

## RURAL MIDWIFERY: OVERCOMING BARRIERS TO PRACTICE *LA PRATIQUE SAGE-FEMME EN MILIEU RURAL : SURMONTER LES OBSTACLES*

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### ABSTRACT

Access to the delivery of health services, including midwifery, is a challenge for rural parturient women due, in part, to the closure of practices and centralization of health care services. The Centre for Rural Health Research and the Midwives' Association of British Columbia (MABC) Rural Midwifery Committee convened a meeting in June 2008 consisting of researchers and rural midwives with the objective of clearly identifying barriers to practice. Barriers and potential solutions to the sustainability of rural midwifery arose from the discussion. The article divides the barriers into six themes: professional and social barriers, health service delivery challenges, education challenges, integration issues, inadequate models of remuneration for care in rural environments, and geographic barriers to practice. Potential solutions and recommendations are explored in order to reduce or eliminate barriers to access and move towards a sustainable future for rural midwifery.

### KEY WORDS

*Rural midwifery, sustainability, remuneration, social barriers, geographical barriers, access to midwifery care.*

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### RÉSUMÉ

L'accès à la prestation de services de santé, dont ceux des sages-femmes, se présente comme défi aux femmes parturientes des milieux ruraux. Ceci est attribuable en partie à la fermeture de cabinets et à la centralisation des services de soins de santé. Lors d'une réunion en juin 2008, le Centre for Rural Health Research et le Midwives' Association of British Columbia (MABC) Rural Midwifery Committee ont réuni chercheurs et sages-femmes pratiquantes en milieu rural afin d'identifier les obstacles à la pratique en milieu rural. La discussion s'est penchée sur la viabilité de la pratique en milieu rural afin de soulever ses obstacles et les solutions possibles. L'article traite ces obstacles par l'entremise de six thèmes : les obstacles professionnels et sociaux, les défis au plan de la prestation de services de santé, les défis au plan de la formation, les enjeux liés à l'intégration, le manque de modèles de rémunération adéquat pour les soins en milieu rural, et les obstacles géographiques. L'article aborde les solutions possibles ainsi des recommandations visant à réduire ou à éliminer les obstacles à l'accès ainsi qu'à assurer que la pratique sage-femme en milieu rural soit viable dans le futur.

### MOTS CLÉS

*Pratique sage-femme en milieu rural, viabilité, rémunération, obstacles sociaux, obstacles géographiques, accès aux soins de sage-femme.*

*Cet article a été évalué par des pairs.*

## Introduction and Background

Increasingly, the health service delivery system in Canada is not meeting the needs of rural parturient women. This is due to issues of access which are related to closures of service. Reasons for closures are diverse and often community-specific, but tend to be related to health human resource challenges across the spectrum of care providers (nurses, general practitioner surgeons, family physicians, and specialists);<sup>1,7</sup> lack of access to specialist (surgical) services (for example, limited access to epidural anaesthesia, labour augmentation, or caesarean section back-up);<sup>2,7</sup> and the trend towards the centralization of health services in Canada.<sup>1,8-9</sup>

In the face of this changing environment, several solutions have been suggested to ensure that the needs of parturient women and their families are being met. Broadly, they include either improved mechanisms for insuring alternate place of delivery for the expectant mom (GP or midwife in the referral community) or endeavours to strengthen local care.<sup>7,10-11</sup> The latter initiative focuses on sustainable systems in isolated, remote, low-resource and low-volume communities and the attendant challenges to which these environments give rise. One solution, precipitated by the growing recognition of the profession of midwifery in Canada, has been the move to introduce midwives into rural communities where there has not previously been midwifery services, either in independent practice or as part of inter-professional care teams.<sup>12</sup> Beyond providing a solution to the health service delivery challenges that decision makers face, rural midwifery also addresses the growing call for choice in place and care provider for birthing women. Currently, 27 per cent of all midwives in British Columbia are practicing in rural environments, and out of those, many increasingly feel professional and personal challenges.<sup>12,13</sup>

In recognition of the potentially significant role midwives can play in meeting the needs of rural women, planners, decision makers, and researchers have paid increasing attention to the challenge of sustainability.<sup>13</sup> As its contribution to clearly articulating the barriers and issues in rural midwifery sustainability and growth, the Centre for Rural

Health Research and the Midwives' Association of British Columbia (MABC) Rural Midwifery Committee convened a meeting of researchers and rural midwives with the objective of clearly and systematically identifying barriers to practice by those on the front lines: rural midwives themselves. The Invitational Rural Midwifery Symposium took place June 19-20, 2008 in Vancouver (as a central meeting spot for those coming from diverse communities around British Columbia), and included 13 rural midwives from across the province. The following barriers and solutions arose from a consensus-based discussion of midwives who are currently actively providing care in communities with populations ranging from 400 to 100,000 and health services delivery infrastructure ranging from two hours to nearest cesarean section access to local access to specialist (surgical) back-up.

## Barriers and Solutions to Sustainable Practice

Barriers can be broken down into six themes, including professional and social barriers, health service delivery challenges, education challenges, integration issues, inadequate models of remuneration for care in rural environments, and geographic barriers to practice. Each one will be reviewed in brief below.

### *Professional and Social Barriers*

Professional barriers can be broken down into issues regarding the model of care. The present funding model penalizes care providers for transferring patients to specialized care prior to or during labour. There is a need for a payment method for midwives (and other maternity care providers) that supports inter-professional models of care. Additionally, professional sustainability has been challenged by the dearth of locums to alleviate call, and the impending retirement of many experienced rural midwives. Despite the growing contingent of midwives working in rural environments, historically many rural midwives have perceived limited representation in their professional association and in contract negotiations. Social barriers include the lack of organized peer support in rural communities (professional isolation) and challenges to the introduction of midwifery in communities that have not previously had access to regulated midwifery care.

Solutions to these professional and social barriers include the need for the Ministry of Health to make changes to funding structures to remunerate rural midwives for courses of care regardless of pregnancy outcome or transfer, and to create a fee for service or other remuneration structure that facilitates shared primary care with other care providers. Additionally, policy makers need to prioritize the creation of a funded locum pool of established midwives to provide service to low volume practices in rural areas, alternative funding models to allow midwives to limit practice (for example, prenatal and postpartum part-time care), as well as funding for locum expenses as per their family practice colleagues.

To mitigate the effects of geography on professional isolation and representation within professional venues, the ministry should provide funding for face-to-face and peer support for rural midwives in addition to funding provided by MABC for teleconference communication. Regional departments of midwifery may facilitate participation in collaborative CME, chart reviews, and morbidity and mortality rounds. Additionally, the Ministry of Advanced Education and Training needs to prioritize increasing the number of seats in the University of British Columbia (UBC) Midwifery Program to raise the number of graduates who will enter rural practice in underserved areas.

#### *Health Service Delivery Issues*

Health service delivery issues include the challenges of addressing unassisted home births, which may be part of a community's historical birthing culture prior to the regulation of midwifery. Other issues include lack of surgical coverage, particularly in low volume communities; and the concomitant challenges to accessing care. Taken together, these realities may force women to consider unassisted

home births. Additional barriers often surround home birth in the midwifery model of care in Canada in rural communities, due to concerns about timely transport where necessary, distance to care facility, and overall feelings of lack of support of the care providers practicing in these communities. Although solutions to this issue are outside the purview of recommendations for change and the

responsibility of rural midwives, an awareness of the context is useful in understanding some of the challenges of rural practice.

Solutions include the need for a public education plan to introduce community members and health care providers to the role and scope of practice of registered midwives. In communities where women choose to have unassisted home births, midwives can mitigate potential negative outcomes by providing prenatal and postpartum outreach to these at-risk women. Typically, rural women who elect to have unassisted home births receive no maternity care. For these women who refuse any intrapartum care, they should at minimum be offered prenatal and postpartum support. Such strategies could also provide women with a better understanding of midwifery care and the qualities of midwifery-assisted birth, creating a greater likelihood that such women will consider midwifery care for future deliveries.

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In low resource communities, midwives must continue to engage in informed choice discussions with women considering local birth to clearly explain the potential risks and benefits. As midwives are mandated to offer choice in place of birth, according to their model of care, concerns around home birth in rural communities may be addressed by ensuring efficient communication with transport personnel and through informed decision making with the family and collaboratively agreed upon

criteria for home delivery.

#### *Education and Continuing Professional Development*

Education barriers include difficulties in accessing midwifery training for rural residents interested in pursuing the profession. For practicing rural midwives, barriers to continuing professional development include finding time and funding to leave the community. Solutions to these issues include facilitating transfer of course credits from community educational programs to UBC, underscored by the value of educating practitioners from rural communities. Additionally, the Midwifery Education Program can move towards increasing the number of rural-specific skills that are necessary in isolated, low-resource environments and by increasing opportunities for placement in rural settings during the degree program. To facilitate rural midwives gaining continuing professional development, the Ministry of Health and regional health authorities need to provide funding as part of ensuring evidence-based rural practice, in parallel to the education and practice bonuses offered to rural physicians.

#### *Integration Issues*

Integration issues centre on the difficulty of rural midwives gaining privileges in rural hospitals and the challenges of articulating roles and responsibilities, particularly with nurses, within an inter-professional environment. Before requesting privileges rural midwives need to engage in discussions with key stakeholders at a local and regional level and become familiar with the rules and regulations of privileging as it pertains to their hospital. In addition, applying midwives will find it helpful to consult with other midwives who have successfully integrated into the health service delivery area. Clarifying roles and responsibilities generally takes place over time but can be additionally supported by information and education documents such as the Multidisciplinary Collaborative Primary Maternity Care Project (MCP2), the CMBC Hospital Implementation Manual, MABC documents,<sup>14</sup> inter-professional education and training programs such as MoreOB, and a province-wide educational tour facilitated by the Ministry of Health, with all key stakeholders, to

visit rural communities and provide an overview of midwifery as well as a resource for care providers.

#### *Inadequate Models of Remuneration*

Rural midwives identify insufficient funding as the greatest barrier to sustainable practice, particularly through the lack of remuneration through travel, lack of start-up funds for midwives moving to new communities, and lack of professional benefits for practitioners, including maternity leave and retirement benefits. Solutions to these issues include the prioritization of increased funding by the Ministry of Health Services, including a start-up fund for rural midwives as is provided to rural midwives in Ontario, and the provision of vehicle mileage and gas funding based on catchment geography. Other solutions may include funding through service contracts, particularly in low-resource environments, which would address remuneration for activities such as well-woman care, education, lactation consulting, and outreach to meet the needs of rural communities. Additionally, professional associations and ministry negotiating groups must continue to increase the involvement of midwives in all funding decision discussions.

#### *Geographic Barriers to Practice*

Midwives in rural and isolated communities face challenges around transport, including to the client's home, community or to higher levels of service if needed, due to geography and weather. Although these variables cannot be ameliorated, strategies can contribute to working within the realities of rural practice, engaging in the seasonal selection of home birth clients based on the ease of accessing care, and resolving the barriers for good and clear communication that have existed with BC Bedline (the province's bed management system responsible for facilitating patient transfers) around midwives' roles and responsibilities, a review of transport models, and funding for travel.

#### **Recommendations**

The Invitational Rural Midwifery Symposium reflects a leap forward in achieving sustainability for rural midwives. It was, however, only the first part of what needs to be an on-going series of discussions between rural midwives, their professional

association and college, policy makers, and the research community. To this end, the group recommends the following:

1. Ongoing dialogue and discussion with all key stakeholders in order for relevant bodies to address solutions to care, including the participation of rural midwives in strategic planning of the delivery of services.
2. On-going discussions between rural midwives, health authorities, provincial ministries and the midwifery stakeholders in the MABC to further develop and support mechanisms for communication and to articulate the nature of the relationship between these bodies.
3. The acknowledgment of the unique needs of rural midwives and the conditions of their practice, and the concomitant professional support of midwives by their professional associations and the MOHS to help rural midwives meet these needs.
4. The implementation of a start-up fund for midwives interested in rural practice to mitigate the onerous start-up costs of beginning practice in a new community and to acknowledge that midwives need fair remuneration for starting up a practice. This fund would be provided to all midwives who commit to setting up rural practice and will improve the feasibility of midwifery in communities that have never had such care. This fund would be appropriate for midwives starting new practice, as well as current practitioners in both rural and urban environments.
5. Homebirth back-up and supplies funded by MOH rather than from midwives' income, which is particularly problematic in rural areas with a higher percentage of home births.
6. Support from Health Authorities, Medical Advisory Committees and hospitals for the privileging of midwives seeking to open practices in underserviced rural areas.

Currently in British Columbia, there are no registered Aboriginal midwives. Aboriginal representatives with an interest in midwifery were invited to the symposium but regretfully could not attend due to schedule conflicts. Future meetings of rural midwives must have Aboriginal representatives present in order to learn of the barriers unique to Aboriginal rural families and the midwives who serve them. Existing research indicates that Aboriginal rural women are at greater risk than their urban counterparts of experiencing poor childbirth outcomes and heightened financial and social stress due to birthing away from their family, community, and culture. Historically, Aboriginal women in British Columbia have given birth close to home with the support of experienced women in their communities or with midwives. With the introduction of regulated midwifery, greater efforts must be made on the part of the Ministry of Health and associated decision makers to facilitate training of Aboriginal midwives, with particular attention to the cultural needs of Aboriginal student midwives, the importance of training close to home in rural communities, and the unique issues that Aboriginal birthing women face.

### Conclusion

Since the regulation of midwifery in British Columbia on January 1, 1998, midwives have made steady progress in meeting the maternity care needs of more and more parturient women across the province. Although perhaps most noticeable in urban centres, inroads to practice have also been made in small urban and rural and remote communities. This is despite the considerable barriers rural midwives face, barriers distinct from those encountered by their urban colleagues and rooted in the unique geography, isolation, and low-resource settings characteristic of rural British Columbia.

After ten years of regulated midwifery and the concomitant gains achieved, the current model of care can now be refined to better meet the needs of rural midwives and the communities they serve. To truly honor the contributions of rural midwives and meet the needs of parturient women, we need to now focus our energy and attention on how to



sustain practice within a context of low volume, potential lack of immediate access to surgical care and, for many, professional isolation.

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