Delivering An Alternative:

An Overview of the Regulation of Midwifery in Manitoba

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Preface

The development and implementation of regulated midwifery in Manitoba was an enormous undertaking. Its history begins in the early 1980s and even before that, when women first began to reclaim their births and found other women who could help them do so. My own involvement began in the mid-80's, first as a mother seeking a midwife's care, and then as Chair of the Equity and Access Committee of the Midwifery Implementation Council. I worked in that capacity for over 5 years, as well as on other committees, until the College of Midwives of Manitoba opened for "business", when I became the first Registrar.

It is not possible to cover all aspects of the many pieces that contributed to the eventual Proclamation of the Midwifery Act in 2000 in anything less than a book. Besides the involvement of the Midwifery Implementation Council, there was a concentrated effort within Manitoba Health to see the work to completion. There was also good political will across the board – the Bill sailed through all readings, with all parties signing on without debate!

This paper gives only a mere overview, developed in keeping with the theme of the Working Symposium, Midwifery: Building Our Contribution to Maternity Care (Vancouver, 2002). I wish to thank my colleague, Yvonne Peters, who contributed a great deal to this paper, which we delivered in an alternative way in Saskatoon in 2001.

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Delivering an Alternative: An Overview of the Successes and Challenges of the Regulation of Midwifery in Manitoba.

Introduction

In 1994 the Minister of Health for Manitoba announced the formation of the Midwifery Implementation Council. The Council consisted of 13 hand-picked women who were given 2 and a half years to put into effect the recommendations from a Working Group Report which was released on the same day. Six years later, in June 2000, the Manitoba Government proclaimed the *Midwifery and Consequential Amendments Act* which identified midwives as autonomous health care providers. Coincidentally the Manitoba Government confirmed the mechanisms to make midwifery care available as a funded service for women, including the means for payment to midwives and for collaboration with other health care providers.

The presentation will examine some of the steps taken, and the successes and challenges of making midwifery care available to women, particularly for those who live outside of Winnipeg. The presentation will include a brief outline of the policies in place, and the struggles to implement those policies in rural and remote Manitoba because of challenges in human resources (recruitment and retention), local acceptance, providing culturally appropriate care and so on. Finally the presentation will identify the need for further research and evaluation of the true availability and accessibility of midwifery as a primary health care service in rural and remote Manitoba, including women's satisfaction with the newly-regulated profession.

Maternity Care in Rural and Remote Manitoba:

Women's choices for maternity care in rural and remote communities of Manitoba have historically been limited. Many Manitoba women must travel considerable distances to Winnipeg or Thompson because there is no obstetrical care available in their community. Those from northern and remote communities are transported to Winnipeg for childbirth because nurses employed by the Medical Services Branch or at other small clinics are not "qualified or permitted to provide care during labour and birth, except in emergencies" (MSB, pers comm). This is ironic because until the late 1970s British nurse-midwives were actively recruited to northern Manitoba because they *could* provide maternity care. Rural women in the south have also had to travel further for childbirth, as fewer and fewer family physicians provide obstetrical services.

Women have continually voiced their concern about having to leave their families, homes and communities for childbirth. Moving from one centre to another always leads to a certain fragmentation of care. For Aboriginal women from northern reserves it can mean being flown to Winnipeg as much as two to four weeks before the expected due date, to a city where both the medical staff and the language may be unfamiliar. Each new nurse, technician or doctor must be re-told the history for the current pregnancy and those in the past.

As in the other provinces, there had always been some Manitoba women who chose to have a midwife attend their home births. The few midwives, located in and near Winnipeg and Brandon, traveled to see women pre-natally, for the labour and births, and as well as for the early days after the babies' births. One family in northern Manitoba, for instance, arranged over the years for a southern-based midwife to travel to their town and be available for the births of several babies among the mothers, who were sisters or sisters-in-law. In the extreme southwest of the province some women hired a midwife from North Dakota to attend them. There are not accurate statistics on the number of home births attended by midwives in northern and southern Manitoba, but there were approximately fifty home births in southern Manitoba each year by the early 1990s. The midwives who attended home births reported that they were unable to meet the demand for their services by then.

Among Aboriginal women there may have continued to be incidences of local women providing midwifery care in some communities. Because of potential repercussions it was not openly discussed with members of the MIC. A few Manitoba women did contact and choose to have the home birth midwives attend them.

The few midwives who provided care and attended births at home before regulation did not have admitting privileges, could not order or interpret diagnostic tests, and had only infrequent working relationships with physicians. This is in contrast to the many more midwives in BC, Ontario and Quebec who were in practice before regulation in those provinces, some of whom had on-going working relationships with local physicians. Therefore, some women in Manitoba also saw a family doctor or obstetrician for prenatal care and in some cases, a mother may have received midwifery care pre- and post-natally (including physician care) but for a hospital delivery the midwife's role became more like that of a birthing companion

Consultations Held with Rural Women

The Council was determined from the outset to ensure that this newly regulated profession should be available to all Manitoba women, that it would not become yet another resource only available to urban middle-class women.

The Equity and Access Committee was asked to consult with women across the province and document their concerns, suggestions, and comments for the development of regulated midwifery. Over two winters evening meetings were held in 15 rural communities, reaching more than 200 women in all. Women who attended the gatherings spoke as consumers, as well, in some cases, about what they wanted to be able to do as providers. ***Most women who attended had already had some form of midwifery care and were worried that their already tenuous access to care would be withdrawn with regulation***. Stories mothers had heard from other provinces about new restrictions on midwives' practices caused them to be very clear that ***they did not want geographical restrictions placed on Manitoba midwives when the profession became regulated***.

Consultations with Aboriginal Women in Manitoba

The Equity and Access committee also hosted numerous consultations with Aboriginal women in the province. When the draft legislative proposals were first drawn up by the Council, we decided to suspend submission of the draft to the Legislature because we were not satisfied with the level of consultation we had done so far with Aboriginal women.

In order to get the best response from the most possible women in northern Manitoba, the Council commissioned two northern women to train other women and conduct consultations in various communities. In all, more than 200 women in over 20 communities met and contributed to the consultations. Similarly committee members traveled to 10 southern communities to meet with women and health care providers. We also commissioned separate consultations among Metis women in southern and central Manitoba. The results of the consultations were compiled and summarized and used to direct further developments in the regulation of midwifery practice and protocols.

In general the Council found cautious acceptance of the idea of regulated midwifery among Aboriginal women. At a time when many people see only death and tragedy in their communities, the opportunity to "bring birth back" was welcomed. However, women did not want to be receiving any sort of second-rate care for themselves or their families. Aboriginal women we met with agreed that midwives who are able to bring current, medical knowledge to a practice that also relies on more traditional, holistic and culturally appropriate care would be acceptable.

Communities do differ in their plans to introduce regulated midwifery. At Nelson House, for instance, there is a new birthing centre waiting for midwives to begin practice. Berens River, a First Nations community on the east side of Lake Winnipeg, is looking for midwives to provide pre and post natal care on reserve with no immediate plans for births to take place in the community.

Following the consultations, the Council proposed that there be ensured, continued participation of Aboriginal women in the development and regulation of midwifery. Therefore, the *Midwifery and Consequential Amendments Act* requires a Standing Committee on Issues Related to Midwifery Care for Aboriginal Women (known as Kagike Danikobidan). The Committee was first convened, following passage of the bill, in June 1997.

Commitment to the Results of The Consultations

Committed to the recommendations of the consultations the Council worked to incorporate women's concerns within the structure of the College and practice standards. We also worked with Manitoba Health to establish target populations for the introduction of midwifery. It was vital that midwifery not become another resource available only to urban women.

The results are seen in the Manitoba Standards for Care:

The Regulation and Act allow midwives to provide care in all settings. Decision on place of birth rests with the mother. Midwives must provide care in all settings and there are sunset clauses for midwives who are establishing their competency in one setting or another.

The Standard for Consultation and Transfer of Care includes protocols to maximize care by midwives, as appropriate to their scope of practice.

The Standard for Out of Hospital Birth criteria take into consideration the geography and distance of communities in Manitoba. In the absence of conclusive evidence about what is acceptable for distance, the College does not assign arbitrary figures to distance, time to physician help, etc. Instead the onus is on the midwife and women to reassess the circumstances around the pregnancy and the proposed place of birth. The midwife does have set guidelines for ensuring appropriate back-up, access to emergency assistance within reasonable limits.

Criteria for Second Attendants at births are more inclusive, to take into consideration the likelihood that midwives may be in solo practice at least at the outset. Based on recommendations from other jurisdictions and community standards, midwives can be responsible for a second attendant at births who may be another midwife, a nurse (labour nurse), emergency medical personnel, or physician. The second attendant must have training and competence in being able to assist a midwife during neonatal or maternal obstetrical emergencies.

There is nothing under the regulation of midwifery in Manitoba preventing midwives from continuing their registration as nurses. This is not the case in other Canadian provinces. In Manitoba it is possible for midwives to still earn income as nurses in remote and rural communities, where a midwifery practice may be small.

Integration with Other Health Care Providers

At the same time, the Council coordinated three separate integration committees. These three committees each worked for over a year to plan for the smooth integration of midwifery with other health care professions. Working with provincial and some local representatives, we developed templates for how midwives and public health nurses, emergency measures personnel, and hospital staff could clearly define their roles and responsibilities for care of mothers and babies.

With thanks to our counterparts in BC and Ontario, in Manitoba we were able to bypass some of the friction of expected when physicians and midwives began to work in collaboration. Some months before regulation was fully in place, we were able to secure a physician billing code for consultation with a midwife.

The Assessment and Upgrading

Manitoba Health provided funding for 50 midwives (in groups of 10) to go through the Assessment and Upgrading which was Manitoba's qualification and registration process. Briefly, we used a competency model for the process and over the years we developed an English-for-Midwives language course which provided familiarity with terminology as well as appropriate study skills and support. Proclamation of the *Act* was delayed until a number of midwives had completed the process and were able to register under the new regulation. There are 28 registered, practising midwives, seven of whom were trained in non-English speaking countries.

Before the *Midwifery Act* was proclaimed it became clear that providing midwives to northern and rural Manitoba would be problematic. Therefore the Council actively sought, recruited and held placements for midwives who said they were prepared to work outside the cities of Winnipeg and Brandon.

Education Programs

Following the establishment of the Assessment and Upgrading process, the Council Education Committee devoted considerable time to developing a curriculum outline for a competency-based full education program. This was done, in large part, in conjunction with and with support from the Faculty of Nursing at the University of Manitoba. Briefly, candidates can be assessed for their knowledge and competency at any stage of the program, access is simplified by placing the early modules in the community colleges, and the program is designed to include a large distance-education component.

Currently the proposal sits on a shelf, unsupported, because no department of the Manitoba government will agree to funding the new program through the University or its affiliates. Without the developed curriculum, a Refresher program, designed especially for foreign-trained midwives, is also undeveloped.

It is possible for midwives to train as apprentices in Manitoba. However, final assessment of some competencies depends on unreliable funding. Also, as is the case in the rest of Canada, midwives are so few in number that taking on apprentices makes for a very heavy workload.

The College of Midwives has recently supported the development of a PLEA process for Manitoba applicants. This too is awaiting necessary funding.

Midwifery and Regionalized Health Care

In Manitoba most health care services are delivered by the twelve Regional Health Authorities (RHAs). RHAs are provided with a global budget which must be used to cover the costs of required health services. Because of its newness, there was some concern that, without a specific pot of money allocated to retaining midwives, most RHAs would not take advantage of midwifery services. Initially, most RHAs were unfamiliar with the training and qualifications of midwives and with their scope of practice. For this reason, since June 2000

Manitoba Health has designated a specific midwifery budget to cover the costs of employing midwives in RHAs. In the 2000/2001 fiscal year, funding was provided for 26 fulltime midwifery positions.

There are not enough registered midwives to meet the ever-increasing demand for midwifery services. With no education program in place Manitoba Health is relying on strategies for recruiting midwives from outside the province; and that has not been too successful. In addition, to build for success, time is needed to work with the RHAs to develop policies and practices that welcome and include midwives as an integral part of the health care team. For these reasons, the provision of midwifery services is voluntary for RHAs. Manitoba Health has therefore developed a detailed process for allocating funds to RHAs wishing to offer midwifery services. It is unlikely that midwifery care will become a required RHA service until there is an adequate supply of registered midwives and RHAs have had more experience with midwives.

To date, six RHAs have applied for and been approved for funding, however, due to funding limitations, only five have received funding. Of the six approved RHAs, two are in the north, three are rural and one is RHA of Winnipeg. Of the 26 fulltime midwifery positions allocated to RHAs, 16 are in Winnipeg and 10 are located in the rural and northern RHAs.

Compensation for Midwives and the Model of Payment

In May of 1999, the Midwives Association of Manitoba advised Manitoba Health that it had been appointed by the midwives to negotiate with the government for a compensation package. Though the Association does not have the same legal status as a certified union, it does officially represent the professional interests of midwives. A Policy Committee on compensation issues was formed with representatives from Manitoba Health, the Midwives Association of Manitoba and the Regional Health Authorities.

In Ontario and British Columbia midwives are paid according to a course of care or a fee for service model of payment. According to this model, a midwife bills the government for the performance of specific aspects of midwifery care provided to a client during pregnancy.

The Committee rejected this model for two reasons. First, the Committee recognized that, for various social and economic reasons, some clients may require more midwifery time and care than other clients. Otherwise marginalized populations were considered a target for midwifery care, and the committee felt that it would be too complicated to structure a course-of-care model that took into account the special needs of certain clients.

Second, to facilitate the integration of midwives into the health care system, the Committee recognized that midwives would have to be available to participate on RHA committees and to attend RHA meetings. Again, incorporating that work into a course-of-care model seemed difficult to the Committee.

With the course-of-care model off the table, the two remaining models of payment to be considered were independent contractor or employee. The Midwives Association of

Manitoba argued that both models should be available to midwives. Initially, Manitoba Health was open to this idea. However, it sought legal opinion and learned that, from a labour relations perspective, the government may have difficulty supporting the notion that the same job could be done by either an independent contractor or an employee. As well, there was some concern that a two-model system would not be accepted by Revenue Canada. Therefore a choice had to be made.

This decision was particularly difficult for the Midwives Association of Manitoba. The Association consisted of both midwives who had worked independently and midwives who were already employed with the RHA (often as nurses) and thus had employee pensions and benefits to protect. Given this situation, it is easy to understand why the Association preferred a two model system. However, in light of the legal advice given to Manitoba Health, Manitoba was persuaded that only one model of payment could be established.

The Midwifery Act describes midwives as "primary health care providers", meaning that midwifery care is provided in collaboration with other health care professionals and community supports so that all the health and social needs of the pregnant woman are met. For this reason, Manitoba Health and many of the RHAs supported the employment model of payment; i.e. midwives becoming employees of RHAs. They hoped that an initial employment relationship would ease integration within the RHA and with the other staff and professionals.

In June 2000, the Midwives Association of Manitoba and Manitoba Health signed a two year Implementation Memorandum of Understanding which specified that publicly funded midwives must be employees of an RHA. The Memorandum also established a salary scale which placed the compensation level of midwives between a nurse 5 and a family physician. The scale included an increase in remuneration for those midwives practising north of the 53rd parallel.

Successes and Challenges

1. Integration

Each funded RHA has established a Midwifery Implementation Committee made up of health professionals, including midwives, and other staff to oversee the integration of midwives. These Committees have proven to be invaluable and have encouraged RHAs to develop policies and procedures for integrating midwives which meet the specific needs of their region. These Committees look at admitting privileges for midwives, emergency transport procedures from home to hospital, orientations to RHA policies, particularly those in hospitals, orientation for health professionals, such as nurses and physicians, on the role and scope of midwifery practice and the development of policies, protocols and relationships that take into account the service provided by midwives.

What's needed now is an evaluation of the progress within the RHAs, and steps toward making the service available in RHAs that do not yet have enough midwives practising.

2. Supply and Demand

As in other provinces, the demand for midwifery services is fast outstripping the supply of midwives. This is particularly true in Winnipeg where women are being turned away because of overflowing case loads. Case loads in rural Manitoba are not quite so heavy, but we believe that it is only a matter of time before they too reach their maximum.

There are only a few registered midwives who are not employed or practising in Manitoba. Thus, training programs for new midwives and recruitment from outside the province are necessary to ensure significant expansion of midwifery services. This is especially true for providing culturally-appropriate care to Aboriginal women outside Winnipeg. The work of the Council, and the continued work of Kagike Danikobidan generated a lot of interest in some communities and now there are insufficient midwives and not an appropriate, funded means of training new midwives.

3. Recruitment and Retention in the Rural and Northern Regions

Not surprisingly, most midwives have opted to work in a city, mostly in Winnipeg. Where this is not possible, the next option is to work in a rural region that is close to an urban area. As a result it has been very difficult to recruit midwives into the north.

The RHA of Burntwood which includes the city of Thompson and several Aboriginal communities in a vast geographical area, has funding for four fulltime midwifery positions. To date, they have only been able to fill one position.

The Prairie Women's Health Centre of Excellence will be undertaking research in the coming years which will look at recruitment and training models from other countries. The research will be used to develop policy implications for northern and rural health care to women, including midwifery care.

4. Access

Currently, many Manitoba women do not have access to a midwife. This is particularly disappointing and frustrating for members of the public who led the fight to have funded regulated midwifery service. There are a number of factors which make it difficult to provide full access at this time.

a) Currently, the provision of midwifery services by a RHA is voluntary. In other words, while Manitoba Health is encouraging all RHAs to provide midwifery services, it is not a mandatory service at this time. At the outset, Manitoba Health believed it would be more politic to introduce midwifery care where it was wanted and where effectiveness and value of providing midwifery services can be demonstrated. However, Manitoba Health may eventually declare midwifery to be a core service which must be provided by all RHAs.

b) Generally speaking, employed midwives can only provide service to residents living in their employing RHA. In certain circumstances, a RHA will accept an out of region client. However, as case loads grow, it will be difficult to continue with such arrangements. As a result, most women living in RHAs which do not employ midwives are without service.

Even where a RHA provides midwifery services, access can still be limited. RHAs do not yet have the number of midwives required to provide region-wide service; thus they have specified that midwifery services will only be provided in a certain part of their region. Women living outside this specified part of the region can still get midwifery services, but they must travel to receive care, including for an out-of-hospital birth.

c) One of the most significant factors affecting access to midwifery care in Manitoba is the lack of supply of midwives. To provide midwifery care in all 12 RHAs we would require well over 100 midwives. As I mentioned, there are only 29 midwives registered with the College of Midwives of Manitoba.

Conclusion

For two years now we have seen the fruition of the five and half years of preparation and work done by the Council and many others. In many ways we have demonstrated that it is possible to build feminist, and women-centred policy, although it is clear we cannot consider the work done until midwifery is truly accessible to all Manitoba women. Despite the good attempts to make sure that midwifery in Manitoba would not be just another Winnipeg-based service, women are now without care in many parts of the province. Universal difficulties of recruitment and retention persist.

Research and evaluation and narrative projects will help document the success of the process, far beyond what can be covered in this short paper, and provide insight into what didn't work well. It is essential to keep the momentum of interest and good will, both in the community and in government. The challenge for Manitoba and the rest of the country is to ensure there are adequate budgets and support for new midwives to receive appropriate training and experience which is relevant to the communities they will serve. At the very least, we must ensure that there are means for midwives with some experience and training to upgrade and be assessed.