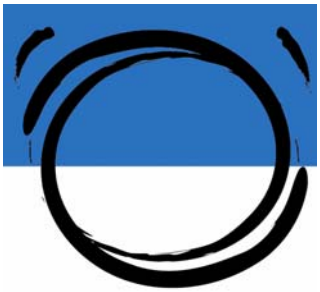

Ajunnginiq Centre

Conference Notes from:

The Cascade of Normal: Reclaiming Confidence in Birth

6th Annual General Meeting, Conference and Exhibit
of the Canadian Association of Midwives

October 18-21, 2006
Lord Elgin, Ottawa, Ontario

Prepared by[1]:
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November 29, 2006

[1] These notes were compiled following attendance at this conference. The notes have not been verified by the presenters.

The Cascade of Normal: Reclaiming Confidence in Birth
6th Annual General Meeting, Conference and Exhibit
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Conference Notes

Conference Purpose

The conference was the Canadian Association of Midwives' annual gathering of midwives from across Canada, including the international midwifery community and national professional associations and health organizations.

"We are in Ottawa this year to ensure that our politicians and policy-makers are aware that midwives are part of the solution to the maternity care crisis, and that the continuing development of the midwifery profession is essential to sustainable, accessible, high quality maternity services for all Canadian women." (Kerstin Martin, President of CAM)

Goal: to explore and articulate the steps, pathways, clinical skills, and professional actions that support the power and confidence of women in pregnancy and birth. With obstetrical intervention on the rise in industrial cultures, it is vital for us all to further our understanding of how 'the cascade of normal' works.

The conference plan also included a gathering of First Nations, Métis and Inuit midwives on Saturday, October 21.

One key point from the conference program was: In Ontario, even as the number of midwives continues to increase, they cannot keep up with the demand for their services, turning away approximately 40 per cent of all clients. There is much room for growth in every province and territory.

Notes from some presentations attended

Aboriginal-related presentations during the Conference Program – Friday, Oct. 20, 2006

For abstracts and/or summaries of these and all other presentations, see the conference program at: http://www.canadianmidwives.org/CAM_Conference_2006.pdf

Sara Tedford Gold, PhD
Returning birth to remote communities: collaboration and the roles of Inuit and non-Inuit midwives in visions for sustainable change

See the "Resources" section at www.inuitmidwifery.ca for the powerpoint presentation and other related information on this research.

Kerry Bebee, RM, AM
Midwifery and Aboriginal Midwifery in the North: Can we help fill the gaps through collaborative care and an expanded scope of practice?

The presentation noted:

- The First Nations and Inuit Health Branch has not yet recognized registered midwives as primary care providers;
- Midwives can prescribe contraceptives and antibiotics for urinary tract infections;
- The better the communication between the care providers, the better the care;
- In the North, midwives often have an "expanded scope of midwifery practice" which can include: well-women care; STD counselling; education and treatment; nutritional education; and peer counselling/referral services;
- The midwife becomes part of the family's health care and is trusted by the community;
- In this region, 70 per cent of the population are Aboriginal and 25 per cent are under the age of 25.

Betsi Dolin, RM
Darlene Birch, RM
Manitoba's Aboriginal Midwifery Education Program

The presentation noted:

- This is a university program that is community friendly – run through the University College of the North;
- It is a rigorous four-year degree program and has passed four formal reviews; it uses a cohort model (six students in Norway House and three in The Pas – It will see these students through the program before accepting a new cohort). The program also has useful exit points during the four years associated with different levels of certificates;
- The program was developed through funding from the Aboriginal envelop of the Primary Health Care Transition Fund;
- Ann Peterson and Margaret Dumas (Elder) were involved in the curriculum development – every course is layered on top of a cultural foundation;
- Aboriginal people participated in the development of the regulations;
- Aboriginal cultural knowledge is combined with Western knowledge;
- The developers looked for models that worked well for Aboriginal students;
- Community involvement is an important component – the community is involved in the mentoring model;

- Various meetings were held during the development phase: Elders meeting – they gave details about their practices and explained that the lengthy apprenticeship occurred through observation, assisting, then doing; meetings held with First Nations and Métis; meeting held in Rankin Inlet, Nunavut on how to collaborate.
- Language is integral – used the Common Curriculum for Aboriginal Languages and Cultural Framework;
- They offer Cree courses, but if a student has another Aboriginal language they can challenge this.

Poster Presentations:

Melanie Paniaq, Maternal and Child Health Project Officer, presented Pauktuutit Inuit Women of Canada's poster on their research that documents traditional Inuit practices related to pregnancy and childbirth.
See http://pauktuutit.ca/pdf/publications/pauktuutit/MidwiferyPoster_e.pdf

Catherine Carry, Research Officer, presented NAHO's Ajunnginiq Centre poster on Inuit midwifery in Canada: Supporting its restoration through information-sharing.
See http://www.naho.ca/inuit/midwifery/Presentations.php

Aboriginal Midwifery in Canada - Saturday, Oct. 21, 2006

This day specifically focused on Aboriginal midwifery and was attended by 40-50 participants. Some of the presenters were:

Laura Jacobs from the Six Nations birthing centre stated that they looked at the Inuit model when they developed their own program which is now 10 years old. They use the Ontario College of Midwives screening guidelines for low/high-risk assessments and provide a full range of care including well-woman clinics, menopause counselling, pandemic preparedness, childbearing workshops including sessions with teenagers for girls and for boys.

Natsiq Kango, traditional midwife from Iqaluit, Nunavut and member of the Midwifery Association of Nunavut (which was incorporated in February 2006), presented on cultural, research and policy issues. She noted:some of the doctors in Ottawa are receiving cultural competency training; and, there is no insurance system for midwives set up in Nunavut.

Brenda Epoo, Community Midwife from Inukjuak, Nunavik (Northern Quebec) and President of the Nunavik Midwives Association, gave a presentation on the Nunavik Midwifery Gathering held in Inukjuak in the fall of 2005: Elder and younger people attended from each Nunavik community along with the community and student midwives. A report of that gathering should be available soon. The Puvirnituq maternity is celebrating its 20th year of operation with additional centres now in Inukjuak and Salluit.

Catherine Carry from NAHO-AC made an oral presentation about the poster mentioned above.

A special gathering attended by the Aboriginal midwives was held after the lunch break.

Summaries from other Presentations Oct. 19-20, 2006

Panel presentation
Midwives and Hospital Relations: Overcoming Challenges
Presenters: Arlene Kraft (HIROC); Don Rogers, LLB; Alan R. Stewart, MD; Christiane Leonard, SF (replaced); Lee Saxell, RM

Panelist: Arlene Kraft (HIROC)

- The purpose of the insurance discussion was to increase awareness of the things you can do to avoid problems in the future;
- The Board of this not-for-profit insurance group (HIROC) are members of the profession and share in the risk management;
- Record keeping (documentation of the work with the client including the birth, etc.), good collaboration with a team and good communication are key regarding potential complications;
- Protocols should be established first, before things happen and those that are inefficient/ineffective should be revised;
- Midwives and team members must know the policies and procedures;
- Most of the claims disclose: a failure to monitor; a failure to follow policies; poor documentation; late entries; missing records; poor communication; interpersonal challenges and lack of co-operation; repeat incidents; and misunderstandings regarding transfers, etc.

Panelist: Bobbi Soderstrom – Moderator

- Soderstrom serves on the Professional Liability Issues Insurance Committee of CAM;
- Some statistics on levels of coverage, provider enrollment and law suits were given;
- All kinds of insurance companies folded due to terrorist attacks in the U.S. on Sept. 11 , so it became much harder to obtain insurance and it became more expensive for less coverage; (insurance issues will eventually be of concern to the Inuit midwives in the North);
- six per cent of midwives in the U.S. have been sued;
- How are we going to continue to maintain a viable insurance option in a so-called risky environment?;
- An environmental scan of insurance options across the provinces has been presented to the CAM Board;
- Need to keep up-to-date with the evidence;
- There are no real trends yet in Ontario regarding claims because it is too early;
- There are access problems to other provinces' data;

- Midwives should take leadership in reviewing cases to develop guidelines.

Panelist: Dr. Stewart

- Midwifery came to the Guelph Hospital in 1994;
- A framework for their inclusion had been developed before they arrived;
- The policies and practice were very restrictive;
- In the 2004 third-party review, it was found that midwives were not well respected by nurses and obstetricians – 53 recommendations resulted;
- A multidisciplinary quality of care committee was struck to develop a Code of Conduct which established expected behaviours and listed unacceptable ones – tailored after the College of Midwifery scope of practice;
- There has been much improvement since, recognizing that beliefs change slowly;
- The funding practices for midwives and obstetricians do not fit together well.

Panelist: Replacement Speaker from Quebec

- Midwives are hired by the CLSC – which is the local health centre in each community and they do not have hospital privileges per se;
- Pregnant women register at a hospital, but are not admitted. This allows the midwives to attend to them but also allows for easy transfer or admitting if problems develop;
- This system has been in place in the hospitals for two years;
- There have been fewer midwifery supervised births in the hospitals than expected;
- Some unsolved challenges include: three hours after the birth, the woman is to go home and if they want to stay longer they have to be admitted; if the midwife has to leave the woman, she loses responsibility [I don't think these issues apply in the Nunavik (Northern Quebec) CLSC maternities];
- The physicians want to solve the challenges;
- There is a need for stakeholders to 'trust the complementarity' of their roles and to examine the issues together.

Panelist: Lee Saxell, RM

- Saxell is the Head of Midwifery at BC Women's Hospital; in practice since 1980s;
- Midwifery use is exploding;
- Midwives have dual privileges at Women's and at St. Paul's;
- It is a good location for entry-level midwives because of the high volume; then it's good to go to the more rural areas;
- Midwives are automatic members of the various committees and they are well-integrated and do speak up;
- The midwives also work with doulas;
- Activist workshops are held; they facilitate conflict resolution—they are moving away from pointing fingers;
- The midwives collaborate with family physicians and obstetricians, but a staff person such as a nurse must be present for the births;
- Conflict is mainly in the area of money and 'salary' is a 'bad word'.

Deanne R. William, CNM, MS, FACNM
Cesarean Delivery on Maternal Request: An Action Plan for Midwives

The presentation noted:

- Discussed the public advocacy, grassroots and professional call to action approaches that have been utilized by midwives to address the increase in (unnecessary) C-Sections in the U.S.;
- The benefits of cesarean are overstated; the risks of C-Section are understated;
- There is no evidence that C-Section helps avoid incontinence issues associated with birthing;
- Numerous authors have suggested that "maternal choice" accounts for much of the increase in primary cesarean deliveries in the U.S., but evidence of women actually electing to have a C-Section with no cause (U.S.) is very small at 1 out of 1574 or .06 per cent; See the Listening to Mothers Survey at www.childbirthconnection.com (down for maintenance at the time of writing);
- Midwives (and others) can be taught how avoid using episiotomies;
- Journal of Midwifery and Women's Health;
- There is a need to build the evidence and fund research that supports best practices regarding vaginal birth;
- Midwifery is a public health issue.

Lawrence Oppenheimer, MD, FRCSD, FRCOG
Cesarean Rates: Where are we going?

The presentation noted:

- Discussed the reasons for the increase in cesarean rates and suggested ways to reduce the rates;
- We need to focus on collaborative practice;
- Eighty-five per cent of obstetricians and gynecologists in training are women;
- For public health data see Health Canada website – CIHI report;
- C-section babies may be at more risk of Sudden Infant Death Syndrome (SIDS);
- WHO statistics from 1985 noted that 10-15 per cent of births were by C-Section; Sweden – 14 per cent of births were by C-Section and they have a low infant mortality rate and are industrialized; Canada's rate is going up to 30 per cent;
- Induction rates contribute substantially to C-Section;
- The guideline should be to induce after 4 weeks past due date;
- Some of the factors also contributing to higher rates of C-Section are physiological including Body Mass Index and increasing numbers of births after 35 years of age;
- Forceps training has stopped, but this intervention is less invasive than C-Section;
- Fetal heart rate monitoring doubles C-Section rates and doesn't seem to show many benefits and is not based on evidence;
- There is no reduction in the rate of cerebral palsy through use of C-Section;
- What we need is better risk assessment;

- We need to continue to teach vaginal breech birth skills, but organizing the mentoring is difficult.

Francine de Montigny, PhD
Midwifery Students and Fathers: An Encounter to Discover
http://w3.uqo.ca/oregand/publications/2004-2007plansanteQc.pdf
Francine.demontigny@uqo.ca

The presentation noted:

- Father involvement in the perinatal process with midwives supports mothers and improves child outcomes;
- There are benefits for the fathers;
- Health-care providers need to be more accessible to fathers;
- Develop ways to interact with men;
- "Undergraduate midwifery and nursing education need to make space for more concrete opportunities for father-student dialogue, in order to foster the growth of a generation of health-care providers that do consider fathers as part of the family."

Cathy Ellis, RM, MSc
Kathrin Stoll, MA
Evaluation of the University of British Columbia Midwifery Program's First Graduates

The presentation noted:

- This is a four-year Bachelor of Midwifery program that focuses on problem-based learning;
- The survey was conducted in June 2006;
- The findings indicate that the program is overall very effective;
- After graduation, it is best to work with an established practice for six months;
- Graduates felt well-prepared and appreciated the clinical placements in five of the semesters - Some midwives had international placements and these are usually in Africa;
- Senior midwives interviewed gave a range of comments for program improvement;
- The program did not improve students' counselling skills enough – the graduates need more in this area and also in the area of business skills as many will eventually run their own practices.

Jay MacGillivary, RM
HIV and Pregnancy: The New Reality
Combining Global Awareness, Current Research and Common Sense

The presentation noted:

- Who defines normal? The woman;
- Discussed issues around disability and pregnancy – attitudes, beliefs, etc.;

- Six HIV positive women have been through the midwifery-run program in Toronto and so far the babies are HIV negative;
- Thirty per cent of Canadians living with HIV don't know it; there is a great need for testing and talking about HIV;
- Twenty million people worldwide have died from AIDS since 1981 when the statistics collection began;
- Need HIV protocols and guidance related to birthing;
- Universal precautions should be used for everyone working with women and babies;
- Use of the drug AZT for pregnant HIV positive women and for the baby after birth helps prevent transmission;
- It is rude to ask a woman [or anyone] how they got HIV;
- There was some technical discussion of viral loads and optimum goals and the fact that 'super HIV infection' is possible when each person in a couple has a different strain;
- Ms. MacGillivary and Dr. Mark Yudin, an international expert on HIV and pregnancy, are developing a new model and standard of care for this community.

Judy Rogers, RM, MHSc
Collaborative Maternity Care in Rural Ontario

The presentation noted:

- The major findings from the Integrated Maternity Care for Rural and Remote Communities project;
- The handout included project recommendations on the following themes:

    1. Creating and Sustaining a New Vision of Maternity Care
    2. Leadership and System Coordination
    3. Maternity Care Human Resources Planning
    4. Maternity Care Education
    5. Promoting Woman-Centred Maternity Care (Access and Input)
    6. Ensuring Sustainable Maternity Care Models
    7. Mechanisms to Support Collaboration: Creating a Philosophy of Cooperation, Mutual Respect and Trust
    8. Mechanisms to Support Collaboration: Addressing Regulatory and Legislative Barriers
    9. Mechanisms to Support Collaboration: Addressing Liability and Malpractice Issues
    10. Mechanisms to Support Collaboration: Funding and Compensation

Emmanuel Bujold, MD, FRCSC
Vaginal Birth after Caesarian (VBAC)

The presentation noted:

- The research focused on measurement of the uterine wall in order to predict the risk of uterine rupture in vaginal birth after caesarian;
- A certain thickness of the wall is required for safe VBAC.

Teresa Pitman, Executive Director and Leader, La Leche League of Canada
Samantha Leeson, CCE, LE
How Birth Affects Breastfeeding (and what to do when it already has)

The presentation noted:

- If possible, it is best to have no separation at birth;
- It is best to let the baby breastfeed first immediately following the birth before being washed;
- Support during labour increases the positive relationship with breastfeeding;
- Early skin to skin contact is the first step in stimulating that natural reflexes and hormones;
- IV can influence the rate of breastfeeding success; i.e. IV can contribute to edema of the aerola – treated by reverse donut pressure;
- It is not necessary to sanitize the nipples before initiating breastfeeding – unwashed nipples are easier for the baby to find;
- The candida (yeast) that 'hangs around' in hospitals is more resistant to treatment;
- See the La Leche League website: http://www.lllc.ca/ and also http://www.lactations.com/links.php

Tasha MacDonald, RM, BHSc
Disease, Decision and Dilemmas: Ethical Considerations for Midwives in the Event of Pandemic Influenza

The presentation noted:

- We are overdue for a pandemic outbreak – there is a WHO pandemic alert on now;
- Avian H5N1 virus can cause serious illness in humans; "Influenza A viruses periodically cause worldwide epidemics";
- About 15 – 35 per cent are expected to become ill during a pandemic leading to 11,000-58,000 deaths in Canada alone;
- "Women in pregnancy are considered to be at high risk of adverse outcomes if infected with a virulent strain of influenza";
- In a pandemic there are screening challenges; there is a focus on equipment and more urgent cases;
- "Difficult ethical decisions in the event of an influenza pandemic will be made at all levels, by leaders in government and health care, as well as by individual clinicians and health care workers";
- During the SARS outbreak, more pregnant women requested home births to avoid hospitals;

- Midwives need to be part of the pandemic planning working groups at the provincial levels as they will be severely affected; some discussion with the Six Nations program is underway as well as in Ontario and British Columbia.

Allison Campbell, RM, MA
Maternity care needs of incarcerated, parturient women in BC: The role of midwifery care

The presentation noted:

- There is little research available in Canada on this subject;
- The project interviewed 10 women in provincial custody in BC to compare it with existing literature and to consider whether a midwifery model of care could be useful in this context;
- For the incarcerated women compared with similar women not incarcerated, being in custody while pregnant has benefits: they are not on the street; they have access to prenatal care; they have adequate food and shelter; reduced lower-birth-weight babies; fewer pre-term births;
- Health care varies across the institutions;
- Most of the women have drug issues;
- They need advocacy and their care needs to be community-linked for continuity of care;
- The women need prenatal education and good quality prenatal care;
- A major challenge: It would be better if the health-care providers were not part of the correctional institution – trust issues, etc.;
- There are five federal institutions in the regions with a mother/child program.

Nicky Leap, RM, Msc, Dmid
The role of pain and the empowerment of women in normal birth

The presentation noted:

- "Respecting physiology and the important role of pain in labour enables midwives to be alongside women, encouraging them to find their inner strength without resorting to pharmacological pain relief. This skill is fundamental to midwifery and is in direct opposition to the nursing and medical skills of 'pain relief'";
- We need to understand the concept of 'normal' vs 'abnormal' pain;
- The pain is coming to help – natural chemicals (endogenous opiates) cascade in the body during labour;
- Grampling with pain is central to normal birthing;
- The same debates happen 'then and now';
- A women's 'right' to pain relief contributed to the move to hospitals and the medicalization of care;
- "women report a great sense of achievement and satisfaction in coping with labour pain".

Vicki Van Wagner, RM, PhDc
Reinterpreting Evidence in Favour of Normal

The presentation noted:

- "The application of evidence seems to be leading maternity care practice away from normal birth";
- "Evidence-based practice is not a neutral scientific tool" – it is always interpreted and then claimed to be the truth – we need to acknowledge multiple truths;
- Science is often a cover for other interests – the dominance of the business model…industrialized birth;
- "If evidence is understood to always be interpreted, then midwives and other advocates for physiologic birth can be actively involved in interpreting and reinterpreting evidence in the direction of normal";
- "We are all spin doctors" – Patricia Crowley;
- Evidence is always changing and a lot relates to the practitioners skills;
- There is a difference between what evidence says and values – we need both – removing the values leads to fear and intervention – current studies have turned away from the integration of knowledge and values to focus on randomized trials;
- We need to become more social in our approaches;
- Birth is a natural process; the onus of proof rests with the intervention;
- Guidelines should maximize normal birth;
- The term 'normal' is a problematic term.

Abstracts and/or summaries are available in the Conference Program at: http://www.canadianmidwives.org/CAM_Conference_2006.pdf

Other websites:

- See the Society of Obstetricians and Gynaecologists website: http://www.sogc.org/home/pdf/Birthing-Strategy_Version-4-0_aug-22-2006.pdf for the August 22, 2006 draft of the National Birthing Strategy for Canada. This is a concept paper. Its development involved five university programs and more than 450 Registered Midwives. It contains a section entitled "Bringing Birth Back to Rural, Remote and Aboriginal Communities."
- www.maternity.org