The Prince Edward Island Roundtable on the State of Maternity and Newborn Care

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Prepared by

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Submitted to:

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"Birth is an empowering experience if women and their families are supported in the process of labour, delivery and postpartum"

(PEI Roundtable Participant Story – Personal Experience Appendix E)

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1. Editor's Introduction

This workshop was ACEWH's second undertaking under its midwifery initiative, which is aimed at assisting with the development of legislative and regulatory models that will facilitate the provision and accessibility of midwifery care to women in the Atlantic region.

This final report reflects a summary of the discussions at the Prince Edward Island (PEI) Roundtable on the State of Maternity and Newborn Care. The PEI approach to the topic was broader than in other Atlantic provinces which may in part be due to the focus of the partnering organization in PEI, the Birth Options Research Network (see brochure Appendix A). To facilitate the immediate next steps and future strategies, the document also provides a complete list of participants and contact information, as well as a complete list of those who were invited.

While this document is primarily written for those who attended the workshop, it is also for those who were invited but were unable to attend, and those who have been identified as having an interest in these issues in Prince Edward Island. It will also serve as a brief reference document for people outside of the province who have an interest in these issues and ACEWH's work in this area. It will be posted on the ACEWH website and available at www.acewh.dal.ca.

Christine Saulnier, PhD
Senior Research Officer
Atlantic Centre of Excellence for Women's Health

2. Introduction

The first province to legislate and regulate midwifery as an autonomous profession was Ontario in 1993. Since then, midwifery has become an accessible option for many women in Canada. This is not the case, however, for women living in the four Atlantic provinces, which remain without midwifery legislation and funding. As part of its policy research programme centred on midwifery and more broadly on women's reproductive health, the Atlantic Centre of Excellence for Women's Health co-hosted a roundtable to discuss the status of birthing options in Prince Edward Island with Women's Network PEI and the Birth Options Research Network (BORN). BORN is a community-based group in PEI advocating for a formal uptake of the Family-Centred Maternity and Newborn care: National Guidelines 4th Edition (Health Canada, 2000) to enable empowerment of women and families in the birthing experience and accessibility to mid-wives and doulas.

The letter of invitation (see Appendix B) for this meeting highlighted the main reason for ACEWH's involvement in this initiative as being "in the interest of exchanging ideas and developing strategies for ensuring that women on PEI receive the most appropriate primary maternity care, this roundtable aims to bring together policy makers, health care providers, programme planners, administrators, community activists, and consumers to discuss what is working and what needs to be improved." This report of roundtable proceedings summarizes the issues that were raised, and includes not only the immediate next steps but the discussion of strategies that could assist with creating more holistic care options including the introduction of a regulated, autonomous midwifery profession.

3. Roundtable

3.1 Roundtable Objectives

The workshop agenda and objectives were developed in a pre-consultation meeting with representatives from Women's Network PEI and BORN. The workshop objectives were identified as follows:

1. To create an opportunity for people to come together, connect, be educated about options for maternal and newborn care; and,
2. To reach a common ground in understanding that holistic maternal and newborn care contributes to a healthier community

Organizers also identified that the event would be viewed as a success if they were able to achieve an increase in the number of people willing to work with their organization and in the longer term make the link with the healthcare agenda.

3.2 Roundtable Participants

Twenty-five in-person stakeholders from various professions, as well as consumers, who have an interest in advocating for options for newborn and maternal care participated in the PEI roundtable. Representative organizations included Aboriginal Women's Association of PEI, BORN, Canadian Association of Midwives, Carousel Family Resource Centre, La Leche League, PEI Advisory Council on the Status of Women, PEI Breastfeeding Coalition, PEI Department of Health and Social Services, PEI Doula Association, UPEI School of Nursing, Prince County Hospital, Public Health Nursing, Queen Elizabeth Hospital, and Women's Network PEI

3.3 Roundtable Agenda

The agenda included an information session open to the public from 9:30 - 10:30 am and an invitational roundtable from 10:30 - 2:30 pm.

Panel 9:30 – 10:30
Christine Saulnier, Introductions and Background.
Susana Rutherford, Family Centered Maternity and Newborn Care
Joyce England, Midwifery: Status and Opportunity in Canada
Sylvie Arsenault, Doulas: Role and Benefits
Patsy Beattie-Huggan, Moderator

Roundtable Discussion
10:30 Introductions
10:45 Current initiatives - What is happening now?
11:30 Impacts of present service - What are the impacts of present level of service?

12:15 Lunch and networking

12:45 Future dreams - What are your dreams for the future?
13:15 Barriers/opportunities - What are the barriers/opportunities to achieving the dream?

13:45 Collaborative Action - What needs to occur to achieve the dream?
14:15 Review of discussion and next steps
14:30 Roundtable adjourns.

"I wouldn't change a thing about my experiences. I bonded quickly to my girls and felt empowered by my births. I became a good mother partly because of my experiences."

(PEI Roundtable Participant Story – Personal Experience Appendix E)

"Mothers and fathers-to-be need education, empowerment, and peace and quiet to labour, to let a woman's body do what its built to do, and to welcome their new baby. Let normal, healthy women have normal, healthy births."

(PEI Roundtable Participant Story – Personal Experience Appendix E)

4. Panel

4.1 Presenters and Presentation Outlines (Full text presentations Appendix D)

Christine Saulnier, Senior Research Officer and coordinator of the midwifery project at the Atlantic Centre of Excellence for Woman's Health, welcomed those in attendance and outlined the objectives for the meeting and how this initiative fits with ACEWH's current programme areas and projects. The goal of ACEWH is to support research, influence policy and promote action on the social factors that affect women's health and well-being over their life span. (See www.acewh.dal.ca for more information). She then set the context for the day asking "What are the options for women in Canada? PEI? for maternity care?" In addressing these questions she noted the pending maternity care crisis and troubling trends in statistical maternity data for PEI against a national comparison. She closed the opening remarks by challenging participants to focus on "Appropriate providers for appropriate care".

Susana Rutherford, Coordinator and one of the founders of BORN, has spent many hours of volunteer time working on maternity care issues. She also had the most recent home birth in PEI. Susana is also an accomplished professional artist - a painter of wild and domestic animals. She outlined the Guidelines for Family Centered Maternity and Newborn Care (2000). She began by providing background on "family-centered" care, describing that it originated with obstetrical nurses in the 1970's, viewing the woman and family as a unit of care and allowing for inquiries, planning, concerns from prenatal through to postnatal care. She provided a brief overview of guidelines and her hopes to see the guidelines as an official 'unified' policy on PEI, where currently pieces and excerpts are applied, in hopes of seeing maternity care "working together better."

Joyce England, a registered nurse, certified midwife and currently PEI's representative to the Canadian Association of Midwives, has a wide range of experience working as a Community Health Nurse in Manitoba and Rankin Inlet; as well as working as a midwife on PEI, Goose Bay Labrador and Rankin Inlet. Indeed, she coordinated the Rankin Inlet Birthing Project. She also served as a Nursing Consultant with the Association of Nurses of Prince Edward Island and has been assisting with the facilitation of the Family Health Centres with the P.E.I. Dept. of Health and Social Services. She spoke on the topic of Midwifery: Status and Opportunity in Canada. In her presentation, she entered into an international comparison of the status of midwifery, ranking Canada amongst the lowest in provision of midwifery services. The total number of registered midwives in Canada is 454; Nurse Practitioners (NP) in Canada is 600, with only three provinces presently housing midwifery education programs. PEI is amongst those provinces which do not have legislation for midwifery practice, while a growing number are responding to avert a pending maternity crisis by doing so. For example, the North West Territories passed legislation in 2003 with a registry being developed and funded. She described the supportive positions of the Canadian Medical Association and the Canadian Nurses Association and challenged maternity nurses, midwives, obstetricians and family physicians to collaborate.

Sylvie Arsenault is a member of the Doula Association of PEI and a member of BORN. She is also an accomplished singer. She spoke about doulas, about the kind of care they provide to women on PEI and the benefits. She first defined a doula as a woman trained to help women during childbirth and described her role as being a consulting, continuous presence, supporting and facilitating

informed choice, breast feeding and postpartum support. A doula assists with "reframing the experience" if necessary to view birth outcome positively and often is there to remind women of their strength, and a focus on "positive memories no matter what the outcome"

Patsy Beattie-Huggan of The Quaich Inc. served as panel moderator and facilitator for the Roundtable. She recapped the presentations and called for questions.

4.2 Questions and Answers

Q: Do women in PEI pay for doula care?
A: Yes, out of pocket, meaning the service is not available to all women. Some flexibility noted in billing depending on ability to pay.

Q: Are any women on accreditation meetings? Regarding Family Centered Care?
A: Yes, obstetrics accreditation is happening now as part of accreditation at QEH and PCH, and yes, nurses are involved.

Q: What is accreditation?
A: Hospitals volunteer to be surveyed by accreditation body. Seventeen standards are used to review, implement, and monitor obstetric process. This involves many levels including systems, nurses, physicians, volunteers, and obstetricians.

Q: Who accredits?
A: The Canadian Accreditation Council.

Q: Is the person using the service included in accreditation?
A: Yes, if they volunteer.

Q: Do doulas have to go through the same training as midwives?
A: Not as rigorous as midwives, different training that is more focused on support
There is a PEI Midwives Association with 2 members, Joyce England and Sylvie Arsenault.

Q: Does the PEI Midwives Association do advocacy at medical level/setting?
A: Midwifery is pretty silent; although experience elsewhere has shown that midwives and obstetricians work well together. I have hopes for better collaborative effort in the future to address the lack of available primary maternity care providers.

Q: Does the PEI Medical Society take a position on midwifery?
A: PEI Med Society never made a position, although Nursing does state support of midwifery.
SOGC also supportive of midwifery

Patsy commented on the level of interest and participation in discussion on this topic, asking if there were any other questions from people who were there from the public who would not be attending the Roundtable. Given the time factor and no further questions, she concluded the public session at 10:20.

5. Summary of Full Group Discussions

The Roundtable began with introductions around the table. Patsy Beattie-Huggan was introduced as facilitator and Gillian Clayton introduced as a recorder.

In recognition that everyone comes to the table with their own stories, participants were asked to use a story writing template (see Appendix D) to write a story that motivated them to come to the Roundtable today in order to focus thinking on issues that emerged from their stories. Participants were also invited to contribute their stories to be included in the report. Of the 25 participants in the Roundtable, 10 submitted their stories to be included in this report.

5.1 Current initiatives – What is happening now

There was a great deal of discussion around these questions and participants educated each other on the options that presently exist on PEI. Discussion was not linear, and one idea stimulated another. However for clarity discussion points are outlined separately from the following list of options.

- Tool: Published by the International Childbirth Education Association. A card that fits into your wallet that instructs you to ask certain questions when either a test is recommended or when an intervention is recommended "When this test is ordered, ask these questions ….". This card is designed so that the patient understands options and is able to weigh them in terms of their ramifications.
- A birthplan: clarifying what is "ok and not ok" in the experience; understanding doctors, hospitals, philosophies and policies. Developing a birthplan can occur in prenatal classes and with a doula.
- Public Health Nurses provide prenatal classes and individual counseling on PEI. Nurses are open to this concept and referral to counseling can be made by physician or self-referral.
- Referral to obstetrician
- Prince County – has family physicians who deliver babies
- Support person or coach can be present through labour and delivery
- Nursing care: e.g. they provide important quality care during active labour
- Labour and delivery in same room is now possible but still limited
- Internet information; also access to expertise to interpret information
- Family Resource Centres (have Canadian Nutritional Prenatal programs) can call a FRC for referrals and information
- Contact information from physicians
- La Leche League supports breast feeding; likes to have women come before birth; "buddying up" happens early while in hospital
- The Best Start program provides support and follow-up after delivery
- Private doula
- Complementary therapies e.g. therapeutic touch, Reiki, massage, homeopathy
- Information on midwifery is available through Joyce England
- Accessing midwives from out of province who come to PEI for home births

Initiatives presently underway

- A prenatal resource document will be upcoming through physician office and public nurses.

A comment was made during the discussion that not seeing nurses as part of the earlier presentations is a concern, especially since evidence that one-to-one care reduces interventions.

A comment was made: "Are all these options really options? They look good on paper, but what is the reality? What's the difference between options and choices? Only certain women would actually be able to choose certain options depending on their economic, social situation; what they know; where they live etc. There was a strong sense that Obstetricians should also give out community referral information.

Another person commented that "there is a difference between what is offered and what could be asked for (e.g., only some mothers might push for different treatment)." This led to a discussion regarding the "Passive consumer" on PEI and the need for active education.

- How has PEI integrated National Guidelines for Family Centered and Newborn Care?

There was also good response to this question with a sharing of information as to how the Guidelines are implemented on PEI and the issues involved in implementation.

< Nursing students are taught by guidelines in Family Centered maternity care

< Guidelines were introduced to the mother/baby committee 6 months ago. Feedback was very positive suggesting that every nurse should read them and incorporate them into their practice in pediatrics and maternal /child. There are some issues with this. Guidelines have increased six times since the last edition ('80s) and there is concern about simply handing new nurses the large set of guidelines, however "We're definitely moving in that direction".

The remainder of the discussion focused on the fact that it is not as easy as passing on information, that a "cultural shift" is required in how we view maternity care and recognizing where people fit. The approach in which there is respect for all services, values, and perspectives needs to be aligned with Health Canada's guidelines, but also needs to align with consumer's needs and values. Even now, women and their families can be active participants, not recipients, "They just don't realize they can."

There are also issues of fear around responsibility. People need to be invited "feel welcome to make those choices". Some people may perceive being invited to be involved as "downloading". "Is having a cot in the room sending the message that the mother has to bring someone to take care of her? Whose job is whose and when?"

There may be real concerns regarding the impact of family involvement that need to be considered. A scenario was presented regarding expectations where a father stays in hospital with the mother, but the kids are at home. He feels he is expected to be at the hospital as a support, but also needs to tend to the kids at home, and may not have resources to cope with demands.

One participant commented that family-centered maternity care has cultural sensitivity as a principle. The intent is that "providing good information, providing partnership and letting them make the

decision, respecting the client's definition of family, and respect for the client are implicit".

There was agreement with this: "You shouldn't *should* on anybody"….

There were some suggestions as to how to make this shift recognizing that the approach has to align with consumers' knowledge, culture and values.

"Be sensitive to not just the culture but also the person within the culture"

One suggestion was to begin with preconception and a review of reproductive health in the curriculum for all ages and that this could be coordinated through schools, family resource centres, etc. "There needs to be a cultural shift to realize all women need preconception care." Another was that it be encouraged as a topic in family discussions. A third is that professionals work to build confidence in self and baby care. And the final recommendation is that respect is key.

5.2 Impacts of present service - What are the impacts of the present level of service?

- What research presently exists on satisfaction, outcomes?

Janet Bryanton, UPEI School of Nursing was asked what the research is telling us regarding outcomes. She outlined the following:

< Nurse client, family satisfaction increased
< Belief in themselves – highlighted
< Increased breastfeeding, bonding
< Labour support: decreases the number of caesarian sections, increases breastfeeding, bonding, improves marital relations
< The relationship of women's birth experience with parenting has rarely been researched
< Satisfaction with care and with self are intertwined but do not necessary go hand in hand
< Two of the most important factors (of which there are approximately 20) in positive birth experiences include labour support (partners, nurses, midwives, and doulas) and being involved in informed choice

Others in the Roundtable also offered research findings on impacts of psychosocial, pre-conceptual, and complementary interventions:

Psychosocial

< Psychosocial issues affect totality of childbirth experience. Labour and delivery is less traumatic if there is specialized education and support for certain groups such as those with diabetes, or those with experiences of sexual abuse.

Preconceptual Care

< A collaborative approach in families (and with professionals) results in delayed sexual activity, delayed planning for families and pregnancy choices.
< Specialized education makes a difference for pre-conceptual care whether there is a pre-

existing condition or not.

Complementary Therapies

< There is good evidence that therapeutic touch and Reiki are effective in pain control. The literature demonstrates that there it contributes to a good experience with labour and contributes to empowerment.

- What is your experience, observations?

A consumer confirmed the research findings through her own birth experiences saying that due to preparation and planning she viewed the experience as positive even though things did not go exactly as planned and there were interventions. "I understood why things happened….felt in control, no loss of control".

Hospital based nurses reported that 7 years of feedback in client satisfaction surveys noted that flexibility in care was welcome. Messages provided in prenatal classes are that "You and your baby have the same nurse, and be cared for as a unit". Although women are encouraged to keep the baby with them they are also told that "There are times when the baby will need the care of others and that your nurse will help you find the way." "Mother baby care is not just having woman and child in the same room all the time. Care changes, and one model is not absolute."

Nurses on PEI are trained in complementary therapies and according to ANPEI, these complementary therapies can be used if there is a policy in the hospital. In many other places nurses are trained for pain management. The National Guidelines for Maternal and Newborn Care also discuss non-pharmaceutical methods of pain control including massage. Water has been found to be the most efficient tool. Joyce offered that many midwives are certified herbalists, acupuncturists and have good outcomes with complementary therapies.

> *"I am striving for a homebirth should I have another child. Should I birth in the hospital setting, it will only be with an even more explicit birth plan, a doula and a 24 hour stay at most. My baby will remain with me at all times unless there is significant reason not to."*
>
> (PEI Roundtable Participant Story – Personal Perspective Appendix D)

- What are your concerns for the future given current trends?

The greatest discussion around concerns related to lack of real options either due to need for resources and/or legislation.

Early discharge is not for everyone but there is very little room to make a decision based on an individual's home life situation (i.e., whether she has numerous kids at home to take care of and 'needs a break' to be able to take care of the new baby). Mothers know that the length of stay is shorter and even if nervous, "don't want to stay because they will look like a failure". Being a mother is a role not learned yet. Targeting at-risk populations might imply they need extra help *but* if length of stay was increased for all women, there wouldn't be the issue of targeting. However in the absence of this, follow-up is essential. The Best Start program provides support and follow-up – could we do more?

There is some success in educating physicians and ensuring that psychosocial assessments are undertaken by them, *but* making it a reality is "like pulling teeth". There is a need for all carers to have time to know their client and provide continuity of care. The Best Start program was referenced as providing psychosocial assessments – how can this approach be more widely used?

Three care options warranted extensive discussion due to accessibility and legal issues:

1. There are three naturopaths on PEI who provide services: homeopathy, acupuncture, herbal medicine. They know how to help in prenatal care, but are not accessible to everyone due to cost.

2. Doula services present issues of affordability as they are a private service. Furthermore, because they are a private service they may be hidden from the mainstream referring source or body of knowledge. A question emerged – "How are doulas profiled: Are they hidden either visually, financially, geographically?"

3. Two external (to PEI) midwives who come for births in PEI, can only offer homebirth, have no admitting privileges and no legal status in PEI. The question was asked "What are the legalities around that?"

Joyce England indicated that a midwife on PEI needs signed consent but still could be sued for a 'bad' outcome. A trained midwife would insist on collaboration with an obstetrician for transfer during delivery if necessary. The emergency room would accept the woman if there was an emergency. A consumer indicated that her midwife wanted prenatal records, visited the obstetrician to make sure presentation was normal, had oxygen for mother and child, drugs for hemorrhage, fully equipped for immediate emergency or transfer. She also indicated that she felt her obstetrician suspected her choice for homebirth and provided explicit instructions that he did not condone home births.

This story raised issues related to the existing gap between midwife and obstetrician/GPs and the need for legislation to support having a midwife as an option rather than placing the burden on the woman who wants the choice of midwifery.

"I didn't want to fight a legal battle while I was pregnant. I wanted to focus on being healthy."

5.3 Future dreams - What are your dreams for the future?

The participants were asked to put forward their dreams for the future and to consider how continuity of maternity and newborn care be ensured, what role would professionals play, where will midwifery and doulas fit, and what would be the outcomes. Dreams were solicited through a roundtable brainstorming approach, and are grouped are as follows:

Principles of Family Centered Care

- Having family centered guidelines accepted provincially, as they are used but not standardized, by Provincial Government, Nursing and Department of Health
- Having both provincial facilities working toward implementation of family centered guidelines

Women's Health – Continuum of Care

- Women's health would be provided along the continuum of care and across the lifespan
- Continuity of Care, i.e. a woman goes to see her doctor, is given options, given the name of the public health nurse in her area, and is provided with information for choice/input
- Infrastructure for Women's Health, e.g. Women's Centre (centralized care) and Family Resource Centres, Community Health Cares Centres (decentralized) would be based on building on what we have.
- General awareness of preconception - "You're not having an impact until the baby is in your arms" – a big impact in preconception but it just isn't recognized

Holistic care

- Addressing body, mind, spirit in holistic care model

Collaborative Team

- Gives the best care for women and their families including parenting support throughout the life span
- Principle of family centered care, collaborate across disciplines

Accessibility of services

- Access to all services through integration
- "Under one roof" – the "Concept of a community health centre"

Midwifery an option

- Midwifery would be legislated and funded as part of a primary maternity care team with direct entry as an option.
- Midwifery available in Canada and on PEI in future, and in a collaborative team; working toward the goal of providing best possible care for women and family, including preconception through to postpartum care

Doulas an option

< Doulas part of hospital system – integrating in the team, e.g. at the IWK Health Centre in Halifax, doulas are a part of team through a volunteer program

Increased Support for Breast Feeding and Mothering

< New Mother support – women need support and confidence to call resources for help
< More supports are developed in community for breast feeding, e.g. drop in clinics
< Hospitals to be accredited as "baby-friendly"; currently, there are only 2 in Canada, one in Quebec and one at St. Joe's in Hamilton. Hospitals should work toward the guidelines but they are very difficult to fulfill. Addressing contracts with formula companies should be the last to be addressed because the hospitals would have to agree to pay for formula that is needed.
< Education of key persons such as grandmothers re benefits of breast feeding
< Local group of moms who had breastfed self-identified to hospital, as peer support to those in need with breastfeeding and mothering more broadly (Cape Breton) "help at 2am, when you're desperate"

Increased Choice in Education and Care

< More choices for childbirth education for women; look at and explore more education makes for more individualized choices, and therefore more success

"A lot of ways to do it right"

Modeling/Mentoring Support

< Successful breastfeeding the best promotion

Sharing Resources

< Umbrella committee to share resources potentially through Web site development; online posting forum. Noting the large list of options available on PEI that emerged in the morning session was developed collaboratively, but could not have been developed by any one person individually.
< Important to have "front-line" nurses in the discussion

Ongoing Training of Professionals

< Increased capacity and depth of people who are working in the system currently; given we can learn from a variety of professionals
< Professionals need more and ongoing professional development to enhance their skills
< Ongoing continuity in training needs to happen in order to address the problem of "mixed messages" from caregivers.

"Either you breastfeed or you don't", largely a misconception, can interchange bottle/breast –it is better to breastfeed a little than not at all because this does give the baby the best healthiest beginning"

Facilitative decision making

< Intuitive knowledge about a woman's own health and body should be a part of the decision making process
< Support/questions/concerns need to be addressed beforehand; getting the word out is

important
< Empowerment in hearing the voice of women

"It comes back to listening about what women and families want to do"

5.4 Barriers/opportunities - What are the barriers/opportunities to achieving the dream?

- What are the barriers?

Although there was consensus on the dream for the future of maternal and newborn care on PEI it was acknowledged that barriers exist to seeing the dream become reality. Since knowing the barriers is part of developing a plan of action, participants were asked to consider costs to professional groups, financial costs and public readiness in identifying barriers. Barriers were identified through a roundtable brainstorming and are grouped as follows:

Resource availability
< People who hold purse strings don't always understand the benefits or models
< Money: moving it around, finding it, keeping it there

Legislation/policy
< Liability and litigation – Doctors fear of litigation impacts options offered – "not the wisest choice legally"
< Lack of legislation for midwifery
< Governing bodies not responsive

Existing structures
< Need "services all under one roof"
< Delivery rooms need to be close to maternity units

Lack of support from medical profession
< Lack of presence from medical community, i.e. "Where are the doctors today? We're not getting paid to be here either"
< Medical community seen as biggest barrier to midwifery, i.e. "Turf-protection is an issue"

Attitudinal readiness
< Staff attitude requires a philosophical shift. The will is there, they recognize the attitude/philosophy but they need support (education) to do that
< Lack of presence today of front-line nurses
< Consumer acceptance of status quo

Societal Attitude to Women
< Lack of women in politics
< This is a woman's issue, and therefore, a barrier

"I feel that a greater awareness needs to be made about the benefits and needs of holistic family centered care for low risk pregnancies."

(PEI Roundtable Participant Story - Personal Experience Appendix D)

- What are the opportunities?

Knowing the opportunities that exist in the Island community will make it easier to direct efforts and maximize resources in achieving the dream. Participants identified the following opportunities as ones that need to be factored into any planning.

< The will of maternal child staff and administration in both hospitals to support the National Guidelines for Family Centered Care.
< The existence of BORN and attention to the listserv on BORN pamphlet. The National Council of Women in Canada (NCWC). If BORN becomes a study group or local council of the NCWC, it can use their policies to lobby government. Karen Dempsey, Vice President, National Council of Women of Canada can be reached at DKanum@aol.com
< National and provincial interest in supporting the early years
< Primary health care renewal. Midwifery is on the table because of primary maternity care renewal. Through transition funds there are examples of collaborative maternity practice, and also examples of community health centres. For example, the Canadian Association of Midwifery is part of SOGC (Society of Obstetricians and Gynaecologists of Canada) collaboration, as is the Canadian Nurses Association (CAN), Family Physicians of Canada, Aboriginal Nurses Association of Canada (ANAC) in a project funded by the Health Transition Fund.
< Voices of women are being heard, not just administration. Empowerment comes from us as women
< Existing programming for example, even with breast feeding there are several options that need to be built upon, e.g. La Leche League supports breast feeding; likes to have women come before birth; "buddying up" happens early while in hospital, Family Resource Centre breastfeeding support available.
< The human resources crisis and the fact midwives take a holistic approach to maternal infant care.

"If a woman was to have a midwife, a contact person wouldn't be an issue because the woman would know exactly who to call up to 6 weeks after birth"

5.5 Collaborative action – What needs to occur to achieve the dream?

Through the discussions that occurred throughout the day, participants became aware of the fact that they have more commonalities than differences and a momentum to take collaborative action began to emerge. They were asked to consider action on policy change, human resource planning and public education and working together. They immediately began to focus on how they could work together to advance their collective dream.

The group concluded that they all had a common goal. "We're all out for improving women's and families health" "We're all trying to help each other". With a common purpose, the main strategy discussed was that of creating a "web-effect" and "building a critical mass with like-minded organizations."

To do that it was proposed that the group continue talking, sharing information and networking.

- BORN will promote its flyer, website and posting capabilities as a means of communicating
- UPEI will continue educating students in family centered care and reinforce principles in practice settings.
- Attendance at an April 19, 2004 workshop by BC Doula Association "Providing sensitive and supportive care to childbearing families" will be promoted.
- Obstetric RNs who teach classes for labour, training for neonatal resuscitation can bring awareness to nursing staff.

And it is proposed that

- A list of resources/options already existing on PEI be developed to make sure people know what is in their community
- Integration of family centered services in community health centres be supported.
- Facilities work towards incorporating guidelines regardless because they feel they're "right"
- The PEI Medical Society and staff nurses need to be brought on board
- Education needs to be planned for staff, community and consumer populations

> *"PEI is the smallest Canadian province, must be able to capitalize on the small size of PEI and try to work with it as a unified body"*

6. Closing

Patsy closed the Roundtable by asking each participant to provide a comment on the day:

- I continue to support of family centered care and learned a lot.
- The day was informative - I am amazed at how interconnected we are.
- From what I have heard here, NCWC needs to update and expand policy on midwifery and in regards to women's health issues. The more policy we have, the more we can advocate.
- I am here to represent that our facility is committed to this goal.
- Appreciative of the invitation
- Moved by the passion of the women in this room…the passion to improve women's health…we all want the same thing.
- Positive and proactive meeting and discussion and glad to be a part of it.
- Much more hopeful…there may be midwifery care for women on PEI.
- Opportunity to learn and hear what is happening already.
- Looking forward to being part of the changes.
- Working together as a group.
- Not just a hospital issue, preconception through to postnatal.
- Guidelines as a unifying force, Midwifery coming along side.
- A want to improve the health of women and families.

Christine Saulnier (ACEWH) commented on her excitement in hearing "passion around women's health" and that it was a privilege to partner with BORN, Women's Network of PEI, to "come and hear people engage in discussions about the importance of the social determinants of women's health."

Susana Rutherford (BORN) commented on the good turnout and points raised. She also called attention to the fact that there are only 3 members of BORN., and that members welcome. BORN wants legislated, funded midwifery on PEI and sees that it could play a role in serving as an umbrella group. She asked "Do people think it makes sense for BORN to lobby directly to the government regarding the family centered guidelines?" The response came from Karen Dempster "It's never too early to start lobbying".

Patsy commented on the power of the Roundtable and that "Today was grounded in real experience and learnings". She thanked everyone for their participation and the organizers for the privilege of facilitating. She then invited a smaller group to meet with representatives of BORN to begin planning next steps. A meeting convened as other participants were leaving.

> *"I would like to see the collaboration of formal and informal systems to shift the outlook to a presumption that pregnancy/birth is a healthy, life-affirming experience for all, with the myriad of options available."*
>
> (Story from PEI Roundtable Participant – Professional Perspective Appendix D)

APPENDIX A

Excerpts from BORN Brochure

BORN
Birth **O**ptions **R**esearch **N**etwork
159 Pinette Rd. Belfast, PE C0A 1A0
(902) 659-2330
birthoptionsresearchnetwork@yahoogroups.com

BORN is a community-based group interested in exploring birthing options for women in PEI. The group is currently comprised of health practitioners who specialize in maternity care and health consumers. We are bringing new members in at the moment and invitations have been extended to hospital administration, alternative practitioners, public health nurses, obstetricians, labour and delivery nurses, doulas and midwives.

It is our belief that a successful birth involves more than simply a healthy baby and mother. Research show that the long-term personal impact of childbirth on women reveals the importance of the attitudes of care giving staff and the degree of emotional support they provide. (Simkin P. The Experience of maternity in a women's life. JOGNN 1996; 25 (3): 247-52)

The Family-Centred Maternity and Newborn Care: National Guidelines 4th Ed.2000 from Health Canada recognizes the importance of the involvement of women and their families in their birth experience. " Increased participation of women and their families in decisions concerning their pregnancy, birth and early postpartum experiences promotes greater self confidence in caring for children. Building the foundation for nurturing parent child relationships begins before pregnancy, continues through the prenatal period, and can extend through the participation of both parents in the birth and care of their infant. Confidant and competent parents are a powerful influence in society. Their contribution is critical to the healthy growth and development of their children."

Continuity of care through this period to allow women and their families to make informed choices about their health care is very important. Health care providers can provide this type of care. Midwives and Doulas are uniquely positioned to provide continuity of care and provide valuable labour support to women in healthy pregnancies. Prince Edward Island does not currently have a way of integrating these professions into our health care system. BORN will explore ways that we might bring these practitioners into the system.

If Prince Edward Island is to make an official policy of integrating the National Guidelines into our health care system we will not only need to make the commitment to policy change but we need to make sure that the facilities for birthing women are as current as they can be. We need to insure that the standard of care at both our hospitals is equal so that practitioners and birthing women will have the best care possible.

BORN will meet with policy makers, politicians and hospital administration to continue to express the concerns of birthing women in PEI. We have begun to build a library of resource material related to the concerns addressed. We will be a referral service for women looking for birthing options on PEI. We have partnered with The Atlantic Centre of Excellence for Women's Health and can share resources with them.

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Coordinator: Susana Rutherford
Contact: (902) 659-2330
E-mail: birthoptionsresearchnetwork@yahoogroups.com

APPENDIX B

Letter of Invitation

January 30, 2004

Invitation to a *Prince Edward Island Roundtable on the State of Maternity and Newborn Care*

Co-Hosted by the Atlantic Centre of Excellence for Women's Health,
with the Birthing Options Research Network,
in partnership with the PEI Women's Network

February 21, 2004; Best Western Charlottetown, 238 Grafton St., Charlottetown, PEI

Information Session 9:30 -10:30am (open to the public), Room: Stanhope A
Roundtable 10:30am - 2:30pm (by invitation only), Room: Cavendish/Brackley

You are invited to attend an information session and roundtable to discuss the status of maternity and newborn care on Prince Edward Island. The public information session is designed to provide the public and roundtable participants with an overview of some of the troubling trends in maternity care - indeed, some have called it a national crisis - that have inspired this roundtable. Many of these trends raise questions about how to ensure that maternity and newborn care services are provided to women by the most appropriate health care provider.

In the interest of exchanging ideas and developing strategies for ensuring that women on PEI receive the most appropriate primary maternity care, this roundtable aims to bring together policy makers, health care providers, programme planners, administrators, community activists, and consumers to discuss what is working and what needs to be improved. The following questions will guide this meeting:

1. What maternity and newborn care options are available?
2. How has PEI integrated the National Guidelines for Family-Centred and Newborn Care ? How could PEI further ensure that care provided during pregnancy, labour and birth, as well as early postpartum care of the mother and infant, adhere more closely to these guidelines? (Excerpts of these guidelines have been attached here)
3. What current health human resource issues affect the status of this care in the province? Other regions of Canada have integrated midwives as integral primary maternity caregivers in the health care system. How might the inclusion of midwives and doulas improve the situation? (Background information on the state of midwifery in Canada, as well as a backgrounder on doulas is attached.)

Please find attached a list of people who are invited to the meeting. Please RSVP by **February 13th**. I welcome your questions and comments and look forward to meeting with you. I can be reached at christine.saulnier@dal.ca 494-7877. You can also contact Susana Rutherford, Coordinator, Birthing Options Research Network at oceanmuse@pei.sympatico.ca.

Sincerely,

Christine Saulnier, PhD
Senior Research Officer, Atlantic Centre of Excellence for Women's Healthmailto:christine.saulnier@dal.ca

APPENDIX C

Detailed Agenda

OUTLINE

Roundtable on the State of Maternity and Newborn Care
Prince Edward Island

Co-hosted by

The Atlantic Centre of Excellence for Women's Health
Birthing Options Research Network
PEI Women's Network

February 21, 2004
(Storm date March 13)

Information Session on work of BORN open to the public from 9:30 – 10:30 am

Panel
Christine Saulnier, ACEWH Introductions and Background
Susana Rutherford, Family Centered Maternity and Newborn Care
Joyce England, Midwifery: Status and Opportunity in Canada
Sylvie Arsenault, Doulas: Role and Benefits
Patsy Beattie-Huggan, Moderator

ROUNDTABLE DISCUSSION

10:30 **Introductions**

10:45 **What is happening now?**

- What maternity and newborn care options presently exist?
- What initiatives are you involved in?
- What other initiatives are presently underway or being planned?
- How has PEI integrated National Guidelines for Family Centered and Newborn Care?

11:30 **What are the impacts of the present level of service?**

- What research presently exists on satisfaction, outcomes?
- What is your experience, observations?
- What are your concerns for the future given current trends?

12:15 **Lunch and Networking**

12:45 **What are your dreams for the future?**

- How could continuity of maternity and newborn care be ensured?
- What role would professionals play?
- Where will midwifery fit? Doulas?
- What would be the outcomes?

13:15 **What are the barriers to /opportunities for achieving the dream?**

- What is at stake for professional groups?
- What are the costs?
- What is level of readiness of the public?
- What are the opportunities?

13:45 **What needs to occur to achieve the dream?**

- Policy change?
- Human resource planning?
- Public education?
- Working together?

14:15 **Review of discussion and next steps**

14:30 **Roundtable Adjourns.**

APPENDIX D

Panel Presentations

- Introduction
    - Speaker: Christine Saulnier

- National Guidelines for Family-Centred Maternity Care
    - Speaker: Susana Rutherford

- Midwifery: Status and Opportunity in Canada
    - Speaker: Joyce England

- Doulas: Role and Benefits
    - Speaker: Sylvie Arsenault

Introductory Speaker
Christine Saulnier, PhD
Senior Research Officer
Atlantic Centre of Excellence for Women's Health

♦♦♦♦

Good Morning and welcome to the PEI Roundtable on the State of Maternity and Newborn Care.

I am Christine Saulnier, SRO at the Atlantic Centre of Excellence for Women's Health, which is located in Halifax. This is one of four such centres in the country funded by the Women's Health Bureau, Health Canada. The goal of the Atlantic Centre is to support research, influence policy and promote action on the social factors that affect women's health and well-being over their lifespan. Obviously, this roundtable fits very well into our mandate.

I am going to begin the roundtable this morning and then introduce the other panel members who will also be providing some brief remarks; after the entire panel has spoken we will have time for some question and answers from the audience. The panel will be moderated by Patsy Beattie-Huggan.

My opening remarks will focus on the 'troubling trends' in maternity care that prompted not only this roundtable but the formation of the co-host for this event, the Birthing Options Research Network or BORN. BORN is a community-based group interested in exploring birthing options for women in PEI. So what options do women in Canada, and women in PEI specifically have and what options should they have?

In November 2000 a conference was convened in London Ontario to address what was then called the maternity care crisis in Canada. The crisis was that women's access to appropriate care was being compromised because there would soon be a severe shortage of maternity and newborn professionals in Canada - in 2000 this shortage was already being seen in many rural and remote communities, but the concern was that it would not be confined to those areas if action was not taken immediately. Action needed to address the trends that have been developing for the last two decades that led to the shortage- these trends include:

- fewer and fewer family physicians are willing to do labour and delivery, or even prenatal care and the few that are left are experiencing burnout.
- As the number of family physicians willing to do obstetrical care drops, the workload of obstetricians increases because there are fewer of obstetricians as well, this means more obstetricians are feeling overworked.

In short, this means that, while as little as fifteen years ago, most babies were delivered by family physicians, now obstetricians do "almost all of the work and there are fewer of them". We see this quite starkly in PEI where Only 11% of all family physicians deliver babies (the national average is 17.7%); this means that (aside from the very few women who have arranged for a midwife-attended homebirth) the rest of the births on PEI are attended by obstetricians.

Alongside these provider trends are some other troubling trends that should be noted:

- The c-section rate for 2000 (the most recent figures we have) was 24.2%; that means that virtually 1 in every 4 women have their babies delivered by cesarean section on PEI.
- This is above the national average of 21.2%, which itself is nothing to be proud of when the

World Health Organization has concluded that C-section rates should be in the range of 10-15%.

- Only 38.7% of women in 1999 had spontaneous labours (33.2% were induced, the rest were augmented or had planned c-sections); 19.7% is the national average for induction
- episiotomy rates are still too high but have decreased significantly from 64% in 1992 to 29.5% in 1999 (23.8% is the national average)
- 78.9% of women who delivered vaginally received an analgesic (some kind of pain killer);
- The breastfeeding initiation rate has improved but remains lower than the national average (61.7% of women were breastfeeding at the time of discharge from the hospital in 1999); the highest rate is 95.2% in BC. What is the state of maternity and newborn care then? Most women (80% or more of whom would be classified as low-risk, normal pregnancies) are receiving treatment from obstetricians who are highly skilled practitioners who specialize in the management of illness and disease in pregnancy. Is this a good use of health human resources? Is this the most appropriate care for most women? Many women do not need this kind of medical attention; indeed, many women need additional social support in their community or services that are more tailored to their diverse range of needs and experiences such as aboriginal women. Where have we left them?

It is clear that the problems in maternity and newborn care are not just about who is providing care but what kind of care is being provided. Women have the right to appropriate, high quality, family-centred, evidence-based, sustainable community-based maternity and newborn care. It is my hope that this roundtable will serve to open up a dialogue where we can explore different perspectives and strategies about how to move this agenda forward for all women on PEI.

Thank You.

The following speakers were introduced by Christine and their reports are included in their entirety.

National Guidelines for Family-Centred Maternity Care.
Speaker: Susanna Rutherford
Coordinator and one of the founders of BORN, Susana has spent many hours of volunteer time working on maternity care issues. She also had the most recent home birth in PEI. Susana is also an accomplished professional artist - a painter of wild and domestic animals.

♦♦♦♦

Introduction to the Guidelines
The national guidelines for maternal and newborn care are published by Health Canada and involve the participation of 70 professionals and consumers across Canada. The most recent edition of these guidelines is the 4th edition published in 2000. The Guidelines are titled Family Centred Maternity and Newborn Care; National Guidelines. The guidelines could provide a unifying vision for maternity and newborn care in PEI. Not only do the guidelines discuss attitudes and practices but also there are also clear directions for the physical structure of birthing facilities.

PEI is unique in being Canada's smallest province. We have a population that is equal to many small cities in Canada. It is not unreasonable to hope that we could have one standard of care throughout the province. Obviously we cannot make this change overnight and it will take some time to make these changes but by agreeing to adopt the national guidelines as official policy and by committing to meeting this standard of care we would have a common goal to work towards. There are 10 areas that the guidelines cover. I have included ways in which I think the guidelines may be applied to our situation in PEI. If there are errors the fault is mine. The Guidelines are about 500 pages long and there are many more points to review.

- **Organization of services**

This outlines the ways in which structural changes can be made to incorporate the guidelines including making written policy commitments to the guidelines.

- **Preconception Services**

Assuring that appropriate reproductive education is provided to children and youth for the best health and sexual knowledge appropriate to their ages.
Providing health information to women in their reproductive years.

- **Care During Pregnancy**

Creating a system in which families at risk and first time mother get the maximum amount of education as well as good physical health care. This is an area where we could really use the sharing of information amongst healthcare agencies and providers to see that women are prepared emotionally and intellectually for birth. Evidence shows that where women receive health care from Midwives or Doulas there are fewer interventions and complications in pregnancy and birth. The factor that is critical here is the amount of time these practitioners can give their clients, building trust and giving women confidence in their own bodies.

- **Care During Labour and Birth**

Family Centered Care is inclusive of women and their families as partners in their own care. Birth is approached as a natural stage of life. Family Centered Care is augmented by single room maternity care. We need this at both our hospitals.

- **Early Postpartum Care and Transition to the Community**

Providing a strong system to let consumers know all the resources available to them in the

community and creating links with breastfeeding support and preschool parenting centers.

- **Breastfeeding**

Striving to see that both our hospitals meet the WHO guidelines to be Baby Friendly Hospitals and our community fully supports breastfeeding.

- **Loss and Grief**

Following Family Centered Maternity philosophies and seeing that all of the community of healthcare providers share resources to help families at this time.

- **Transport and Facilities and Equipment**

Theses are technical points that clearly lay out physical standards of care.

Midwifery: Status and Opportunity in the Canada

Speaker: Joyce England

Joyce is a registered nurse, certified midwife and currently PEI's representative to the Canadian Association of Midwives. Joyce has a wide range of experience working as a Community Health Nurse in Manitoba and Rankin Inlet; as well as working as a midwife on PEI she worked as a midwife in Goose Bay Labrador and Rankin Inlet. Indeed, she coordinated the Rankin Inlet Birthing Project. She has also served as a Nursing Consultant with the Association of Nurses of Prince Edward Island and has been assisting with the facilitation of the Family Health Centres with the P.E.I. Dept. of Health and Social Services.

♦♦♦♦

Historical Facts:

Fact - Midwifery is the oldest female profession known to have provided service to women in such ancient cultures as the Incas, Chinese, Babylonians and Egyptians.

Fact - Midwifery textbooks date from the 7th Century.

Fact - Obstetrics grew out of midwifery, becoming the scientific branch when women were excluded from universities.

Fact - Historians tell us that even in ancient times a "professed" midwife was actually apprenticed to a senior midwife for several years, and that these women were more often of the middle class and lower gentry.

Fact - Of 210 countries comprising 98% of the world population, Canada, has been listed as one of the nine countries which until 1993 did not recognize the midwife as a valuable member of the health care team. Those other countries are Venezuela, Panama, New Hebrides, Honduras, El Salvador, Dominican Republic, Columbia and Burundi.

Fact - Midwives are the experts of normal maternity. They provide prenatal, intra-partum and newborn and postpartum care to 6 weeks, 24 hours a day, 7 days a week, in homes, birthing centres and hospitals.

Midwifery Today:

WHO statement on midwifery:

"**Midwifery is essential**. Even today the midwife attends two-thirds of all births in the world. She is the basic caregiver for maternity care services in every single European country. And in the European countries with the lowest infant mortality rates (all lower than the United States, which ranks an embarrassing 21st in infant mortality), the midwife is the senior person attending at 75 percent of all births, whether the birth occurs in a hospital, a clinic or the home. It is, therefore, an incredible enigma that women within the United States and Canada can be denied the services of a midwife when the rest of the world considers midwifery to be an essential and basic service."

Marsden Wagner, M.D., Former Director of Women's and Children's Health, World Health Organization (WHO)

The ICM Definition of Midwifery:

"Definition of the midwife - World Health Organization

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery, and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should include antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domicillary conditions or in any other service."

Jointly developed by the International Confederation of Midwives and the International Federation of Gynaecology and Obstetrics, 1972

Midwifery in Canada:

The Canadian Association of Midwives (CAM) incorporated in 2001, formerly known as the Canadian Confederation of Midwives, is the national midwifery organization. It consists of a board of representatives from each of the 10 provincial and 3 territorial midwifery organizations in Canada. The CAM's role is to promote, protect, and enhance the profession of midwifery. It advocates for high quality maternity and newborn services by:

- promoting universal access to midwifery care for all women in Canada,
- promoting continuity of care, informed choice, and choice of birthplace,
- developing policies and position statements for midwifery and maternal and newborn care, and
- reviewing policies and position statements developed by Canadian and international organizations for maternal and newborn care.

It has an annual conference, the most recent in both official languages, and has joined forces with the American Nurse-Midwives Association to provide one conference and are presently planning our next in September in Calgary.

ICM Code of Ethics

It has adopted the ICM Code of Ethics, and has published the Canadian Journal of Midwifery Research and Practice (CJMRP).

Provinces with midwifery legislation:
Ontario- 1993- 250 midwives registered
B.C.-1998- 65 midwives registered
Alberta- 1998 (not funded) - 20-30 midwives but dwindling due to not being funded
Saskatchewan- 1999 (not funded) – 6 midwives
Quebec- 1999- 55 midwives - 7 birthing centres
NWT-2003- 20 (mostly nurse-midwives and most not providing intra-partum care). Registration process being developed.

Total midwives: 454

Provinces without legislation:
Some provinces, like Nova Scotia, have organized midwives within an association. They keep a registry of practicing midwives, have standards of practice and usually have adopted the ICM Code of Ethics. Some provinces, again like N.S. have an organized consumer midwifery support group who advocate for both midwifery services and women who are looking for midwives to care for them.

Midwifery education in Canada:
There are 3 midwifery programs in Canada. Ontario has 3 schools graduating 33 new graduates each year (next year to rise to 60 seats), B.C. school is graduating 10 each year, and Quebec 9. All midwifery programs are direct entry, 4 year programs leading to a baccalaureate degree in midwifery.
-To remain registered midwives in regulated provinces must maintain competence through annual Emergency Skills Workshops, More Ob programs, NRP, CPR, and through group client case audits.
-In most provinces midwives are expected to carry a case load of 40 clients annually plus assist with 40 other births.
- In Ontario most midwives work in practice groups of 4 to 6.

PEI:
As you know midwifery is not part of the health care system neither is there legislation governing the practice of midwifery in P.E.I. PEI has a tiny midwives association consisting of 2 non-practicing members but who represent the province on the CAM Board, are a member of BORN, and the PEI Breastfeeding Coalition.

Doulas: Role and Benefits

Sylvie Arsenault

Sylvie is member of the Doula Association of PEI and a member of BORN. She is also an accomplished singer. She will speak to us about doulas, about the kind of care they provide to women on PEI.

♦♦♦♦

Doula is a Greek word meaning "woman's servant". Today the term has come to mean a woman who is trained to help women during pregnancy and childbirth. A doula provides emotional, physical, and informational support to clients.

Doulas typically offer the following services:

- **Prenatal meetings** – these often last an hour and it's a chance for a woman and/or couple to talk about their hopes and fears and prepare for birth and parenting.
- **Continuous presence during labour and birth** – a doula usually spends early labour with a woman in her home and then accompanies her to the hospital where she often only takes bathroom and snack breaks during the labour and delivery. She will stay with her for several hours after the birth, offering comfort and breastfeeding support.
- **Comfort measures for labour and birth** – emotional support includes encouragement and reassurance. Physical support may be in the form of massage, relaxation techniques, suggestions for speeding up a labour that is slow starting or has slowed down, and a comforting touch to help a labouring woman cope with the intensity of labour and birth. A doula also offers informational support. This can be in the form of giving information on a particular aspect of labour and/or birth or helping a woman or couple interpret or process the information received by medical staff so that they can better make an informed decision.
- **Breastfeeding support** – this includes education beforehand and support and information after the birth of the baby.
- **Postpartum visits and support** – a doula visits the new mother several times to answer any questions she may have and to offer breastfeeding and parenting support during this life altering time. This is also a time to process the birth with the mother. A doula can help mothers see that they did the best job possible, regardless of whether the birth was complicated or was not what was anticipated. For example, when a mother feels that she has failed, a doula can remind her of the 15 hours of labour before she asked for pain medication. Through gentle discussion and reframing, she can help assure positive memories for both parents.
- **24 hour on-call support** – this is available during the pregnancy leading up to labour and during the postpartum period.
- **Assistance in writing birth plans** – a birth plan helps a woman clarify what is important to her and what kind of experience she is hoping and planning for. A doula will always stress the fact that labour and birth are unpredictable and plans may have to be changed. Often some options for unplanned events are included in the birth plan.
- **Bonding with the baby** – a doula promotes a strong connection between mother/father and baby.

The birth of a baby has a long lasting impact on the physical and mental health of mother, baby and family. In the twentieth century, we have witnessed vast improvements in the safety of childbirth,

and now efforts to improve psychosocial outcomes are receiving greater attention.

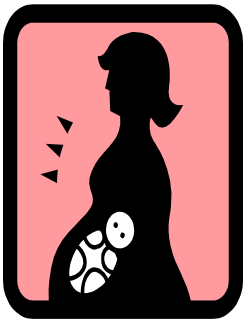
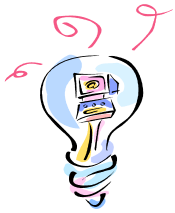
The importance of fostering relationships between mothers and infants cannot be overemphasized, since these early relationships largely determine the future of each family, and therefore of society as a whole. The quality of emotional care received by the mother during labour, birth and immediately afterwards is one vital factor that can strengthen or weaken the emotional ties between mother and child. Furthermore when women receive continuous emotional support and physical comfort throughout childbirth, their obstetric outcomes improve.

APPENDIX E

Story Grid and Stories Submitted

SHARING YOUR STORY.....

Stories are powerful vehicles for putting meaning to experience and for passing on knowledge. Think back over your experience with maternity and newborn care on PEI and reflect on an experience that illustrates the benefits of and/or need for holistic family centered care.... and make some notes. This will be helpful preparation for our discussions and will also provide stories of present care and its impact. With your permission we may weave these stories through our Roundtable report.

WHAT did you experience? Describe some of the details:		
WHY do you think care was delivered as it was? Identify things that contributed to the care provided.		
So WHAT insights do you have from the experience? What did you or others learn?		
WHAT can be done so lessons learned benefit future care of mothers and newborns?		

"Sharing Your Story"

At the beginning of the roundtable participants were provided with the template for story telling and asked to focus on an experience that motivated them to respond to the invitation and engage in the Roundtable. The intent was that participants could reflect on lessons learned from personal reflection as they offered input during the session. As indicated in the template on the previous page, participants were given the following instructions:

Stories are powerful vehicles for putting meaning to experience and for passing on knowledge. Think back over your experience with maternity and newborn care on PEI and reflect on an experience that illustrates the benefits of and/or need for holistic family centered care…and make some notes. This will be helpful preparation for our discussions and will also provide stories of present care and its impact. With your permission we may weave these stores through our Roundtable report.

Of the 25 participants in the Roundtable, 10 submitted their stories to be included in this report. Their stories are organized by two themes, i.e. personal experience and professional perspective.

Personal Experience

Story 1

What did you experience? Describe some of the details:

2nd birth at a PEI hospital. Labour and delivery nurses very respectful; Dr. very supportive of my birth plan (I hoped for a drug free, intervention free birth); had a doula again; was able to labour and push standing, kneeling, and finally squatting to birth. I had complications (shoulder dystocia); doctor worked quickly and explained everything to me and my husband. No need for sutures, baby was fine. Very lucky to have been able to utilize the "birth room". Not so happy with experience on the (postpartum) unit or dealing with the nursery for various reasons.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

I made my wishes known by providing a birth plan to the staff. I would never go into a hospital birth without one. I was dissatisfied with the lack of individualized care from some unit RNs – kept wanting to give me painkillers, lack of attention to details in my baby's chart. I specifically asked for a PKU test not to be done until 1 week postpartum. It was routinely done against my wishes. Baby was not allowed to sleep in my bed with me.

So what insights do you have from the experience? What did you or others learn?

I am striving for a homebirth should I have another child. Should I birth in the hospital setting, it will only be with and even more explicit birth plan, a doula and a 24 hour stay at most. My baby will remain with me at all times unless there is significant reason not to.

What can be done so lessons learned benefit future care of mothers and newborns?

More education, midwives and doulas as an option, more birth rooms, connecting the labour and delivery room to the (postpartum) unit and nursery, more individualized care, awareness that each woman is different, encouraging birthplans and involving family more. * Accepting midwifery as an option by having them funded * so that they can be present at a hospital birth if that is where the family wishes to birth.

Story 2

What did you experience? Describe some of the details:

I have 3 children who were born in hospital on PEI, the oldest is now 20. For the first 2 my prenatal care and deliveries were attended by my family physician – the third by an OBS as my family physician was no longer providing prenatal care. For all 3 I was an active participant in my care and interventions were not an issue. I was also able to keep my babies with me 24/hrs day in hospital and received support for this even though it was not necessary common practice.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

Recently I was with my sister during the labour/birth experience – where 2 of us were with her for her entire labour, other family members were welcomed at times during that experience. Staff was very open to our presence and involvement. Also staff were very supportive when the labour went on to a C/S delivery. Dad and I were both able to be present at the birth in the OR. We and approximately 10 additional family members were all present for the initial exam and admission.

So what insights do you have from the experience? What did you or others learn?

Staff are very open – discuss wishes – questions up front, don't leave to last minute. Most will try their very best to accommodate and are embracing the principles of Family-Centered Care. Some are slower to respond to change. Family were impressed with care provided by nurses and accessibility to care.

What can be done so lessons learned benefit future care of mothers and newborns?

Continue to press for family-centered maternity care as common policy
All aspects of Health Canada Guidelines
Administration does not always seem to understand the importance and long-term implications for families
Open discussion with caregivers about desired options in advance – encouraged

Story 3

What did you experience? Describe some of the details:

I work as a doula with birthing women
I am also the mother of two children born at home under midwifery care.
My first child was born before the midwife arrived because of weather.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

So what insights do you have from the experience? What did you or others learn?

I wouldn't change a thing about my experiences. I bonded quickly to my girls and felt empowered by my births. I became a good mother partly because of my experiences.

What can be done so lessons learned benefit future care of mothers and newborns?

Birth is an empowering experience if they are supported in the process of labour, delivery and postpartum

Story 4

What did you experience? Describe some of the details:

Pregnancy #3 was extremely difficult, spent a total of 6-8 weeks in hospital. This was a negative experience for my entire family. After the birth, care for my newborn was excellent, but my needs were seemingly overlooked. I found a lack of support, and felt there was no push to "bond" with my baby. This made early weeks-months of postnatal period very difficult.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

I feel care was delivered on a physical needs basis, while I am more of a holistic person. Shortages of beds, a large caseload on part of Ob's, and perhaps lack of other family centered care contributed to care provided.

So what insights do you have from the experience? What did you or others learn?

I feel that if I had knowledge of other options available to me, my story may have been different. I also feel that due to the huge caseload of Ob's, if there were other means of caring for healthy pregnancies, my case my have been different, and my OB could thoroughly have handled my case.

What can be done so lessons learned benefit future care of mothers and newborns?

I feel that a greater awareness needs to be made about the benefits and needs of holistic family centered care for low risk pregnancies.

Story 5

What did you experience? Describe some of the details:

I've had 4 babies at a PEI hospital. All were fairly routine, although the second was a vaginal breech. My husband and I prepared for these births and wanted minimal intervention. For the most part, our wishes were granted and we were left alone to labour, but while some nurses thought we were prepared and self-possessed, others thought we weren't very regular and questioned us. I did not want a tub, but staying in one room and peace and quiet I craved for. Mostly it's the noise I resented - others' squawking ultrasound monitors, too much light and noise in the (postpartum) unit. I was thankful for a kind place to have babies, but ready to leave.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

I think hospitals are factories. Individual attention requires too much time. Change is scary. I've met mothers completely unprepared for birth. How does the staff know when a mother walks in if she needs major help and attention or just wants peace?

So what insights do you have from the experience? What did you or others learn?

I wanted to be a low cost user of the health system – go to my family doctor for routine prenatal visits, eschew excessive test/procedure, stay in one room and have my baby with my husband and an attendant. It was impossible not to waste huger amounts of time at an OB's office for simple checkups. We communicated as best we could with staff.

What can be done so lessons learned benefit future care of mothers and newborns?

To save money and promote a more family –like atmosphere – MIDWIVES! Nurse practitioners! A birth centre (I know that's asking a lot). Mothers and fathers-to-be need education, empowerment, and peace and quiet to labour, to let a woman's body do what its built to do, and to welcome their new baby. Let normal, healthy women have normal, healthy births.

Professional Perspective

Story 1

What did you experience? Describe some of the details:

Reproductive health is the overarching passion that drives my work

Women's relationships to their own reproductive health and their relationship to the health care system remains the area of tension that deserves attention

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

The most dramatic expression of this tension occurs during the childbearing years.

PEI approaches birthing from an OB/Gyn perspective, which presumes the likely possibility of "problems", and therefore likely interventions

So what insights do you have from the experience? What did you or others learn?

I would like to see the collaboration of formal and informal systems to shift the outlook to a presumption that pregnancy/birth is a healthy, life-affirming experience for all, with the myriad of options available.

What can be done so lessons learned benefit future care of mothers and newborns?

Public awareness and political will must converge for change

What great timing as we "reassess" health care and how we deliver and receive it in PEI

Story 2

What did you experience? Describe some of the details:

Prenatal classes were a resource that couples valued and looked forward to as part of prenatal experience.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

Desire to inform couples having a baby so they could make informed decisions and lower anxiety surrounding the birth event.

So what insights do you have from the experience? What did you or others learn?

Couples, especially first-time parents, are excited and interested in "what will happen" during prenatal period.

What can be done so lessons learned benefit future care of mothers and newborns?

Promote prenatal education – especially for first-time parents

Build on enthusiasm of satisfied couples

Recognize that not all birth parents do participate/have interest and curiosity in birthing

With population decline becoming an important area.

Story 3

What did you experience? Describe some of the details:

During my experiences accompanying many aboriginal women to hospital for their labor and delivery, I found staff and doctors were not always sensitive to the needs of different cultures or the staff tended to judge all from their experiences with one.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

I think it happened because staff just did not realize they were being insensitive. Sometimes staff is just too busy or do not realize the importance of seeing people as individuals instead of categorizing – example - "all Indians are the same"

So what insights do you have from the experience? What did you or others learn?

I also realize that the women themselves needed to be empowered themselves to make their needs known

What can be done so lessons learned benefit future care of mothers and newborns?

I also think there has been much improvement in this area.

Story 4

What did you experience? Describe some of the details:

My first story relates to how I learned about midwifery. During my travels throughout the world and working as a nurse I met many midwives who described a very different personal care that they provide to women. I realized that Canadian women were losing out on a wonderful and very special caring without midwives.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

I became a midwife mostly because I wanted to work in Northern Canada and knew that a large part of what I would be doing would be with women and children. The lack of midwifery services in those small communities had resulted in a policy that all pregnant women should give birth in a large urban setting hundreds and even thousands of miles from their family and community and in a different language.

So what insights do you have from the experience? What did you or others learn?

As an outcome of the situation, I agreed to coordinate the Rankin Inlet Birthing Project

What can be done so lessons learned benefit future care of mothers and newborns?

License midwifery on PEI

Story 5

What did you experience? Describe some of the details:

As a doula, I have witnessed women having medical things done to them and not feeling part of decision making. Women need to feel empowered and not have unrealistic time constraints. Personally, I have had positive birth experiences (1 Summerside, 1 Charlottetown), despite the system. I feel that my experience and knowledge allowed me to ask the questions and ask for specific things to take place for my births. Women need education and options available to them to have positive birth experiences.

Why do you think care was delivered as it was? Identify things that contributed to the care provided.

Health care workers feel bound by policies and traditions. There needs to be a willingness to work with families to help achieve a positive experience. Flexibility is important. PCH was more flexible. Better environment. I was assertive with my beliefs.

So what insights do you have from the experience? What did you or others learn?

Tell health care providers what you are looking for. Ask for things to be changed. Challenge standard practices. Support from a doula is incredibly helpful. I was fortunate to have 2 doulas at my 1st birth and 1 at the 2nd birth.

What can be done so lessons learned benefit future care of mothers and newborns?

I requested to not be transferred to a delivery room at hospital on PEI and was allowed to deliver in the labour room. This type of option needs to be available to all families.