A study of sustainable systems for making childbearing safe and accessible for disadvantaged women

A report for the Winston Churchill Memorial Trust of Australia

Prepared by
Dr Jenny Gamble
2007 Churchill Fellow

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Dr Jennifer (Jenny) Gamble
11 August 2008

Signed
Dated
Acknowledgements

I would like to acknowledge the contributions of the following people and organisations for making my Fellowship possible, valuable and pleasurable.

The Winston Churchill Memorial Trust of Australia for financial support and the Trust staff for advice in planning my trip.

I would like to thank everyone I met for their generosity with sharing information, knowledge and resources.

A special thanks to Ólöf Ásta Ólafsdóttir, Janneke Langeveld, Dr Hennie Wijnen, Professor Jane Sandall, Jill Demilew, Professor Janet Tucker, Dr Tracy McDonald, Associate Professor Vicki VanWagner, Nowyah Williams, Rachel Jones, Diane Tiktak, Martha Aitken, Kris SikSik and Amanda Marshman for organising my visit to their country and/ or organisation and their hospitality, which often included welcoming me into their homes, providing food, and graciously extending my understanding of their country and health care system.

Griffith University for providing me with paid leave to undertake the trip.

Thank you to Professor Debra Creedy and Dr Cherrell Hirst AO for providing professional and project referee reports for my application to The Winston Churchill Memorial Trust.

To those people in my professional network who helped me plan my trip and used their extensive networks to put me in touch with key informants.

To my family – Fred for his continued support while I pursue my passions and missions; to my daughter, Nicole, for expressing her love for me by saying “Just come home” almost every time we spoke while I was away; to my sister, Susan, and nieces, Rachael and Melody, for providing extra support to my daughter; to my sister-in-law, Gina, for ‘lifting and laying’ me when I visited Glasgow; to my niece, Cotney, for providing a bed, company, and executive assistant services when in London; to my brother-in-law, Peter (Churchill Fellow, 2006), for encouraging me to apply.
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Introduction

Australia faces significant challenges in the provision of maternity care. The closure of rural birthing units, a 50% increase in the caesarean section rate in the last 10 years with no improvement in outcomes for babies, and widespread workforce shortages indicate that current service models are unsustainable. Encouraging sustainable, safe, locally available maternity services that build local capacity and focus on health promotion and primary care will provide substantial benefits to the community (improved safety, reduced surgical birth, improved mental health for mothers and infants, improved breastfeeding rates with the flow on benefits of reduced infant infections, SIDS and obesity, and improved cost effectiveness and workforce retention.

This report details the finding of my 2007 Churchill Fellowship travels to Iceland, Netherlands, England, Scotland, Canada including northern Canada (Nunavat) and attendance at the 23rd International Confederation of Midwives Congress in Glasgow.
Executive Summary

Project description: Making childbearing safe and accessible for disadvantaged women. My project focuses on the provision of services to women disadvantaged by geography (rural and remote), aboriginality and/or poverty. The purpose is to examine successful models of maternity care, policy, training and registration/credentialing, roles of maternity service personnel, evaluation and data collection processes for measuring success/outcomes.

Highlights

I was able to arrange to meet with midwifery leaders, maternity clinicians and researchers, policy makers, and government officials in each country (see itinerary). The International Confederation of Midwives Congress in Glasgow (75 countries represented and close to 4,000 delegates) enabled me to meet many people for short chats about maternity care in their country, region or health service.

Major lessons

In countries with the best outcomes for childbearing women, midwives have a strong professional identity and are deployed as the main primary maternity care provider. Robust consultation, referral and retrieval processes, and well-skilled obstetricians providing consultant/specialist services are built into the system.

Except for the Netherlands, the process of implementing a system of primary care by midwives is slow and challenging, despite convincing evidence that women want midwifery care, it is safe and cost effective and in some places will be the only means by which maternity services will be sustainably provided.

Inattention to workforce planning leading to an over or undersupply of maternity personnel is major destabiliser to implementing and maintaining best practice maternity care. It is also a significant barrier to innovation.

Careful analysis of the economic drivers that facilitate or hinder best practice is needed. Specific attention should be given to how services are “purchased” or “commissioned” from providers or agencies.

The private sector (or in Canada’s case the private sector within the public sector) needs careful regulation as it leads to a self-serving system that underperforms in services to childbearing women.
Dissemination and implementation plan in Australia

I plan to modify this report to submit as a briefing paper to The Hon Kevin Rudd MP (my Federal MP), the Hon Stephen Robertson, Minister for Health, Qld. and The Hon Anna Bligh. I will also seek a meeting with both Anna Bligh and Stephen Robertson. Some issues, such as an analysis of various funding models will require further work. I plan to write scholarly papers for publication on models for funding maternity services. Other issues are inherently political in nature and require lobbying, alliances, negotiating with other stakeholders. I will also present at seminars and conferences, and provide briefings to key people in my existing networks – Australian College of Midwives, Maternity Coalition, academics at Griffith University and at other institutions.
I left Australia on 19 May 2008 and travelled to five countries and 11 cities/towns. I took 15 flights and 8 intercity train journeys and met with hundreds of people to gain a macro picture of what works, what needs improving, and the opportunities and barriers to improving maternity services. I returned to Australia on 5 August 2008.

### Iceland 22 – 29 May 2008

<table>
<thead>
<tr>
<th>Date</th>
<th>Town/ city</th>
<th>Venue</th>
<th>People</th>
<th>Activity/ Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday 23 May</td>
<td>Reykjavik</td>
<td>School of Midwifery, University of Iceland</td>
<td>Ölöf Ásta Ólafsdóttir, Helga</td>
<td>Discuss maternity health care system and midwifery education</td>
</tr>
<tr>
<td>Friday 23 May</td>
<td>Reykjavik</td>
<td>School of Midwifery, University of Iceland</td>
<td>Graduating midwives, clinical teachers, midwives, midwife academics.</td>
<td>Informal ceremony for graduating midwives followed by a celebration of 10 years of midwifery at the University of Iceland. Discuss their education program, readiness for practice.</td>
</tr>
<tr>
<td>Monday 26 May</td>
<td>Reykjavik</td>
<td>University Hospital</td>
<td>Head midwife Rannveig and Birna, Head of Prenatal Care Unit – hospital</td>
<td>Discuss the system of prenatal care</td>
</tr>
<tr>
<td>Tuesday 27 May</td>
<td>Reykjavik</td>
<td>Prenatal care centre in the Reykjavik area</td>
<td>Head midwife, Jóna Dóra Kristinsdóttir and the midwives at the prenatal care centre in the Reykjavik area – community</td>
<td>Discuss the system of prenatal care</td>
</tr>
<tr>
<td>Tuesday 27 May</td>
<td>Selfoss</td>
<td>Birth Centre/ prenatal care centre and labour ward and maternity ward of hospital</td>
<td>Midwives - Bjork – birth centre/ prenatal care, Sýanorg – head midwife labour unit</td>
<td>Birth centre and hospital tour and meeting. Discussed models of care and sustainability issues.</td>
</tr>
<tr>
<td>Wednesday 28 May</td>
<td>Reykjavik</td>
<td>Reykjavik, Directorate of Health</td>
<td>Anna Bjorg Aradóttir, chief nurse and Hildur Kristjánsdóttir, head midwife</td>
<td>Meeting about structure of health care system, funding, issues</td>
</tr>
<tr>
<td>Wednesday 28 May</td>
<td>Reykjavik</td>
<td>Reykjavik, University Hospital</td>
<td>University Hospital</td>
<td>Presentation/open lecture</td>
</tr>
</tbody>
</table>
Glasgow – Scotland 1-6 June 2008

International Confederation of Midwives 23rd Congress Highlights

- Presentation about continuing professional development in Argyllshire, Scotland
- Midwifery education in New Zealand
- Midwifery in Afghanistan, speaking with Pashtoon and Sheena Currie
- Met with Gisela Becker, midwife from Fort Smith, North West Territories, Canada
- Met with Susanne Houd, midwife, Greenland
- Presentation of Professor Eugene Declercq, School of Public Health, Boston University regarding research into caesarean section and promoting normal birth.

Annual Leave 14 June to 10 July 2008
### Netherlands 10 July to 15 July 2008

<table>
<thead>
<tr>
<th>Date</th>
<th>Town/City</th>
<th>Venue</th>
<th>People</th>
<th>Activity/ purpose</th>
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<tbody>
<tr>
<td>Thursday</td>
<td>Amsterdam</td>
<td>Primary care midwife in private practice</td>
<td>Janneke Langeveld</td>
<td>To discuss the Dutch maternity system including educational preparation of midwives, entry into practice arrangements, funding.</td>
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<tr>
<td>10 July</td>
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<tr>
<td>Friday</td>
<td>Amsterdam</td>
<td>Homes of clients, Midwifery Practice at van de Hoopstraat</td>
<td>Karien de Munk</td>
<td>Discuss Dutch maternity system and meet practicing midwives, review practice rooms and systems for running private midwifery practice, funding and clinical visits to postpartum women</td>
</tr>
<tr>
<td>11 July</td>
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<tr>
<td>Monday</td>
<td>Eindhoven</td>
<td>Maastricht University</td>
<td>Dr Hennie Wijnen, midwife and researcher</td>
<td>Discuss Dutch maternity system – particularly Maternity Assistants – visited Kraamzorg bureaus (bureaus that organise maternity assistants)</td>
</tr>
<tr>
<td>14 July</td>
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### England 16 July to 18 July 2008

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<th>Date</th>
<th>Town/ City</th>
<th>Venue</th>
<th>People</th>
<th>Activity/ purpose</th>
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</thead>
<tbody>
<tr>
<td>Wednesday 16 July</td>
<td>London</td>
<td>Kings College London</td>
<td>Professor Jane Sandall</td>
<td>Discuss reform agenda in England, funding, outcomes, structure, policy, progress so far – opportunities and barriers.</td>
</tr>
<tr>
<td>Thursday 17 July</td>
<td>London</td>
<td>Kings College Hospital</td>
<td>Jill Demilew</td>
<td>Strengths and weaknesses of the current system – funding, outcomes, structure, policy, progress and the reform agenda.</td>
</tr>
<tr>
<td>Thursday 17 July</td>
<td>London</td>
<td>Children’s Centre Midwife</td>
<td>Anna Cannon</td>
<td>Norwood area (South of catchment area) Opportunity to ‘walk the patch’, discuss alternative model of provision of ‘enhanced care to pregnant women and in child's first year of life. (previously ‘Sure Start’ Programme)</td>
</tr>
<tr>
<td>Thursday 17 July</td>
<td>London</td>
<td>Albany Midwifery Practice SE</td>
<td>Pauline Armstrong and Albany midwives</td>
<td>Midwifery Group Practice Caseload Model (Individual) Self employed contracted into NHS Local population highest IMD, representative of King’s population Some of best outcomes for women &amp; babies for whole service</td>
</tr>
<tr>
<td>Thursday 17 July</td>
<td>London</td>
<td>Midwifery services for HIC positive women – Kings Hospital</td>
<td>Devi Aleksin Specialist Midwife HIV</td>
<td>Based in hospital, works closely with Ruskin Midwifery Group Practice (high risk caseload).</td>
</tr>
<tr>
<td>Thursday 17 July</td>
<td>London</td>
<td>Drug and Alcohol midwifery services – Kings Hospital</td>
<td>Tracy McCormack</td>
<td>Midwife for problem drug &amp; alcohol use. Woodvine service: Based on assertive outreach model aim to reach and work with the most socially excluded women/families</td>
</tr>
<tr>
<td>Friday 18 July</td>
<td>London</td>
<td>RCM</td>
<td>Sue Jacobs</td>
<td>Overview of maternity services in England and the RCM role, activities and outcomes.</td>
</tr>
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</table>
### Scotland 20 – 25 July 2008

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Venue</th>
<th>People</th>
<th>Activity/purpose</th>
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</thead>
<tbody>
<tr>
<td>Monday 20</td>
<td>Edinburgh</td>
<td>RCM offices</td>
<td>Gillian Smith (RCM Director for Scotland), Fiona Dagge-Bell, Professional Practice Development Officer NHS Scotland</td>
<td>Scottish system, role of RCM Scotland, barrier to change,</td>
</tr>
<tr>
<td>July</td>
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<tr>
<td>Tuesday 21</td>
<td>Aberdeen</td>
<td>Dugald Baird Centre</td>
<td>Dr Janet Tucker and Tracy McDonald</td>
<td>Rural maternity services, research and evidence about the organisation of care.</td>
</tr>
<tr>
<td>July</td>
<td></td>
<td>Department of O &amp; G University of Aberdeen Aberdeen Maternity Hospital</td>
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<tr>
<td>Friday 25</td>
<td>Glasgow</td>
<td>Princess Royal Infirmary</td>
<td>Ann Holmes</td>
<td>Implementing evidence-based care and new service delivery models. Evaluating and reviewing service delivery models.</td>
</tr>
<tr>
<td>July</td>
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### Canada 26 July to 3 August 2008

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<th>Date</th>
<th>Place</th>
<th>Venue</th>
<th>People</th>
<th>Activity/ purpose</th>
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</thead>
<tbody>
<tr>
<td>Sunday 27-28</td>
<td>Toronto</td>
<td>Ryerson University and Midwives Collective</td>
<td>Assistant Professor Vicki VanWagner</td>
<td>Discuss maternity system in Canada - funding, outcomes, structure, policy - opportunities and threats</td>
</tr>
<tr>
<td>July</td>
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<tr>
<td>Tuesday 29</td>
<td>Rankin Inlet – west coast of Hudson Bay</td>
<td>Wellness Centre (for prenatal and postnatal visits and education) and Health Centre (for birthing)</td>
<td>Martha Aitken (midwife), Kris SikSik (midwife), Amanda Marshman (midwife), Rachel Jones (student midwife), Diane Tiktak (maternity care worker). Inuit women using maternity service</td>
<td>Observe them at work. Discuss the service delivery model, funding, process (including referral and retrieval), and outcomes. Discuss health issues in the community and additional primary services available. Talk with women about their experience and views of the service.</td>
</tr>
<tr>
<td>July – 1 Aug</td>
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Trip Notes

In this section notes from each country visited are provided. It is not intended to be a complete report of all that was covered/learned from each country visit.

Iceland

Iceland is an island in the North Atlantic Ocean and one of the Nordic countries with a proud Viking heritage. It is a very small society in a country of 103,000 km², the most sparsely populated country in Europe with 63% unoccupied and the 300,000 inhabitants living around the coastal belt in urban centres, mostly in the South and South-West. Because of the Gulf stream, Iceland enjoys a warmer climate than its name indicates with average temperature in July being 10.6 and just below freezing in January. Iceland is a country of a rough natural setting with extremes in weather, dark winters and 24 hours of light in the summer. Earthquakes, volcanic eruptions as well as snow avalanches in the winter are fairly commonplace on this island of ice and fire.
Until recently Icelanders have been one cultural group with low immigration, however this has been changing; foreign citizens were 1.8% of the population in 1995 and 4.6 % in 2005 (Statistics Iceland, 2006). Fishing and farming has been the main livelihood, with tourism and high technological industry growing. Investment in banking and retail was growing however is likely to be adversely affected by the economic downturn.

Iceland has a strong publicly funded primary health care system. It is accessible, local and community based. Healthy pregnant women receive antenatal care from midwives at community clinics if they are healthy/ low risk and hospital-based antenatal care if they are at increased risk or experiencing complications

As most western countries, Iceland is moving to distinguish midwifery from nursing and establish structures and strategies to strengthen midwifery within the health care system. For example, the Department of Health is establishing a Chief Midwife separate from the Chief Nurse to progress issues relevant to the profession and midwives’ roles in maternity care. A recent (2007) policy development reinforces the role of midwives stating that midwives should provide antenatal care where possible (meaning if a midwife is available).

Icelandic maternity services are characterised by:

- Low caesarean section rate - 18%
- Few midwives in private practice
- Small private obstetric sector
- Predominantly hospital birth - 98%
- Small community services often use midwife as child health/ women’s health practitioner if not enough work for full time work as a midwife.

In keeping with Nordic cultural values, maternity services facilities were clean, and pleasantly decorated. Water birth and use of tubs for labour pain relief is common, although, as elsewhere in the world, neonatologists as a group are somewhat nervous about water birth and may be resistant.

Iceland – Education of midwives

Iceland, through the University of Reykjavik, is planning a 5-year Bachelor of Midwifery. Currently midwifery is offered a postgraduate qualification to nursing.

Professional identity and strength

The professional association of midwives is growing in strength. Out of the 200 midwives in Iceland, 17 attended the 2008 International Confederation of Midwives Congress in Glasgow.
ICM Delegates with Dr Jenny Gamble (middle right)

Speakers on rural and remote services in:
- Scotland
- Afghanistan
- Greenland
- Canada

Netherlands

Netherlands maternity services are characterised by;
- A high homebirth rate (30+%)  
- Low perinatal mortality rates, however that are no longer best in Europe. From the people I spoke with this was attributed to poor hospital staffing of obstetricians at night and on weekends.
- Very low C/S rate – 14%
- Women are expected to self-educate about pregnancy, labour and birth and early parenting including breastfeeding.
- Average 15 minute antenatal check up except for the first booking visit which takes 45 min and the visit at 20 weeks gestation which takes about 30 minutes. This provides very limited
time for addressing psychosocial needs or educational needs or the woman or much family involvement in antenatal care. Women are expected to assume responsibility about having a baby.

- Rates of vaginal birth after a previous caesarean section are “high”
- Doctors are positive about normal birth
- Kraamzorg (maternity care workers) provide in home care and support for a set number of hours in the week following the birth. They also attend the birth (and possibly some of the labour) and assist the midwife.

Netherlands uses a private practice model based on midwives as primary care providers with large caseloads (120 births per year per midwife). Midwives have strong professional identity with 20,000 midwives in Netherlands including some males. Midwives look after normal women (no previous caesarean section, twins, breech, women in premature labour, HIV positive women, women with meconium stained liquor, diabetes etc.) and provide no pharmacological pain relief for homebirths. If women develop complications they are referred to hospital and there is little follow-through once referral/ transfer has occurred. Women are transferred back the midwife after hospital discharge at about 5 days postpartum if she has experienced a caesarean section.

There was some evidence of business diversification with a midwifery practice. For example, a midwifery practice had purchased its own ultrasound clinic and contracted sonographers and an obstetrician. Women are offered scans for dating the pregnancy, nuchal fold screening and 20 week gestation abnormality scan.

Some doctors are suggesting that to provide better hospital care, especially after hours, smaller units should close to build critical mass of doctors at larger centres. This would undermine homebirth as then the women and midwives would have longer transfer/ travel times including for urgent and emergency cases and this may negatively impact on outcomes.

Health insurance companies offer different member packages; however, by regulation they must offer primary midwifery care including antenatal, labour and birth at home and postpartum to about 10 days and a 6 weeks postnatal check. Under the universal government required cover, only women referred to hospital by a midwife for a complication (or known to have a pre-existing complication) can access obstetric care. Fertility treatment in itself is not a pregnancy complication. Health insurance funding is through subscription plus government funding. Asylum seekers and migrants are covered under government policy. Some insurance companies are now offering, for extra cost, obstetric care and hospital birth.

The Netherlands does not have a history of midwives being educated as nurses first. Midwives enter midwifery directly and complete a comprehensive 4 year education.
England

The National Health Service England (NHS England) is large and complex. NHS England uses a different health funding system to Scotland. There are ten Strategic Health Authorities (SHA) receiving money from Treasury. The SHAs have service level agreements. The Primary Care Trusts and the NHS Trusts are accountable to the SHAs. Funding is allocated to the Primary Care Trusts which then commission the hospitals and other health agencies (secondary care services) to provide services to the community. There are also NHS Trusts (hospitals) and some of these have been given independent status and as known as Foundation Trusts.

There are no dedicated maternity funds, therefore senior executives allocate funding according to needs of community and political pressures (e.g. waiting lists, ambulance queuing etc.). The hospitals and other services then report to the Primary Trusts for the services they are commissioned to provide – i.e. number and quality of services/ service episodes). Previously the health service was commissioned based on the number of clients provided with a particular service and based on historical data (i.e. what is “usually” provided – e.g. standard antenatal visits, number of births per year) however this is changing to include reports on outcomes and other quality indicators.

There is a very small private maternity sector, virtually all maternity care is in the public sector. The CS rate is 24% (and climbing) and the homebirth rate 2.5%. NHS England has a well established history of review/ audit and policy development in maternity services. There are strong maternity policy statements setting the reform agenda that date back to the Winterton Report in the 1991. Since then a number of audits and policies document the problems and make sound recommendations based on evidence and a consensus views of good practice yet struggle to implement reforms. Rolling out implementation across England has been slow despite good policy over many years and although there are significant pockets of innovation it is not widespread and is far from being universally available.

Implementation of reform is still piecemeal where it is happening. For example, Children’s Centre Midwives – previously SureStart midwives – provide intensive support to families in need (those with relatively chaotic lives, significant perinatal mental health issues etc). The Children’s Centre Midwives may see women antenatally or postpartum and the discharge point is flexible relative to need however up to a year is considered acceptable. Women will also receive services from other service providers e.g. GP, Health Visitors and other midwives. Children’s Centre midwives do not provide intrapartum care. Although the idea of providing intensive support to families at risk and in need is a good idea, the fragmentation of services, the lack of continuity of care through labour, the potential for overlap, and the ‘special program’ approach rather than a flexible system/ service with adequately skilled health workers to accommodate the individual needs of women and families seems cumbersome and overly bureaucratic.

Most reform happens at an agency level and is dependent on effective leadership, quality management, education, research, and reform oriented organisational culture. Without adequate support from senior health service executive, maternity managers/leaders trying to drive maternity service reform are vulnerable. Maternity managers also need support from midwives in their agency and outside the organisation e.g. NCT.
NHS - England experienced problems with overspending in Primary Trusts in 2005-2007 and were unable to sustain the number of midwives positions despite existing shortages relative to workload. Other services were continued in maternity and other health services (e.g. fetal screening including nuchal fold screening). It is possible midwives positions were easy targets. This seems to be a serious set back to reform and contributes to maternity staff feeling jaded and careworn.

A list of documents informing the Quality of Midwifery Care Project, England provided by Professor Jane Sandall (Kings College London) is provided as Appendix 1.

Scotland

NHS-Scotland is considerably smaller than NHS-England and seems a little less bureaucratic. Funding mechanisms are different. Funding is distributed from Westminster to Scotland using the Barnett formula and then divided using the Arbuthnott formula. There are 14 health Boards in Scotland and some special Health Boards (e.g. NHS 24/ NHS Direct; NHS Education; NHS Quality Improvement). Like Queensland and other States in Australia, NHS Scotland has both regional and Scotland wide Clinical Networks to facilitate service improvements. BirthRate Plus is the model used to determine midwifery staffing levels.

NHS Scotland is implementing Keeping Childbirth Natural and Dynamic which aims to implement Scotland wide referral criteria and care pathways, the midwife as the first point of professional contact in pregnancy (self-referral), use of the midwife as the lead maternity professional for healthy women experiencing uncomplicated pregnancies, normal birth pathway regardless of birth setting. There is a current strong emphasis on targeting services to those most in need.

Canada

Toronto

While I was primarily in Canada to examine services for aboriginal women, I also spent time in Toronto speaking with key informants at Ryerson University and the Midwives Collective; A/Professor Van Wagner, who is also a founding member of the Midwives Collective and Holliday Tyson who runs the international baccalaureate midwifery program.

Midwives in Toronto work in private practice and receive funds for course of service. They provide full primary care with birth in hospital, birth centre or at home. Not all midwives are able to provide services when women are admitted to hospital (not provided with admitting/ visiting right). Obstetric nurses provide in-hospital care to women booked in the care of an obstetrician. Obstetric nurses have been a long-term feature of maternity services, as prior to the 1990’s midwifery in Canada was not recognised and consequently there were no training programs for midwives. There continue to be economic barriers to midwives providing services to more women. For example, obstetricians are paid on a fee for service basis within the public health care system. This results in reluctance to “share” clients as it would negatively affect the obstetricians’ income. Furthermore, to achieve a sustainable lifestyle, some obstetricians want to increase the hospital client base (clients they are servicing) to enable more obstetrician to be employed thereby providing opportunities for
additional days when they are not “on call” without impacting on income. This approach may result in centralisation of services and pressures to close local smaller services.

### Maternity services in Inuit communities in Nunavik

Nunavik has a very young population and a birth rate that is twice the Canadian average. First-time mothers are young, and most women have three or more children.

On the east coast of Hudson Bay, above the tree-line, the Inuulitsivik Health Centre serves seven communities on the Hudson Bay and Hudson Strait coasts, with a population of about 5500. Inuulitsivik encompasses a local health centre in each community, often called “the nursing station”; a small, 25-bed general hospital in Puivirnituq; and a mental health centre in Inukjuak. All of the communities are remote fly-in villages, with transport for tertiary care more than 1000 kilometres to the south, in Montreal. This internationally recognised model of care has returned childbirth to the remote communities of Nunavik, Quebec. Outcomes are better now than when the policy and practice was to arrange medical evacuation of women from remote, isolated, and semi-isolated communities at 36 weeks of pregnancy, for birth in major urban areas, separated from their families and communities.

Associate Professor Vicki Van Wagner has researched the Inuulitsivik midwifery service and education program on the east coast of Hudson Bay over several years.


### Maternity services in Inuit communities in Nunavut

Nunavut became Canada’s newest territory on 1st April 1999. The government of Nunavut is elected by all residents and as most of the population are Inuit, the government reflects their culture, traditions, values and goals. There are no political parties in the territorial legislature and decisions are made by consensus. Like Nunavik the population is young and the birth rate is high.

### Rankin Inlet

I visited Rankin Inlet, a central Arctic community on the west coast of Hudson Bay in the Kivalliq region with a population of approximately 2,000 people.

The birthing centre in Rankin Inlet was a pilot project from 1993 to 1995. It was initially staffed with nurse-midwives by the North-West Territories Department of Health. Later it accepted registered direct entry midwives from other jurisdictions (primarily UK nurse/ midwives) due to difficulties in recruiting experienced nurse-midwives in Canada. Staff retention meant that the service could not operate continuously. It is now an established program under the Nunavut Department of Health, with positions for three midwives, two Inuit maternity workers, a student midwife and a clerk interpreter. Although it is a permanent facility, it operates without a legislative framework due to absence of midwifery legislation in Nunavut.
Prior to re-establishing the current service, most women were sent to larger centres to deliver their babies in a hospital under the care of a physician. Most often they leave their spouses and family at home to look after their other children. Travelling to larger centres places a monetary burden on families that do not have extended health benefits or medical insurance through their employer. Childbirth, which was once an important ceremony in the life cycle of the family and community, became a stressful event that disrupts rather than strengthens families and communities.

Rankin Inlet has a small hospital that does not yet provide inpatient services except for birthing. Doctors and nurses in this health centre do not provide care for pregnant and birthing women. The midwives, health workers and student midwife provide care to growing number of women. They hold a fortnightly/monthly teleconference with a consultant obstetrician and the midwives choose cases/charts to review. This year they expect to have 70 women birthing in the community and have excellent outcomes. There are facilities to medivac women in labour to an urban centre such as Winnipeg – weather permitting – however this takes several hours.

Recruitment and retention of midwives in Nunavut continues to be a significant problem. An agreement has been made with Nunavut Arctic College and the government to educate maternity care workers, who may go on to become midwives.
Conclusion and recommendations

Elements of quality maternity service

The elements of a quality maternity service are provided below. These elements are distilled from an analysis of ‘what’s working’ in the countries visited; however no single country had implemented all of the elements comprehensively. Countries where the midwife is clearly identifiable and midwives themselves have a strong identity have the best maternal and perinatal outcomes.

- There is a primary focus on the needs of women – women at the centre of care
- Continuity of care provider from early booking (or preconception) to 6 weeks postpartum is a key aspect of safe and satisfying childbearing – midwives are the only practitioner suitably placed and skilled to provide this service.
- Midwives provide care in pregnancy wherever possible
- Midwives are the primary care provider for healthy pregnant women (women with no complications)
- Midwives are involved in the antenatal, labour and postpartum care for all women regardless of risk
- Midwives are predominantly based in the community with access / visiting rights to hospital
- Pregnancy and postnatal care is community based where possible (i.e. woman’s physical and social health status suits home based care).
- Pregnancy and postnatal care provided on a flexible basis – e.g. contact midwife at anytime as needed; midwife to visit women at any time if needed
- Women have the option of homebirth – this should be an accessible option
- Regional and tertiary referral hospitals for women with complications have adequately trained and sufficient numbers of obstetricians – especially at night and weekends
- If/ where the private sector provides maternity care, careful regulation is needed to prevent fee for service models creating models of health care geared towards maximising income for individual practitioners and professional groups rather than the health needs of women and communities.
- Strong consumer involvement in care - both individual consumers and consumer groups are protective, stabilising and help drive innovation.
- Midwives and GPs communicate well – GPs refer pregnant women to midwives and midwives refer back to GP following birth. Both GP and midwives provide relevant health information about women to the other. GPs continue to provide medical care (rather than maternity care) as needed.
- Planning to ensure number of midwives trained and working in midwifery matches the demand for midwifery services. Large fluctuations - under or over supply seriously undermines the system, impacts negatively on reform and demoralises midwives. This applies to specialist obstetricians too.
- Other health workers in maternity care are important. Their roles, educational preparation, regulation and/or supervision issues need to be addressed. They should not be used as a short or long term response to a shortage of midwives or doctors or as a cost cutting measure.
• Because midwives are struggling to be able to work to the full scope of the midwife in many countries, (even the Netherlands – high caseloads limit attention to some aspects of care e.g. breastfeeding support) little consideration has been given to a fuller primary role of the midwife such as prevention and early interventions for promoting perinatal mental health, community development, and health promotion.

**Policy**

Supports and reflects the principles above.

**Funding**

Supports and reflects the principles above.

**Education of maternity care workers**

All maternity care workers should train together in emergency care and other areas where applicable.

**Midwives**

- Should include all competencies for graduates to assume a primary care role
- Needs to include skills to promote and protect women’s rights and the midwifery profession – advocacy, political activism, and sociology.
- There is no justification for requiring that midwives be educated as nurses first. It is a barrier to qualification as a midwife and may contribute to workforce fluctuations.

**Obstetricians** need a greater understanding of

- models of service delivery,
- alternative approaches to the medical model
- the role of other maternity care workers
- Aboriginal Health Care workers
- Need real opportunities to participate in providing maternity care
- Need opportunities to progress as train as midwives

**Research and Scholarship**

Maternity should be a national research priority area and the focus should be sustainable implementation of evidence-based models of service delivery and addressing the social determinants of health.

**Specifics for rural and remote**

- Provide real opportunities for local women to train locally as midwives
- The answers to maintaining and developing skills, competence to practice and professional attributes are not solely found in larger centres. There are excellent examples of local (rural)
identification of need and locally supplied solutions. Some of the approaches to CPD and resources/ opportunities would be of value to clinicians in large centres/cities

- Avoid fee for service models
- Avoid private oligoplies
- GPs with obstetric training are valuable contributors to rural maternity care and should be integrally involved. However, basing primary maternity services on GPs (or obstetricians) tends to medicalise maternity care and makes the service vulnerable to skill shortages/ fluctuations.

### Specifics for indigenous women

- Provide specific funded affirmative action strategies for indigenous women to become midwives
- Provide direct entry into midwifery rather than nursing training as a prerequisite to entry into midwifery training.
- Facilitate the development of working alliances with indigenous health workers and other care providers.
- Return maternity services including birthing services to local communities
- Reorient services to a primary health approach (social model of health).

### Specific for women disadvantaged by poverty

In western countries, women in low socio-economic circumstances may face multiple obstacles to a healthy life including domestic violence, HIV, drug abuse, unemployment, poorly educated, migrant, non-English speaking, compounding health problems etc. The primary care system should be robust and flexible to needs. In addition, health professional education programs need to teach practitioners how to address complex health problems from a social model of health perspective. Once skilled practitioner are able to deliver a robust primary maternity service, assessment about the range of additional integrated primary services to address the needs of specific groups and women/ families with specific problems should occur. In some places it seems that the specialist services have developed in the absence of good primary services.

### Dissemination

I plan to modify this report to submit as a briefing paper to The Hon Kevin Rudd MP (my Federal MP), the Federal Health Minister, the Hon Nicola Roxon, the Hon Stephen Robertson, Minister for Health, Qld. and the Hon Anna Bligh. I will also seek a meeting with both Anna Bligh and Stephen Robertson. Some issues, such as an analysis of various funding models will require further work. I plan to write scholarly papers for publication on models for funding maternity services. Other issues are inherently political in nature and require lobbying, alliances, and negotiating with other stakeholders. I will also present at seminars and conferences, and provide briefings to key people in my existing networks – Australian College of Midwives, Maternity Coalition, academics at Griffith University and at other institutions.
Appendix 1: Documents informing Quality of Midwifery Care Project England

NHS Next Stage Review

NHS Next Stage Review: A Quality Workforce
http://www.ournhs.nhs.uk/2008/06/30/nhs-next-stage-review-a-quality-workforce/

NHS Next stage Review: Health Informatics

NHS Next stage Review: Engagement Analysis

National Service Framework (NSF)
www.dh.gov.uk/childrensnsf

Evidence to inform NSF

Maternity Matters
and self-assessment tool and

PSA Targets
Better Care for All Public Service Agreements 2007 Access, breastfeeding, infant mortality
http://www.hm-treasury.gov.uk/media/5/A/pbr_csr07_psa18.pdf
http://www.hm-treasury.gov.uk/media/3/A/pbr_csr07_psa19.pdf

NICE Guidelines
http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7252&view=all
Antenatal and postnatal mental health
Antenatal care
Antenatal care (replaced by CG62)
Caesarean section
Diabetes in pregnancy
Electronic fetal monitoring (replaced by CG55)
Fertility
Heavy menstrual bleeding
Induction of labour
Intrapartum care
Long-acting reversible contraception
Postnatal care

Standards for Maternity Care, Report of a Working Party

Making normal birth a reality

Modernising maternity care, a commissioning toolkit
http://www.appg-maternity.org.uk/resources/mmctoolkit06.pdf

HCC Report 2008
http://www.healthcarecommission.org.uk/_db/_documents/Towards_better_births.pdf

HCC Survey of Mothers 2007
http://www.healthcarecommission.org.uk/_db/_documents/Maternity_services_survey_report.pdf

HCC Trust Review 2008
http://www.healthcarecommission.org.uk/_db/_documents/Maternity_Review_Information_for_Tr ustsv2.pdf

HCC Trust scoring methodology 2008
http://www.healthcarecommission.org.uk/_db/_documents/Scoring_Methodology_For_the_Matern ity_Service_Reviews.pdf

Modernising medical careers

Modernising nursing careers
Developing the best research professionals

http://www.ukcrc.org/PDF/Nurses_report_August_07_Web.pdf

Children's and Maternity services in 2009: Working Time Solutions


NHS Workforce maternity matters web resource

http://www.healthcareworkforce.nhs.uk/maternity.html