emotional care
3. Developing group antenatal and postnatal sessions, providing an opportunity to share discussions on key issues concerning women.

Bio of presenter
A registered nurse and midwife I achieved my first degree with the Open University followed by a Masters in Business Administration and a Doctorate in Health Research at the University of Hertfordshire. I have been a practicing midwife for over thirty years, predominantly as a midwifery lecturer. For the past thirteen years I have worked in management positions within Schools of Health and Social Care at Hertfordshire, Brighton and currently London South Bank University, where I am Head of Department for Primary and Social Care. I have undertaken key roles in academic quality and the student experience. I have also had a strategic

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Professor Hilary Thomas, Programme Director, Centre for Research in Primary and Community Care, University of Hertfordshire, UK
**Women leaving or ending domestic violence and barriers to disclosure**

Lyn Francis

I will discuss PhD findings regarding women ending or leaving domestic violence particularly in relation to disclosure of abuse and responses of health professionals. Scenarios based on narratives will be utilised followed by discussion relevant to midwifery practice.

**Background**

Approximately one in four women in Australia have experienced at least one incident of abuse from an intimate partner since the age of 15. The impacts for women experiencing domestic violence are well researched and may include adverse physical, mental and psychological health consequences including death. So why don't women disclose and how do women leave and/or end domestic violence in their lives?

The aim of this study was to explore in detail how women who have experienced domestic violence make sense of their personal and social world regarding ending such relationships and examined how service providers identified their professional role in assisting these women.

**Method**

Twelve semi-structured interviews with women who had experienced and ended violent relationships was undertaken in addition to three focus groups with professionals whose work included assisting women experiencing domestic violence. The research process was undertaken using a narrative inquiry framework with thematic analysis utilised to identify themes.

**Result**

The women in this research faced many complex barriers that prevented or delayed them from disclosing abuse and ending violent relationships. Services, including health services, often did not give participants the time, a safe space or privacy that may have provided the opportunity for disclosure of violence and offers of support.

Participants said that even if they had been screened for domestic violence using a screening tool they would have denied the violence. Some of the participants suggested that just relying on screening tools to obtain a disclosure about domestic violence is not always appropriate. Participants suggested that health professionals, including specialists, need further education in order to detect domestic violence, provide appropriate responses to women experiencing abuse and enhance service
provision to women experiencing domestic violence.

Conclusion
Screening for domestic violence, on its own, may not be enough and several women in my study did not identify or acknowledge the abuse in their relationship even when screening was undertaken. The consistent use of evaluated screening tools might improve disclosure of domestic violence, but appropriate training and education in detecting its presence, for referral, and for the provision of services to assist women who do disclose is also required.

Bio of presenter
Lyn is a mother, grandmother, maga, sister and partner to Jim. Lyn has qualifications in midwifery, nursing, health management, law, early childhood and community health and completed her PhD in 2015. Lyn has been an academic for 10 years and has worked at the University of Newcastle, Charles Darwin University and commenced at Griffith University in Queensland in January this year. Lyn has also worked as a midwife and nurse in both the private and public sector.

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Supervisors - Deborah Loxton Associate Professor, Deputy Director, Research Centre for Gender, Health and Ageing, Deputy Director, Australian Longitudinal Study on Womens Health, The University of Newcastle,
The Culture of Homebirth: What can women teach us?

Ellise Adams

Background
Out of hospital birth rates in the United States increased from 1.3% in 2011 to 1.4% in 2012. Home birth births increased from 0.84% in 2011 to 0.89% in 2012 and birth center births increased from 0.36% in 2011 to 0.39% in 2012. With this increase in the incidence of homebirth, it is important to understand the culture of homebirth so that safe, effective, patient specific and culturally-sensitive care can be provided to these families. This understanding can also be used to assist hospital-based personnel in developing collaborative agreements and transfer protocols with homebirth providers.

Aim
The researchers sought to discover and describe the basic social process or core variable(s) leading women to choose homebirth. Research questions for this study are:
1) what factors led to the decision to birth at home? and 2) what factors related to hospital birth led to the decision to birth at home?

Methodology
This grounded theory, qualitative study was designed to learn from women the elements important in the choice of a homebirth.

A convenience sample of (n=6) English-speaking women of childbearing age, with varying childbirth histories, who planned to give birth at home in the last five years was used.

Interviews were conducted in a private, natural context of the participants choosing. They were recorded using a transcription service. Participants had the opportunity to review and edit the transcription prior to data analysis. Data was entered and analyzed into common themes using the qualitative program, NVIVO for assistance.

Results and Conclusions
The narrative provided by these women describe why homebirth was attractive to them and also why hospital birth was not attractive to them. Many examples were given by these women of having to fight to achieve their goal of homebirth.

Participants described in detail what they would tell hospital personnel about their homebirth and about their decision to give birth at home. Strong themes also emerged describing the character traits of the participants in this study. These character traits can be used to better understand the choices women make and ultimately can be used to guide the care of these women to promote positive maternal and newborn outcomes.
Perhaps the most valuable results from this study will be the expressions and voices of these women who do not fear the birth process, but fear the institutionalization of birth.

Bio of presenter
Ellise D. Adams, Associate Professor, The University of Alabama in Huntsville. She is a member of the Physiologic Birth Task Force, American College of Nurse-Midwives. As a nurse researcher, Dr. Adams’ studies include intrapartum nurses impact on patient outcomes, the culture of homebirth and skin-to-skin care. She presents regularly including the Normal Labour and Birth International Research Conference, China, 2012.

Ashley Stewart WHNP, MSN provides care to laboring women at Huntsville Hospital and will be a provider in Womens Emergency this Fall. While an Instructor, The University of Alabama in Huntsville, she provided nursing students with opportunities to understand normal birth such as visits to The Farm to interact with Ina May Gaskin.

Christine Schueler RN, BSN, staff nurse, Centennial Hospital, Nashville, TN. As an honor student, Christine conducted a study about the choices made by women who have a homebirth related to pain relief methods.

Authors and Affiliations
Ellise D. Adams PhD, CNM, Associate Professor, The University of Alabama in Huntsville
Ashley B. Stewart WHNP, MSN, Staff Nurse, Huntsville Hospital
Christine Schueler RN, BSN, Staff Nurse, Centennial Hospital
The clock is ticking

Hilary Gatward

Background

Is the clock in the birthing room a visual representation of the dominant discourse of labour? Traditionally labour and birth were understood in a social and cultural context where rituals, traditions, and beliefs provided a common understanding and meaning to birth. Today progress in labour is measured against the clock. Research by Freidman in the 1950’s measured the average duration of labour and the average time taken to progress through the various stages of labour. Friedman’s timeline has now become part of medical and midwifery knowledge and practice creating a temporal discourse of labour. Measuring progress against the clock has become an everyday practice and is a taken for granted practice in midwifery. This presentation will report on findings from a discourse analysis to demonstrate the effects of temporal discourses on women.

Aim

The aim of this study was to analyse the discourse/s around time in labour, from the perspective of midwives and women.

Method

Five midwives and ten women participated in in-depth semi structured interviews that were transcribed and analysed using discourse analysis. Discourse analysis as a methodology was chosen because it exposes how organised bodies of knowledge have shaped language and defined practice in midwifery over time in specific social contexts. By talking to midwives and women who interact around the timing of labour, it is hoped that their understandings and assumptions embedded in their language, experience or practice will be revealed.

Results

One of the themes emerging from this study was how women seemed to change their language and descriptions of their experience to fit into the medically prescribed timeline for labour. For example, when ringing the hospital to gain admission women often made two or more phone calls. Initially they described labour in their own terms, however, often by the second call they changed their description to meet the required discourse of established labour. In the interviews women used a situational discourse to describe their labour before admission and seemed to switch to a medical discourse after admission.

The switch from one discourse to the other was something that they seemed to be unaware of. Women also described a disjuncture between their experiences in labour and the prescribed pattern of labour. For some women labour started in a different place on the time line of labour to that described in the textbooks. For example, their waters broke first before they started to have strong and frequent contractions.
Conclusion

These study findings suggest that women often express their experience in labour in different ways than the prescribed temporal discourse of labour. It is hoped that this presentation will begin a midwifery conversation about time in labour and add to the increasing evidence that measuring labour progress by the clock does not necessarily encompass women’s actual experiences.

Bio of presenter

Hilary Gatward is a midwife and PhD candidate. After training as a midwife in London, UK, Hilary worked in Auckland, Sydney and Singapore. Her interest in time as a subject came about while working as part of a research team at Sydney University exploring, women’s experience of induction for post term pregnancy. Her PhD explores the discourse/s that surround time in labour by seeking to understand midwives and women’s constructions of time in labour. This paper is an analysis of some of the data from the women’s experiences of time in labour.

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Dr Elaine Burns. Lecturer. School of Midwifery. UWS.
Why do women choose an unregulated birth worker to birth at home in Australia: A qualitative study

Elizabeth Rigg

In Australia the choice to birth at home is not well supported and only 0.4% of women give birth at home with a registered midwife. Regulatory requirements are restrictive and there is no insurance product that covers private midwives for intrapartum care at home. Freebirth (planned birth at home with no registered health professional) with an unregulated birthworker who is not a registered midwife or doctor (eg. Doula, ex-midwife, lay midwife etc.) appears to have increased in Australia. The aim of this study is to explore the reasons why women choose to give birth at home with an unregulated birthworker (UBW) from the perspective of women and UBWs.

Methods

Nine participants (five women who had UBWs at their birth and four UBWs who had themselves used UBWs in the past for their births) were interviewed in-depth and the data analysed using thematic analysis.

Findings

Four themes were found: A traumatising system, An inflexible system; Getting the best of both worlds and Treated with love and respect versus the mechanical arm on the car assembly line. Women interviewed for this study either experienced or were exposed to mainstream care, which they found traumatising. They were not able to access their preferred birth choices, which caused them to perceive the system as inflexible. They interpreted this as having no choice when choice was important to them. The motivation then became to seek alternative options of care that would more appropriately meet their needs, and help avoid repeated trauma through mainstream care.

Conclusion

Women who engage UBWs see them as providing the best of both worlds that is birthing at home with a knowledgeable person unconstrained by rules or regulations and who respects and supports the womans philosophical view of birth. Women perceive UBWs as not only the best opportunity to achieve a natural birth but also as providing a safety net in case access to emergency care is required.
Bio of presenter
As a British trained community midwife with over 30yrs experience, Elizabeth has cared for women in both the public and private sector in the UK and Australia. She has also trained and worked as a Health Visitor in the UK prior to migrating to Australia 1992. Since then she has completed two degrees, a Bachelor of Learning Management 2008, Master of Midwifery 2011 and is a mother with two children. She is currently completing a PhD investigating The role of unregulated birthworkers in Australia from the perspective of women and birthworkers. Elizabeth is also a full time lecturer in Nursing and Midwifery at the Australian Catholic University.

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Professor Hannah Dahlen, RN, RM, BN (Hons), Grad Cert Mid (Pharm) MCommN, PhD, FACM
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<td>Peggy Seehafer</td>
<td>Static terms for a multifactorial influenced process of body movements during birth</td>
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<td>Pei-Chi Liu</td>
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<td>Pascale Pagola Davis</td>
<td>Prenatal education in private health in Chile: Empowering couples and promoting normal birth</td>
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<td>Helen Hall</td>
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<td>Federico Girosi</td>
<td>Economic analysis of the Complete Birth Study: A randomised controlled trial of antenatal integrative medicine for pain management in labour</td>
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<td>The influence of socioeconomic and medical factors on emotional changes during the postnatal period</td>
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<td>Meei-Ling Gau</td>
<td>Efficacy of ergonomics ankle support aid for squatting position on pushing skills and birth outcomes during the second stage of labor</td>
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<td>Swedish fathers contemplate the difficulties they face in parenthood</td>
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<td>Mary-Ann Davy</td>
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<td>The delivery driver: Attributions of accountability for medical intervention use during childbirth</td>
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<td>It takes years to achieve: Swedish midwives about professional confidence</td>
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<td>Laura Gabriel</td>
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<td>Risk factors for exclusive breastfeeding lasting less than two months: Identifying women in need of targeted breastfeeding support</td>
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<td>Julie Arthur</td>
<td>Establishing the first alongside primary maternity facility in New Zealand</td>
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<td>Jessie Johnson-Cash</td>
<td>Stages of labour: A systematic review</td>
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<td>Jayne Garrod</td>
<td>Making childbirth choices: Women’s use of social and traditional media</td>
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<td>Jane Henderson</td>
<td>Women’s worries about and experience of labour pain and associated outcomes</td>
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<td>Joycelyn Toohill</td>
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<td>The effects of skin-to-skin care during an uncomplicated caesarean compared skin-to-skin care after a complicated caesarean on maternal and newbork outcomes</td>
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<td>Ellen Blix, Helena Lindgren</td>
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**Poster Presentation – Thursday 13th October**

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<td>Christa Buckland</td>
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<td>Catherine Donaldson</td>
<td>Keeping the flame alive: Exploring and invigorating normal birth practice amongst postgraduate mid-wifery students</td>
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<td>Beryl Davies</td>
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<td>Anne Marie Lilleengen</td>
<td>Continuity of care in midwifery studies – a qualitative study of students’ reflections from home visits postnatal</td>
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<td>Robyn Gasparotto</td>
<td>Birth unit outcomes with and without central fetal monitoring</td>
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<td>Amanda Hutcherson</td>
<td>Setting up a volunteer doula service in the London UK: A scoping study</td>
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<td>Andrew Symon</td>
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<td>Leonie Hewitt</td>
<td>Australian midwifery leaders views on the attributes required in managers to effectively manage a midwifery group practice</td>
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<td>Jane Carpenter</td>
<td>Water immersion during labour and waterbirth in Australia: A prospective observational study</td>
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<td>Jane Sandall</td>
<td>Are guidelines for gestational weight gain achievable, and does it matter, in obese pregnant women? Findings for the UPBEAT trial</td>
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<td>Annika Karlstrom</td>
<td>Swedish women’s experiences of emergency caesarean section</td>
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<td>Alys Einion</td>
<td>Making a difference: Student midwives holistic understanding of women with complex needs</td>
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<td>Using dynamic narratives to facilitate enquiry-based learning: Developing holistic knowledge for maternity care</td>
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<td>Maggie Redshaw</td>
<td>How does peer support on women’s emotional wellbeing during pregnancy and following childbirth? A qualitative study</td>
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<td>Lisa Davenport</td>
<td>Placental birth practices: Exploring midwifery and medical management of the third stage of labour in a regional Queensland Hospital</td>
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<td>The challenge of employing and managing new graduate midwives in midwifery group practices in hospitals</td>
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<td>Jeffrey Craig</td>
<td>A guide to twin zygosity and chorionicity</td>
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When you have a new baby, you can have all sorts of questions. Raising Children Network provides new parents with trusted information about behaviour, sleep, nutrition, family relationships, communication, safety and what you can expect in the months (and years) to come.

New parents welcome!

Free parenting videos, apps and articles backed by Australian experts

What's your baby trying to tell you?

Easy-to-follow demo videos Grow and Learn Together

Sign up for free newsletters

Find out with Baby Cues - our video guide to baby behaviour.

Topics include how to get a good attachment when breastfeeding.

Get ideas and practical tips on different child health and wellbeing topics.

It is not possible to 'spoil' a newborn. Every bit of attention you give now helps your baby grow and develop. In your baby's early months, she is working out what the world is like. If your newborn cries and someone comes, and if she is cuddled, kissed and played with, she is going to think the world is a pretty OK place.

Grow with Us

Newborn behaviour

Dear Jessica

Raising Children Network is supported by the Australian Government Department of Social Services. Its member organisations are the Parenting Research Centre and the Murdoch Childrens Research Institute with The Royal Children's Hospital Centre for Community Child Health.

Understand and boost your child's development with fun play ideas and video demonstrations.