Proceedings from the 2nd Invitational Rural Midwifery Symposium

Sheraton Wall Centre Hotel, Vancouver, BC
October 23-24, 2008

Hosted by the Centre for Rural Health Research

Centre For Rural Health Research

CIHR IRSC
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Contents

Centre for Rural Health Research staff on Day 2 of the symposium (left to right): Sarah Munro, Bryce Westlake, and Melanie McDonald

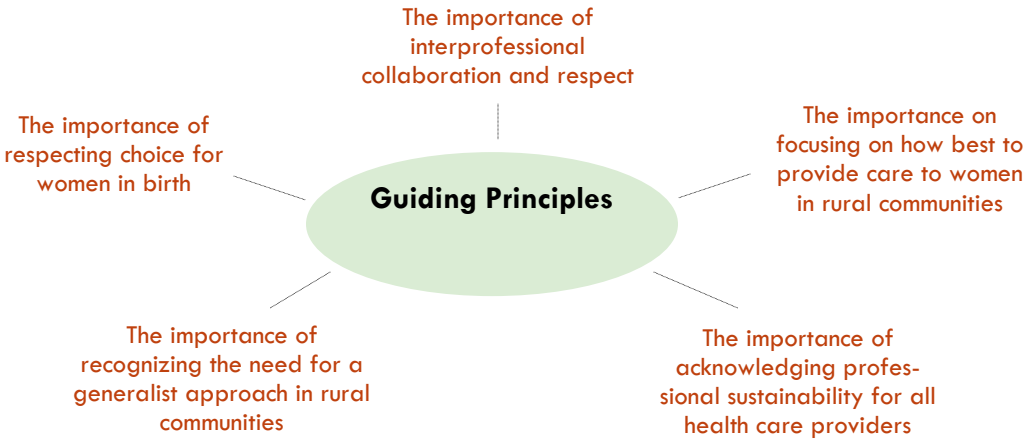
Executive Summary

The objective of the *2nd Invitational Rural Midwifery Symposium* was to bring together rural midwives and decision makers to articulate the barriers to sustainable rural midwifery and to brainstorm innovative solutions for positive change. A complete list of the barriers, solutions, and target decision makers articulated at the symposium can be found in Appendix 1 (page 29) of these proceedings.

The **decision makers** at the meeting consisted of representatives from the following organizations (*see Appendix 2 for full list*):

- Interior Health Authority
- Vancouver Island Health Authority
- Society of Obstetricians and Gynecologists of Canada
- BC Medical Association Joint Standing Committee on Rural Issues
- BC Ministry of Health
- Midwifery Education Program at UBC
- First Nations and Inuit Health
- BC Perinatal Health Program
- College of Midwives of BC
- Midwives' Association of BC

The **guiding principles** that underpinned this meeting, as agreed upon by all participants at the outset of Day 2, are as follows:



Day 1, which included 13 midwives from rural communities across BC and members from the Centre for Rural Health Research Team, began with reflections on the outcomes of the first

invitational meeting. The agenda then moved on to an open-ended discussion among midwives on rural practice issues, followed by the prioritization of barriers and issues that midwives brought forward on Day Two. The **barriers** articulated included the following thematic categories:

- Interprofessional collaboration
- Education
- Sustaining local birthing services
- International recruitment
- Expanded scope of practice

Research presentations from two rural midwives, Ilene Bell, RM (Nelson), and Maggie Ramsey, RM (Salt Spring Island), reviewed preliminary findings from their studies of care providers' experiences of the integration of registered midwifery in a rural community and maternal and newborn outcomes in a midwifery-led rural practice, respectively.

Day 2, which included key decision-makers and professional stakeholders along with rural midwives, began with an overview of **models of midwifery care** in rural British Columbia, focusing on the following communities:

Salt Spring Island	Midwifery-led maternity care with no local physician back-up
Nelson	Midwifery practice with local obstetrician back-up
Campbell River	Midwifery practice with local obstetrician back-up
Sechelt	Midwifery practice with local GP Surgeon back-up
Creston	Shared physician/midwifery practice with local GP Surgeon back-up

The midwives from each community described their model of practice, summarized the barriers they encounter, and took questions and comments from decision makers. These presentations provided the context for a discussion of rural practice as they delineated the range of current models and the associated – and unique – challenges inherent in each one. This provided the context for the next session, individual presentations of **decision makers' barriers** to the support and integration of sustainable rural midwifery. The following list summarizes the barriers that representative decision makers identified:

College of Midwives of BC

- Shortage of registered midwives in British Columbia
- Need for an expanded drug prescription schedule

Health Authorities

- Lack of systematic planning for rural maternity care and urban-centric nature of priorities
- Lack of framework for interprofessional models of care
- Lack of opportunities for rural care providers for continuing education
- Lack of guidance for midwives regarding Health Authority norms and protocols, particularly regarding hospital privileges

First Nations and Inuit Health

- Lack of First Nations midwives
- Lack of framework for educating providers regarding culturally sensitive care for First Nations communities
- Lack of knowledge about Midwifery care in First Nations communities

- Lack of system resources to mitigate the social, financial, and cultural stressors faced by First Nations women when they leave their communities to give birth

UBC Midwifery Education Program

- Lack of rural-specific skills training
- Need for early onset (e.g., 1st year) of rural mentorship and clinical experience in a rural setting
- Lack of distance education options for rural midwifery students
- Need for training for an expanded scope of practice to off-set logistical challenges of low volume practice in rural communities

Midwives' Association of BC (MABC)

- Midwives remuneration structure is unsustainable in the context of rural practice
- Delays in granting hospital privileges to midwives affects rural recruitment
- Lack of advertising for rural midwifery practice spaces to facilitate international recruitment

Physician Representatives

- Lack of education of other care providers on midwifery profession and safety of home birth
- Decline number of family physicians interested in rural practice
- Inequitable funding for maternity care between the professions

Society of Obstetricians and Gynaecologists of Canada (SOGC)

- Diminishing number of rural obstetricians to back-up midwives in rural communities
- Lack of attention to providing appropriate care for Aboriginal communities
- Lack of wide-spread implementation for programs like MoreOB to support and facilitate interprofessional collaboration

Small group workshops in the afternoon of Day 2 provided the opportunity for participants to brainstorm solutions to barriers in the thematic categories of Education, Aboriginal Midwifery, Interprofessional Collaboration, and Decision Making. Below is a summary of the solutions that were addressed:

Education

- Increase funding support for midwifery education program to allow expansion of activities to include a rural focus including: Providing a rural stream, rural specific courses, and distance education program for midwifery students
- Fund preceptor pay
- Create temporary faculty positions for rural midwives for practicum supervision to continue over university holiday breaks
- Establish a third year direct entry stream for rural nurses wishing to pursue midwifery education.
- Improve access to continuing education through funding, online components, and education retreats/intensives

Aboriginal Midwifery

- Establish an Aboriginal midwifery pilot project in a rural reserve community in BC
- Educate Aboriginal communities on midwifery model and traditional birthing practices
- Provide an expanded scope for midwives in low-volume communities
- Advertise midwifery as a career for Aboriginal women
- Create access to Aboriginal-specific education electives and practicum placements for Aboriginal midwifery students

Interprofessional Collaboration

- Amend funding model to support collaborative practice (e.g., fee for service per-visit billing to allow for shared care)
- Provide care providers with evidence-based education and workshops on: the midwifery model of care, home birth and the safety of midwifery without cesarean section back-up
- Support and encourage collaborative team practice, beginning at the student level

Policy and Decision Making

- Revive the BCPHP's Rural Sub-Committee to act as a multidisciplinary provincial advisory group for rural midwifery decision making and objectively reviewing midwives' requests for hospital privileges
- Ensure midwifery representation in Health Authority Medical Advisory Committees (HAMAC) through designated seats
- Establish regional Departments of Midwifery throughout the province
- Ensure rural midwives decide who will speak on behalf of rural midwifery at the decision making table
- Ensure that midwives are provided with copies of the provincial hiring by-laws, hospital act, and local by-laws.
- Provide a start-up stipend for rural midwives based on assessment of community need

The expansive list of barriers, solutions, and target decision makers was agreed upon at the close of the meeting and represent the first steps in moving forward in the effort to make rural midwifery practice more sustainable.

Rural midwives Maggie Ramsey and Leah Barlow connect during a break on Day One of the symposium.

Agenda

October 23

Room: Port Alberni, Sheraton Wall Centre

2:00-2:15	Introduction, welcome, and updates since last symposium
2:15-3:15	Open sharing and discussion
3:15-3:30	Coffee break
3:30-4:30	Prioritization of barriers and discussion for Friday (Identify small group participants)
4:30-5:00	Discussion of mechanisms to best meet the needs of rural women from a professional practice perspective
7:00-9:00	Dessert Reception (Room: Azure, South Tower, Sheraton Wall Centre)

October 24

Room: Port McNeil, Sheraton Wall Centre

8:00-8:30	Breakfast Served
8:30-9:00	Welcome/ Introductions/Context *Jude Kornelsen and Stefan Grzybowski, CRHR*
9:00-9:30	Presentation of existing models of rural midwifery in BC *Salt Spring Island, Nelson, Creston, Sechelt, Campbell River*
9:30-10:00	Presentation of Barriers to Rural Midwifery Practice *Jude Kornelsen, CRHR and Ilene Bell, Nelson, RM*
10:00-10:30	Discussion
10:30-10:45	Break

cont'd →

11:00-12:30 Presentations of challenges to rural midwifery from key stakeholder perspectives

- College of Midwives of BC — *Jane Kilthei*
- Health Authority — *Dr. Peggy Yakimoff (Interior) & Jeannie Wheeler (Vancouver Island)*
- Ministry of Health — *Beverlee Sealey*
- First Nations and Inuit Health — *Elizabeth Harrold & Penny Stewart*
- Education, UBC School of Midwifery — *Saraswathi Vedam, RM*
- Midwives' Association of BC — *Shannon Norberg, RM & June Friesen, RM*
- BC Perinatal Health Program, Vancouver Coastal Health Authority — *Dr. Brenda Wagner*
- BC Medical Association Joint Standing Committee on Rural Issues — *Dr. Granger Avery*
- Society of Obstetricians and Gynecologists of Canada — *Dr. Andre Lalonde*

12:30-1:30 Networking lunch

1:30-2:30 Theme-based small group sessions

- Education
- Aboriginal midwifery
- Interprofessional collaboration
- Decision making (Ministry of Health and Health Authorities)

2:30-3:45 Small group reporting strategy

3:45-4:00 Break

4:00-4:45 Group discussion: Prioritization of barriers and solutions

4:45-5:00 Closing and Next Steps

Preface

The *Second Invitational Symposium on Rural Midwifery* was planned as part of a sequence of engagements with practitioners and decision-makers to identify and document barriers to rural midwifery practice and engage in strategic discussion about the best ways to address these barriers. The context of the meeting was the increasing urgency of the need to find interdisciplinary, sustainable solutions for providing care to rural parturient women in BC and an acknowledgement of the role midwives can play in solutions.

The initial meeting with rural midwives in June of 2008 focused on documenting challenges to practice as a precursor to further discussion. Participants recognized the need for follow-up through dialogue with the larger community of affected care providers, policy and decision makers, and community members and saw the June meeting as laying the groundwork. This approach reflected a systems view of the problem: that is, an acceptance of the inter-related roles and relationships of all key players and the importance of understanding and acknowledging all perspectives and challenges in effecting an integrated solution. Beyond simply accepting the reality of the need for inter-disciplinary solutions, however, the notion of the strength of such an approach clearly emerged.

"Key players" effecting solutions were seen to include other rural care providers, Health Authority and Ministry decision makers, and professional leaders from a variety of disciplines. This approach demands the good will of everyone involved, the ability to step outside traditional professional or political silos, and the mutual commitment to work towards solutions that will best serve rural women and their families within the context of safety and sustainability. Without a doubt, an audacious pursuit.

Audacity, however, sometimes yields results that we would not otherwise see; in this case results included the productive and dynamic dialogue of interested parties who had not previously had the opportunity to gather around a table together. Whether the discussion was formal, as in the case of invited presentation, or informal, through the sharing of spontaneous insights at lunch time or between sessions, interactions were characterized by a sense of facing a common challenge and the desire to take it up.

Discussions were also marked by a sense of realism, however, which gave rise to an understanding of the barriers to integrating midwives into rural communities. According to symposium participants, these barriers include interprofessional challenges stemming from models of care and remuneration that are not easily merged; they include pragmatic barriers around inadequate funding and resources for the profession, and the educational program, and they stemmed from the lack of precedent and protocol for integrating the profession into new environments without destabilizing existing services. These thematic areas are large and daunting. Breaking them down systematically into discrete issues, however, and targeting who can initiate change gives us a blueprint for moving forward.

The following proceedings endeavor to capture the key barriers – if not nuanced discussion – covered at the symposium. As such they are a tentative first step in providing a map for moving towards solutions for those who attended and, we hope, those who were unable to attend but can provide guidance on how best to achieve the goals of sustainable rural midwifery care within the context of sustainable maternity services. Our heartfelt appreciation goes out to all who attended the meeting. We look forward to engaging in the sustained relationships that will be necessary to effect change.

Respectfully,

Jude Kornelsen & Stefan Grzybowski on behalf of the Centre for Rural Health Research Team

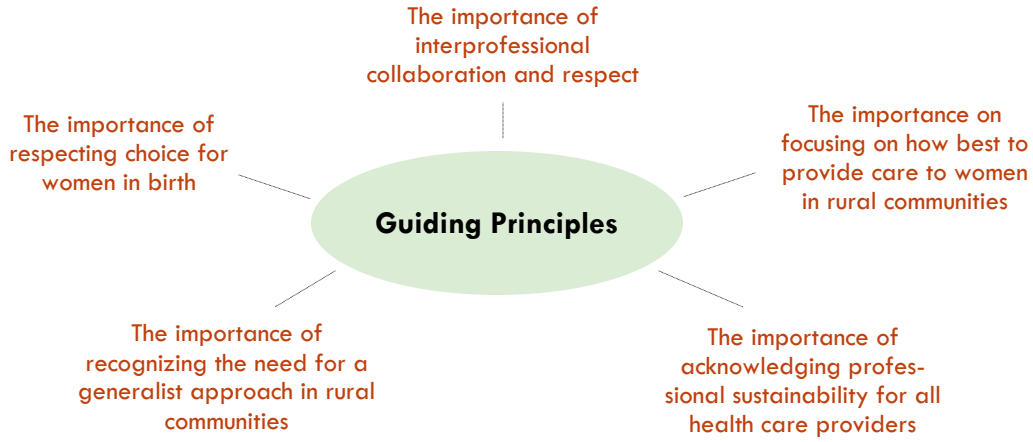
Introduction

In June 2008, ten years after the regulation of midwifery in British Columbia, the Centre for Rural Health Research and Midwives' Association of BC Rural Sub-Committee co-hosted the *1st Invitational Rural Midwifery Symposium*. The event was an opportunity to bring together rural midwives to honour their commitment to rural birthing services and to discuss barriers of rural practice and solutions to those challenges. Concurrent with this meeting, the centre was also conducting a research study investigating the regulatory and legislative barriers to interprofessional collaboration between midwives and other rural maternity care providers in BC. Many communities across the province are interested in local midwifery services, but significant barriers to integration exist. The symposium presented an opportunity for rural midwives to articulate these barriers from practice and professional perspectives. The discussion focused on articulating rural midwives' barriers to sustainable practice. This discussion was captured through proceedings, which were circulated to midwives and decision makers. A second product of the symposium was a collaboratively authored commentary on barriers to practice.

As the objective of the first meeting was to bring together midwives to articulate barriers, participants recognized the necessity of a follow up meeting to share the findings with decision makers who can implement change. The *2nd Invitational Rural Midwifery Symposium* brought the rural midwives together with representatives from Interior Health Authority, the Vancouver Island Health Authority, the Society of Obstetricians and Gynecologists of Canada, the BC Medical Association Joint Standing Committee on Rural Issues, the BC Ministry of Health, the Midwifery Education Program at UBC, First Nations and Inuit Health, BC Perinatal Health Program, College of Midwives of BC, and the Midwives' Association of BC. These stakeholders participated in an evening reception followed by a day of presentations and facilitated discussion to identify decision makers' barriers to rural midwifery and solutions for mitigating challenges.

Day One consisted of open-ended discussion among midwives and began with a reflection on the outcomes of the first invitational meeting, followed by a discussion of the barriers and issues that midwives wished to discuss with policy makers on Day Two. The midwives outlined their strategic approach for the following day's discussion with policy makers, which focused on the need for multi-stakeholder dialogue; evidence-based decision making; and goals grounded in the needs of rural women.

Participants articulated the values (see diagram below) that they believed should inform the discussions at the symposium.



These guiding principles were ratified by all the participants at the beginning of day two and provided the context for the ensuing discussion.

Many key stakeholders were unaware of the barriers to rural midwifery practice. To establish a common knowledge base for dialogue, day two began with a presentation of models of midwifery care in communities across the province, followed by presentations by individual decision makers articulating *their* perceived barriers to interprofessional collaboration. The afternoon consisted of small, interdisciplinary group sessions to identify barriers specific to different key stakeholder topics. These topics included:

- Education,
- Aboriginal midwifery,
- Interprofessional collaboration, and
- Decision making.

From these discussions, Centre for Rural Health Research staff compiled and thematically organized a list of the barriers, solutions, and target decision makers, which was presented to participants in the final session of the symposium.

The following proceedings outline the discussions that took place during the two-day symposium and present the barriers outlined by participants. The road to sustainable rural midwifery requires the collaboration of rural women, midwives, and the extended community of care providers and

DAY ONE

Day One provided an opportunity for the rural midwives to gather together and reflect on the outcomes of the *1st Invitational Rural Midwifery Symposium,* as well as discuss the key points for discussion with decision makers. The barriers and solutions discussed were originally listed in the *Proceedings of the 1st Invitational Rural Midwifery Symposium* (Available online at: http://www.ruralmatresearch.net/documents/RM-NETMidwiferySymposiumProceedings.pdf).

Midwives' Barriers

The following sections represent the thematic solutions midwives discussed: interprofessional collaboration, education, sustaining local birthing services, international recruitment, and expanded scope of practice. Each is described below.

Theme	Solution
Interprofessional Collaboration	Facilitate **respect** for the profession of midwifery from other care provider groups.
	Increase **education** to care providers on the profession of midwifery.
	Create **trusting relationships** with other care providers.
	Improve and facilitate midwives' efforts at gaining rural **hospital privileges.**
	Create **regional departments of midwifery**.

cont'd →

Participants in the day one afternoon session (left to right): Jacqueline Humchett (UBC Midwifery student); Shannon Norberg, RM (MABC); Sarah Hilbert-West (UBC Midwifery student); Leah Barlow, RM (Creston); Carolyn Thibeault, RM (Cranbrook).

Evening reception (left to right): Sheila Jager, RM (Campbell River); Maggie Ramsey, RM (Salt Spring Island); and Sarah Hilbert-West (UBC Midwifery student, from Quesnel).

Theme	Solution
Midwifery Education	Establish and maintain students' **existing relationships** with rural communities and rural care providers.
	Create **distance education** options for rural students.
	Provide **rural-specific skills** training to students.
	Begin **clinical experience** earlier in program and lengthen practicum placements.
	Secure funding for **preceptors**.
	Utilize **temporary faculty** to mitigate full-time instructors' workloads.
	Provide advanced standing for **nurses** (Year 3).
	Improve access to **continuing education**.
	Increase number of **interdisciplinary** maternity care courses.
	Train more **Aboriginal** midwives.

Theme	Solution
Sustaining local birthing services	Develop evidence and examples of successful communities with local birthing services with **no local cesarean section back-up**.
	Establish **maternity care pathways** for women who have to travel for birthing services.
	Support community **needs**.
International recruitment	Support **evidence**-based community-responsive maternity service planning.
	Streamline **immigration** and **accreditation** process for international maternity care providers
	Increase **incentives** for rural practice
	Create a structured BC training program for **GP Surgeons**.
Expanded scope of practice	Provide remuneration for services such as sex education and abortion counseling

Rural midwives (left to right): Terri Murray, RM, and Maggie Ramsey, RM, (Salt Spring Island); Deborah Kozlick, RM (Courtenay/Comox); and Sheila Jager, RM (Campbell River).

midwives' voices

It's about the bigger picture. Women in rural communities deserve health care. Midwives are ideal to deliver that care. It doesn't matter if Bella Coola only has 30 births per year, that community deserves care and needs certain people to provide it. It's about improving maternal health, education, and outreach. After the last symposium, I felt that our work is not about what we do, it's about our communities' health.

Years ago I came to the community in the shadow of a fabulous established midwife who was an icon in the community, and the turning point of my acceptance came about 9 months after arriving. There was a woman who refused to go to the referral community at 42 + weeks: I was baptized by fire and the nursing staff saw that I could perform in an emergency.

When I first met one of the physicians near my community, she looked at me and demanded, "Are you doing homebirths?" And I said, "Yes, if the client wishes." And she went "Hmphf." And my first thought was, "Who are you and why are you reacting this way." And we began to talk and I could hear the fear in her voice. We were able to form a good relationship and work well together. I had to get off my high horse and start at square one with her in order to develop a good relationship and get acceptance.

Midwifery research presentations

On day one of the symposium, community-based researchers Ilene Bell (RM, Nelson) and Maggie Ramsey (RM, Salt Spring Island) presented preliminary findings from their studies on rural midwifery practice. Both researcher are supported through initiatives of the Centre for Rural Health Research, including Community-Based Clinician Investigator and Seed Grant programs. The Community-Based Clinician Investigator (CBCI) program provides research fellowships in the form of buy-out time for rural practitioners interested in developing a program of research. The Seed Grant program provides $5000 in research and infrastructural support for independent, community-focused research projects addressing issues in rural maternity care. Through the CBCI program, Ilene Bell has conducted a qualitative investigation into Nelson's experience with integration of regulated midwifery and subsequent interprofessional collaboration; through the Seed Grant program, Maggie Ramsey's involves a chart review of outcomes of midwifery clients on Salt Spring Island from 1998-2008.

"The Integration of Registered Midwifery into a Rural Maternity Care Delivery System"

Ilene Bell, RM

At the first invitational symposium, Ilene Bell, RM, gave a presentation on the preliminary results of her qualitative study of interprofessional collaboration in Nelson, British Columbia. Her research update at this meeting outlined her publication plans and directions for moving forward.

Outcomes from this research project include findings of local care providers' early responses to the integration of midwifery, how those attitudes changed, and their perceptions of different professions' approaches to childbirth and maternity. One significant finding was on the complex relationship between nurses and midwives. Nurse participants expressed feelings of exclusion, fear of losing their role, and, conversely, a desire to give midwives more responsibilities in order to mitigate nurses' increasing workload. The methods midwives employed to overcome interprofessional challenges with nurses centred on communication, clarification of roles and responsibilities, and socializing with nurses in neutral environments apart from the maternity ward.

Various outcomes from this project include plans to create a policy brief, publish multiple academic papers, create a video based on the recorded interviews, and to facilitate workshop sessions for other rural communities facing interprofessional collaboration challenges.

"Midwifery-Led Rural Maternity Care in BC: A Case Study of Salt Spring Island, Preliminary Results"

Maggie Ramsey, RM

Summary and Overview

As the only community in the province where local intrapartum care is provided solely by midwives, Salt Spring Island is a unique research setting for the investigation of the safety of midwifery-led maternity practices in British Columbia. The objectives of this case study were to:

- Document maternal and newborn outcomes; and
- Identify maternity care system characteristics, including
  - Organization of primary care practice,
  - Relationship to consultants in referral communities,
  - Intrapartum emergency transport procedures,
  - Local infrastructure (resources at hospital),
  - Risk assessment protocols, and
  - Local interdisciplinary communication with other care providers.

Preliminary results from the chart review portion of the project indicate good maternal/newborn outcomes for the study population. The results of this case study are significant as they provide decision makers with evidence to buttress the integration of midwifery in other rural and remote regions of British Columbia.

Context

Since 1998, registered midwifery has been the primary mode of maternity care on Salt Spring Island, with birth taking place locally at women's homes or at Lady Minto Hospital. Women who must receive intrapartum care at a tertiary centre typically travel to Victoria or Duncan for care. For charting purposes, the Salt Spring midwives indicate "place of birth" as the place where, once

Rural midwives Sheila Jager, RM (Campbell River) and Ilene Bell, RM (Nelson) catch up during a break on Day One.

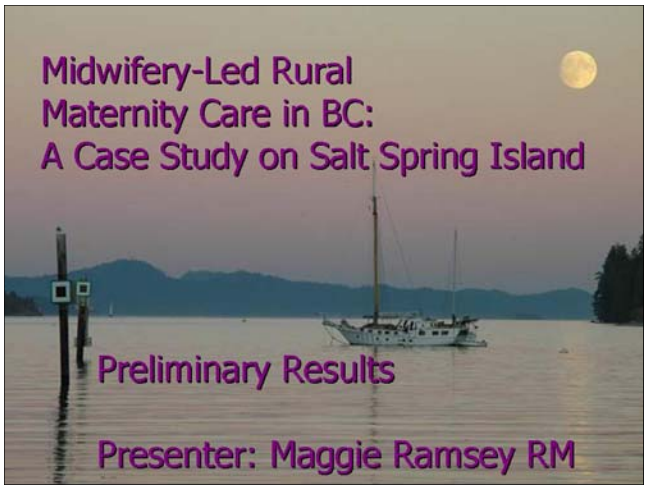
a woman has gone into labour, she plans to have her baby. Thus a woman who hopes for a home birth and goes into labour at 28 weeks, delivering at Victoria General, has a planned hospital birth. Women with planned births off-island (10-15%) may still receive primary care from the Salt Spring midwives until transfer to the care of another practice in the community they intend to deliver. The local hospital, Lady Minto, has become an accepted and often preferred birth location for many women in the community, who are attracted to the comfortable, private room with birthing tub.

Transfer of care to providers off-island is the biggest challenge to the Salt Spring model of practice, due to the associated financial disincentives. For instance, if a woman who plans to birth in Victoria presents on Salt Spring Island in precipitous labour, the local midwives will provide care until transport can be secured. In the current funding model, these services are not remunerated, which presents a challenge to financially sustainable rural midwifery practice.

Method of transport out of the community varies depending on whether or not the transfer is emergent. Helicopter transfer depends on BC Bedline and ranges from 1 hour to 2-3 hours from transfer request to arrival at tertiary destination, weather, and daylight permitting. Private vehicles traveling by BC Ferries take a minimum of 1.5 hours between destinations. The water taxi service, which travels between the Gulf Islands, takes 40 minutes from neighbouring islands to Salt Spring, and another 45 minutes to Swartz Bay.

Total sample	589 births (1998-2008)
Average gestational age	39 weeks, 2 days
Parity	More primiparous births than multiparous (parity not an exclusion factor for birth on-island)
Place of birth	70% of women on-island 30% off-island (10-15% of pregnancies deemed off-island deliveries at start of pregnancy – ex. no VBACs)
Mode of delivery	83% SVD 1.5% assisted delivery 15.4% c-section
Cesarean section	7.3% (n=43) intrapartum; 8.1% (n=48) planned (22 breech, 22 repeat, 6 other)
Nutrition	7/10 (average client self-rating)
Trends	Increase in number of water births; decrease in home births; increase in clients with complex social needs

Detailed findings are outlined in the powerpoint slides on the following page.



Study Objectives

- Document maternal outcomes of women in care, including:
  - Location of birth
  - Rate and mode of transport from planned local deliveries, including indication
  - Spontaneous vaginal delivery
  - C-section rates
  - Breastfeeding rate at 6 weeks

Study Objectives, con't

- Document newborn outcomes, including:
  - Outcomes requiring transport or pediatric follow-up
  - Gestational age
  - Birthweight
  - Apgar scores

Maternity Care System on Salt Spring

- Organization of primary care practice
- Relationship to consultants
- Emergency transport procedures
- Local infrastructure
- Risk assessment protocols

Preliminary Results

- Initial overview of 10-year retrospective chart review from 589 births
- Detailed analysis pending

Births by Parity

	98	99	00	01	02	03	04	05	06	07	Oct 08	TOTAL
No. of RMs	*	*	**	**	**	*	**	**	**	**	**	
Births Primip	19	20	28	22	27	30	25	35	31	31	32	237
Births Multip	10	20	28	40	33	23	25	27	28	29	26	234
TOTAL	**29**	**40**	**56**	**62**	**60**	**53**	**50**	**62**	**59**	**60**	**58**	**589**

Place of Birth on Salt Spring Island (SSI)

	98	99	00	01	02	03	04	05	06	07	Oct 08	TOTAL	% of all 589 Births
Home	12	14	25	22	22	10	14	13	22	20	11	154	32.48
LMH	12	19	20	24	20	25	21	27	19	18	19	187	40.12
TOTAL SSI	**24**	**33**	**45**	**46**	**42**	**35**	**35**	**40**	**41**	**38**	**30**	**341**	72.6

Place of Birth Off-Island

	98	99	00	01	02	03	04	05	06	07	Oct 08	TOTAL	% of all 589 Births
SPH	1	2	6	5	3	0	0	0	0	0	0	17	2.8
VGH	3	5	5	11	13	13	11	20	17	17	24	139	23.6
CDH	1	0	0	0	2	2	4	0	0	5	4	17	2.8
Other	0	0	0	0	0	2	0	2	1	0	0	5	0.84
TOTAL	**5**	**7**	**11**	**16**	**18**	**17**	**15**	**22**	**18**	**22**	**28**	**180**	30.56

Maternal Outcomes

	98	99	00	01	02	03	04	05	06	07	Oct 08	TOTAL	% of all 589 Births
SVD	25	38	50	54	51	44	41	45	47	49	46	489	83
Assisted	1	1	0	1	0	1	0	1	2	0	2	9	1.5
C-section	3	1	6	7	9	8	9	16	11	11	10	91	15.4

- Average gestational age: 39 weeks 2 days (preliminary)

Intrapartum C-sections

- 91 c-sections total (15.4% of all births)
  - **Intrapartum: 43**
    - 7.3% of all births
    - Indications:
      - 38 failure to progress
      - 5 other (abruption, non-reassuring FHR)

Booked C-sections

91 c-sections total (15.4% of all births)

- **Booked: 48 (8.1% of all births)**
  - 52% of all c-sections
  - Indications:
    - 20 breech
    - 6 other (HSV, placental previa, maternal choice, twin)
    - 22 repeat c-sections (including: some with secondary indications, previous classical incision and/or 2nd or 3rd c-section)

Transports

- Definition: Intrapartum/neonatal transport from planned place of birth after the onset of labour

	98	99	00	01	02	03	04	05	06	07	Oct 08	TOTAL	% of all 589 Births	% of all Transports
IP	4	3	4	6	3	7	1	5	3	10	6	52	8.8	84
PP	0	1	0	0	0	0	2	0	1	1	0	5	0.84	8
NEO	0	0	3	0	0	1	0	1	0	0	0	5	0.84	8
TOTAL	**4**	**4**	**7**	**6**	**3**	**8**	**3**	**6**	**4**	**10**	**6**	**62**	10.5	/

Transport Method

Transport Method	Total Number	% of all 589 Births	% of all Transports
Helicopter	28	4.75	45
Private Vehicle	18	3	29
Water Taxi	2	0.3	3.2
Ambulance and/or Ferry	14	2.3	22

Transport Details

- 1998-2008
  - intrapartum urgent: 45% (helicopter)
  - Intrapartum non-urgent: 55% (other)

Emerging Trends

- Stable SVD rate
- Stable intrapartum c-section rate
- Stable LMH delivery rate
- Increase in water births
- Decrease in homebirths
- Decrease in local deliveries
- Increase in booked c-sections (eg. breech, repeat)

Emerging Trends

- Increase in non-eligible for local delivery (eg. VBAC)
- Low preterm delivery rate
- 39 weeks 2 days average gestational age
- High awareness of prenatal nutrition, average person self-rates diet at 7/10
- Near 100% breastfeeding initiation rate
- Near 95% breastfeeding at 6 weeks

Emerging Trends ?

- Increase in planned unattended births?
- Increase diagnosis of labour dystocia?
- Increase in use of labour analgesia?
- Increase in women eligible to birth locally going off-island to access epidural?
- Increase in clientele with complex social risk factors?

What's Next?

- Complete detailed chart review
- Complete analysis of chart data
- Client and stakeholder interviews
- Planned completion date????

DAY TWO

Introduction

Jude Kornelsen, PhD, Centre for Rural Health Research

Dr. Kornelsen began by noting that the symposium was an opportunity to bring together rural midwives, decision makers, and researchers to engage in strategic planning and collaboration to determine the barriers to sustainable rural midwifery and solutions for mitigating these challenges. At the *1st Invitational Rural Midwifery Symposium*, rural midwives identified the barriers they encounter in practice. The intention of this follow-up meeting was to provide decision makers with a forum to name the barriers they recognize to supporting and sustaining the integration of midwives into rural practice.

The Centre for Rural Health Research has engaged in a number of studies related to rural midwifery, and the symposium represented an opportunity for sharing their research findings and identifying research questions for future studies. Dr. Kornelsen reviewed preliminary findings from the "Collaborative Maternity Care in Rural Environments" project undertaken in Trail, Campbell River, Smithers, and Creston.

Turning again to the **guiding principles** established by rural midwives on day one of the meeting, Dr. Kornelsen opened the floor to all participants to comment on and ratify the common values underpinning the meeting (see page 2). All symposium participants agreed to these underlying principles.

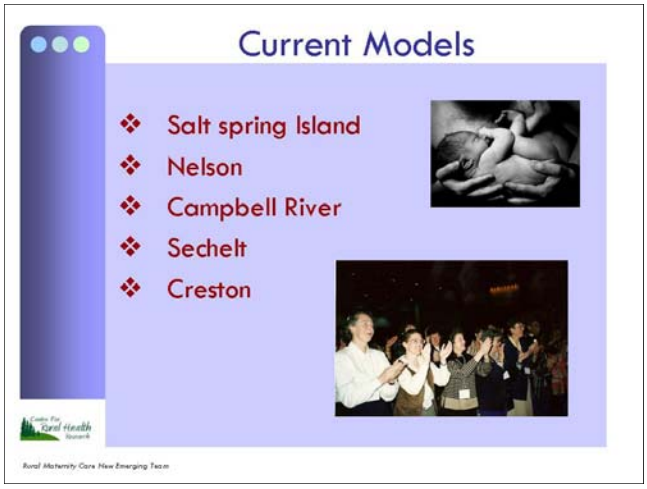
In addition to these guiding principles, **research** on rural midwifery care was central to the day's discussion. Evidence from the Centre for Rural Health Research study of interprofessional collaboration indicates:

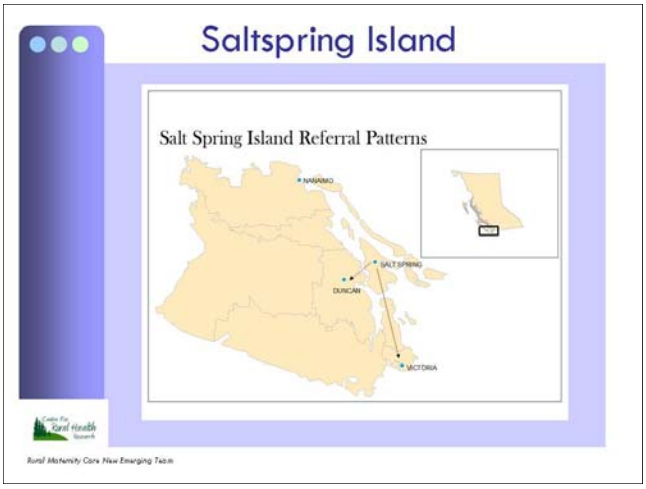
- Many BC communities are interested in rural midwifery as an option for local maternity care;
- Barriers include:
  - Limited care provider and community education on the model of midwifery care,
  - Financial disincentives to midwifery practice, and
  - Recruitment and retention challenges;
- Decision makers are interested in solutions to the declining numbers of physicians practicing maternity care in low-volume communities; and
- Women desire to have choice in care provider, continuity of care, and improved access to midwifery care.

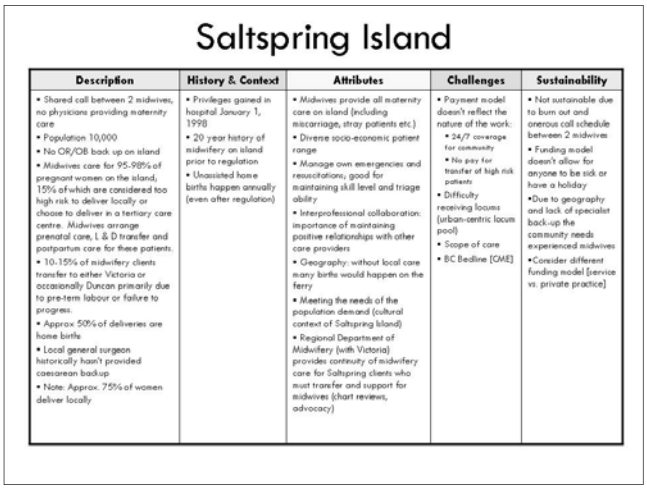
Models of Midwifery Care in Rural BC

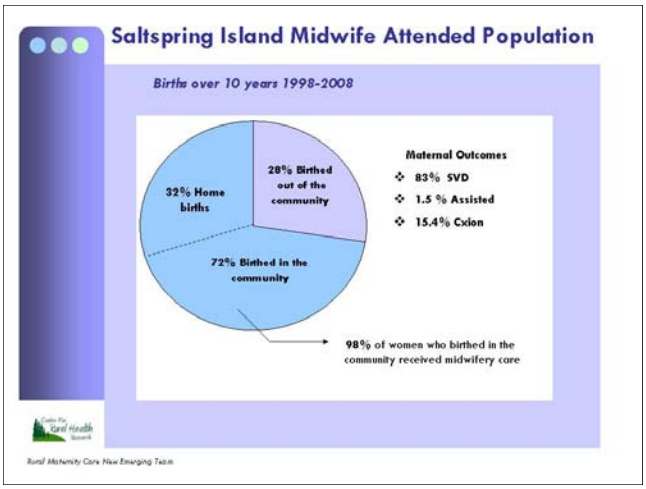
Models of midwifery care in rural British Columbia vary province-wide, depending in large part on the needs and birth volume of local populations, the skills and experience of individual midwives, and their relationships with other care providers in the community. The following representative community descriptions illustrate the characteristics and distinct challenges that each service model encounters.

The following five examples are models of midwifery care in the province, ranging from independent midwifery care with no local physician or surgical back-up to midwifery care in a community with local support from obstetric and pediatric specialists.

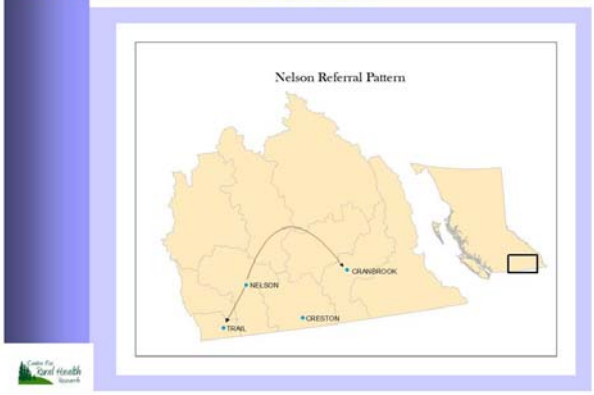








Nelson



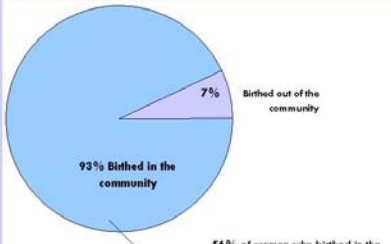
Rural Maternity Care New Emerging Team

Nelson

Description	History & Context	Attributes	Challenges	Sustainability
• 3 midwives in 1 practice with shared call • 1 midwife practicing solo • 4 midwives have privileges in Creston and East Shore who occasionally transfer to Nelson • 2 Obstetricians & 1 GP Surgeon provide surgical back up • 1 Pediatrician, with a GP back up, not part of regional pediatric call schedule	• Long history of unregulated midwifery in the region, pre-regulation • Privileges gained at Kootenay Lake Hospital in December 1998 • Interprofessional collaboration challenges despite history of midwifery in community pre-1998 • Department of Midwifery was created at Kootenay Lake Hospital in September 2008 • Midwives do approx. 25% of community deliveries at Kootenay Lake Hospital • Midwifery practice does approx. 120 births a year in total • Since 1998 the practice has more than doubled • Home births make up approx. 20-25% of practice • Almost lost OB specialist services 2 years ago	• Extreme importance of local specialist back-up (OB and pediatric) due to geography, weather and transport issues • GP Surgeon helps to reduce OB burn out • Having 3 midwives helps reduce burn out due to more flexible call schedule • Large home birth catchment (dependent on weather/time of year) • Midwifery meets the needs of the population (cultural context of Nelson)	• Geography, mountainous terrain • Weather: winter conditions last between October and April) • Travel: Large distances traveled (up to 2 hours) by clients for prenatal care, and labour and delivery • Travel: Large distances traveled by midwives for postpartum Home birth. Decision making for distance of travel • Unregulated midwifery in the area (approx 10-15 births/ year) • Emergency transport service: ground, air • Inadequate funding model	• Model of practice is currently sustainable • Factors for sustainability include: # of births, 3 midwives, specialist back-up • Regional issue, Trail hospital has not granted midwives privileges despite the community need • Soon there will be a regional department of midwifery

Nelson

Births over 6 years 2001-2007



Rural Maternity Care New Emerging Team

Campbell River

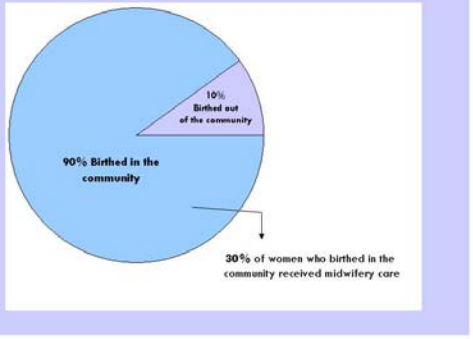
Rural Maternity Care New Emerging Team

Campbell River

Description	History & Context	Attributes	Challenges	Sustainability
• Shared care between 2 midwives • 1 obstetrician (IMG) provides back-up (historically 2 OB's have been in community) • 2 pediatricians • Intermittent GP Anesthesia coverage leads to intermittent cesarean section back-up • Home birth catchment does not extend outside of the Campbell River area due to transportation difficulties • Home births make up less than 5% of midwifery practice (due to culture of Campbell River) • Approximately 5% of women transfer to a tertiary care centre (however 12% this year) • Approximately 15% of women transfer care to OB	• Midwives gained privileges at Campbell River General hospital in August 1998 through regional Campbell River Hospital board; since then privileging has been external • 1 OB helped facilitate/ support privileging process • 1 midwife had relationship with hospital as a maternity nurse for 20 years prior to practicing midwifery • Not all midwives easily accepted into the community, however current support for midwifery care in community • History of unregulated midwifery on Cortez Island	• Shared care with OB's and midwives on high risk patients (ex. Twins). This is due to limited number of care givers in the community • Midwives are the only female obstetrical care providers in the community (besides a female locum physician) • Midwives work with 'Babies Best Chance' and 'Healthy Beginnings' programs (interprofessional relationships) • Positive working relationships with GP's who don't do obstetrics. These GP's send many of their patients to midwives • Relationship building with First Nations community (Gold River)	• Privileging •T here is no separate Department of Midwifery, midwives are members of the Department of Obstetrics • BC Bedline -High risk transfer loss -Second attendant • Winter travel and transfer • Birth rate fluctuates in an 'industry-based' community • Some GP's remain resistant to midwifery	• Midwifery care has helped sustain maternity care in the community due to attrition of GP's doing maternity care • Third midwife: Are we sustainable without a third midwife? How could we sustain the practice of a third midwife? • Current model is sustainable with a few alterations (ex. Funding) • Funding model needs to incorporate pay for 'situational' assistance of physicians/ward emergencies • Funding model needs to incorporate coverage for locums

Campbell River

Births over 6 years 2001-2007



Rural Maternity Care New Emerging Team

Sechelt

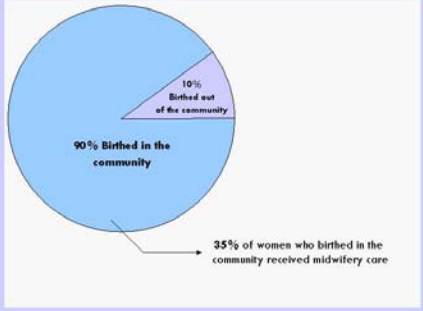
Rural Maternity Care New Emerging Team

Sechelt

Description	History & Context	Attributes	Challenges	Sustainability
• Shared call between 2 midwives • 1 OB provides back-up, shared call with 1 GP Surgeon • 2 pediatricians come to community once a month • With local access to cesarean section and no immediate pediatrician, the midwives are responsible for 'baby care.' Midwives are not compensated for this • 50 births for entire practice/year • Midwives do approximately 1/3 of maternity care in community • Approximately 50% of clients have home-births [2 nurses available for back-up] • Home birth catchment: 30-40 minutes from hospital • Recently, there have been more incentives for rural physicians to do obstetrics so more (newer) physicians are doing maternity care in the community	• First midwife privileged in July 1999 under supervision of head of medicine; privileges gained without physician supervision January 2000 • 1 midwife was unable to receive hospital privileges • History of unregulated midwifery in region, currently still an issue • Culture of unassisted home births	• Positive relationships and support from nurses and OB back up • Midwives organize regular OB meetings with physicians, nurses and obstetrician. - Positive inter-professional relationships	• Midwives responsible for intra- and post-patrum 'baby-care' without pediatrician in community • Financial model: - Transfer of care to tertiary centre - No on-call stipend - Locum - Lack of CME funding	• The current model is not sustainable due to the low number of births (part-time practice) & onerous call schedule • Sustainability possible with a different funding model covering expanded scope of practice, education in schools, pap smears etc.

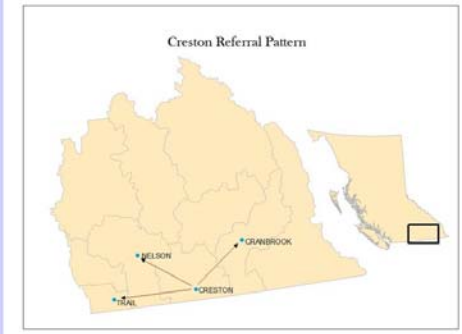
Sechelt

Births over 6 years 2001-2007



Rural Maternity Care New Emerging Team

Creston



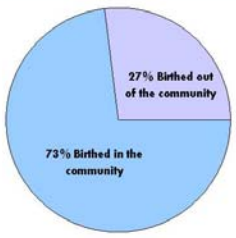
Rural Maternity Care New Emerging Team

Creston

Description	History & Context	Attributes	Challenges	Sustainability
• Collaborative practice with shared call between 1 midwife and 3 physicians at Creston Valley Hospital, no home births • 2 midwives with independent practice (shared call) have privileges at the Creston hospital • All midwives in Creston are also RN's • 1 midwife who practices in Grey Creek (10-20 births/year) also has privileges at the Creston hospital & consults with care providers in Creston • All midwives in Creston have privileges in Cranbrook and Nelson • 1 GP Surgeon provides intermittent back-up • Most regular consultations happen through OB's in Cranbrook or Nelson	• Privileges gained at hospital in Creston in 2000; privileging challenges encountered • Creston midwives gained privileges in Cranbrook in 2003 • Home births make up approximately 40-50% of independent midwifery practices • There is a history of unregulated midwifery on Grey Creek • Threat of cessation of maternity services in Creston, May 2008, due to GP burn-out • Collaborative maternity care model created in June 2008 to sustain maternity care in Creston	• Collaborative model allows for shared decision making (each person brings something different and has different strengths) • Collaborative learning from each other's different skills (ex. GP's have learning from midwives' alternative therapies) • Midwife is able to fill in nursing shortages • Collaborative model decreases burn out for midwife and GP's due to shared call schedule • Midwife does most of the postpartum care (physicians only paid for 2 visits, therefore midwife does more). This has benefited women in the community • Grey Creek: practice style (low volume, rural environment) meets the needs of local midwife and offers choice to women in the community. Midwife also offers well-woman care in community.	• Standing orders when midwife is on call • Scope of practice is different between midwives and physicians (this doesn't impact patient care) • Funding model - No on-call stipend - Midwife unable to bill for 1 time service (ex. Routine checks) • Grey Creek: limits to scope of practice, uncompensated for well-woman care	• The collaborative maternity care model has sustained maternity care in Creston • For long-term sustainability the funding model must be addressed

Creston

Births over 6 years 2001-2007



Rural Maternity Care New Emerging Team

Decision maker challenges

Rural midwives gathered together to articulate their barriers to practice at the *1st Invitational Rural Midwifery Symposium*. These barriers were ratified and explored further on Day One of the second symposium. As solving the challenges relies on collaboration and input from decision makers, Day Two of the symposium brought key stakeholders and decision makers into the discussion. To this end, the agenda prioritized short presentations from these groups regarding their barriers to supporting rural midwifery practice. Below is a summary of the key barriers expressed by each stakeholder group.

College of Midwives of BC

Jane Kilthei, Registrar and Executive Director for the College of Midwives of BC, opened the session through a video presentation of the barriers the college faces in contributing to the sustainability of rural midwifery. The key barriers she addressed included the current shortage of registered midwives and practical challenges to expanding midwives' scope of practice, including changes to the Canada Health Act to include additional drug prescribing. Solutions put forward by participants included drawing on the support of the Society of Obstetricians and Gynecologists of Canada to expedite these legislative processes. Ms. Kilthei suggested that midwives in British Columbia will likely have an expansion to their scope of practice in Spring 2009.

Decision maker	Barrier
College of Midwives of BC	There is a **shortage of registered midwives** to meet the needs of rural women.
	Health Canada determines the timeline to approve an expanded **drug prescription** schedule for midwives.
	There is a **communication lag** between policy makers and the profession of midwifery, sometimes leading to frustration for midwives who are awaiting new legislation that affects their scope of practice.

Health Authorities of British Columbia

Dr. Peggy Yakimoff, (Interior Health), **Marty Willms** (Interior Health), **Dr. Brenda Wagner** (Vancouver Coastal Health), and **Jeannie Wheeler** (Vancouver Island) presented the barriers they face in supporting and integrating midwifery into rural communities. Key barriers include limited planning by health authority regarding: rural maternity care in general, and specifically rural midwifery. This has led to inadequate communication with existing care providers regarding midwives' training, accreditation, and scope of practice, which has made interprofessional relationships difficult at times. Likewise, midwives have not had orientation into health authority protocol. To this end, it was recognized that planning rural maternity services requires a holistic, integrated, system approach.

Decision maker	Barrier
Health Authorities	There is **no systematic planning** for funding, human resources, and infra-structure for rural maternity care.
	There is no **education** for midwives regarding health authority norms and protocol.
	Other care providers need **education** on the practice and profession of midwifery.
	Cesarean section capability is the lynchpin of sustaining a rural midwifery service; we need more care providers with **cesarean section skills**.
	Decision making is generally **urban-centric**; there is a limited rural voice.
	To maintain competence and confidence in practice, rural maternity care providers need more **continuing education** opportunities and funding.
	Interdisciplinary models of care are not widely taught in the education programs; midwives and other care providers must learn how to work together.
	Centralization of services, **under-funding**, and **urban-centric** resource allocation have adversely affected women's health care.
	Health authorities lack paid physician positions as **perinatal advisors**.

First Nations and Inuit Health

Elizabeth Harrold and **Penny Stewart** of First Nations and Inuit Health identified barriers to providing Aboriginal populations with adequate, culturally sensitive maternity care. Local midwifery care for Aboriginal communities has the potential to meet the cultural and social needs of Aboriginal birthing women. However, communities lack knowledge on the midwifery model of care and traditional Aboriginal birthing practices. To provide care close to home for Aboriginal women, more Aboriginal care providers and care providers working in Aboriginal communities are needed, in addition to culturally-sensitive education programs to train them.

Decision maker	Barrier
First Nations and Inuit Health	The **scope of challenges** to rural maternity care is amplified in small Aboriginal communities (most have populations less than 2,500).
	Many Aboriginal communities do not know that **midwifery care is an option** for them and have forgotten their traditional birthing practices.
	Aboriginal communities need more **Aboriginal care providers,** but there are limited resources for role models, training, and cultural components of education.
	Non-Aboriginal midwives need support and resources to provide **culturally sensitive care**.
	More **doulas** are needed in Aboriginal communities.
	Midwives in Aboriginal communities must have **expanded roles** to mitigate low birth volume.
	Aboriginal women face greater **risks** (social, financial, cultural) when they leave a community to give birth than if they stayed in the community without adequate intrapartum care.

Rural midwives and decision makers brainstorm solutions during the networking lunch on Day Two.

UBC Midwifery Education Program

Saraswathi Vedam, RM, PhD (Hon.), Director of the Midwifery Education Program at UBC, presented via video on the challenges currently faced by the UBC Midwifery Program. She emphasized that it is our social responsibility as educators and decision makers to prepare and support midwives to practice in rural environments. To this end, Dr. Vedam noted that the midwifery program plans to provide midwives with more rural-specific skills training, to work more closely with rural mentors, and to open more seats to Aboriginal midwifery students to support the effort to bring local birth to rural Aboriginal communities in the province. The presentation on educational barriers created lively discussion among the group. The following summary outlines the barriers that emerged from this discussion.

Decision maker	Barrier
UBC Midwifery Program	Some practicing midwives observed that new graduates are **unprepared** for the challenges and scope of rural midwifery practice.
	It was the experience of some practicing midwives that the program does not fully utilize their expertise and **mentorship.**
	Clinical mentorship and **observation** should begin in the first year of study.
	Rural health education programs do not currently work together to **pool resources** for initiatives such as continuing and distance education, and for educators to travel to rural communities to provide local training.
	Practicing rural midwives need support for **continuing education** and to connect with the evolving evidence base.
	Lack of midwives from **Aboriginal** and other **ethnic** communities.
	Low volume precipitates the need for **expanded roles** in rural communities.

Opposite page: *Participants during welcome and introductions on Day Two of the symposium (left to right):* Shannon Norberg, RM (MABC); Andre Lalonde, MD (SOGC); Leah Barlow, RM (Creston); Sylke Plaumann, RM (Gray Creek); Karin Gerlach, RM (Prince George); Terri Murray, RM (Salt Spring Island); Maggie Ramsey, RM (Salt Spring Island); and Sheila Jager, RM (Campbell River).

Midwives Association of BC (MABC)

Shannon Norberg, RM, spoke on behalf of the MABC to identify the association's barriers to the support of sustainable midwifery care. She expressed the MABC's mandate to increase the professional profile of midwifery in British Columbia, integrate midwives into the public health system, and encourage interdisciplinary, woman-centred maternity care. She reiterated that the MABC works on the behalf of urban and rural midwives to overcome these barriers and promote the sustainability and growth of the profession. However, from the MABC's perspective, key legislative and funding barriers pose challenges to the growth of the midwifery profession.

Decision maker	Barrier
MABC	Despite a **high consumer demand** for midwifery care, there are not enough registered midwives to serve the childbearing population in British Columbia, particularly in the Interior and Northern Health Authorities.
	The **profile** of the midwifery profession in the province needs to be enhanced through care provider education and workshops, with support from the Ministry of Health and Health Authorities.
	Limited funding and seats available in the UBC Midwifery Education program pose challenges to **recruitment and retention** of midwives.
	Without advertising for rural midwifery practice spaces, it is difficult to recruit **international midwives** to rural British Columbia.
	Delays in the granting of **hospital privileges** prevent midwives from integrating into rural communities and create a backlog of midwives waiting to begin rural practice.
	Midwives' **remuneration** structure must change to promote sustainable rural practice.

Physician Representatives

Granger Avery, MD, Chair of the BC Medical Association (BCMA) Joint Standing Committee on Rural Issues, provided his observations of the challenges to sustainable rural maternity practice from the perspective of a rural physician. Issues common to both provider groups include the lack of a responsive funding model. Dr. Avery noted the lack of agreement on the safety of low risk intrapartum care without local cesarean section back up and the influence this dissonance has on decision making. He suggested rural maternity care providers must be flexible and collaborate in order to overcome the historical friction between the professions and to improve the quality of care for rural women and their babies.

Decision maker	Barrier
Physicians/BCMA	There is a lack of education of **care providers** on the midwifery profession and practice and the safety of home birth.
	There is a **decline** in the number of family physicians interested in rural practice.
	There is **inequitable funding** for maternity care between the professions.

Ministry of Health

Beverlee Sealey, pointed out that despite challenges around integrating and supporting rural midwifery practice, there is currently a high level of interest at the Ministry of Health commitment to support maternity care in British Columbia. She noted the positive relationships that have been developed with physicians and midwives as the context for engaging in productive planning and priority setting. She recognized the need for existing infrastructure to support new midwives in new communities, and expressed a desire for developing models of rural midwifery care that will likely lead to success.

Society of Obstetricians and Gynaecologists of Canada (SOGC)

Andre Lalonde, MD, FRCPS, Executive Vice-President, SOGC, provided an overview of the society's support for midwifery, rural maternity care, and women's right to choice of care provider and place of birth. The SOGC advocates for interprofessional collaboration in practice and the representation of all voices in policy making, through mechanisms such as joint committees and joint memoranda or position statements on maternity care issues. Key barriers to successful collaboration include the lack of formal distinction between rural and urban scopes of practice, limited communication between care provider colleges and societies, and limited access to team-building programs such as MoreOB. Dr. Lalonde emphasized the SOGC's commitment to support and advocate for rural midwives.

Decision maker	Barrier
SOGC	There is a diminished number of **rural obstetricians** to provide full obstetrical back-up for midwives practicing in rural communities.
	No attention has been given to solving the challenge of providing appropriate care to **Aboriginal communities**.
	There is limited access to the MoreOB program to facilitate **interprofessional collaboration** and the establishment of a common evidence base.

Rural midwives and decision makers gather together to collaboratively address solutions for the challenges of rural midwifery.

Small Groups Workshop

Participants split into four theme-based groups: **Education**, **Aboriginal Midwifery**, **Interprofessional Collaboration**, and **Decision Making**. Together, all key stakeholders in each group brainstormed solutions to the barriers to rural midwifery practice that were outlined. They identified key activities and target decision makers instrumental in solving each challenge. Below is a summary of the solutions brainstormed by each group. Issues of **Funding** were addressed in detail during the final discussion session of the day and are outlined in Appendix 1.

Education

Participants in the Education group identified a range of constructive activities and solutions that may mitigate the educational challenges faced by rural students, new graduates, and established midwives seeking continuing education. Underpinning these suggestions was the recognition that the UBC Midwifery Education Program needs increased funding to sustain existing educational instruction and implement the additional initiatives suggested below.

To overcome the **lack of support for students interested in rural practice**, participants proposed:

- Creating a rural stream for midwifery students;
- Alerting students to existing rural midwifery loan forgiveness and bursary programs;
- Creating a start-up stipend for rural midwives to establish new practices in rural communities ; and
- Making distance education available for first year of study to allow rural students to stay in their home communities.

Regarding clinical training and the **difficulty of securing preceptors for rural midwifery students**, solutions include **funding** and providing incentives for rural preceptors midwife, physician and nurse preceptors.

During their education, **midwifery students lack rural-specific training**, which can lead to a lack of confidence and undermine, rural practice. To address this, participants suggested that the UBC Midwifery Program do the following:

- Where possible, provide practicum placements for students in the community in which they intend to practice;
- Establish a coordinator position for practicum placements (responsible for overseeing logisitics, mediating between the university and rural practitioners and being a resource for both students and communities);
- Establish temporary faculty positions so that rural midwives can supervise students during holiday months to allow students to continue practical experience;
- Provide rural clinical (observational) experience for students in their first year;
- Create courses that are more directly linked to the conditions of rural practice; and

- Establish a third year direct entry stream for rural nurses wishing to pursue midwifery education.

It was noted that the UBC Midwifery program has made a significant contribution to the profession of midwifery in British Columbia and the province's maternity care system and that currently there is an urgent need for **increased institutional and financial support for the training program** to ensure its sustainability. Institutional support could be through increasing other institutions' awareness of the program (UVIC, UNBC) and establishing partnerships for rural interprofessional placements and satellite teaching for rural students. Additionally, more funding, resources, and student seats are necessary, which are being pursued through ongoing dialogue between the UBC Midwifery program and the Ministries of Health and Advanced Education.

Practicing rural midwives also face continuing education challenges due to difficulties gaining time off, finding locums, and lack of funding to travel for CME events. Increased funding to the Midwifery Education Program could lead to resources that may contribute to increased opportunities for rural midwives to access continuing education by:

- Providing easier access to continuing education for rural midwives through online and teleconference components; and
- Organizing education intensives, which would also establish communities of practice for isolated rural midwives.

Aboriginal Midwifery

The discussion of this small group was focused on an acknowledgement of the importance of providing culturally and physically safe care to Aboriginal populations. Where possible, this should occur on or close to their traditional land. Group members felt midwives are well-positioned to meet the maternity care needs of rural and isolated Aboriginal reserve communities due to the principles underscoring the model of care (e.g., continuity of care and informed decision-making) and the mechanisms used to actualize these principals (e.g. longer prenatal visits). Group members were unclear, however, what the uptake of local access to midwifery care would be by First Nations women. To this end, the group brainstormed a proposal for an Aboriginal midwifery pilot project that could

Rural midwives (clockwise from top left): Ilene Bell, RM (Nelson); Petra Pruiksma, RM (Roberts Creek); Karin Gerlach, RM (Prince George); Sylke Plaumann, RM (Gray Creek); Maggie Ramsey, RM (Salt Spring Island); Deborah Kozlick, RM (Courtenay/Comox); Sheila Jager, RM (Campbell River); and Sadie Parkin, RM (Courtenay/Comox).

address the need for culturally sensitive care for Aboriginal women close to home. Additional strategies for increasing the provision of midwifery care to Aboriginal communities and supporting midwives who practice with Aboriginal populations include:

- Creating linkages between existing Aboriginal Community Health Workers and midwives;
- Educating communities on the midwifery model of practice and the history of traditional Aboriginal birthing practices;
- Training students and currently practicing midwives in an expanded scope of midwifery care for low volume communities;
- Considering alternative funding schemes that would allow for billing for services exceeding currently billable services (e.g., sexual health in schools, etc.);
- Provide education to all care providers on the cultural needs of Aboriginal women; and
- Providing Aboriginal women who must leave their homes to give birth with the option of midwifery care in their referral community.

Regarding the education of Aboriginal midwifery students, the group suggested the following:

- Advertise midwifery as a career for Aboriginal women, and
- Guarantee access to Aboriginal-specific education electives and practicum placements.

Interprofessional Collaboration

Successful and sustainable rural midwifery care depends on the collaboration of all rural maternity care providers which is predicated on ongoing communication, and opportunities for shared learning. Considering the current **lack of mechanisms to support interprofessional collaboration**, group members recommended:

Rural midwives taking a break for discussion (clockwise from left): Sheila Jager, RM (Campbell River); Maggie Ramsey, RM (Salt Spring Island); Leah Barlow, RM (Creston); and Sarah Hilbert-West (UBC Midwifery student, from Quesnel).

- Providing care providers with evidence-based education and workshops on the midwifery model of care, safety of homebirth, and what is currently known about the safety of care without local cesarean section back-up;
- Supporting and encouraging collaborative team practice at a community level (e.g., through policies and incentives geared to reward such practice);
- Encouraging interprofessional collaboration at the student level; and
- Expanding and advertising the UBC Interprofessional Rural Placement Program.

Many physicians are uncomfortable with homebirth and rural maternity care without cesarean section back-up. To facilitate the introduction of midwives into low-resource environments and increase physicians' level of comfort with the midwifery model of practice, group members suggested creating an ongoing dialogue between rural midwives and physicians to collaboratively establish standards of care for the rural communities they jointly serve.

Policy and Decision Making

Rural midwives currently have a **limited voice in decision making**. To bring the issues rural midwives face to the attention of policy makers, this small group proposed the following:

- Revive the BCPHP's Rural Sub-Committee to act as a multidisciplinary provincial advisory group for rural midwifery decision making. The mandate of the group would be to provide evidence-based standards and protocols to Ministry of Health, Health Authorities, and communities on the safety of rural practice in low resource environments;
- Ensure midwifery representation in Health Authority Medical Advisory Committees (HAMAC) through designated seats;
- Have HAMACs and BCPHP Rural Sub-Committee work together to address regional and provincial rural midwifery issues such as privileging;
- Ensure rural midwives decide who will represent their concenrs at the decision making table; and
- Establish regional Departments of Midwifery throughout the province.

Decision makers within **Health Authorities have paid limited attention to rural maternity care issues** in general. The following activities may encourage greater prioritization of perinatal issues:

- Create in Health Authorities paid physician positions for representatives with specific perinatal experience; and
- Have rural representatives work with Health Authorities to make programs responsive to rural needs.

Decision makers also identified significant barriers for midwives who seek to begin practice in rural communities with no current registered midwives. Historically, these midwives seeking hospital privileges have met resistance from local physicians and in some cases **physicians have blocked a midwife's request for hospital privileges**. It can also be difficult to gain permission to practice in a rural hospital as many **midwives have not been provided information on the privileging process**. Some solutions the group posed include:

- Establishing a provincial body responsible for privileging of midwives;
- Having regional multi-disciplinary maternal child committees undertake impact analyses to provide evidence-based recommendations on the impact midwifery would have on a community;
- Enforcing Health Authority by-laws to move privileging process forward in a timely fashion; and
- Ensuring that midwives are provided with copies of the provincial hiring by-laws, hospital act, and local by-laws.

Appendix 1

Barriers and Solutions to Sustainable Midwifery

The following barriers and solutions were discussed throughout the two day symposium and were ratified at the close of the meeting. Target decision makers were identified to move solutions forward. This document represents the first steps toward supporting sustainable rural midwifery practice.

Decision Making

Barrier	Solution	Target Decision Maker
Rural midwives have a limited voice in decision making	**Revive the BCPHP's Rural Sub-Committee** to act as a multidisciplinary provincial advisory group for rural midwifery decision making, to provide evidence to Ministry of Health, Health Authorities, and communities on safety and significance of rural midwifery, particularly in circumstances where midwives are refused hospital privileges and in funding recommendations for rural care providers.	BCPHP; Rural Midwives
	Ensure midwifery representation in Health Authority Medical Advisory Committees (HAMAC) through designated seats.	Health Authorities; Rural Midwives
	Have HAMACs and BCPHP Rural Sub-Committee work together to address regional and provincial rural midwifery issues such as privileging	Health Authorities; BCPHP Rural Sub-Committee; Rural Midwives
	Rural midwives need to consensually decide who will speak on behalf of rural midwifery at the decision making table.	Rural midwives
	Establish regional Departments of Midwifery throughout the province.	Midwives
Perinatal issues are not adequately prioritized by Health Authorities	Create in Health Authorities paid physician positions for representatives with specific perinatal experience.	Health Authorities
	Have rural representatives work with Health Authorities to make programs responsive to rural needs.	Health Authorities; Midwives' Association of BC Rural Sub-Committee

Education

Barrier	Targeted Solution	Action Plan
Lack of support for students interested in rural practice	Create a formal rural stream for midwifery students.	UBC Midwifery
	Alerting students to rural midwifery loan forgiveness /bursary programs.	UBC Midwifery; Ministry of Advanced Education
	Create a start-up stipend for rural midwives to establish a sustainable practice.	Ministry of Health
	Make distance education available for study in first year to allow rural students to stay in their communities	UBC Midwifery
Difficulty in securing preceptors for rural midwifery students	Funding for rural preceptors regardless of primary maternity care profession; make preceptors available to students	Ministry of Advanced Education
	Provide incentives to rural preceptors (e.g. access to UBC Library and journal subscriptions)	UBC Midwifery
Lack of institutional support for UBC Midwifery	Create awareness of UBC Midwifery program among other institutions (UVIC, UNBC) to establish partnerships for rural interprofessional placements and satellite teaching for rural students.	UBC Midwifery
	Provide more funding, resources, and student seats for UBC Midwifery Education Program.	Ministry of Advanced Education; Ministry of Health. (Ongoing dialogue.)
Continuing education is expensive and inaccessible	Increase funding for CME.	Ministry of Advanced Education; Midwives' Association of BC
	Provide easier rural access to CME through online and teleconference components	Ministry of Advanced Education; Midwives' Association of BC
	Organize educational intensives for rural midwives (e.g. bring isolated rural midwives together to establish a community of practice).	UBC Midwifery; Ministry of Advanced Education
Lack of rural-specific training	Provide practicum placements for students in the community they intend to practice (preceptor could be L&D nurse or family physician).	UBC Midwifery
	Establish a coordinator position for practicum placements (eg. a rural midwife).	UBC Midwifery

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	Establish temporary faculty positions so that rural midwives can supervise students during holiday months to provide relief for full-time faculty and allow students to continue practical experience.	UBC Midwifery; University of British Columbia
	Provide rural clinical (observational) experience for students in first year.	Currently on UBC Midwifery faculty agenda
	Create courses that are more responsive to rural practice (in Business, Communication, Counseling, Breastfeeding, Charting).	Currently on UBC Midwifery faculty agenda
	Establish mandatory placements for midwifery students in rural midwifery, as well as nursing and family, practices.	UBC Midwifery
	Fast-track rural nurses into third year of midwifery program.	UBC Midwifery

Privileging

Barrier	Targeted Solution	Action Plan
Physicians can block midwives' requests for hospital privileges	Establish a provincial body responsible for privileging of midwives (ex. Have the BCPHP Rural Sub-Committee act as an external reviewer of	Health Authorities; BCPHP
	Have regional multi-disciplinary maternal child committees undertake impact analyses to provide evidence-based recommendations on the mid-	Health Authorities
	Enforce Health Authority by-laws to move privileging process forward in a timely fashion.	Health Authorities; individual hospitals; midwives
Lack of understanding of privileging process	Ensure that midwives are provided with copies of the provincial hiring by-laws, hospital act, and local by-laws.	Health Authorities; individual hospitals; Midwives' Association of British Colum-

Aboriginal Midwifery

Barrier	Targeted Solution	Action Plan
No practicing Aboriginal midwives in BC	Advertise midwifery as a career for Aboriginal women.	Ministry of Advanced Education; First Nations Inuit Health
	Guarantee access to Aboriginal-specific education electives and practicum placements.	UBC Midwifery
Other activities are needed to support sustainable Aboriginal midwifery	For Aboriginal women who must leave their homes to give birth, provide them with the option of midwifery care in their referral community.	Ministry of Health
	Aboriginal midwives can provide an expanded scope of care to communities.	UBC Midwifery
	Make doula training available throughout the province through distance education.	Doula training organizations (e.g. Kwantlen University College; xx)
Aboriginal women need culturally sensitive care	Create community-specific maternity care programs (avoid geographic clustering of programs).	Ministry of Health; Health Authorities; First Nations Inuit Health
	Provide education to all care providers on cultural needs of Aboriginal women.	Ministy of Health; Health Authorities; First Nations Inuit Health
Aboriginal women want and need to birth on their own lands	Provide an expanded scope of midwifery care for low volume communities (with alternative funding scheme).	First Nations Inuit Health; Ministry of Health
	Begin an **Aboriginal midwifery pilot project.**	FNIH; CRHR; Aboriginal Band Councils
	Link existing Aboriginal Community Health Workers with midwives.	First Nations Inuit Health; Health Authorities
	Educate communities on risks and benefits of midwifery care; educate communities on model of practice and history of traditional Aboriginal birthing practices.	Midwives' Association of British Columbia; Ministry of Health

Interprofessional Collaboration

Barrier	Targeted Solution	Action Plan
Lack of mechanisms to support interprofessional collaboration	Provide evidence-based education and workshops for care providers on midwifery model of care; safety of homebirth; safety of midwifery without local cesarean section back-up.	Midwives' Association of British Columbia; Health Authorities
	Support and encourage collaborative team practice (e.g. midwives with ob/gyn; midwives with family physicians).	Midwives; individual communities; professional associations; Ministry of Health
	Encourage interprofessional collaboration at a student level.	University of British Columbia; Ministry of Advanced Education
	Expand and advertise UBC Interprofessional Rural Placement Program.	University of British Columbia
Disjointed care in rural communities for women from outlying communities	Establish clear maternity care pathways for rural women (e.g. Have charts travel under woman's possession).	BCPHP; Ministry of Health
Physicians' discomfort with rural maternity care without surgical back-up	Ongoing dialogue with rural midwives and physicians to collaboratively establish standards of care for the community.	Midwives; physicians; professional associations
Physicians' discomfort with home birth		

Model of Funding

Barrier	Targeted Solution	Action Plan
Develop innovative solutions to funding challenges	Compose a **joint policy statement** on alternative modes of funding for midwives (and rural primary care maternity care providers) from stakeholder groups - point to goals of MCP2.	Midwives' Association of BC; BC Medical Association; Society of Rural Physicians of Canada; College of Midwives of BC; Society of Obstetricians and Gynaecologists of Canada
	Explore potential under Master Agreement for sub-agreements that include alternative payment schemes (e.g. for expanded scope of practice).	Midwives' Association of BC

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	Consider shorter contract terms (less than 6 years).	Midwives' Association of BC
	Create an evidence base to determine the most efficient innovative solutions (e.g. start-up stipend for rural midwives to establish sustainable practices).	Ministry of Health
	Revise professional fees to make part time practice economically viable.	Midwives' Association of BC; Ministry of Health
	Fund midwives for partial courses of care (to avoid disincenting midwives for transfer of care).	Midwives' Association of BC; Ministry of Health
	Create a formal funding system for second attendants (e.g. not responsibility of primary midwife).	Midwives' Association of BC; Ministry of Health
	Fund "midwife-on-call" programs (ex. Midwives in Victoria who are on-call for Saltspring Island transfers).	Midwives' Association of BC; Ministry of Health

Health Human Resource Challenges

Barrier	Targeted Solution	Action Plan
Shortage of rural midwives	Advertise openings for midwives through Health Authority websites and other mechanisms.	Health Authorities
Care providers in communities without intrapartum services are untrained for precipitous/ emergent deliveries	Provide on-site training in management of precipitous deliveries for care providers working communities no longer providing maternity care.	Health Authorities; MoreOB
Traveling to provide care can be dangerous (weather, mountain passes)	Establish midwifery practices in remote communities that have high birthing populations.	Health Authorities; Midwives
Difficulty accessing locum coverage	Funding for "midwife-on-call" programs.	Midwives' Association of BC; Ministry of Health
	Traveling rural midwifery locum program.	Midwives' Association of BC

Appendix 2

Symposium Attendees

Midwives	
Leah Barlow, RM	Creston
Ilene Bell, RM	Nelson
Michelle Cameron, RM	Surrey
Karin Gerlach, RM	Prince George
Jacquelyn Humchett	UBC Midwifery student (Bella Bella)
Sarah Hilbert-West	UBC Midwifery student (Quesnel)
Sheila Jager, RM	Campbell River
Deborah Kozlick, RM	Courtenay
Terri Murray, RM	Salt Spring Island
Shannon Norberg, RM	Vancouver
Sadie Parkin, RM	Courtenay
Sylke Plaumann, RM	Gray Creek
Petra Pruiksma, RM	Roberts Creek
Maggie Ramsey, RM	Salt Spring Island
Carolyn Thibeault, RM	Cranbrook
Decision Makers	
Granger Avery, MD	Chair, BCMA Joint Standing Committee on Rural Issues
Sheryll Dale	Manager, BC Perinatal Database, BCPHP
June Friesen	President, BC Midwives Association
Elizabeth Harrold	Nurse Lead, First Nations and Inuit Health
Andre Lalonde, MD	Executive Vice-President, SOGC
Lorna McRae, RM	UBC Midwifery Education Program
Beverlee Sealey	Ministry of Health
Brenda Wagner, MD	BCPHP Medical Director; Vancouver Island Health Authority
Jeannie Wheeler	Vancouver Island Health Authority, Mount Waddington
Marty Willms	Perinatal Lead, Interior Health Authority
Peggy Yakimov, MD	Medical Director, Kootenay Boundary, Interior Health Authority
Research Team	
Jude Kornelsen	Co-Principal Investigator
Stefan Grzybowski	Co-Principal Investigator
Melanie McDonald	Research Assistant
Bryce Westlake	Research Assistant
Sarah Munro	Editorial Manager


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