



Midwifery Pathways
A framework for sustainable
rural midwifery

Produced by
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FOREWORD

Midwifery Pathways is based on the cumulative understanding of the realities of integrating midwifery into rural communities in British Columbia as expressed through a series of rural midwives symposia (<http://crhr.ca/resources/symposia-proceedings/>) and community consultations (<http://crhr.ca/our-research/reports/>). This document – like midwifery practice in rural settings – is a dynamic process, evolving with every new community midwives begin practicing in.

We welcome updates and additions that may be helpful as other rural communities welcome midwives into their maternity care planning.

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Midwifery Pathways

A FRAMEWORK FOR
SUSTAINABLE RURAL MIDWIFERY

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So you want local midwifery care?

Midwifery Pathway is targeted at midwives, administrators, and rural communities that have expressed an interest in rural midwifery practice. Underpinning this toolkit is the belief that *our responsibility as health care providers is to meet the needs and desires of birthing women. If women desire midwifery services, we must make rural practice sustainable.* For the growth of rural midwifery to be sustainable, the decision making process in a rural community should be inclusive, shared, and long-term. This document is intended as an accompaniment to the Midwifery Pathways infographic.

Phase 1: Planting the seed



Step 1: Can your community support midwifery care?

You need to consider the following:

- ***Is your population smaller than 10,000 people?***
In very small rural communities, there are a number of barriers to professional sustainability for midwives, including low patient caseloads leading to financial stress.
- ***Are there currently any maternity care providers in the community?***
If not, we recommend that you consider alternative practice schemes, including salaried positions, part-time practice, or utilizing midwives' expanded scope of practice.
- ***What is your local fertility rate?***
If there are fewer than 20 births per year in the community, the midwife may have to leave the community to complete her minimum number of deliveries as defined by the CMBC (40 births in 2 years). (Resource: CMBC Requirements for Active Practice).
- ***What is your community's distance from other communities with midwifery care? Are women in your community accessing those services?***
The midwife may benefit from having colleagues in nearby practices. Building relationships with these midwives is important for professional sustainability as well as to ensure that any surrounding practices are not destabilized as patients in your community access midwifery care closer to home.
- ***What is your community's distance from caesarean section back-up?***
If there is no local caesarean section service in your community, it is important to consider the risks and benefits of local birth, including criteria for local deliveries.

Visit <http://crhr.ca/resources/toolkits/rural-midwifery-pathways/> to review the current evidence on the safety of maternity care in small rural communities, particularly in communities with no local caesarean section services.

Can your community support midwifery care?

YES: Move forward to Step

NO: Contact MABC and CMBC for further information

Step 2: Is your community ready for midwifery care?

Begin an inclusive, community based, decision-making process regarding the integration of local midwifery.

Talk to women in the community about their level of interest in local midwifery care:

- *What is your understanding of midwifery care?*
- *If midwives practiced in the community, would you go to them for maternity care?*
- *Would you be interested in the option of home births?*

Talk to all local physicians, public health nurses, hospital nurses, ambulance personnel, hospital administrators and staff, community based health organizations, doulas, childbirth educators, Healthy Beginnings leaders, and Mom and Tot group leaders. Survey, interview, or hold a public forum to ask these stakeholders about their attitudes and beliefs toward midwifery care.

Questions to Ask may include:

- *What is your understanding of midwifery care?*
- *What are/would be the challenges of interprofessional collaboration in your community?*
- *What resources or activities would you need in order for interprofessional collaboration to work in your community?*

Is the community ready to move forward with midwifery care?

YES: Move forward to Step III

NO: Pause and continue engagement

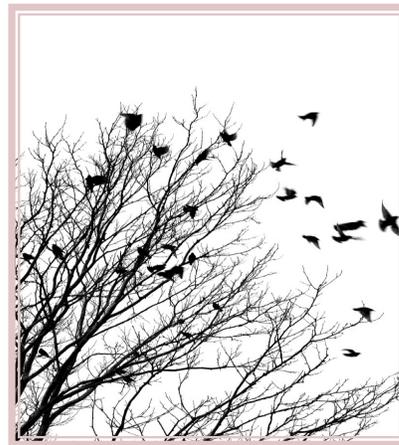
Step 3: What does your community need for sustainable local midwifery?

Planning for a new service should involve all stakeholders in the community from birthing women and their families, elders, health care administrators and health care providers. It is helpful to establish a Community Advisory Council to ensure all voices are heard (see Appendix A for a check list of members to include in Community Advisory Council).

The **Advisory Council** is responsible for **community engagement**. The main role of the Advisory Council is discuss and identify issues specific to the community relating to the provision of maternity care. For example, the communities need to identify the level of care and local services available, and strengths and limitations of the current system. The Advisory Council will also explore desired improvements to the current maternity care system specific to the community.

The Council will also invite community stakeholders to form a working committee to assist with implementation and improving maternity care support at the community/non-primary care level; or in an advisory capacity, where parents, advocates, doulas can discuss and organize breastfeeding support drop-ins, or consider a family-oriented website specific to community.

When your community is ready to begin the process of midwifery service integration, a **Working Committee** needs to be established. It is advantageous for this group to have board representation from key stakeholders. The task of the working group is to support a smooth integration of midwifery into the community by addressing the following potential issues, challenges and concerns.



Issues, challenges and concerns

The Working Committee need to consider the feasibility of integrating midwifery into the community by exploring the potential challenges that might arise. Members of the Advisory Council can bring questions to table for discussion of concerns and clarification of particular issues. Members of Working Committee team are to clarify issues or collect information regarding the concerns and issues raised. It is also the Working Committee's Create strategies for potential challenges.

Community History

- What is the history of lay midwifery in the community?
- Are there any lay (unregistered) midwives currently attending deliveries in the area?
- Is there a population of women who choose unassisted homebirths?

Review past hospital service reviews and local perinatal outcomes data for an understanding of the history of local birth and the needs of the community.

No Local Midwifery Care?

If your community does not have the population to support local midwifery care but birthing women would like to access midwifery, determine the nearest community that supports registered midwives. Build relationships with midwives in referral communities, develop plans for transfer of care, support women to meet and build relationships with referral midwives, and develop a mechanism for transferring charts to the referral care provider before and after delivery. ^

^Recognizing that in any rural population at least 10% of birthing women will have to travel to access tertiary care for clinical reasons, visit <http://crhr.ca/resources/toolkits/> for strategies to support women who must travel to access services.

Starting a Practice

Midwives Association of BC is currently working on resources for practice start up that will be available late 2013. Along with this, the following issues also need to be addressed by the midwife integrating into a new community.

Hospital Privileges

The midwife should establish a relationship with the local Medical Advisory Committee (MAC) or Regional Department of Midwifery early on to facilitate the process of obtaining privileges. The midwife should apply for privileges as per the applicable Health Authority and/or hospital privileges application protocol or bylaws. If privileges are denied, consider mediation and follow the appropriate process for resolution of issues (i.e. hospital, Health Authority, Hospital Appeals Board).



Billings and Payments

Review midwife and physicians billing protocols for clarification. Identify and/or clarify anticipated issues with billing such as physicians or nurses attending home birth as second attendants, physician acting as consultant, midwife covering physician's call or assisting at birth (i.e. for NRP).

Review hospital policies on costs for non-insured patients, including U/S and lab as indicated.

Funding

For a midwife entering rural practice in a community with no existing midwifery, she will have to establish a new practice and client case-load. Realistically, if the midwife gains clients immediately upon starting up practice, she will not receive her first course-of-care payment until 3 months later. Midwives should prepare for this gap in their income.

- Will the midwife be paid via course of care or through an alternative payment plan such as salary?
- Will she be part-time or full-time?

An alternative funding model: South Community Birth Program (SCBP)

SCBP was started in January 2004 with funding from the Federal Primary Health Care Transition Fund and the Provincial Health Services and Vancouver Coastal Health Authorities in British Columbia. Midwives, family physicians, nurses and doulas provide care in a team-based shared-care model. Midwives and physicians pool their Medical Services Plan billings and are remunerated at the same rate on a sessional basis for their services.

Source: Harris SJ, Janssen PA, Saxell L, Carty EA, MacRae GS, Petersen KL. Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. Canadian Medical Association Journal 2012; 184(17): 1885–1892

Places of Birth

A core tenet of the midwifery model of care is choice in place of birth for the childbearing woman. This includes both hospital and home. Due to this, in order to maintain their professional license, midwives must attend at least 10 homebirths per year.¹

- *Are birthing women in the community interested in home births?*
- *Are other local nurses, physicians, ambulance attendants, and surgeons supportive of home deliveries?*
- *What activities and education needs to take place to create a supportive professional environment for home births?*
- *If it is unfeasible to attend 10 homebirths in a given year, where can the midwife go to attend enough deliveries to meet her professional requirements? Ideally, the midwife would go to her referral community or be a locum in a high-volume setting.*
- *What is a reasonable catchment size for the midwife? For home births? For client populations?*

Maintaining Competency

If the midwife must leave the community to achieve her minimum annual deliveries, she should do so in her referral community to maintain continuity of care with clients. If the midwife works in a solo practice and must leave for skills upgrading or to achieve her minimum number of annual deliveries, continuity of care with clients should be honoured. Support incoming locums and referral centre care providers to form a relationship with the client before transfer of care takes place, for instance by meeting clients in advance in person or through Telehealth.

¹In communities without local access to caesarean section, a hospital birth *and* a home birth.

Health Human Resources

- What care providers currently practicing in the community are willing and able to support the integration of midwifery care?
- Will you need to recruit maternity care providers or provide maternity skills training to local nurses?
- Will there be a solo or a group midwifery practice?
- Are there midwives or student midwives who have expressed an interest in local practice?

Second Attendants

Consider the list of eligible second attendants for midwifery-assisted deliveries. Are there individuals in the community who would be interested in working as second attendants? For CMBC's list of acceptable second attendants, visit: www.cmbc.ca/Registrants-Handbook-13-05-Policy-for-Second-Birth-Attendants.pdf

Specialist Back-Up

Midwives cannot order a caesarean section; they consult with specialists and the final decision rests with the surgeon. If there is no local specialist available for consult, this has to occur through distance consultations. Consequently, midwives need strong relationships with referral specialists.

Interprofessional Relationships

To create mutually beneficial, trusting relationships with other maternity care providers, midwives will need to meet with other local maternity care providers, develop collegial relationships, and create strategies for mutual sustainability. A few issues to consider:

- *How will the new midwife's presence impact the sustainability of other midwifery practices in surrounding communities?*
- *Are there physicians providing maternity care locally? Is there a large enough local population to support sustainable parallel maternity practice between physicians and midwives?*
- *What will the roles be of local nurse practitioners, public health nurses, and hospital based nurses.*

Lifestyle Sustainability

Given the high rate of burnout among rural practitioners, the midwife should have professional and lifestyle support through:

- Locum coverage for vacations and leaves of absence
- On-call coverage from physicians in the community
- Promoting social support through communities of practice or regional Departments of Midwifery
- Supporting professional development and skills maintenance through locum coverage and financial support for travel
- Supporting and funding local GPs to get trained and assist and/or conduct homebirths

Bylaws and Policies

Review existing maternity care bylaws, policies, forms and guidelines. Where appropriate, change language as indicated to reflect all primary care providers. Identify additional policies that may need to be drafted, associated with the addition of midwifery services. Examples may include: transfer of planned home births, VBAC, induction, augmentation, consultation and/or collaborative care, emergency room maternity care, etc. See Appendix C for further details regarding the identification of community protocols related to antenatal, intrapartum and postpartum care). Assign the drafting of policies to appropriate individuals or groups and establish a timeline for their completion.

Risk Management

Explore risk management concerns. Request Midwives Protection Program (MPP) and/or BCMA/CMPA/CPSBC and/or Hospital Risk Management involvement for clarity.

Is your community equipped to sustain local midwifery?

YES: Move forward to Phase 2

NO: Continue to work with community stakeholders, Health Authority, MABC and other parties to identify and resolve outstanding issues

Phase 2: What model of care?



Step 4: Choose a model

After speaking with all key stakeholders, considering the nuances of the community, including the presence or absence of local caesarean section services, consider which model of local midwifery might be a suitable fit.

Potential models include:

- Midwifery only (no local physicians provide maternity care)
 - Physicians involvement in maternity care
 - ◊ Physicians offering prenatal/postpartum care
 - ◊ Physicians offering prenatal/intrapartum/postpartum maternity care
 - Physicians and midwives practicing in parallel (not integrated)
 - Physicians and midwives practicing in shared care (integrated)
 - ◊ One to one care (separate client lists) with collaborative call
 - ◊ Shared client list with collaborative call
 - ◊ Shared client list with collaborative call + one-to-one community based midwifery
- + Midwifery outreach to satellite communities
- + Home birth
- + Well woman care, family planning
- + Sexual health education for teens and youth

TIP: Consider group-based maternity care programs where prenatal is delivered in a group setting via an interdisciplinary team so that both the patients and the care providers get to know one another.

Call and Clinic Scheduling

Review physician and midwife call and clinic schedules. Identify existing call groups, anticipated issues with coverage, new call groups and/or alternate coverage arrangements. Note that collaborative practice agreements must be approved by the College of Midwives of BC (CMBC) as per Shared Care Policy (cmbc.bc.ca).

Review means of communication and contact information for hospital and all primary care providers and the process of notifying hospital of changes. Share contact information with all stakeholders (i.e. emergency room staff, lab technicians, ultrasound department, etc.).

Step 5: What resources will you need?

The midwife should develop a plan to set up her clinical practice, which will include:

- Finding a practice site
- Purchasing the necessary inventory for the clinic
- Taking inventory of existing resources:
 - ◇ Birthing rooms in hospital
 - ◇ Nurses comfortable with maternity care/postpartum
 - ◇ Neonatal resuscitation supplies/emergency pediatric supplies
 - ◇ Birth center/labor space appropriate for midwifery births?
 - ◇ Ambulatory/transport services for emergency relocation from home to hospital
- Developing relationships with and an understanding of BC Bedline

If there is no local caesarean section, create transport protocol to the nearest referral centre. If the community could support a local OR, consider recruiting a GP Surgeon to join the community.

Diversion Policy

Clarify diversion processes as per individual community and/or hospital. Protocols should be drafted or revised to include transfer of midwifery clients including home birth transfers to other communities if the hospital is on diversion. Communicate changes to staff and paramedics as indicated.

Home Births

Review midwifery scope of practice for home births, including reasons to transfer, the transfer process involving BC Ambulance and hospital, medications and supplies brought to births, and the role of the second attendant (see CMBC Home Birth handbook www.cmbc.bc.ca and discuss any need for clarity). Determine a system for the supply of home birth disposables, medications and equipment sterilization.

As per the diversion policy above, draft a policy for the transfer of home birth clients both in and out of the community when the hospital is on diversion or when there is a need for higher level of care.

Step 6: Who will the midwife be?

Is there a midwife interested in practicing in the community?

Do you need to recruit a midwife to the community?

- Contact MABC to begin recruitment. Put ads on Health Professional hiring websites, in provincial newspapers, and distribute to the MEP, CMBC, and Health Authority.
- See sample advertisement [forthcoming].

Are there skills and cultural traditions that you would like your community's midwife to incorporate into her practice?

- Decide if you want an Aboriginal midwife. There is currently a shortage of Aboriginal midwives in Canada and communities should consider if they are willing to accept a non-Aboriginal midwife who practices within a culturally-sensitive framework.



Phase 3: Preparing for midwifery



Hire the midwife.

During the relocation phase, set up frequent community visits to begin engagement and relationship building with the community.

Step 7. Building connections

The midwife will need to build connections and make introductions with all care providers and allied health professionals in the community .

Use a culturally appropriate method of education in Aboriginal communities. Build relationships with Aboriginal community through visits to Elder’s luncheons, participate in “Walks,” mom and tot groups.

Determine the cultural activities taken up by the local community and which ones are appropriate to engage in. These should be investigated by the local midwife (this is a big diversion in the Aboriginal pathway).

- Referral community relationships
- Are there local doulas?

Step 8: Community education

Communicate the following:

- Rationale & benefits of introducing midwifery care into the community
- Issues of safety given the resources and care provider skills available in the local community
- Scope of midwifery practice; roles and responsibilities [Model these discussions of risk and safety on “Reclaiming Birth,” 2006 Vicki Van Wagner]

Outputs:

- Collaborative process to establish criteria for local deliveries; catchment size; referral communities consultant relationships; shared agreements for scope of practice where any overlap takes place
- Formal notices about new model of care in the newspaper and in care provider offices, hospital, etc.





Step 9: Skills enhancement

Enhancing local skills of care providers who will participate in midwifery-led maternity care.

- *Are there nurses in the community who will support maternity care? Do they need additional skills and training? Are they able to receive this training locally, through in-house training (potentially by the new midwife), or in a referral centre?*
- *Do ambulance attendants or first responders in the community need additional training?*
- *[Consider other practitioners, lab technicians, physicians]*

Phase 4: Integrating midwifery into the community



Circle of Life (1997) Susan A. Point

Step 10. Community acknowledgement of the midwife

Welcome in both ceremonial and practical ways the integration of midwives to the community.

Changing the community of practice standards.

- Update language in documents and within the hospital to include midwives as care providers.

Provide midwives with an orientation to: the community hospital, facilities, policies, administration, obstetrics ward/area, ER, lab(s), U/S, etc. BC Women's hospital has clear orientation guide for midwives PRN.

Provide orientation to current staff on the role and scope of practice of midwives within the hospital and in the community (consider in services).

Step 11: Establish a community of practice

Connect with other midwives close by, midwives in the region, and rural midwives through the MABC to create a network of professional support.

- Establish connections with specialist colleagues in regional and tertiary centres.
- Establish local or regional interdisciplinary Departments of Maternity Care, or for midwives, develop Regional Departments of Midwifery.
- If there is local caesarean section coverage, also connect with the proposed Virtual Department of Operative Care.

Step 12. Quality assurance

- Set up a quality assurance system where outcomes are tracked and deviations are noted (PSBC has an annual reporting system that could be used).
- Check in with referral communities to see how the midwifery practice is faring.
 - *Are relationships and communication successful?*
 - *[Will midwives travel to referral community with patients; privileges?]*
- Maintain good communication with all local care providers and allied health professionals; have a “check-in” to see that the system of relationships is working smoothly.
 - *Is there good communication with other professionals?*
- Address any regulatory, professional, communication or logistical issues quickly and equitably to ensure equality between all care providers and maintenance of mutual respect.
- Review requirements for moving to and maintenance of active privileges as well as medical staff bylaws.
- Clarify in which capacity midwives are represented within hospital (Department or Division, depending on HA bylaws and protocols).
- Determine midwifery availability for committee participation.
- Establish interprofessional “maternity care rounds” on an ongoing basis.
- Ensure that the midwife is included on all health care committees.
 - Establish an open door policy where midwives are included in all meetings, activities, education sessions etc. that any other new primary care provider entering the maternity field in that community would be included.

Phase 5: Sustainability



Step 13: Interprofessional sustainability

Ensure that the midwife has regular time off for vacation and continuing professional development, with paid locum coverage.

Provide Continuing Medical Education (CME) and Continuing Professional Development (CPD) for the core maternity team (physicians, nurses, and midwives).

- Funding may be accessed through the Rural Education Action Plan (REAP), the local health authority, or First Nations Health Council.
- Provide appropriate locum coverage for providers accessing CME/CPD.
- Provide, where possible, team-based and hospital in-service CME/CPD.

Step 14: Financial sustainability

In a fee for service environment, if there are not enough local deliveries to maintain a successful practice locally, go to a high-volume setting to attend a greater number of births. What community will they go to? What coverage will they provide for their clients?

In low-volume environments, consider alternative payment schemes (i.e. salaried positions).

Step 15: Monitor the new maternity service

Determine the population catchment (patients living within 1 hour and within 2-4 hours of local care).

Track clinical outcomes through Perinatal Services BC data.

Compare with outcomes of like-sized communities and pay close attention to variance.

Establish a process for quality improvement.

Establish a process for documenting care provider, allied health professional, and community responses and satisfaction with service.

Consider maintaining the Advisory Council, to meet on less frequent basis, to review success of integration and implementation.



The “Birthing Canal”, Haida Gwaii



Step 16: Quality improvement

- Set outcome based goals and re-evaluate progress.
- Consider the ongoing sustainability of the model from a professional standpoint.
 - ◇ *Would the midwife benefit from having another practice partner?*
- In low birth volume areas, consider utilizing the midwife's expanded scope of practice to provide well woman care, community sexual health programs, etc.
- Provide ongoing community education to ensure that birthing women have a clear understanding of the model of midwifery care in the community.

Appendix A: Advisory Council Membership Checklist

Name of community: _____

The membership of an Advisory Council for overseeing the planning and integration of local midwifery care should be composed of appropriate stakeholders and/or representatives including but not limited to the following (add names of community members following each stakeholder designation):

- Committee Chair _____
- Representative (s) of Aboriginal community
 - Band Council representative _____
 - Health Council representative _____
 - Health Centre representative _____
 - Elder _____
- Health Authority representative _____
- Hospital / MAC representative _____
- Nursing – Intrapartum representative _____
- Nursing – Public Health representative _____
- Nursing – Nurse Practitioner _____
- Physician Representatives (varies by community)
 - Pediatrician _____
 - OB _____
 - FP _____
 - ER _____
 - Anaesthesia _____
 - GP surgeon _____
 - Surgeon _____
- Midwife / midwives _____
- MABC Representative _____
- Liaison(s) between Committee and Lab/Ultrasound /Paramedics and/or other community stakeholders such as lactation consultants (LCs), etc. _____

Appendix B: Starting a Practice Check List



Appendix C: Identification of Community Protocols Checklist (Part A)

✂ Name of Community: _____

A. Antenatal Care

Identify community protocols around the following:

- Miscarriage management / D&C / Options
- Abortion services
- Genetic screening and counseling
- Amniocentesis
- Consultations and transfers of care
- Antenatal hemorrhage and other emergencies presenting in ER
- Domestic violence
- Ministry / social worker involvement in care
- Other items identified by committee

Identify community protocols related to U/S, Lab & NST services:

- Fetal Health Surveillance and follow up of anomalies identified by ultrasound or other means
- Ultrasound availability and scheduling of appointments
- Lab availability for in and outpatient services
- NST protocols: booking, during regular and 'off' hours

Administration and community protocols:

- Registering at hospital
- Faxing / sending antenatal records to hospital
- Prenatal education options and scheduling
- Available services such as mental health, lactation consultants, etc.

✂ Review roles and responsibilities of midwife, nurse, physician and identify and discuss any community-specific variations.

Appendix C: Identification of Community Protocols Checklist (Part B)

B. Intrapartum Care

Identify community protocols around the following:

- Induction of labour
- Augmentation of labour
- Complications of labour
- Management of Group B Strep
- VBAC
- Cesarean sections
- Cord Blood Gas Collection
- Anaesthesia
- Narcotic orders
- Consultations and transfers of care within community
- Consultations and transfers of care out of community
- Intrapartum emergencies
- Other items identified by community

Review roles and responsibilities of midwife, nurse, physician and identify and discuss any community-specific variations.

Appendix C: Identification of Community Protocols Checklist (Part C)



C. Postpartum Care

Identify existing community protocols around the following:

- Routine in hospital postpartum maternal care
- Routine in hospital newborn care
- Complications in the postpartum period prior to discharge
- Complications in the postpartum period requiring readmission
- Management of hyperbilirubinemia and other nb complications
- Newborn screening process (note that midwives can do test at home)
- Postpartum mental health concerns
- Lactation services in hospital
- Newborn levels of care provided by hospital
- Transfer of newborn back to midwifery care after complications
- Other items identified by committee

Identify existing community protocols around the following:

- Role of public health following discharge from hospital
- Lactation services in the community
- Schedule of midwifery visits postpartum

Review roles and responsibilities of midwife, nurse, physician and identify and discuss any community-specific variations.



We want to hear from you!

The midwifery pathways poster and booklet are still in the development phase. If there are information that were helpful, or information that was missing, please let us know. This is a dynamic document and updates will be forthcoming. Please send comments and feedback to info@crhr.ca.





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