

Rural Midwifery—Towards a Sustainable Model of Care

Centre for Rural Health Research

The Problem

Across Canada, the sustainability of rural maternity care is being threatened. Small maternity services are closing as a result of health human resource challenges, lack of access to specialist (surgical) services, and the trend towards centralization of health services.¹ As a result, many women who wish to birth in their home communities are unable to² and rural maternity care providers face increasing practice related stress.³

One solution to these challenges is to improve access to care for birthing women from within a rational planning process. This approach focuses on developing sustainable systems in isolated, remote, low-volume, and low-resource environments. This can involve the introduction of midwives into rural communities. Beyond providing a solution to current health service delivery challenges, midwifery also offers birthing women greater choice in place of birth and care provider.⁴ Currently in British Columbia, 53 midwives practice in 23 rural communities, representing 29% of midwives in the province.⁵

While engaging in efforts to expand midwifery to more communities, policy makers must consider the challenges involved in introducing the profession to environments that have not previously encountered midwifery. Midwives face significant personal and professional challenges to rural practice. Consideration of barriers to rural midwifery practice will assist health planners in making sustainable choices for maternity service delivery involv-

ing midwives. To that end, the Centre for Rural Health Research invited rural midwives, midwifery students, policy makers, and professional organization leaders to a series of research symposia to identify the barriers and solutions to integrating midwifery into rural environments. The barriers and solutions identified are outlined in this policy brief. Further reading, including the symposia proceedings and an editorial on sustainable rural midwifery, can be found at:

www.crrh.ca/knowledgetranslation.

Barriers and Solutions

The barriers to rural midwifery practice can be broken down into seven themes:

1. *Remuneration* barriers,
2. *Professional and social* barriers,
3. *Health service delivery* challenges,
4. *Education* challenges,
5. *Integration* issues,
6. *Geographic* barriers to practice, and
7. Providing culturally responsive care to *Aboriginal communities*.

Each barrier is reviewed below, with discussion of potential solutions.

1) Remuneration Barriers

Inadequate funding for practice in rural environments is the most significant barrier to sustainable rural midwifery. Specific challenges include:

SUMMARY

Maternity services across Canada are currently facing a shortage of practitioners. One solution to this crisis is the introduction of midwifery to rural communities. This approach should be taken within a rational planning process with attention to the barriers to sustainable rural midwifery. The most significant barriers include inadequate funding models for rural practice, limited rural-specific midwifery training opportunities, and resistance to midwifery from existing rural obstetrical care providers. Solutions are diverse and include new remuneration models to support interprofessional practice and the establishment of Regional Departments of Midwifery. Consideration of these issues will help planners make sustainable choices for maternity service delivery involving midwives.

- **Interprofessional care:** There are no funding models to support interprofessional care provided by midwives and physicians, creating a disincentive for rural midwives and physicians to work together in shared practice.
- **Professional benefits:** Midwives do not have professional benefits typical of health practitioners, including maternity leave and retirement benefits.
- **Travel costs:** Rural midwives have large patient catchments and must pay out-of-pocket for travel expenses related to driving long distances for home visits and home births.
- **Specialist transfer:** In the “course of care” funding model, when midwives transfer a patient to another practitioner for care, they cannot bill for the course of care provided to that point (e.g. an intrapartum transfer to an obstetrician after a patient’s trial of labour).
- **Home birth:** Midwives currently pay out-of-pocket for home birth supplies.
- **Start-up costs:**

Some financial solutions have been recently adopted. **Start-up funding** for midwives moving to new communities and establishing new practices will offset the significant expenses of setting up a clinic and building a patient caseload. As well, **home birth second attendant funding** has been recently added to the BC Midwives’ contract. Other potential solutions include increased funding from the Ministry of Health, including the following:

- **Vehicle gas and mileage** funding based on rural midwives’ catchment geography.
- Payment for midwives for **home birth expenses**.
- **Alternative funding arrangements** to support expanded scopes of practice in low volume environments (e.g. Ministry of Health establishes fee for service or salary structures or service contracts).

2) Professional and Social Barriers

- **Locum coverage:** There is a dearth of locums to alleviate call and the impending retirement of many experienced rural midwives.
- **Professional isolation:** Midwives have limited

organized peer support to combat professional isolation in rural practice.

Funding to cover **locum expenses** was recently included in the BC Midwives’ contract. Other potential solutions include:

- Establishing a provincial position for a **locum midwife**.
- Establishing funding from the MABC for rural midwives to travel to **face-to-face meetings** either for continuing professional development (CPD) or regular meetings with colleagues (e.g. MABC meetings), in addition to funding for teleconference communication.
- Establishing **Regional Departments of Midwifery** to facilitate participation in collaborative CPD, chart reviews, and morbidity and mortality rounds.

3) Health Service Delivery Issues

These issues involve access to care, home birth, and geographic isolation:

- **Unassisted home births**, which are a part of some communities’ local birth culture prior to the regulation of midwifery, can result in negative outcomes for birthing women and ideological challenges for the patient-midwife relationship.
- **Planned home birth:** Concerns can include timely transport from home birth to hospital where necessary, distance to care facility, and lack of support for home birth from other care providers.
- **Limited surgical coverage:** Many communities have intermittent caesarean section and anesthesia coverage due to small hospital size or a shortage of care providers. Access to specialist back-up can be challenging in these low-resource settings.

Potential solutions include:

- Provide community members and practitioners **public education** on the midwifery scope of practice to mitigate concerns about the safety of home birth and to reduce unassisted home births.
- For women who refuse intrapartum care, pro-

vide **prenatal and postpartum support** as a harm reduction strategy.

- Address concerns about home birth in rural communities through **communication** with emergency transport personnel and **informed decision making** with families involving mutually agreed upon criteria for home delivery

4) Education Barriers

These challenges include difficulties in accessing midwifery training and Continuing Professional Development (CPD):

- **Midwifery education:** Many rural residents are deterred from pursuing midwifery, as the only provincial training program is at UBC in Vancouver and leaving one's community can be challenging.
- **Nursing skills:** There is no advanced entry to UBC's Midwifery Education Program (MEP) for applicants with nursing degrees.
- **Rural scope of practice:** There is a lack of rural-specific education for midwives wishing to practice in isolated and low-resource environments.
- **Continuing Professional Development (CPD):** Practicing rural midwives lack time and funding to leave the community to access CPD.

UBC's MEP recently increased by 50% the number of seats available to students (from 10-15 seats) in the hopes of training more graduates to meet the needs of birthing women in the province. Other potential education solutions include:

- Offering courses through **rural colleges** for transfer to the MEP (e.g. based on the University of Victoria web-based nursing program and the Northern Medical Program).
- Offering advanced entry (3rd year) to MEP applicants with nursing degrees, a strategy that is being tentatively explored by the MEP.
- Increasing the number of **rural-specific skills** taught through the MEP and increasing opportunities for student placements in rural settings during their degree.
- Continuing to encourage midwifery students to participate in the **Interprofessional Rural Program of BC**, which provides on-the-ground, interprofessional experience in rural communities.

- Creating **incentives for new graduates** to enter rural practice including formal mentorship programs for midwives entering new communities, a student loan forgiveness program, as well as training, compensation, and travel expenses for rural midwifery preceptors.
- Providing **funding for CPD** through the Ministry of Health and regional health authorities to support evidence-based rural practice (e.g. based on existing education programs and practice bonuses offered to rural physicians).

5) Integration Barriers

These issues include midwives' difficulties in acquiring hospital privileges and challenges in defining roles and responsibilities in an interprofessional environment.

- **Hospital privileges:** Where physicians are resistant to midwifery and are responsible for Medical Advisory Committees, they can prevent rural midwives from gaining hospital privileges.
- **Roles and responsibilities:** Midwives and other care providers can have difficulty defining roles and responsibilities where scopes of practice overlap (e.g. for obstetrical nurses and midwives in the labour and delivery suite).

Potential solutions include:

- Before requesting privileges, rural midwives can **engage in discussions** with local and regional key stakeholders, and learn their hospital's rules and regulations of privileging.
- Establish **Regional Departments of Midwifery** to be responsible for the privileging process.
- Have existing midwives in the area act as **midwifery integration facilitators** within the context of a Regional Department of Midwifery.
- Support the clarification of roles and responsibilities by using **information and education documents**, such as the Multidisciplinary Collaborative Primary Maternity Care Project (MCP²), the BC College of Midwives Hospital Implementation manual, interprofessional training programs such as MoreOB,⁶ and a provincial tour facilitated by key stakeholders and the Ministry of Health to provide public and hospital education on midwifery.

The *Issues in Rural Maternity Care* policy brief series addresses current issues in the provision of maternity care in British Columbia and provides timely recommendations for improving the quality and safety of rural intrapartum care. Targeted at policy makers and maternity care providers, it is produced by the Centre for Rural Health Research.

ABOUT MIDWIFERY

Midwives' scope of practice⁸ includes:

- Assessing, monitoring, and caring for women during normal pregnancy, labour, birth, and postpartum periods;
- Providing counsel, support, and advice to women during pregnancy, labour, birth, and postpartum periods;
- Managing normal vaginal deliveries;
- Providing care for, assessment, and monitoring of the healthy newborn; and
- Providing advice and information on infant care, contraception, and family planning.

Midwives are also authorized to provide a variety of diagnostic and screening tests, as well as prescribe a variety of medications. If a woman needs additional care, a midwife will seek collaboration with other health care professionals through discussion, consultation, or transfer of care. In the event of transfer of care, the midwife provides supportive care to the woman and resumes primary care when appropriate.

6) Geographic Barriers

Rural midwives face barriers related to the geography of the province:

- **Transport:** Midwives in rural and isolated communities face challenges to patient transport and travel due to geography and weather. Issues include travel to patients' homes and transport of patients to community hospitals or higher levels of service if needed.
- **Home birth:** Travel challenges related to seasonal and inclement weather can make it difficult for midwives to support choice of home birth for some women.
- **BC Bedline:** The province's bed management system for facilitating patient transfers lacks understanding of midwifery and the challenges of rural practice, leading to communication difficulties when a patient must transfer to a higher level of care.

Although geography is a variable that cannot be adjusted, potential solutions include resolving existing barriers to **clear communication between midwives and BC Bedline.**

7) Culturally Responsive Care for Aboriginal Communities

Currently in the province there is a shortage of registered Aboriginal midwives to meet the needs of Aboriginal birthing women. 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 and community.⁷ Historically, Aboriginal women in BC have given birth close to home with the help of experienced women in the community. Potential solutions include:

- Facilitating **training of Aboriginal midwives.**
- Giving attention to the **cultural needs** of Aboriginal students including training closer to home.

→ Providing midwifery training with attention to the unique issues that Aboriginal birthing women face within a **culturally responsive framework.**

Conclusions

Since the regulation of midwifery in British Columbia in 1998, the profession has grown most visibly in urban communities. Rural midwives have made inroads in spite of the numerous practice challenges they face, challenges that are unique to rural environments and are not shared in an urban setting. Given the multifaceted barriers to sustainability for rural midwives, all key stakeholders must be involved in creating solutions. Rural midwives, their professional associations and colleges, policy makers, and the research community should engage in an ongoing dialogue to enact solutions to the above barriers. To honour the needs of birthing women across the province and the contributions of rural midwives, we need to now focus our attention on how to sustain midwifery in the context of rural practice.

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