INMO / RCM NI

All Ireland Midwifery Conference
Thursday, 18 October 2018
Crowne Plaza Hotel, Santry, Dublin 9

Theme: All Island Midwifery (1918 - 2018) - No, slow, full progress or full circle?

CONFERENCE PROCEEDINGS

Category I Approval from NMBI = 5.5 CEUs
Co-creating maternity care  
Past, present, future  
BOTH/AND not EITHER/OR

Co-creation (co-production)  
definition and pre-requisites  
TLAP National Co-production Advisory Group

'Co-production is not just a word...it is a meeting of minds coming together to find shared solutions.

In practice, co-production involves people who use services being consulted, included and working together from the start to the end of any project that affects them.

When co-production works best, people who use services and carers [and staff?] are valued by organisations as equal partners, can share power and have influence over decisions made'.

All Ireland conference  
Crowne Plaza Hotel  
Dublin, Ireland  
October 17th 2018

Soo Downe,  
With thanks to all those who feature in the photographs, or who gave permission for them to be used
Complete co-creation
Pieters and Jansen 2017, p. 15

The "transparent process of value creation in ongoing, productive collaboration with, and supported by all relevant parties, with end-users playing a central role"

Levels of co-creation (-production)
Needham and Carr 2009

- **Basic**: Patients taking medicine, or children doing their homework.

- **Intermediate**: Recognises that people using services have skills to offer….services recognise and support people's contributions and ideas for improvement... if it is helping to deliver services.

- **Transformational**: Power and control changes...people who use services are actively involved in all aspects of designing, commissioning and delivering services. People are encouraged to be involved....
We have come a long way...

*Oakley 1984*

The 1930 Departmental Committee on Maternal Mortality and Morbidity reported:

“The patient herself is often her own worst enemy whether from ignorance or apathy, ill health or prejudice, etc, and until she is able and willing to co-operate, doctors’ and nurses’ attempts to assist her can never be fully effective.”

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Have we...?

Service user engagement ≠ coproduction

*Twilight sleep*

**wikipedia**

- 1914–1915 National Twilight Sleep Association organized by wealthy upper- and middle-class women
- advocated *relentlessly* for physicians and women to adopt twilight sleep for painless childbirth.

---

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Have we...?

Service user engagement ≠ coproduction

*Twilight sleep*

**wikipedia**

- 1914–1915 National Twilight Sleep Association organized by wealthy upper- and middle-class women
- advocated *relentlessly* for physicians and women to adopt twilight sleep for painless childbirth.
Push from wealthy women, researchers, journalists

Mrs. Carmody: “the twilight sleep is wonderful but, if you women want it you will have to fight for it, for the mass of doctors are opposed to it

Co-creation?

• Widespread controversy in the medical community

• Enormous discrepancy in practice

• Amnesic effects, intense labor pains, screaming and thrashing, women placed in “crib beds” to avoid accidents
Consequences...

• Adverse events reported (maternal delirium, asphyxiation of newborns)
• Sharp decline in use by summer of 1915
• In August 1915, Mrs. Carmody died under scopolamine’s influence.

From then to now...
The insidious legacy of beautiful tech...
From the machine that goes ping to 4D U/sound & iphones
Demand for ‘midwife supported freebirthing’
Nothing about me without me...
but co-creation requires collegiate relationships, not conflict

At the extreme..

I just heard from my Chinese colleagues that the study received extensive coverage in China. Last week a violent event between a patient and an obstetrician was widely reported in the Chinese press (an obstetrician in a large teaching hospital in Beijing refused to do a caesarean section, and the family of the patient responded with violence – this is not uncommon in China), So the publication of the series was timely.

Carine

Conflict driver: toxic systems
http://www.youtube.com/watch?v=arCITMfxvEc
Cross-talk, frustration, lack of trust...

- Managerialism/professional vocation
- Individualised care/adherence to guidelines
- ‘Woman centred’/individual choices
- Economics/ethics
- Mother versus baby
- ‘mummy wars’

Consequences of Either/Or:
Vicious circles

Overdiagnosis means making people patients unnecessarily, by identifying problems that were never going to cause harm…

...or by medicalising ordinary life experiences through expanded definitions of diseases.

‘Conclusion: Overdiagnosis is one of the most harmful and costly problems in modern healthcare...’

What does this do to the values and beliefs of service users, providers, funders, societies, and how does this influence co-production?
Either/Or framing
The interpretation of Montgomery vs Lanarkshire

Vaginal birth comes with risks too – so should it really be the default option?

July 25, 2018 11:26am BST

Author
Michaela Bluck
Cochrane Lecturer and Research Fellow, University of Aberdeen

Disclosure statement
Michaela Bluck has received funding from the Wellcome Trust as part of her research training fellowship to investigate the long-term effects of surgery and other interventions during labour.

Any colour as long as it is black

The reduction of childbirth to a “choice” between safe, predictable surgical birth and dangerous, unpredictable vaginal birth can be read as a consequence of assumptions about the fundamental failure of the female body.

‘Informed choice’ (rather than co-creation) when childbirth provision is based in fight/flight...

...a defence mechanism

• By professionals against women
• By women against professionals
• By staff against managers...
Co-creation at the policy level:
starting the move from Either/Or to Both/And...
BUT...
Policy based on what women say: but will midwives agree to co-create this?

The NHS is committed to introducing continuity of carer to all new mums by 2020/21.

Co-creation from the beginning at the macro (global) level

Antenatal Guidelines for a positive pregnancy experience 2016
Intrapartum guidelines for a positive childbirth experience 2018
Guidelines for reducing unnecessary CS 2018
Guidelines for uterotonics to prevent PPH (forthcoming)
### What outcomes matter?

**What women want and need in pregnancy**

**Both-and not either-or**

*Women want, need, and value a positive pregnancy (birth) experience:*

- Maintaining physical and sociocultural normality.
- Maintaining a healthy pregnancy for mother and baby (including preventing and treating risks, illness and death).
- Effective transition to positive labour and birth.
- Achieving positive motherhood (including maternal self-esteem, competence, autonomy)
'Positive’ pregnancy experience
WHO ANC Guidelines 2016

What women want and need to achieve a positive experience

• Support
  – social, cultural, emotional and psychological

• Relevant and timely information
  – physiological, biomedical, behavioural, sociocultural

• Clinical care/therapeutic practices
  – biomedical interventions and tests, integrated with therapeutic spiritual and religious practices, where appropriate
Positive birth experience

BOTH-AND

(Downe et al 2018)

- 35 studies, 19 countries, moderate to high confidence

- What matters to most is a positive experience that fulfils or exceeds their prior personal and socio-cultural beliefs and expectations.

- This includes:
  - giving birth to a healthy baby in a clinically and psychologically safe environment
  - practical and emotional support from birth companions, and competent, reassuring, kind clinical staff.
  - a physiological labour and birth, though the need to ‘go with the flow’ was acknowledged
  - If intervention is needed or wanted, women want to retain a sense of personal achievement and control through active decision-making.

Changing the conversation creates emergence

"To achieve the Every Woman Every Child vision and the Global Strategy for Women’s Children’s and Adolescents’ Health, we need innovative, evidence-based approaches to antenatal care. I welcome these guidelines, which aim to put women at the centre of care, enhancing their experience of pregnancy and ensuring that babies have the best possible start in life." Ban Ki-moon, UN Secretary-General
Co-creation: service provision and practice
‘getting beyond the gargantuan struggle’
Expecting, and making, positive relationships

'I would like to thank you for your support with the lady I looked after in the pool the other day. They both said that they had a fantastic experience that exceeded the other four... she just smiled the whole way through. It was amazing as she had been induced with all her other babies, and had an epidural every time.... and she coped so well and even said 'what a difference water makes! when i watched it, i had tears in my eyes, as it was a wonderful experience....... i felt like i was being a midwife.I am glad that Caroline was on duty and supported me.'

Louise 2009
Effective multidisciplinary teams and service users who like (trust, respect, care for, constructively challenge) each other...

and who take responsibility for their choices and actions

Co-creating a healing birth
Nicolas story
Co-creation in Bulgaria *(via Italy and the UK)*
Yoana Stancheva, Tracey Cooper and Sandra Morano.

From 46% CS, 80% + episiotomy in primigravid women, and the Kristaller manoeuvre to...

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...email from the front line
Sept 23rd 2016

The great news is that today feels like we fast-forwarded twenty years...

The conference made it possible for two hospital chiefs to grow increasingly interested in...the possibility of setting up an AMU...
...email from the front line
Sept 23rd 2016

The hospital officials were interested in the...women [in our practice]...who could potentially give birth with them...

... (they) suggested legal amendments to autonomous midwifery competencies...

Getting from here to there
Creating the initial conditions
Can theory help with co-creation?
Diffusion of innovation theory

Everett Rogers (1962): adopters can be categorized as:
- innovators (2.5%),
- early adopters (13.5%)
- early majority (34%)
- late majority (34%)
- laggards (16%)

You don’t need to persuade everyone:
IF YOU CAN CONVINCE THE PEOPLE IN RED ABOVE – YOU WILL PROBABLY MAKE CHANGE HAPPEN

Moores crossing the chasm
Theory of planned behaviour/
reasoned action

Human action is guided by three beliefs:

• **Behavioral**: the likely outcomes of the behavior
  (*will I get any benefit?*)

• **Normative**: the normative expectations of others and
  motivation to comply with these expectations
  (*what is usual around here?*)

• **Control**: the presence of factors that may facilitate or impede
  performance of the behavior and the perceived power of
  these factors
  (*is it easy for me to do this?*)

Ajzen 1991

Creating initial conditions
an on-going real-life example

October 2018

Qual/Quant
evidence from:
- Service users and communities
- Service providers
- Those working in organisations and systems
Guideline key messages

- Multifactorial – single component interventions are not ideal
- All stakeholders – women, families, healthcare providers, organizations...
- Context- or country-specific factors
- Prior to implementation, you need to know your local situation!

Professional driver:
FIGO statement on reducing CS Oct 2018

CS rates of more than 10–15% are unlikely to improve maternal or perinatal outcomes. (19%).... The rise in CSs has to be stopped.
Starting before the guideline was launched
Consultations in-country

Generic formative research phase protocol

Ana Pilar Betrán
Department of Reproductive Health and Research
WHO meeting of Gulf State maternity care providers to optimise CS rates
Beirut September 2018

Intention to reduce CS: Issues raised
Down stream solutions: mechanisms of effect & outcomes that matter

- 'Happy births'
- Strategies to address the judges (Iran)...

12 steps to MotherBaby Family friendly care

*The tipping point...FIGO Oct 16th 2018*
Towards BOTH-AND and keeping the faith
Not (necessarily) a short term project

All of us at all levels, including civil society, should:

Resist
- Risk-creep
- Othering
- One-size fits all

Use:
- Horizon scanning
- If-Then thinking
- The courage to be an expert/to accept responsibility along with demanding rights…

Getting it right through Both/And
Thomson and Downe 2010

Joy (surprised by joy)
Euphoria
Fantastic
Positive
Amazing
In love
Incredible

'It wasn’t just not negative, it was wow, you know, isn’t the human body amazing...and that kind of positive pain...you know something good is going to come out of it, and it was just fantastic, it really was... (Holly)
Vicious circles to virtuous cycles
love, respect, safety: and joy

Doing the best we can
https://www.youtube.com/watch?v=IGMW6YWjMxw

With thanks to Sheena Byrom
Changing the world, one birth at a time:
always, and despite setbacks:
What will you do?

• IN THE NEXT MONTH
  • in your own practice
• IN THE NEXT 3 MONTHS
  • with your peers
• IN THE NEXT 6 MONTHS
  • with your organisation
Authentic co-production at all levels of the system for positive maternity care

We are made wise not by the recollection of our past, but by the responsibility for our future.
The Impact of Evidence on Practice

Professor Cecily Begley
Chair of Nursing and Midwifery

Trinity College Dublin
Ireland

- To share some interesting research findings that can improve your practice
- To show how easy it is to access and use research findings
- To show the benefits of using evidence-based care.
Undergraduate education

• We teach students how to care for women and babies

Need to continue our education

Elaine Dunn, University of Wollongong, aged 84
Think about the old days....

- Women died of puerperal sepsis because we did not know about the importance of hand-washing.

- Semmelweis in 1847 documented the mortality rate due to puerperal sepsis as 11% (Waterstone 2001).
Think about the old days….

• In 1979, episiotomy rates were 65% in US (Schoon 2001).

• In 1990s, episiotomy rates were 92% in Latin America (Althabe 2002), 38% in Canada (Goldberg 2002).

Now….

• In 2010:
  ➢ 70% in Cyprus, Poland, Portugal, Romania
  ➢ 43-58% in Spain, Belgium, Czech Republic
  ➢ 16-36% in Wales, Scotland, Finland, Norway, France, Switzerland, Germany, England

(EURO-PERISTAT 2013)
Now we know

- Routine episiotomy group: **75.15%** (2035/2708) of women had episiotomies.
- Restrictive episiotomy group was **28.40%** (776/2733).

Restrictive episiotomy resulted in less severe perineal trauma (RR 0.67, 95% CI 0.49 to 0.91), less suturing (RR 0.71, 95% CI 0.61 to 0.81) and fewer healing complications (RR 0.69, 95% CI 0.56 to 0.85) (Carroli and Mignini 2009).

Now we know

- No difference in severe vaginal/perineal trauma (RR 0.92, 95% CI 0.72 to 1.18);
- dyspareunia (RR 1.02, 95% CI 0.90 to 1.16);
- urinary incontinence (RR 0.98, 95% CI 0.79 to 1.20) or several pain measures.

- Restrictive group had more anterior perineal trauma (RR 1.84, 95% CI 1.61 to 2.10).
Now we know

• The only indications for an episiotomy now: fetal distress or medical compromise of the mother e.g., cardiac problem, hypertension (or, maybe, forceps birth).

• In the absence of a valid reason to do one, episiotomy is an unjustifiable assault on women.

In 2010-14

• Rates have fallen to 4.9% in Denmark and 6.6% in Sweden (EURO-PERISTAT 2013) (all vaginal births)

• Rates in Ireland? 16% in the Coombe Hospital, Rotunda 26%, Holles St 27%.

• No information in the IMIS
In 2015

• The “MEPPI” study showed how 21 expert midwives in New Zealand and OLOL Hospital in Drogheda, Ireland were able to achieve rates, in nulliparous women, of:
  ➢ 4% for episiotomy
  ➢ 59% for ‘no-sutures’, and
  ➢ 1.08% for 3rd/4th degree lacerations
(Begley et al 2018)

Why did some countries lower their episiotomy rates so successfully?

Why did some countries not?
Think about the future….

What will the women and midwives of 2038 be saying about us?

Have we got our heads in the sand, and are not recognising the silly, or time-wasting, or harmful things we are doing to women?
Will they say....

Why did they not stop using routine practices such as amniotomy in spontaneous labour (even when prolonged)?

(Smyth et al 2013 have shown that artificial rupture of membranes has no significant effect on length of first stage, CS, maternal satisfaction and low Apgars. So – not recommended routinely).

Will they say....

Why did they keep on performing so many unnecessary episiotomies, even though it caused pain to new mothers?
Why did they not listen to what women wanted?

Why did they not support women’s autonomy, and advocate for them?

Why were they not true midwives?
We need to:

• Read and use the research that has been done, so that our practice will be evidence-based.
How can I find research?

It’s easy....

• Access the Cochrane database:

• Just type “Cochrane Pregnancy and Childbirth” into Google.

• Then click on “Our Reviews” and click on any topic you are interested in.

• All citizens of Ireland + UK have free access.
Cochrane Pregnancy & Childbirth Group

Active management of spontaneous labour versus routine care in women who have had one or more previous caesarean sections
Active versus expectant management for women in the third stage of labour
Acupuncture for induction of labour, treatment of insufficient lactation, turning a breech baby, pain management in labour, reducing blood loss in the third stage of labour
Admission tests other than cardiotocography for fetal assessment during labour

Pain management in labour

Jones et al 2013 (review of 18 reviews):

- Immersion in water, relaxation, acupuncture and massage all gave pain relief and better satisfaction with pain relief.

- Relaxation and acupuncture decreased the use of forceps and ventouse.

- Acupuncture decreased the number of caesarean sections.
Pain management in labour

So we need to encourage use of birthing pools, baths, showers, relaxation, acupuncture and massage

Discontinuing intravenous oxytocin

- Discontinuing intravenous oxytocin in the active phase of induced labour (>5 cms) may result in fewer caesarean sections (RR) 0.69, 95% confidence interval (CI) 0.56 to 0.86, 9 trials, 1784 women (Boie et al 2018)
- probably because it reduces the risk of uterine tachysystole combined with abnormal fetal heart rate (FHR) (RR 0.15, 95%CI 0.05 to 0.46, 3 trials, 486 women; and
- (CTG) abnormalities are reduced (RR 0.65, 95% CI 0.51 to 0.83, 7 trials, 1390 women)
Discontinuing intravenous oxytocin

- So - we need to be vigilant, watch out for women experiencing too many and too strong contractions (can be missed when women have an epidural in situ).

- We need to be brave enough to reduce the rate of infusion, or stop it altogether, to give women and their babies a much-needed rest (only adds 26 minutes to length of labour).

  (AND, if there is any fetal distress, just stop the infusion immediately)

Then...

we need to inform women about the research evidence

Remember, knowledge is power.

So, once we have gained the knowledge, we need to pass it along to women, so that they are empowered also.

If midwives and women band together, we can change the world.
If women only knew…

…how powerful

…they really are

How can we inform women (and the public?)

One-to-one while caring for them
In evidence-based antenatal classes
Through free public lectures (e.g., “Tell-me-about” series) [http://nursing-midwifery.tcd.ie/events-conferences/public-lecture-series/2017-18_tellmeabout_publiclectureseries.php](http://nursing-midwifery.tcd.ie/events-conferences/public-lecture-series/2017-18_tellmeabout_publiclectureseries.php)
Through newspaper articles, radio, TV
Through press releases of research results
Conclusion

We need to read and use research findings to educate ourselves and women;

If all our practice is based on research evidence, then we know we are giving the best possible care.

Safe-guarding women and families
References

- Beie S, Glavind J, Velu AV, Mol BWJ, Uldbjerg N, de Graaf I, Thornton JG, Bor P, Bakker JJH. Discontinuation of intravenous oxytocin in the active phase of induced labour. Cochrane Database of Systematic Reviews
The MAMMI study
(Maternal health And Maternal Morbidity in Ireland)

Ms Brid Kenna O Connor, MAMMI study participant
and
Dr Déirdre Daly
on behalf of
Professor Cecily Begley, Professor Mike Clarke, Queen’s University Belfast, Assoc.
Professor Margaret Carroll & the MAMMI Study research team

The MAMMI Study
Overview of presentation

➢ Background to the MAMMI study
➢ Aim and overview of the methodology
➢ Results
  ➢ up to 3 months after birth (postpartum) from women recruited from Rotunda Hospital and Galway University Hospital (on selected data)
  ➢ Brid’s story and experiences
  ➢ what women said about being asked about their health & health problems
➢ Implications, and take home message
Inspired by one woman’s story

The MAMMI study (Maternal health And Maternal Morbidity in Ireland) was inspired by one woman, back in 2010, who told a midwife - now one of the MAMMI research team - that she leaked urine, could not control when she passed wind, and leaked faeces.

This had been happening to her since she gave birth to her first child two years earlier. Telling her story wasn't easy, and it didn't happen the first time she met this midwife, who was a complete stranger to her. It took a second and third visit, and importantly, time - time for the woman to develop trust in the midwife, and time during the visit for the woman to tell her story. The extent of this woman’s misery was plain to see and painful to listen to as she sobbed her heart out, spilling out the misery she had endured in silence for the previous two years.

Every part of this woman's life had been made miserable by these health problems. At work she was afraid she would 'get caught out' or 'caught short', and at home she found her relationship with her partner was changing for the worse due to her fear of telling

Women birthing in Ireland

A lot of information is collected and reported during pregnancy, labour & birth?

Women's postpartum health (2015 = 65,869 women)
The MAMMI Study 2011

Aim
To identify the existence, extent and severity of maternal morbidities in nulliparous women before and during pregnancy and up to one year postpartum

1,600 nulliparous women
Antenatal, 3, 6, 9 and 12 months postpartum
Data collection from women’s records

General health
Intimate partner violence
Mental health
Pelvic girdle pain
Sexual health
Urinary incontinence
Anal incontinence

One PhD student
Funding: €222,646
A longitudinal (cohort) study with 3,048 first-time mothers: public, private, semi-private. Women are given study information at their booking visit in three maternity hospitals

(1-2 weeks later, a MAMMI team member calls women who gave consent to have their name and phone number shared with us to answer questions, and ask if they are interested in taking part)

- Self-completion survey antenatally (2nd AN survey in 3rd site) and at 3, 6, 9 and 12 months after birth
- Data collection from consenting women’s hospital records
- Interviews (one-to-one conversations) with sub-samples (n=20-30) of women experiencing morbidities (leaking urine, pelvic & back pain, sexual health problems)
Mixed methods design

Data collection from consenting women’s records

Interviews with women experiencing a morbidity

To find out health service and self-help seeking behaviour

Identify factors that could be treated or cured by doing future studies (amenable to intervention)

The MAMMI Study

<table>
<thead>
<tr>
<th></th>
<th>Rotunda Hospital (RH)</th>
<th>Galway University Hospital (GUH)</th>
<th>Coombe Women and Infants University Hospital (CWIUH)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response Rate (n)</td>
<td>Response Rate (n)</td>
<td>Response Rate (n)</td>
</tr>
<tr>
<td>Antenatal</td>
<td>38.3% 1842 (4809)</td>
<td>44.5% 333 (748)</td>
<td>38.3% 873 (2685)</td>
</tr>
<tr>
<td>3 months</td>
<td>86% (1484/1725)</td>
<td>92.8% (287/309)</td>
<td>89% (699/813)</td>
</tr>
<tr>
<td>6 months</td>
<td>84.5% (1381/1634)</td>
<td>87% (260/299)</td>
<td>86% (655/789)</td>
</tr>
<tr>
<td>9 months</td>
<td>80% (1301/1627)</td>
<td>83% (239/288)</td>
<td>81% (610/769)</td>
</tr>
<tr>
<td>12 months</td>
<td>78% (1223/1568)</td>
<td>78.6% (214/272)</td>
<td>75%* (534/737)</td>
</tr>
</tbody>
</table>

* In progress
Combined data from women recruited from Rotunda Hospital & Galway University Hospital

Before &
During pregnancy (n=2173)
3 months postpartum (n=1771)
6 months postpartum (n=1630)
9 months postpartum (n=1517)
12 months postpartum (n=1395)

Data not included in today's presentation

Main focus of today's presentation (on selected data)

The women who took part (participants)

<table>
<thead>
<tr>
<th>Ethnic background</th>
<th>MAMMI</th>
<th>Rotunda Hospital (RH) 2012 (n = 9116) &amp; Galway University Hospital (GUH) 2013 (n = 3060) (all women)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>n=2173</td>
<td></td>
</tr>
<tr>
<td>Irish</td>
<td>1,556</td>
<td>%</td>
</tr>
<tr>
<td>Irish traveller</td>
<td>2</td>
<td>%</td>
</tr>
<tr>
<td>African</td>
<td>23</td>
<td>%</td>
</tr>
<tr>
<td>Chinese</td>
<td>11</td>
<td>%</td>
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<tr>
<td>Any other white background</td>
<td>486</td>
<td>%</td>
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<td>Any other black background</td>
<td>3</td>
<td>%</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>41</td>
<td>%</td>
</tr>
<tr>
<td>Other, including mixed background</td>
<td>41</td>
<td>%</td>
</tr>
<tr>
<td>Not stated</td>
<td>10</td>
<td>%</td>
</tr>
</tbody>
</table>

Trinity College Dublin, The University of Dublin

Irish 71.6 Irish 65.4 76.7
Irish traveller 0.1 EU 21.2 23.3
African 1.1 Non-EU 13.3
Chinese 0.5 Not stated 0.1
Any other white background 22.4
Any other black background 0.1
Any other Asian background 1.9
Other, including mixed background 1.9
Not stated 0.5
## Participants’ Profile – Age

<table>
<thead>
<tr>
<th>Age group</th>
<th>MAMMI (n=2173)</th>
<th>RH (n=3928)*</th>
<th>GUH (n=1252)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>18 to 24</td>
<td>177</td>
<td>8.2</td>
<td>872</td>
</tr>
<tr>
<td>25 to 29</td>
<td>471</td>
<td>21.6</td>
<td>1031</td>
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<tr>
<td>30 to 34</td>
<td>940</td>
<td>43.3</td>
<td>1307</td>
</tr>
<tr>
<td>35 to 39</td>
<td>484</td>
<td>22.3</td>
<td>577</td>
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<tr>
<td>40 and over</td>
<td>94</td>
<td>4.3</td>
<td>141</td>
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<tr>
<td>Not stated</td>
<td>7</td>
<td>0.3</td>
<td></td>
</tr>
</tbody>
</table>

*Nulliparous women (women who are having their first baby)*

## Participants’ Profile – Relationship status

<table>
<thead>
<tr>
<th>Relationship status</th>
<th>MAMMI (n=2173)</th>
<th>ESRI 2012 (n = 71,986)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Married</td>
<td>1,311</td>
<td>60.3</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>4</td>
<td>0.2</td>
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<tr>
<td>Widowed</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Single</td>
<td>78</td>
<td>3.6</td>
</tr>
<tr>
<td>Living with partner</td>
<td>593</td>
<td>27.3</td>
</tr>
<tr>
<td>In relationship, not living together</td>
<td>160</td>
<td>7.4</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>0.8</td>
</tr>
<tr>
<td>Not stated</td>
<td>9</td>
<td>0.4</td>
</tr>
</tbody>
</table>
## Participants’ Profile - Qualification Status

<table>
<thead>
<tr>
<th>Qualification status</th>
<th>MAMMI (n = 2173)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications</td>
<td>51</td>
<td>2.3</td>
</tr>
<tr>
<td>Upper secondary/leaving certificate</td>
<td>257</td>
<td>11.8</td>
</tr>
<tr>
<td>Apprenticeship/certificate</td>
<td>143</td>
<td>6.6</td>
</tr>
<tr>
<td>Upper secondary &amp; vocational qualification</td>
<td>87</td>
<td>4.0</td>
</tr>
<tr>
<td>National certificate/diploma</td>
<td>205</td>
<td>9.4</td>
</tr>
<tr>
<td>Primary degree/professional qualification (degree status)</td>
<td>649</td>
<td>29.9</td>
</tr>
<tr>
<td>Postgraduate certificate, Masters, PhD</td>
<td>767</td>
<td>35.3</td>
</tr>
<tr>
<td>Not stated</td>
<td>14</td>
<td>0.6</td>
</tr>
</tbody>
</table>

## Participants’ Profile - Body Mass Index (BMI) category

<table>
<thead>
<tr>
<th>BMI category (before pregnancy)</th>
<th>MAMMI (n = 2173)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight (&lt;18.5kg/m²)</td>
<td>103</td>
<td>4.7</td>
</tr>
<tr>
<td>Normal weight (18.5-24.9kg/m²)</td>
<td>1319</td>
<td>60.7</td>
</tr>
<tr>
<td>Overweight (25-29.9kg/m²)</td>
<td>375</td>
<td>17.3</td>
</tr>
<tr>
<td>Obese (30-34.9kg/m²)</td>
<td>159</td>
<td>7.3</td>
</tr>
<tr>
<td>Very obese (&gt;35kg/m²)</td>
<td>38</td>
<td>1.7</td>
</tr>
<tr>
<td>Not stated</td>
<td>179</td>
<td>8.3</td>
</tr>
</tbody>
</table>
The way women birthed
(Mode of birth)

n=1972 (%)

91% (n=1972/2173) of women gave us consent to access their pregnancy and birth records.
Mode of birth

n=1972 (%)

- Instrumental birth: 35.3%
- Caesarean section: 31.5%
- Vacuum: 8.4%
- Forceps: 4.9%
- Koli: 17.1%
- Koli & Forceps: 1.1%
- Vacuum & Forceps: 3.9%
- Elective CS: 8.0%
- Elective CS (in labour): 0.4%
- Emergency CS: 23.2%

Leaking urine
(Urinary incontinence)

<table>
<thead>
<tr>
<th>Urinary incontinence</th>
<th>Less than once per month (%)</th>
<th>Once per month or more frequently (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before pregnancy (n=2167)</td>
<td>27.0</td>
<td>7.3</td>
</tr>
<tr>
<td>During pregnancy (n=2162)</td>
<td>23.0</td>
<td>17.0</td>
</tr>
<tr>
<td>3 months postpartum (n=1700)</td>
<td>29.3</td>
<td>29.7</td>
</tr>
</tbody>
</table>
### Bowel problems and leaking stools (Anal incontinence)

<table>
<thead>
<tr>
<th></th>
<th>Constipation (Occ &amp; often) (%)</th>
<th>Passed wind, major amount (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=2155/2155)</td>
<td>16.0</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>During pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=2169/2142)</td>
<td>37.4</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>3 months postpartum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=1701/1676)</td>
<td>33.0</td>
<td>9.5</td>
</tr>
</tbody>
</table>

### Bowel problems and leaking stools (Anal incontinence)

<table>
<thead>
<tr>
<th></th>
<th>Leaked liquid stool (any frequency) (%)</th>
<th>Leaked solid stool (any frequency) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=2167/2167)</td>
<td>4.4</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>During pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=2169/2163)</td>
<td>3.3</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>3 months postpartum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=1724/1713)</td>
<td>8.1</td>
<td>4.0</td>
</tr>
</tbody>
</table>
### Depression and anxiety

<table>
<thead>
<tr>
<th></th>
<th>Depression (occasionally &amp; often)(%)</th>
<th>Anxiety (occasionally &amp; often)(%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any (12 months before pregnancy) (n=2161/2157)</td>
<td>12.7 (9.3)</td>
<td>8.2 (5.1)</td>
<td>Depression: ‘Low mood or sad’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxiety: ‘Intense anxiety or panic attacks’</td>
</tr>
<tr>
<td>During pregnancy (n=2169/2164)</td>
<td>8.9</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>3 months postpartum (n=1714/1700)</td>
<td>17.6*</td>
<td>12.4*</td>
<td>* Women were asked: ‘Since the birth, have you felt depressed (anxious) for 2 weeks or longer’</td>
</tr>
</tbody>
</table>

### Pain in front pelvic joint and back pain

<table>
<thead>
<tr>
<th>Pain in front pelvic joint and back pain</th>
<th>Pain in front pelvic joint</th>
<th>Low back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any (12 months before pregnancy) (n=2173)</td>
<td>1.5</td>
<td>35.5</td>
</tr>
<tr>
<td>During pregnancy (n=1782/1780)</td>
<td>14.0</td>
<td>60.9</td>
</tr>
<tr>
<td>3 months postpartum (n=1390)</td>
<td>15.7</td>
<td>63.5</td>
</tr>
</tbody>
</table>

Trinity College Dublin, The University of Dublin

* MAMMI Study

Trinity College Dublin, The University of Dublin
### Sexual health issues

<table>
<thead>
<tr>
<th>Sexual health issues</th>
<th>Painful penetration</th>
<th>Pain during sexual intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any (12 months before pregnancy) (n=2173)</td>
<td>22.6</td>
<td>21.0</td>
</tr>
<tr>
<td>During pregnancy (n=1475)</td>
<td>16.5</td>
<td>14.2</td>
</tr>
<tr>
<td>3 months postpartum (n=1475/1460/1426)</td>
<td>43.1</td>
<td>38.6</td>
</tr>
</tbody>
</table>

### Women’s health up to three months after the birth

<table>
<thead>
<tr>
<th>Health issues up to three months postpartum</th>
<th>Never/rarely (%)</th>
<th>Occasionally/often (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme tiredness or exhaustion</td>
<td>33.6</td>
<td>66.4</td>
</tr>
<tr>
<td>Frequent coughs, colds, minor illness</td>
<td>89.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Severe headaches or migraines</td>
<td>87.8</td>
<td>12.2</td>
</tr>
<tr>
<td>Backpain (lower back)</td>
<td>51.1</td>
<td>48.9</td>
</tr>
<tr>
<td>Back pain (middle or upper back)</td>
<td>60.3</td>
<td>39.7</td>
</tr>
</tbody>
</table>
### Women’s health up to three months after the birth

<table>
<thead>
<tr>
<th>Health issues up to three months postpartum</th>
<th>Never/rarely (%)</th>
<th>Occasionally/often (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Painful/sore perineum</td>
<td>70.6</td>
<td>29.4</td>
</tr>
<tr>
<td>Perineal wound infection</td>
<td>96.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Pain from CS wound</td>
<td>82.2</td>
<td>17.8</td>
</tr>
<tr>
<td>CS wound infection</td>
<td>96.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Uterine infection</td>
<td>99.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

### Women’s health up to three months after the birth

<table>
<thead>
<tr>
<th>Health issues up to three months postpartum</th>
<th>Never/rarely (%)</th>
<th>Occasionally/often (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain passing urine</td>
<td>93.3</td>
<td>6.7</td>
</tr>
<tr>
<td>UTI (urinary tract infection)</td>
<td>97.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Pain passing bowel motion</td>
<td>69.2</td>
<td>30.8</td>
</tr>
<tr>
<td>Bleeding when passing bowel motion</td>
<td>72.5</td>
<td>27.5</td>
</tr>
<tr>
<td>Constipation</td>
<td>67.0</td>
<td>33.0</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>65.4</td>
<td>34.6</td>
</tr>
</tbody>
</table>
Women’s health up to three months after the birth

<table>
<thead>
<tr>
<th>Health issues up to three months postpartum</th>
<th>Never/rarely (%)</th>
<th>Occasionally/often (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore nipples</td>
<td>61.6</td>
<td>38.4</td>
</tr>
<tr>
<td>Mastitis</td>
<td>93.1</td>
<td>6.9</td>
</tr>
<tr>
<td>Pelvic pain</td>
<td>86.2</td>
<td>13.8</td>
</tr>
<tr>
<td>Major postpartum haemorrhage (bleeding after birth)</td>
<td>98.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Heavy vaginal bleeding</td>
<td>91.9</td>
<td>8.1</td>
</tr>
</tbody>
</table>

What women told us about contact with health services
Brid’s story

- MAMMI study gave opportunity to think about my own health
  - Time out
  - No baby talk
  - Time to consider
    - what was happening
    - what had changed

Brid’s story

- MAMMI study asked the questions no one else did
  - Hospital – good care but left to fend for yourself
  - Home visit – all about baby
  - 6 week check up – excellent obstetrician but very clinical
  - After - nothing
Brid’s story

- Isolation
  - Brilliant support from Partner and Parents
  - Lack of professional support for everyone
- Guilt for not Breastfeeding
  - Not welcome at clinics / groups
  - Online forums / websites point out your failure
  - Pressure to explain
- Older so friends working

What women told us about contact with health services (about their own health)

<table>
<thead>
<tr>
<th>Contact with health services</th>
<th>Attended GP (%)</th>
<th>Attended ER (%)</th>
<th>Readmitted (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months postpartum (n=1701)</td>
<td>32.5 (twice or more often)</td>
<td>10.6</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td>16.6 (three times or more often)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What women told us about
Passing urine when they don’t mean to

Before pregnancy
– 1 in 3 women leaked urine

During pregnancy
– Almost 2 in 5 women leaked urine
Women said it was ‘normal in pregnancy’

After the birth
– Almost 2 in 3 women leaked urine
at 3 months

What women told us about
Passing urine when they don’t mean to

Before pregnancy
– 1 in 3 women leaked urine

During pregnancy
– Almost 2 in 5 women leaked urine
   9 out of 10 women did NOT talk to a health professional

After the birth
– Almost 2 in 3 women leaked urine at 3 months
   3 out of 4 GPs and 2 out of 3 PHNs did NOT ask about it in the first 3 months
What women told us about

Passing stools when they don’t mean to

Before pregnancy
— 1 in 20 women leaked stools

During pregnancy
— 1 in 20 women leaked stools

After the birth
— 1 in 8 women leaked stools at 3 months

3 out of 4 GPs and 2 out of 3 PHNs did NOT ask about it in the first 3 months

What women told us about

Anxiety

Before pregnancy
— 1 in 20 women experienced anxiety

During pregnancy
— 1 in 21 women experienced anxiety

After the birth
— 1 in 12 women experienced anxiety

1 in 2 GPs and 1 in 3 PHNs did NOT ask about it in the first 3 months
What women told us about

Depression

Before pregnancy
– 1 in 10 experienced depression

During pregnancy
– 1 in 10 experienced depression

After the birth
– 1 in 6 women experienced depression at 3 months

1 in 2 GPs and 1 in 3 PHNs did NOT ask about it in the first 3 months

What women told us about contact with healthcare professionals

<table>
<thead>
<tr>
<th>Contact with health care professionals</th>
<th>GP did NOT ask me directly about... %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiredness or exhaustion</td>
<td>45.7</td>
</tr>
<tr>
<td>Involuntary loss of urine</td>
<td>74.4</td>
</tr>
<tr>
<td>Involuntary loss of bowel motions</td>
<td>78.9</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>80.6</td>
</tr>
<tr>
<td>Perineal pain</td>
<td>66.4</td>
</tr>
<tr>
<td>Feeling depressed or low</td>
<td>49.0</td>
</tr>
<tr>
<td>Sexual health problems</td>
<td>86.8</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>88.2</td>
</tr>
</tbody>
</table>
What women told us about contact with healthcare professionals

<table>
<thead>
<tr>
<th>Contact with health care professionals</th>
<th>PHN did NOT ask me directly about… %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiredness or exhaustion</td>
<td>25.7</td>
</tr>
<tr>
<td>Involuntary loss of urine</td>
<td>59.9</td>
</tr>
<tr>
<td>Involuntary loss of bowel motions</td>
<td>65.3</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>74.0</td>
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<tr>
<td>Perineal pain</td>
<td>51.6</td>
</tr>
<tr>
<td>Feeling depressed or low</td>
<td>33.7</td>
</tr>
<tr>
<td>Sexual health problems</td>
<td>87.9</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>80.5</td>
</tr>
</tbody>
</table>

Brid’s story

- Isolation
  - VHI Nurseline provided support and advise not available elsewhere
    - Saved me
  - Nobody wants to hear your not well
Women’s health after birth in Ireland

National ‘silence’

Women’s health problems remain unspoken unheard

What women told us

Most women did not talk about these issues during pregnancy...

Midwives, GPs & PHNs did not ask women about these health issues after the birth
But this information is important because...

Many of these health problems are common but they **not normal** and **can be treated**

The consequence
Opportunities for promoting health (before, during and after pregnancy) are being lost

Health problems that could be prevented and treated persist and may worsen

---

Brid’s take home message

- Follow up services
  - Home visit for all
  - Clinic for all not just breastfeeding moms
  - More general questions rather than all clinical
  - Counseling services for all
• For healthcare professionals...

Find ways of making sure women are asked about postnatal problems and are given time to tell their story

For policy makers...

...stopping maternity care at six weeks postpartum is far too early and is unrealistic

Follow-up visits, three months after becoming a mother, should be an essential part of our maternity services

(Recommended in Ireland’s National Maternity Strategy 2016).
Take home message

Put women first, foremost and central
Listen to our experiences
If women are well, babies and families will be well too.

The MAMMI study 2018

3,048 primiparous women (A/N (x2), 3,6, 9 and 12 months postpartum)
Data collection from women’s records
One-to-one interviews with women experiencing a morbidity in each strand

MAMMI study 2018

3,048 primiparous women (A/N (x2), 3,6, 9 and 12 months postpartum)
Data collection from women’s records
One-to-one interviews with women experiencing a morbidity in each strand

General health
Mental health
MSc (Research) student
Readmission to hospital
MSc (Taught) student
Pelvic girdle pain
Post doctoral work
Urinary incontinence
Post doctoral work
Anal incontinence

Public Participation in research Initiative (PPI)

Three post-docs
Second baby & 5-year follow-up

Midwifery
Health Economics
Epidemiology/bio-statistics

International collaboration and data sharing planned

Diet and Physical Activity PhD student
Caesarean Section PhD student
Intimate partner violence Researcher
Sexual health PhD student

MAMMI 2 NUIG & GUH Research

MAMMI 3 CWIUH

Co-conducting research

Diet and Physical Activity PhD student
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MAMMI 2 NUIG & GUH Research

MAMMI 3 CWIUH

Co-conducting research
Co-producing maternal health research with women

**Co-designing** the second baby & 5-year follow-up studies

- Quarterly meetings/focus groups with women
- Identification of 1-2 qualitative studies on women-directed research studies

---

Co-producing maternal health research with women

**Women-directed research studies**

- Public participation in research initiative (PPI)
  - Quarterly meetings/focus groups with women
  - Identification of 1-2 qualitative studies on women-directed research studies
Co-producing maternal health research with women

✓ Co-presenting research

You can look at ongoing findings

The MAMMI Study

http://www.mammi.ie/

Welcome!
The MAMMI Study is a study looking at the health and well-being of women during pregnancy and up to 1 year after the birth of their first baby. It aims to improve the research that women and their families experience. The study is priced to women who are pregnant or who have just had a baby. The information from the study will be used to improve the care of women after their baby is born.

Who Can Take Part?
If you are interested in taking part, please contact us on the following:
- Phone: 01 802 8028
- Email: mammi@tcd.ie

The study is funded by the National Children's Research Board.

Trinity College Dublin
You can look at ongoing findings

Trinity College Dublin, The University of Dublin

The MAMMI Study

You can look at ongoing findings

Trinity College Dublin, The University of Dublin

The MAMMI Study

Trinity College Dublin, The University of Dublin

The MAMMI Study

You can look at ongoing findings
The MAMMI Study

Sincerest thanks to the women who took part/are taking part

Special thanks to

The midwives and midwifery students

The IT Midwives

The medical records staff

Administrative and other staff who supported the MAMMI study

Sites

Maternity Unit, Galway University Hospital
Antenatal clinic staff

Teresa & staff (Private clinic)

Medical records staff

Coombe Women and Infants University Hospital

Antenatal clinic staff

Hazel & staff (Private & semi-private clinic staff)

Aileen & Ruth, IT midwives

Medical records staff
The MAMMI Study

Sincerest thanks to the MAMMI study team

Margaret Carroll (MAMMI 2), Deirdre O’Malley (sexual health), Francesca Wuytack (pelvic girdle pain), Sunita Panda (caesarean section strand), Jamile Marchi (diet and physical activity), Louise Rafferty (mental health strand (anxiety)), Marcelina Szafrańska (readmission rates)

Francesca Wuytack and Pat Moran (Follow-up studies)

Others who worked/are working on the MAMMI study

Rebekah Maguire and Sophie Clare (summer 2012), Eleanor Russell and Marie O’Shea (April-June 2013), Marianne Hennessy (April-June 2014 & continued to help us on a voluntary basis until September 2016), Susan Hannon (research assistant, summer 2014 to date), Kamilla Correa (Science Without Border student, summer 2015), Ger McCormack (volunteer, summer 2015), Sophie MacQuaile (research assistant, September 2015 to 2017), Monalisa Barros (Visiting researcher January-June 2016), Anna Dowling (summer 2016), Juli Lanyi (research assistant, September 2016 to date), Kathleen Hannon (research assistant, October 2017 to date)
The MAMMI Study

Thank you
A Grounded Typology of Concealed Pregnancy

Regaining Agency & Autonomy

Keeping it Secret
THE KISS STUDY
Your story of concealed pregnancy

www.ul.ie
Baby Maria (2014)

- A 25-year-old woman was charged with concealment of birth (Collins 2014).
- It transpired the infant was stillborn.
- This woman was named by the press (Ferry 2014), and a photo of her was printed by one tabloid newspaper, with many national and international newspapers reporting on this case (Lee 2014, Collins 2014, Cullen 2014, Western Australian News 2014).
- Charges were dropped after a public outcry and she was repatriated back to Ireland.

Australia (2014)

- A 25-year-old woman was charged with concealment of birth (Collins 2014).
- It transpired the infant was stillborn.
- This woman was named by the press (Ferry 2014), and a photo of her was printed by one tabloid newspaper, with many national and international newspapers reporting on this case (Lee 2014, Collins 2014, Cullen 2014, Western Australian News 2014).
- Charges were dropped after a public outcry and she was repatriated back to Ireland.
Background

• Concealed pregnancy can lead to maternal & neonatal death
• The literature approaches concealed pregnancy from a biomedical perspective and links with psychopathology remain unsubstantiated
• Commonly used term -denied pregnancy a lack of clarity around the definition

Literature

• Poor records in relation to incidence & outcomes
• Associations between concealed pregnancy and abandonment & neonaticide
• Fallacy that concealed pregnancy affects only teenagers
• Contemporary cases of concealed pregnancy are reported in Ireland & internationally
Antecedents

- Aware of the pregnancy
- Fear (of others or for others)
- Compares own situation to societal norms & expectations
- Context-culture/religiosity
- Perceives a lack of support or mechanism to mother infant

Attributes

- Secrecy
- Hiding
- Daytime story (cover story)
- Staying away
- Avoidance ie. emotional focussed coping strategy
Consequences

**Woman**
- Maternal death
- Self harm/suicide
- Mothering: forced or voluntary
- Recurrence

**Infant**
- Neonatal death/neonaticide
- Abandonment
- Fostering/Adoption

**Society**
- Increased child surveillance
- Anonymous birthing
- Baby Hatches

Characteristics of Participants

Participants 46 interviews/ 30 women
28 concealed in past and 2 were pregnant when interviewed; pre and post birth

- 6 Adoptions & 5 infants spent time in foster care
- 7 perinatal deaths
- 15 years to 35 years
- 28 women were single
- 26/30 women Irish & 4 were European
Concealed Pregnancy
A Life Altering Experience

- Domestic violence (n=4)
- Sexual trauma (n=4)
- Child sexual abuse (n=3)

- 11/30 experienced significant trauma
- 19 remaining women also reported concealed pregnancy as a fearful, traumatic and life altering experience

Challenging the Discourse of Denial

- Women were generally aware of the pregnancy
- Varying levels of awareness
- Fluctuating awareness (Thynne 2006)
- Denial is actually avoidance
Listening to Women

Concealed pregnancy is like......
“you’d need a mop up team to deal with concealed pregnancy”

“a spectre that hangs over you”

“it never leaves you, it’s in your bones, it’s in your DNA.”

Typology of Concealed Pregnancy

• Generated a typology which reconceptualises concealed pregnancy and theorises the fear experienced
• The typology provides a framework to assist midwives understand the process of concealed pregnancy
• Concealed pregnancy needs to be urgently reappraised from a traumatology perspective

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"so I made up this awful story, I spun them all an awful story that I didn’t know I was pregnant, it was a lie. But I did know, it is still the story I tell today. I have never told anyone my child was very nearly adopted." (Aileen, concealed 7 months, infant spent time in foster care, decided to mother her child after a few weeks)

"I knew I was pregnant, when I took a shower I never looked down, I never wanted to acknowledge it. I told myself from time to time I had a cyst or a tumour. I was terrified and managed by ignoring it." (Eileen, concealed 8 months, adoption)
“Maybe I put blinkers on, I thought if I kept it hidden it would go away. I really did or thought something would happen. I reckon I could have gone on longer.” (Aine, concealed 7 months, mothered her infant)

“I probably would have chanced it on my own. I’d say I would have. I had no plan, no plan at all.” (Pauline, concealed 8 months, mothered infant)

• “I was very aware that I was pregnant ...there was no denial, I was pregnant and no one was going to find out about this but me, I proactively concealed my pregnancy.” (Carrie, concealed 8 months, infant adopted)
Hearing Women’s Stories

“you know like afterwards when you look back on it, would I have been prosecuted you know for having not taken care of my child. You know like that girl in Australia before, they wanted to prosecute her.” (Penny, concealed 3 pregnancies)

“the stuff about she may be in medical need, I wouldn’t trust that, that was the way to get her in...you know it looked like a garda investigation...an interview with the female garda and the social worker on a sofa would have created a completely different image.” (Maeve speaking about Baby Maria Case, tragic outcome)

Summary

• This study reconceptualises concealed pregnancy as a fearful and traumatic experience that has long term consequences
• The typology generated provides a framework to understand the process of concealing a pregnancy and birth
• New areas for research have been identified eg., newborn abandonment, association with IPV & concealed pregnancy, maternal-infant attachment
Conclusions

• Women report concealed pregnancy is a life-altering and traumatic experience
• Women desire privacy & confidentiality
• Professionals must understand that concealed pregnancy may be internally or externally mediated and that women predominantly cope by avoidance

Recommendations

• Integrated carepathways for women who conceal a pregnancy must be developed (Access to antenatal care & therapeutic counselling)
• HSE CPP guidelines require urgent updating
• Media guidelines are urgently required
Ripples that last a lifetime

Thank You

• 30 women who trusted me to share their personal experiences of concealed pregnancy
• The Health Research Board who funded this study
• My supervisors Prof Joan Lalor & Prof Cecily
Contact

Sylvia Murphy Tighe
Email: Sylvia.murphy@ul.ie
Tel: 00-353-86-0208986
Twitter: @sylviamurphyt

Any Questions?
Group Based Antenatal Care and Education

Denise Boulter & Siobhan Slavin
All Ireland Midwifery Conference
18th October 2018
Introducing...

Getting Ready for Baby

Transforming universal antenatal care and parent education

Strategic Context
Women Centred Care
Right Person - Right Place
Right Time
Messages from parents

- More preparation
- Practical parenting
- Home visiting is essential
- Emotional impact: Antenatal & post-natal depression
- Use pregnancy to facilitate social networks
- Consistent Information needs to be provided in a range of formats
- Trusted Relationships: Smaller number of health professionals
- Include Dads

The journey so far

- Opportunity for investment first discussed April 2013
- Recognition that women attend for antenatal care but not always education therefore we needed to change how we provide education
- Attended study day on “centering pregnancy” and established that transformation in form of group based care and education was way forward
- Reviewed the various group based models available e.g centering and FNP but neither of these fully fitted the needs
EITP

Early brain development & Knowledge

Parent support to give babies the “Best start in Life”

Infant Mental Health awareness

Transforming antenatal education & care

New Approach- Antenatal Parenting Programme

Highlight the importance of infant mental health

Opportunities for midwives and others to work together

Solihull Antenatal Parenting Group

Provide social opportunities for expecting parents

Better engage fathers

Combine healthcare assessment and parent education

Group based programme
Antenatal Group is based on Solihull Approach model

Bion
Containment

Reciprocity
Brazelton

Behaviour management
e.g. Skinner, Watson

16 weeks: session 1
1: Helping you and your baby through pregnancy and birth

25 weeks: session 2
2: Getting to know your baby in the womb

28 weeks: session 3
3: You, your baby & the stages of labour

30 weeks: session 4
4: Helping you and your baby through labour & birth

34 weeks: session 5
5: Feeding your baby

36 weeks: session 6
6: Caring for your baby
Solihull Training for Midwives

The Journey to Parenthood

Early Days.....
What did we say we would do and have we done it?

• Establish combined group based care and education  
  – Yes Getting ready for baby is available in all 5 Trusts
• Invite all eligible women to join the groups  
  – Yes- This is improving with addition on to NIMATs and more midwives at booking clinic aware of the programme
• Improve preparation for parenting for first time mothers  
  – Yes- evidence from Solihull and Karitane show that women attending the groups are better prepared
The Bayview Babes

OBA: How Much have we done?

- 4200 women have attended GRfB
- 395 groups between Oct 16 – June 18
- Around 30% of first time mothers booked
- Average 10/12 women per group
- 23 sites in 5 Trusts
OBA: How well did we do it?

- 84% of mothers completed the programme
- 6% were unable to complete for clinical reasons
- 10% did not complete due to personal reasons

Is anyone better off?

- 61% Getting ready for baby mothers breast feed as opposed to 44% maternity population
- 99% attendees thought group based care and education was a good idea
- 97% enjoyed shared experience of group
- 98% felt well prepared for interacting with and nurturing their baby
- 99% valued having the same team of midwives
Impact on parents

“GRfB programme was fantastic, I really enjoyed each session and chatting to the other mums to be. The fact that it tied in around the antenatal appointments really helped. I was so glad of this support as I no longer have my mum and was very nervous about beginning the journey without her to call on for advice. This programme gave me lots of confidence before the arrival of my baby and gave me a good insight of what to expect. I would definitely recommend it to any first time mums to be”

Postnatal questionnaire: baby 4 ½ months old
Impact on midwives

Delivering continuous care - increased job satisfaction

Continued team building

New midwifery role

INCREASED NETWORKING

Recognising the value of partnership
Key Messages

• Implementation moves through different stages
• It takes time
• Our people need skills development and to be sustained
• Organisations and systems need to change
• The “right” leadership is needed
• Resilience and a sense of humour to cope with all the bumps in the road!!

Getting ready for baby

Safe Space
Collaboration
Strong Clinical Leadership
Courageous conversations
Family Centered
Forward thinking
Final thought

Things do not change, we change

• Henry David Thoreau

But maybe, we just need to go....back to the future!!!