POLICY BRIEFS
Issues in Rural Maternity Care

APPLIED POLICY RESEARCH UNIT
FOCUSING ON RURAL HEALTH

CENTRE FOR RURAL HEALTH RESEARCH

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System Enablers of Distributed Maternity Care for Aboriginal Communities in BC

OVER-ARCHING RECOMMENDATIONS

- Develop and implement a system of population-based monitoring and evaluation work for continuous quality improvement in maternity care.
- Plan for and gather data alongside the implementation of any new rural Aboriginal maternity care health service model, to capture the impact of this work and celebrate success.
- Develop an approach to determine relative care needs of communities based on population, isolation and vulnerability measures matched with the capacity of communities to sustain services. (eg. Rural birth index)
- Explore the utility of Birth Centres as locations for labor and delivery in rural communities.

Background

On October 1, 2013 First Nations Health Authority (FNHA) assumed responsibilities from Health Canada for health care of First Nations peoples in British Columbia (BC) through a transfer process that began with the Tripartite Agreement (2007). Transfer, as a finite set of activities, has since given way to the transformation of existing services to better meet the needs of First Nations peoples. One such need expressed through extensive regional and local community-level consultation was for a strategic approach to ensure Aboriginal mothers, children and families' health service needs are met through an effective system that honors diversity, individual customs, values and beliefs. Improved access to services – including services during the childbearing year – are a cornerstone of this work.

This is emphasized in the Transformative Change Accord and First Nations Health Plan (2006; 2007) which note the specific priority of "[i]mproving access to the full range of maternity services for First Nations and Aboriginal women, bringing birth 'closer to home and into the hands of women.'"

The mandate of 'closer to home' resonates with the national policy directives of the Society of Obstetricians and Gynecologists of Canada statement (2010) on the return of birth to Aboriginal, rural and remote communities in Canada. Key to this statement is the recognition of the cultural importance of local birth, of the need to respect women's rights to choose where they give birth, and the need to support the larger infrastructure to facilitate birth in low-resource, low-volume communities.

To provide an evidence-base for policy directions, FNHA and the Applied Policy Research Unit (APRU) at the University of British Columbia (UBC) agreed to review existing international evidence on the question, "What systemically enables the decentralization of maternity services while maintaining safe birth outcomes in rural and remote communities?" A Realist Review methodology was used to adequately capture and account for the nuances of health services in BC. A series of 'system enablers' were suggested as foci, including health human resource enablers (provider type, recruitment, retention, competencies and attitudes, professional development and leadership competencies) and structural and governance enablers (infrastructure and equipment, resources, policy, system incentives and legal requirements). Each enabler was applied to communities with

SUMMARY

There is a well-documented health disparity suffered by indigenous women and their babies living in rural and remote areas of British Columbia. Historically, evacuation to regional or urban centres for intrapartum services has been an accepted practice. More recently, the importance of care closer to home has been emphasized in service policy internationally, responding to evidence of effectiveness and cost-efficiency as well as the expressed values of rural and indigenous people regarding the priority of home and community.

An examination of the health system enablers of effective decentralized, closer-to-home maternity care for rural and remote indigenous women revealed the importance of integrating bio-medical knowledge with traditional-medical knowledge. Changes to policies on accompanied travel, the creation and use of maternal waiting homes and birth centres, and the recognition and remuneration of community care providers and advocates are all enablers of better care. Mandatory anti-racism training for providers and non-hierarchical, team consensus decision making can help mitigate the compounding effect of privilege on social health.

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AT A GLANCE

- According to the 2006 Census, 196,070 persons, or 4.8% of the total population in BC, reported Aboriginal identity
- BC currently has 206 First Nations Reserve communities
- 83 of those communities are more than one hour travel distance from the nearest primary maternity service
- Evacuation for maternity care has been the common practice, but no policy exists
- Canada's neonatal-mortality rate is 3.5 per 1,000 live births, ranked 40th in the world.
- Among Canadian First Nations in Rural areas, the neonatal mortality rate is 2.3 times higher at over 8 deaths per 1,000 live births

"The reason that we can do what we do is because the infrastructure is there... You can come in with all your wonderful ideas, but if you don't have the home care nurse, the band council, the addiction treatment facility, the childcare workers, you need that."
- Physician on community health infrastructure enabling high quality local care (quoted in Buxton et al. 2007, p86)

local prenatal care only, and those with local primary maternity care.

Level One: Pre-Natal/Post-Discharge Care Only, No Local Birthing Services

At this level of service, women are not able to birth in their home communities. Critical findings from the analysis include the need for local, high-quality pre-natal care[13,21,28,148] a re-imagining of how women travel for birth[35,70,86] and effective coordination of discharge and follow-up care[10,12] to improve health outcomes and close the well-documented health disparity suffered by Aboriginal and especially rural Aboriginal people. This primarily rests on adequate (but sometimes non-typical) health human resources through the involvement of the community, including but not limited to: community and/or traveling doulas[137] post-natal workers[161] Aboriginal Health Workers (Australia); Elders (including visiting Elders)[137] intergenerational family[147] care coordinators[12] and outreach medical professionals[91]. Existing literature is clear regarding the need for maternity service models that better meet cultural and community needs of First Nations communities. To this end, immediate, mid-range and long-term targets should be set.

The very way we construct hospital birthing rooms/wards does not fit many cultures of birth found among First Nations[22] and the expectation to evacuate for birth currently comes with a model of travel (alone, to private accommodations) that is known to be stressful and alienating[35,86,98,99,102]. Learning from international work, adjustments can be made in two primary ways. Most immediately, policy can be developed to facilitate supporting partners and/or family in travel, better nutrition while away, and more appropriate accommodation at the referral community[137]. Additional, health care givers may consider referrals to primary care communities (as opposed to the standard referral to higher levels of service) if the care is deemed more suitable by the expecting mother[46,161,171]. Second, investment in different infrastructure might include apartments near the referral hospital available and maintained in part by the local community[147], and/or referral hospital rooms/suites that allow for family, advocates, and traditional birth attendants to be present, eat, cleanse, and celebrate the birth as befits the cultural traditions of the woman giving birth[58].

Level Two: Primary Maternity Services with No C-Section

This level of service can be and is organized in a variety of ways internationally to include midwifery-focused models, physician-focused models, and collaborative models. In addition, the FNHA has already begun work supporting a 'teamlet' model that include health human resources necessary for a culturally recognizable and personally acceptable birth experience for First Nations women in BC. Teamlets

Assumptions Underscoring Review:

- First Nations health care decision making is guided by the Triple Aim goals of improvement in population health; lower per capita health system costs and improved patient and provider experience of care. The latter concept honors and privileges the importance of locally designed care that meets the cultural and psychosocial needs of communities.
- Decisions regarding First Nation's health care are made by First Nations communities based on best available evidence and within the cultural priorities of the communities.
- The First Nations, Provincial and Federal policy initiative of care 'closer to home' be actualized through strategic policy directions that increase the number of communities with access to local maternity services as per population need.
- Health services for First Nations are most effective when community owned, managed and directed and First Nations governance must be respected as an integral part of culturally and clinically appropriate care.

can include doulas, post-partum workers, Aboriginal Health Workers, Elders and intergenerational family members and outreach medical professionals along with traditional and community midwives working in integrated teams with local medical health professionals[45,46,171,172]. The specifics of the model are articulated by the needs of individual communities.

Recruitment of primary care providers and allied professionals to rural First Nations communities has been approached a number of ways, including communities selecting and supporting aspiring midwives to leave the community for university training and then return to be a local provider[46], midwifery students working as Aboriginal Health Workers[91], using overseas-trained doctors[6], incentivizing work in rural areas, improving funding for rural students to attend medical school, early rural exposure programs and collaboration with local community groups, elders, and individuals[5]. The pressing question for health care planners is how big does a community have to be to support primary services?

At a systems level, that question exists within a number of constraints including fee-for-service funding models, professional college and provincial regulatory standards for skill currency, and the inability of providers to bill for advocacy, continuity, and cultural safety work. Some of these challenges are addressed by existing models of midwifery, including examples of Australian caseload midwifery in which midwives have flexibility in work practices and can be remunerated for well-woman and well-baby care[26,170] and outreach group midwifery practice that provides continuity of care to rural women including attending the birth at the regional hospital if necessary as a skilled birth attendant and advocate[91].

The interdisciplinary midwifery care at the Inuulitsivik maternity centre is the current international gold standard, combining traditional and modern approaches to midwifery that are grounded in and driven by the community itself[42,171,172]. Additionally, Indigenous specific maternity centres have been constructed in various jurisdictions[20,139]. Although birth centres do not currently exist in BC., the current policy climate favors introducing culturally-responsive and community-articulated models of care.

What proportion of women can birth locally with primary care only (without local c-section availability)?

- In physician-led models, historically observed trends suggest roughly one-third of women will both choose to give birth locally and be of an appropriate risk profile (Humber and Dickinson 2010; Igelsias et al 2005; Korneslen et al 2013; Tucker et al 2010).
- Encouraging numbers from a midwifery-led Indigenous services model in Nunavut suggest the proportion of women who successfully birth without local c-section services is as high as 92% (Van Wagner et al 2007).

For details of the literature cited within this brief, please see the full report, *System Enablers of Distributed Maternity Care for Aboriginal Women in British Columbia: Findings from a Realist Review*, available on our website at www.crhr.ca/apru

GLOSSARY

Birth Centres are non-hospital spaces where women can access safe and culturally respectful birth services with their families and communities.

Centralized Health Care is the organization of health services around concentrated infrastructural and health human resources, usually for specialized and high-tech procedures such as coronary catheterization.

Distributed (or Decentralized) care means to maximize local access, with service availability based on population size and characteristics. Appropriate examples include chronic disease management and maternity care.

Evacuation for birth is the practice of referring women out of their community for intrapartum care. Women typically leave the community between 36-38 weeks to await labour in a hotel near the hospital. First Nations people use the Non-Insured Health Benefits (NIHB) program that is managed Federally. This program does not pay for escorted travel for care except in the case of disability, travel by a minor, or other extenuating circumstances.

The **Applied Policy Research Unit (APRU)** is an arm of the Centre for Rural Health Research focused on producing and synthesizing policy relevant research to inform rural maternity service planning in a timely, user-friendly way.

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Recommendations

PRIMARY CARE COMMUNITIES

1. Base local primary care provision on an interdisciplinary team model, inclusive of local providers and members from a variety of backgrounds (in the health field and beyond).
2. Identify and support both individuals and teams in their unique and shared career and professional development goals and planning.
3. Consider and coordinate both local and external staff recruitment and retention models for greatest collective impact.
4. Integrate both bio-medical knowledge and traditional knowledge into care models that are driven by Aboriginal needs, and serve Aboriginal communities.
5. Explore ways to establish cultural safety and anti-racism training and ongoing practice support as valued, expected and mandatory.
6. Identify and encourage leadership priorities and qualities valued by individual communities as a condition for practice. These may include political commitment, local leadership and control, collaboration between practitioners, consumer involvement, or ongoing monitoring and sharing of information and results.
7. Explore ways to support the management of clinical decision making through nonhierarchical, consensus-based processes between bio-medical care providers, traditionalmedical care providers, and advocates.
8. Consider Birthing Centres as an alternative place for birth either in the presence or absence of local hospitals within a quality assurance and outcomes monitoring framework.
9. Promote the availability of female physicians (in care models that are physician-led) in support of increasing access to and continuity of care.

NO LOCAL MATERNITY CARE

1. Build on existing care models that successfully respond to the needs of the community and effectively use local resources while maintaining a commitment to seeking additional staff and promoting interdisciplinary team growth where needed and possible.
2. Increase community and health system awareness about the value of doulas and/or birth advocates, and approaches to their sustainable compensation and recruitment and retention in rural settings to aid patient care.
3. Generate a culture of acceptance and appreciation to support integrated and collaborative work of all members of a health team through intentional practice overlaps, joint continuing education, and a protocol for holding shared health records.
4. Explore opportunities for short course training and other community-based modules on obstetrics and obstetrical emergencies to be available for all remote area health staff without prerequisites.
5. Increase access to a wide range of education opportunities grounded in culturally appropriate care and practice standards and expectations for rural settings. Recommended training includes and is not limited to knowledge and skill building in: Self-awareness, listening, independent and resourceful practice, working in low-resource environments, community engagement approaches and teamwork (inclusive of teamwork via phone and tele-health).
6. Develop commonly understood standards and processes for effective clinical and non-clinical care decision making in rural and isolated community contexts. If there are not existing local primary care services, this decision making may fit under the umbrella of other community governance structures (eg. Under the governance of health services in the referral community or through establishing a distinct mechanism of local health leadership.
7. Consider the model of Maternal Waiting Homes (MWH) to mitigate the social challenges and impacts of loneliness and isolation when waiting to give birth in a referral centre. These homes can provide the infrastructure for educational, social and health-related activities in the late pre-natal period.
8. Build and support social resources (family and community) for birthing women in her home community and in particular when women may need to travel or evacuate to give birth. This entails escort policies that acknowledge the importance of and fund accompaniment to and in the referral community.

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