MSc Midwifery: Capstone Project

Provincial Midwifery Strategy:
A Toolkit for Manitoba

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Statement of Acknowledgement of Indigenous Ancestral and Territorial Lands

Health services across Manitoba are provided in facilities located on the original lands of First Nations, Inuit, and on the National Homeland of the Red River Métis. Manitoba's health authorities respect that First Nations treaties were made on these territories, acknowledge harms and mistakes, and we dedicate ourselves to collaborate in partnership with First Nations, Inuit, and Métis peoples in the spirit of reconciliation.

Section 1: Introduction

1.1 Purpose, intent and use of toolkit

The development of this toolkit was inspired and driven by a number of factors including a lack of integration and expansion of midwifery services, ongoing misconceptions and lack of knowledge around the professions, recent changes in College of Midwives of Manitoba standards, and the creation of a provincial consultant in midwifery position.

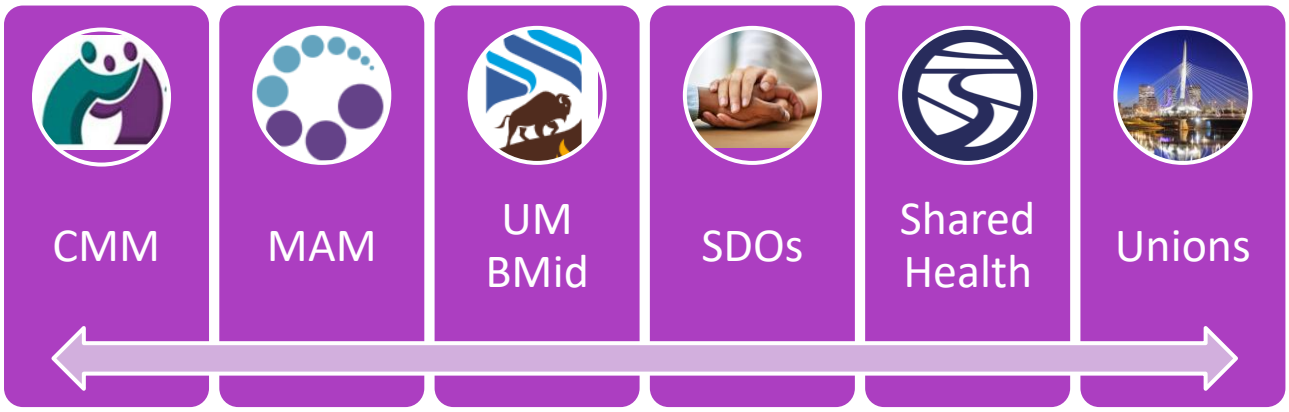
The purpose of this toolkit is to provide guidance to Service Delivery Organisations (SDOs) such as Regional Health Authorities looking to implement, expand or modify services provided by midwives in order to meet a variety of community health needs. The intent is to provide context, information and resources to help SDOs understand the midwifery scope of practice, provide guidance on type of work organisation structures, and clarify the roles of various stakeholders. Suggestions for how midwives may meet community needs are included, with numerous examples of similar programs operating in Canada. Links to relevant resources including websites and journal articles are provided throughout the document. Whenever possible, links to full-text articles are provided.

1.2 Guiding frameworks and documents

Several guiding frameworks and documents have informed the development of this toolkit. Overall, it is underpinned by the importance of equitable and appropriate access to healthcare for all Manitobans. Links to the documents are available by clicking on their name.

LEADS in a Caring Environment Capabilities Framework	A "by health, for health" description of the leadership attributes necessary to be successful in leading modern health systems.
Truth and Reconciliation Commission of Canada: Calls to Action	Calls to action to redress the history and legacy of Canada's residential school system, with specific actions related to health and healthcare
Human rights in patient care: A theoretical and practical framework	Framework that allows for the examination of systemic issues creating barriers to equal access and quality of care. Six standards have been proposed: availability, accessibility, acceptability, quality, participation and inclusion, and accountability
Service Coordination Framework	Framework to facilitate service coordination within My Health Teams and with partner organizations, programs and services across health care.
Patient Safety Framework	Sets a vision for Manitoba's safe, high-quality health care system and sets out the strategic direction to guide patient safety improvements in Manitoba's health care delivery system to achieve measurable improvements

1.3 Stakeholders and roles



College of Midwives of Manitoba
www.midwives.mb.ca

The College of Midwives of Manitoba (CMM) is the regulatory body for the profession of midwifery. The purpose of the College is to:

- Protect the safety of the public in the provision of midwifery services in Manitoba;
- Support midwives in the provision of safe and effective midwifery services in Manitoba; &
- Develop and enforce the standards of midwifery care in Manitoba

This includes:

- Setting registration requirements and standards for education and experience that must be met in order to practice as a midwife in Manitoba;
- Developing, establishing, and maintaining standards for safe and ethical practice for members; &
- Responding to complaints from the public regarding midwifery practice.

Midwives Association of Manitoba
midwivesofmanitoba.ca

The Midwives Association of Manitoba (MAM) is the professional association for midwives in the province. MAM is working to grow and support midwifery in Manitoba.

The purpose of the organization is to:

- Unite into one organization all midwives practicing in Manitoba;
- Promote the profession of midwifery within Manitoba.
- Advocate for public funding of midwifery services across the province;
- Protect the interests of midwives and midwifery students;
- Provide continuing education opportunities for midwives;
- Actively participate in the national and international midwifery community
- Protect the autonomy of midwives

University of Manitoba Bachelor of Midwifery
https://www.umanitoba.ca/explore/programs-of-study/midwifery-bmid

The University of Manitoba offers the Bachelor of Midwifery Program (BMid). The program provides the educational foundation for a career in midwifery. The program takes approximately 4 years to complete, and includes several clinical placements, both with midwives and other healthcare providers.

The program is currently accepting around 8 students per year. At this time, this number is determined in large part by the limited number of clinical placements available. Spots are reserved for Indigenous, Northern and rural students to help bridge the gap in care in these communities.

Service Delivery Organisations (SDOs)

Service Delivery Organisations are not-for-profit organisations tasked with the delivery of healthcare services. These can include the Provincial Health Authority or a Regional Health Authority. Midwives are currently employed by Regional Health Authorities including NRHA, PMH, SHSS, and WHRA. Midwives may be employed by other organisations, including private clinics.

Presently, liability insurance is provided by the employers. There are options for midwives to obtain liability insurance through other organisations such as HIROC, though these need to be explored further.

Shared Health
sharedhealthmb.ca

Shared Health is leading the planning and coordinating the integration of patient-centred clinical and preventive services across Manitoba. The organization was created in 2018 as part of Manitoba's broader Health System Transformation.

Shared Health continues to evolve as staff, departments, services and facilities transition to the organization as part of the transformation's mandate to create a simpler, more efficient and more consistent health system for Manitobans. Shared Health will continue to work collaboratively with regional health authorities, service delivery organizations, communities and other stakeholders to ensure the health needs of Manitobans are fulfilled compassionately, effectively and as close to home as possible.

Unions
mahcp.ca and www.mgeu.ca

Midwives are currently represented by two different unions, depending on where they are employed. NRHA and WHRA midwives are represented by the Manitoba Association of Health Care Professionals (MAHCP). The collective agreements can be found here under Central Table

Agreements (as of February 2025). Midwives in PMH and SHSS are represented by the Manitoba Government and General Employees' Union (MGEU). Their collective agreements can be found here for PMH and here for SHSS.

1.4 Statement on rural and remote communities

Care planning for rural and remote communities is challenging. Difficulties recruiting providers with appropriate skills, the predominance of specialist-based and centralized care, and the closing of services have led to some rural families having limited or no access to perinatal services.

The lack of other services further impacts the families in the community. Perinatal programs are supported by services such as diagnostic imaging, laboratory testing and blood banks, appropriate and functional equipment and effective transport systems.

Research shows families in rural and remote regions overwhelmingly want perinatal services in their communities, with many wanting midwifery care.

Common misconceptions of risk and safety of rural and remote perinatal services prevail. Some include that all services should include surgical birth and that providers should facilitate a minimum number of births per year to remain competent. These presumptions are not supported by current evidence. Rather, research supports the provision of perinatal services regardless of whether or not the community has access to local surgical services, as local access improves outcomes. In particular, neonatal morbidity and mortality rates decrease with the presence of services close to home. Access to surgical services is beneficial as it increases the proportion of births that can occur in a facility.

> *The question is not whether to provide birthing services or not but what level of services is feasible and sustainable. (p.5)*
>
> Miller K, Couchie C, Ehman W, Graves L, Grzybowski S, Medves J. Joint Position Paper of Rural Maternity Care. Canada; 2012

While service providers and healthcare leaders may centre perinatal morbidity and mortality in their evaluation of risk, families who live in rural and remote areas may have different perspectives on risk and safety. Many pregnant people continue to birth outside

Rural and Remote Communities

Association of Ontario Midwives. Rural and Remote Maternity Care in Ontario: Analysis and Recommendations. Ontario; 2015.

Barclay L, Kornelsen J. The closure of rural and remote maternity services: Where are the midwives? Midwifery. 2016;38:9-11.

Grzybowski S, Fahey J, Lai B, Zhang S, Aelicks N, Leung BM, et al. The safety of Canadian rural maternity services: a multi-jurisdictional cohort analysis. BMC Health Services Research. 2015;15(1):410

Grzybowski S, Kornelsen J, Schuurman N. Planning the optimal level of local maternity service for small rural communities: A systems study in British Columbia. Health Policy. 2009;92(2):149-57.

Kornelsen J, Grzybowski S. The Reality of Resistance: The Experiences of Rural Parturient Women. Journal of Midwifery & Women's Health. 2006;51(4):260-5.

Kornelsen J, McCartney K. The safety of rural maternity services without local access to caesarean section. Applied Policy Research Unit at the Centre for Rural Health Research; 2015.

Longman J, Pilcher J, Morgan G, Rolfe M, Donoghue D, Kildea S. ARBI Toolkit: A resource for planning maternity services in rural and remote Australia. Lismore, Australia: University Centre for Rural Health North Coast; 2015.

Miller K, Couchie C, Ehman W, Graves L, Grzybowski S, Medves J. Joint Position Paper of Rural Maternity Care. Canada; 2012.

Sutherns DR. In praise and search of midwifery well-suited to rural women. CMJRP. 2003;2(2):13-21.

their own community, which has financial, social and psychological consequences. These include increased stress and postpartum depression, loss of income, travel costs for support people, childcare fees, feelings of isolation and separation, social disruption, lack of support and the need to navigate a new environment, among others. The effects of birth evacuation are particularly harmful to Indigenous families.

The decision to have or not have birth services in a community is not value or outcome neutral. Both options incur a cost, in resources, experiences, and short- and long-term health outcomes for individuals and communities. Providers and the families they serve may value risk and safety differently.

1.5 Statement on Indigenous communities

The Truth and Reconciliation Commission Calls to Action contain numerous actions related to health and healthcare. These include data collection, monitoring of health outcomes, education of all health care students about Indigenous health, and investment in Indigenous healing centres. Indigenous peoples across the country are further calling for the recognition and integration of Indigenous ways of knowing, healing practices and medicines to the mainstream model of healthcare. The concept of 'two-eyed seeing', where Indigenous worldviews and Western biomedicine are distinct but equally valued, was proposed by Mi'kmaw Elders Albert and Murdena Marshall.

While several programs across the country have rematriated birth to rural and re mote Indigenous communities, access to birth services close to home continues to be markedly inequitable for Indigenous people. Most pregnant people who live in rural and remote reserves continue to be evacuated to communities far from their own to birth. Often, they leave their communities for weeks at a time.

In addition to the negative effects of rural birth practices previously discussed, the practice of evacuation has been linked to increased rates of negative experiences of birth and postpartum depression. They experience loneliness, disconnection and disruption, as do their children, family and community members. Birthing people who are evacuated report having fewer choices in the care, such as choice of birthplace. They have difficulty navigating an unfamiliar city and healthcare interactions, in part due to differences in communication styles and language. They also report experiencing culturally inappropriate care, stigma, prejudice, racism and medical trauma.

Indigenous Communities

Bidulka P, Chuang R, Barise R, Cho M, Mate K. Vol V: Reclaiming Childbirth: The Inuulitsivik Aboriginal Midwifery Program 2020

Cohen-Fournier SM, Brass G, Kirmayer LJ. Decolonizing health care: Challenges of cultural and epistemic pluralism in medical decision-making with Indigenous communities. Bioethics. 2021;35(8):767-78.

Corcoran PM, Catling C, Homer CSE. Models of midwifery care for Indigenous women and babies: A meta-synthesis. Women and Birth. 2017;30(1):77-86.

Fijal D, Beagan BL. Indigenous perspectives on health: Integration with a Canadian model of practice. Canadian Journal of Occupational Therapy. 2019;86(3):220-31.

Gabel C, Powell A. The Future of Indigenous Healthcare in Manitoba: Moving Beyond Soft Reconciliation in Health. International Indigenous Policy Journal. 2023;14(2):1-18

Irvine JDC, Rolzing G, Doyle K, Martel N, Tsang T, Ramsden VR. Exploring how pregnant women in a remote northern community select a delivery location. Can Fam Physician. 2022; 68(6):446-51

Kornelsen J, Kotaska A, Waterfall P, Willie L, Wilson, D. The geography of belonging: The experience of birthing at home for First Nations women. Health and Place 2010; 16(4):638-45.

Kyoon Achan G, Eni R, Kinew KA, Phillips-Beck W, Lavoie JG, Katz A. The Two Great Healing Traditions: Issues, Opportunities, and Recommendations for an Integrated First Nations Healthcare System in Canada. Health Systems & Reform. 2021;7(1):e1943814.

(Continued on next page)

For Indigenous peoples, person, community and land are inseparable. What affects one will affect the other two. Birth is a celebration with significant cultural, spiritual, emotional and social meaning. It is tied to traditional lands, which provides sustenance and medicines. It is also tied to community, which provides support and fosters a sense of belonging. Community involvement helps maintain birth traditions and ceremonies and facilitates the transmission of knowledge between generations. Leaving the land and leaving the community lead to cultural and social isolation, which have untold impact on the overall wellbeing of the person and the community.

> *With the loss of birthing, the communities lost knowledge transmission from Elders, Aboriginal midwives, traditional knowledges and practices, collective caring, reproductive health and sexuality teachings, positive perspectives of sexuality, and ceremonies. The loss of birth ceremonies was also equated with the loss of celebrations in communities, which has left a significant cultural gap. (p. 481)*
>
> Lawford K, Giles A, Bourgeault I. Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance. Women and Birth. 2018;31(6):479-88.

While there are significant political and jurisdictional issues at play (e.g. midwifery is not yet recognised at a federal level, lack of clarity on roles between provincial and federal governments), there are paths available to decolonising birth and reducing health inequities. Facilitating birth close to home, integrating Indigenous worldviews in mainstream healthcare and having more Indigenous healthcare providers are some of the ways to respond to Truth and Reconciliation Commission's calls for action.

Indigenous Communities

Lawford K, Giles A, Bourgeault I. Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance. Women and Birth. 2018; 31(6):479-88.

Olson R. The Landscape of Midwifery Care for Aboriginal Communities in Canada. Montreal: National Aboriginal Council of Midwives; 2016.

Olson R, Couchie C. Returning birth: The politics of midwifery implementation on First Nations reserves in Canada. Midwifery. 2013;29(8):981-7.

Richardson L, Boozary A. Truth and reconciliation in Canada's health system. The Lancet. 2021;398(10303):825-6.

Silver H, Sarmiento I, Pimentel J-P, Budgell R, Cockcroft A, Vang ZM, et al. Childbirth evacuation among rural and remote Indigenous communities in Canada: A scoping review. Women and Birth. 2022; 35(1):11-22.

Smylie J, O'Brien K, Beaudoin E, Daoud N, Bourgeois C, Harney George E, et al. Long-distance travel for birthing among Indigenous and non-Indigenous pregnant people in Canada. CMAJ. 2021; 193(25):E948-55.

Tait C, Mussel W, Henry R. Micro-Reconciliation as a Pathway for Transformative Change: Applying a reconciliation strategy to the everyday relationships Indigenous peoples have with the human service sector. International Journal of Indigenous Health. 2019;14(2).

Van Wagner V, Osepchook C, Harney E, Crosbie C, Tulugak M. Remote Midwifery in Nunavik, Québec, Canada: Outcomes of Perinatal Care for the Inuulitsivik Health Centre, 2000–2007. Birth. 2012;39(3):230-7.

Section 2: History and context of midwifery in Manitoba

2.1 Definition of midwifery

Midwives are primary care practitioners who provide healthcare during pregnancy, birth and the postpartum period, infant care, sexual and reproductive health including contraception. Midwives work in partnership with their clients to provide holistic care that meets the client's needs.

2.2 Review of history of midwifery in Manitoba

Midwifery practice has always existed in Manitoba, both in Indigenous and settler communities. Local midwives cared for the birthing people in their communities for millennia. Skills and knowledge were passed from person to person, often from generation to generation.

From the 17th to 20th centuries, advances in scientific discovery and the rise in power and control of a male-dominated medical profession led to the marginalization and exclusion of midwives and other female health providers. Shifting social norms and gender dynamics, often based in misogynistic, racist and classist ideologies, led to the vilification of midwives, especially Indigenous midwives.

Birthing in hospital became the norm through the medicalization of pregnancy and birth, the enticement of anaesthesia and a break from routine and responsibilities, and increased urbanisation.

Across Canada, protests against increasing rates of intervention and dehumanizing birth practices led to calls for the reclamation of natural childbirth and midwifery. The movement gained traction in the 1970s and 80s, culminating in the recognition, regulation and funding of midwifery services in Manitoba in 2000.

The implementation of midwifery in our province was shaped by extensive consultations with Indigenous and rural communities, learning from other jurisdictions, consideration on how best to meet community needs while ensuring equity and offering choice. The priorities established by the Midwifery Implementation Council included:

Resources on history of midwifery in MB

Howarth-Brockman, M. *Delivering an alternative: An overview of the regulation of midwifery in Manitoba.* Winnipeg: Prairie Women's Health Centre of Excellence, 2002.

Kaufert P. and Robinson K. *Midwifery on the Prairies: Visionaries and Realists in Manitoba*. In: Bourgeault IL, Benoit C, Davis-Floyd R, editors. Reconceiving Midwifery. Montreal: McGill-Queen's University Press; 2004. P. 204-23.

Kreiner, M. *Delivering diversity: newly regulated midwifery returns to Manitoba, Canada, one community at a time.* J Midwif Women's Health. 2009;54(1): e1-e10.

Scurfield, Dr C. *Midwifery Legislation in Manitoba*. Winnipeg: University of Manitoba; 2002

- Access to healthcare for Indigenous communities
- Access to healthcare for rural and Northern communities
- Access to healthcare for equity-deserving groups (priority populations including newcomers, those under 20 years of age, people who are socially isolated, and other marginalised communities)

While many of the priorities continue to guide the delivery of midwifery services, some of the concerns communicated during the initial consultation period have unfortunately been realised. For example, one of the primary concerns expressed was that access to midwifery services would be restricted by geographical boundaries, specifically limiting access for rural and Indigenous communities. Currently, midwives are generally only providing care to residents within their employer's catchment area, though exceptions to these restrictions exist. This leaves many communities without access to midwifery care.

2.2.1 Funding and payment model

In addition to the priorities established by the Midwifery Implementation Council listed above, several factors influenced the decision for Manitoba to adopt an employee-model of payment. Though the course-of-care model was established in BC and ON, it was recognized that this model was less conducive to meeting the priorities outlined by the Midwifery Implementation Council. Both independent contractor and employee models were proposed. A legal opinion sought by Manitoba Health indicated there may be issues with having more than one funding option. Ultimately, the employee model was selected with the theory it would:

- Facilitate access to midwifery services for priority populations
- Facilitate integration of midwives into the healthcare system
- Facilitate the participation of midwives in local, regional and provincial committees
- Facilitate SDOs tailoring midwifery services to the needs of their communities

While the employee-model seems to have facilitated meeting some of the priorities, it has also caused a significant hindrance in the growth of the profession. This and other factors related to the lack of growth in the profession are discussed in the following section.

While the funding model has remained consistent since regulation, a new interpretation of the Canada Health Act may open new doors for midwifery funding (see media releases here and here). How this new interpretation might be applied to midwifery services remains to be seen (as of February 2025).

Compensation

Several consultations have concluded that compensation for midwives should be somewhere between nurse practitioners and physicians who work in community health clinics. This approach was recently (2020) supported by the Human Rights Tribunal of Ontario, in the Association of Ontario Midwives' application for pay equity.

Cost-effectiveness

Walters D, Gupta A, Nam A, Lake J, Martino F, Coyte P. A Cost-Effectiveness Analysis of Low Risk Deliveries: A Comparison of Midwives, Family Physicians and Obstetricians. Healthcare Policy. 2015;11(1):61-75.

Safety

Stoll K, Titoria R, Turner M, Jones A, Butska L. Perinatal outcomes of midwife-led care, stratified by medical risk: a retrospective cohort study from British Columbia (2008–2018). CMAJ. 2023;195(8):E292-E9.

2.3 Lack of growth in the profession

Despite close to 25 years since regulation, growth of the midwifery profession has been limited by numerous factors and Manitoba has fallen well short of the projected number of midwives. At implementation, it was anticipated there would be 140 midwives practicing in the province by 2005. We have yet to reach half that number.

2.3.1 Routes to registration

One significant barrier has been intermittent education programs within the province. The first proposal for a bachelor of midwifery at the University of Manitoba was not funded. The Kanácí Otinawáwasowin Midwifery Program implemented by University College of the North in 2006 yielded 10 graduates before support for the program was rescinded in 2016. Finally, a new bachelor of midwifery program was launched by the University of Manitoba in September 2021. For now, the numbers are limited to around 8 students per cohort due to the limited number of clinical placements available. It is anticipated this number will rise with the number of midwives working in the province.

Access to bridging programs for internationally-educated midwives has also been problematic. Manitoba-based programs have not been available since 2009. Currently, internationally-educated midwives must enrol in the bridging program offered at UBC. Approval is pending for a renewed program projected to be offered in 2025 through Toronto Metropolitan University.

Many jurisdictions, such as in the UK and Australia, offer shortened education programs for nurses who want to transition to midwifery. One such program exists in Canada, through Toronto Metropolitan University. While routes to transition from midwifery to nursing are not as readily available, midwifery roles are much more varied in other jurisdictions when compared to Canada and, specifically, Manitoba.

Manitoba research

Thiessen K, Heaman M, Mignone J, Martens P, Robinson K. Barriers and facilitators related to implementation of regulated midwifery in Manitoba: a case study. BMC Health Serv Res. 2016;16:92.

Thiessen K, Heaman M, Mignone J, Martens P, Robinson K. Trends in Midwifery Use in Manitoba. J Obstet Gynaecol Can. 2015; 37(8):707-14

Thiessen K, Haworth-Brockman M, Nickel N, Morris M, Robinson K, Bourgeault I, et al. Maternity service delivery in Manitoba, Canada: A retrospective analysis of three maternity care provider types. Canadian Journal of Midwifery Research and Practice,. 2020;19(2):6-19.

Thiessen K, Haworth-Brockman M, Nurmi MA, Demczuk L, Sibley KM. Delivering Midwifery: A Scoping Review of Employment Models in Canada. Journal of Obstetrics and Gynaecology Canada. 2020;42(1):61-71.

See links to PIIPC project on p. 18 for more Manitoba-based research

2.3.2 Perceived and historical restrictions

Misperceptions and misconceptions around the profession continue to abound. For example, it is commonly thought that midwives can only provide care to 6 weeks postpartum, yet there is no legislation or regulation stating this limitation. The primary issue is that ordering routine childhood vaccinations are not currently in the scope of practice. While awaiting legislative changes, midwives may use medical directives or standing orders to provide these vaccinations.

An important change to a previous barrier pertains to the requirement to maintain currency of practice. Midwives used to have to attend a certain number of births in a specific time frame to maintain currency. As of April 2024, this is no longer a requirement for midwives who have completed the initial requirements of continuity during their first two years of practice. This significantly changes how and where midwives can work, as intrapartum care is no longer a requirement for currency of practice.

2.3.3 Structural barriers

Numerous structural barriers have contributed to the lack of growth in midwifery services. These include, but are not limited to:

- Restrictive healthcare structures: where does midwifery fit? Midwifery care combines aspects of primary care, acute care, public health and emergency services. Yet, most of these services are siloed and coordination between can be lacking. Midwifery has generally been housed under primary care, despite the service not fully fitting that definition, leading to a lack of inclusion in the other domains.
- Lack of leadership: there are few midwifery-specific leadership positions in the province. A provincial consultant position was re-instated in 2023, having been discontinued a decade earlier. There are no midwifery clinical director positions at any level, though one existed in the WRHA from 2016 to 2019. Only one regional leadership position currently exists, that of a clinical midwifery specialist in the WRHA, which is primarily an educational and clinical leadership role. Leadership roles in hospitals are non-existent and roles in other programs have often not been open to midwives. Consequently, midwifery is underrepresented in provincial, regional and local care coordination strategies.
- Employee-model of funding: While the employee-model of funding is not in and of itself a barrier, this funding model has caused some difficulties in the expansion of services. Some issues include inefficient structures of power with too many layers of management, lack of growth in positions, lack of variety of positions and subsequent difficult recruitment and retention strategies. There have been few incentives for SDOs to increase midwifery positions, especially when funding for these positions comes out of the general budget. Facilitating midwives being independent contractors, as is the case in BC, AB and ON, in addition to employee-model funding, would allow for midwives to start their own practices as needed.
- Lack of insurance coverage options: Liability insurance for midwives is currently provided through the RHA employers. Some options, such as individual insurance through HIROC, exist, though are expensive. Further exploration is needed to find reasonably priced options.
- Interprofessional conflict: sources of conflict include lack of interprofessional education, differences in philosophies of care, unfamiliarity with the midwifery scope, patients/clients being treated differently based on primary provider, bullying, poor communication, short staffing, perceived ‘turf protection’, and overall high levels of stress and burnout.
- Over-evaluation of midwives outside their regulatory body, including from other providers, managers and leadership.

2.4 Review of scope of practice

Midwives are primary care practitioners who provide healthcare during pregnancy, birth and the postpartum period, infant care, sexual and reproductive health including contraception. Manitoba has one of, if not the, largest midwifery scope of practice in the country, which was intentionally created to serve clients with barriers to accessing care. Midwives order lab work and diagnostic imaging, prescribe, order and administer medications and other treatments, and have hospital privileges. Midwives consult other care providers as indicated. For a full review of the scope of practice, please review the legislative and regulatory documents listed below.

Links to legislative and regulatory documents

The Midwifery Act

- Schedule A (Laboratory and Diagnostic Testing)
- Schedule B (Drugs and Devices)
- Schedule C (Minor surgical and invasive procedures)

College of Midwives of Manitoba

- Standards of Practice
- Guidelines, Policies and Statements

One of the current restrictions in the scope of practice is to whom midwives may provide care. Generally speaking, midwives provide care to people who are or who have been pregnant, are giving birth and have given birth. There is no time limitation given for the postpartum period. Midwives also provide care to newborn/infants, with again no time frame provided. Some care can also be provided to partners of clients, such as STI screening.

2.4.1 Delegation of function and standing orders

Although the scope of practice continues to expand, changes to legislation are slow and can impact midwives' ability to provide recommended care to their clients. For example, the administration of the TDaP vaccine in pregnancy has been recommended since 2018. It has been funded by Manitoba Health since January 2019 yet was only added to the midwifery scope of practice in October 2024.

In order to facilitate care for their clients, midwives may collaborate with physicians through the use of orders, medical directives, and delegation, in addition to regular consultations. Revisiting the example of the TDaP vaccine, several midwifery clinics obtained a physician standing order/medical directive for the vaccine in order to administer it to their clients, thus removing potential delays and further barriers.

Delegation is addressed in the CMM's Midwifery Standards of Practice and in the Regulated Health Professions Act (RHPA). Midwives are not currently (as of Feb 2025) regulated by the RHPA, but physicians who may delegate to midwives are, hence its inclusion here.

The CMM is well aware of the common use of orders, medical directives and delegation in midwifery practice. The CMM has encouraged their use as a way to advocate for changes to legislation and regulations while awaiting more sweeping legislative reform that would further reduce barriers and expand care, such as having vaccines as a category instead of listing specific vaccines in the regulations.

The use of standing orders, medical directives and delegations may be considered when evaluating how midwives can meet your organizations needs. Further clarification on potential roles is provided in the following section.

Section 3: Types of midwifery work organisation

Manitoba currently only offers one type of frontline position for midwives, that of caseload midwifery. While caseload midwifery will remain a crucial part of services provided by midwives, limiting job opportunities to this style of work inhibits the recruitment and retention of midwives while failing to utilize midwives to their full potential in meeting community needs.

> *The organization of maternity care must address the needs of communities and providers alike to make the greatest contribution Through collaborative and creative organizational approaches, midwives have an opportunity to contribute in a meaningful way and increase their impact on the provision of services (p.962).*
>
> Malott A, Kaufman K, Thorpe J, Saxell L, Martin K, Yeates L, et al. Models of Organization of Maternity Care by Midwives in Canada: A Descriptive Review. J Obstet Gynaecol Can. 2012;34(10):961-70.

Midwives specifically always providing intrapartum care is a common theme and many SDOs are hesitant to use midwives in other capacities. In reality, midwives can provide much more. In many communities across the country, midwives are providing sexual and reproductive health care, running community jaundice screening and treatment programs, staffing postpartum early discharge programs and newborn clinics, and leading clinics for early pregnancy assessment including pregnancy losses. All these types of community-based programs increase access to care and meet the population health needs of communities while decreasing the number of ER visits, hospital admissions and readmissions, length of hospital stays and use of specialist services for both the pregnant/postpartum individual and the newborn. In other communities, midwives are hired or contracted by hospitals to provide needed services such as conducting births, conducting postpartum and newborn clinics and even being part of newborn resuscitation teams, triaging obstetrical clients, and being first assist at caesarean sections.

Research links

Continuity of Care Model

Sandall J, Fernandez Turienzo C, Devane D, Gillespie P, Gates S, Jones L, et al. Midwife continuity of care models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2024;4.

Tracy SK, Hartz DL, Tracy MB, Allen J, Forti A, Hall B, et al. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. The Lancet. 2013;382(9906):1723-32.

Shared Care and Collaborative Models

Harris S, Janssen P, Saxell L, Carty E, MacRae GP, KL. Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. CMAJ. 2012;184 (17): 1885-92.

Malott A, Kaufman K, Thorpe J, Saxell L, Martin K, Yeates L, et al. Models of Organization of Maternity Care by Midwives in Canada: A Descriptive Review. J Obstet Gynaecol Can. 2012;34(10): 961-70

Munro S, Kornelsen J, Grzybowski S. Models of maternity care in rural environments: Barriers and attributes of interprofessional collaboration with midwives. Midwifery. 2013;29(6):646-52.

Focused scope

Cummins A, Griew K, Devonport C, Ebbett W, Catling C, Baird K. Exploring the value and acceptability of an antenatal and postnatal midwifery continuity of care model to women and midwives, using the Quality Maternal Newborn Care Framework. Women and Birth. 2022;35(1):59-69.

Full-scope midwifery work

Below is an overview of potential ways midwifery work may be organised. Please note that midwives must continue to meet the CMM's Standard for Currency of Practice. New registrants have up to two (2) years to meet the birth and continuity of care expectations, which essentially require them to work in caseload-style midwifery during that time frame. Midwives are otherwise expected to provide care across the continuum of care (prenatal, intrapartum, postpartum and newborn care) within a rolling three (3) year time frame.

3.1. Caseload midwifery with continuity of care

This is the most common model of care across Canada. Antenatal, intrapartum and postpartum care is provided by a small team of midwives. Care is facilitated in clinics, hospitals, birth centres, and client homes. Midwives provide 24 hours on call coverage. They manage their own caseloads and schedules. This type of organisation provides a high level of continuity of care across the childbearing continuum, which is turns increases satisfaction for both clients and midwives. This type of work organisation, however, can lead to high levels of burnout for staff, especially when they are poorly supported.

3.1.1. Deliverables

While it is the responsibility of SDOs to establish the deliverables of their programs, a common parameter for midwives in Manitoba has been a number of courses of care per year. A full course of care consists of midwives providing care to a client throughout the continuum of care. The established norm is for midwives to complete 30 courses of care per year for a full-time EFT. Midwives will also complete a number of partial courses of care. A partial course of care many occur in instances such as if a pregnancy ends, if a client moves, or if care is transferred to another provider.

3.1.2. Recommended team size

For teams working in caseload-style midwifery, important aspects to consider are having an appropriate ratio of on-call staff to combined caseload, potential plans for when the on-call midwife needs support (has more than one client in labour, requires sleep relief or is ill or injured) and how teams may be expected to manage vacations and sudden leaves, both short and long-term.

In the absence of casual, float or locum staff, teams composed of 3.5 EFT to 4.0 EFT allow for flexibility in call schedules, better work-life balance especially when one member is on vacation, a built-in cushion for sudden illnesses or leaves, and an appropriate distribution of workload. Smaller teams will likely struggle when a team member is away while, for bigger teams, the workload will at times be too much for one on-call member.

We acknowledge, however, that team size can vary greatly and what may work in one SDO may not work in another. Further, some midwives prefer to work in a primary call model, staying on call for their own clients the majority of the time. Others may prefer to work in larger teams.

3.1.3. Number of teams

The number of teams most appropriate for any community depends on a number of factors: number of births per year, birth facilities in the community, geographical and logistical considerations including travel time and distance to birthing facilities. In most regions other than WRHA, midwifery services are only available in one or two areas. This leaves large parts of the region without appropriate access to midwifery services. In IERHA, numerous sites may be considered appropriate including Gimli/Arborg, Selkirk, Beausejour, and Oakbank.

3.1.4 Considerations for home/community births

Births are attended by a minimum of two providers, usually a combination of physician, nurse or midwife. Home and community births are generally attended by two midwives or a midwife and designated second attendant. The second attendant may be a nurse, a senior midwifery student, or other provider who meets the CMM Standard for Use of a Second Attendant. If the community has only one team of midwives and therefore only one midwife on call at a time, an alternate second attendant needs to be arranged.

3.1.5 Compensation

Compensation for caseload midwifery has been established in various regions. See the link provided in section on Unions for links to current contracts.

3.2. Shared care with physicians

Collaborative care models require philosophical alignment, strong leadership, strong communication and mutual respect among providers. Financial, legal and regulatory barriers must be addressed to facilitate interprofessional care.

3.2.1 Midwives and GPs

In this model, midwives and physicians share a philosophy of care and provide healthcare to individuals planning to birth in hospital. The organisation of work may look different depending on the reason for a shared care model. Some shared care models may be due to a lack of staff, others may be due to providing care for populations with more complex healthcare or social needs.

The South Community Birth Program (SCBP) in Vancouver is an excellent example of physicians and midwives working collaboratively to fully share the care of the birthing families in their community. With this team, families receive care from both physicians and midwives throughout pregnancy, labour and birth and the first six (6) weeks postpartum. Call is rotated among the staff members. Families are further supported by a team of community nurses and doulas.

While the SCBP is delivered in a large metropolitan centre, this type of work organization also suits less populous settings or settings with difficulties recruiting staff, specifically rural and remote settings. Two examples include the Inlet Community Birth Program in Port Moody, BC and High River Maternity in High River, AB. In these smaller community, teams are often providing care to all pregnant people within their catchment area. They facilitate the low-risk births within the community while providing prenatal, postpartum and newborn care to those who birth elsewhere.

3.2.2 Midwives and Obstetricians

Due to the greater differences in scope of practice and roles, shared care between midwives and obstetricians may require a more delicate balance, especially if the two professions are sharing call. This type of work organisation was trialed in Nova Scotia's Gasha District shortly after the implementation of midwifery services in the province. The goal was to meet the need for essential obstetric services in the region while attempting to offer a sustainable model of obstetric care. This model, which does not appear to have continued, is discussed in Models of Organization of Maternity Care by Midwives in Canada: A Descriptive Review (see full citation on page 16).

A more common work organisation is collaborative care between midwives, obstetricians and other providers. One example is the Partners in Inner-City Integrated Prenatal Care (PIIPC) project which took place in Winnipeg from 2012 to early 2015. The goal of the project was to reduce inequities in use of prenatal through initiatives to improve four inter-related health systems. Results indicate the project was successful in reducing barriers to care, improved pregnancy outcomes and resulted in fewer child apprehensions. Several publications related to this project are linked in the adjacent box. Funding for this project has not continued.

3.2.2.1 Deliverables

Deliverables for shared cared models are likely to vary greatly depending on the reason for this organisation and what other work this team is undertaking.

In the SCBP example, the team is specifically providing care to an otherwise underserved population from pregnancy to six (6) weeks postpartum. They are also supported by a larger team including community nurses and hospital staff. In this scenario, deliverables in terms of courses of care are likely to be higher than caseload midwifery due to factors such as having a large team, the extra support from staff both in and out of the hospital, the limited geographical area, and only facilitating births in one hospital.

Links on Partners in Inner-City Integrated Prenatal Care (PIIPC)

Heaman M. PIIPC Final Report: Evaluation of the Partners in Inner-City Integrated Prenatal Care (PIIPC) Project. Winnipeg; 2017.

Heaman M, Sword, W., Elliott, L., Moffatt, M., Helewa, ME., Morris, H., Tjaden, L., Gregory, P., Cook, C. Perceptions of barriers, facilitators and motivators related to use of prenatal care: A qualitative descriptive study of inner-city women in Winnipeg, Canada. SAGE Open Med 2015; 3.

Heaman MI, Sword W, Elliott LJ, Moffatt M, Helewa ME, Morris H, et al. Barriers and facilitators related to use of prenatal care by inner-city women: perceptions of health care providers. BMC Pregnancy & Childbirth [Internet]. 2015; 15(2):[1-13 pp.].

Wiscombe JD. Envisioning a culturally safe midwifery model from the perspective of Indigenous families: A case study of midwifery care in inner city Winnipeg, Manitoba, Canada. Winnipeg, MB: University of Winnipeg; 2020.

(not directly about PIIPC but about the same population and setting)

3.2.2.2 Team size and composition

Team size and composition will vary greatly according to the deliverables identified and the setting in which they are working. Factors include:

- Setting
    - Rural, remote, or metropolitan
    - Available facilities (including obstetrical facilities, access to ultrasound and labs)
    - Distances travelled (for families and providers)
- Place of birth (i.e. Is home birth offered? Is there a significant number of pregnant people birthing in other communities who still require prenatal and postpartum care?)
- Number of pregnant people and number of births in the community
- Acuity and complexity of care needs
- What services the team is providing (e.g. pregnant to 6 weeks postpartum, primary care for the region, sexual and reproductive health care, extended infant care)
- What services the team members are providing outside the team
    - GPs who provide primary care outside this team
    - General surgeons who perform c-sections but provide other surgical services for the region
    - Midwives who provide extended primary care and sexual and reproductive healthcare

The South Community Birth Program is composed of approximately 15 midwives and GPs. Many of these providers work outside of the SCBP, including as academic staff for the UBC midwifery education program.

A rural practice in Alberta is composed of 6 midwives and 12 GPs. The work is split equally between the two groups. Additionally, the GPs provide on call coverage for urgent care and have their own primary care practices.

A rural practice in BC is composed of 4 midwives and 2 GPs providing care for approximately 130 pregnant people per year. The midwives provide the majority of the intrapartum work and some neonatal/pediatric on call support. The GPs provide the majority of neonatal/pediatric on call support and have their primary care practices.

3.2.2.3 Compensation

Compensation for this type of work organisation would likely be the similar to caseload midwifery given the level of responsibility, scope of practice and care provided. See the section on Unions for links to current contracts.

In most regions with shared care teams composed of midwives and GPs, both types of providers are independent contractors. This enables equitable compensation among providers. Some groups bill for courses of care. Others, especially in rural or remote areas, are offered service contracts where providers are paid a set fee per hour, which allows the service to be more sustainable in that setting. The providers receive a guaranteed income in exchange for providing a variety of services to the region, including obstetric and newborn care.

Focused scope midwifery care

In focused scope care, midwives may not be providing care across the continuum of care to include prenatal, intrapartum, postpartum and newborn care. Instead, they are providing one or more aspects of this care. This type of organisation can suit many different communities, from rural and remote communities to populous centres, and a variety of community needs, from obstetrical services to primary care. There are a number of examples of this type of organisation across the country.

3.3 Midwifery Antenatal and Postnatal Service (MAPS)

In this type of service, clients see a midwife or a small team of midwives for their antenatal and postnatal care. Labour and birth care, as well as care for urgent concerns, is provided by staff at the designated birthing facility or urgent care service.

This type of service would be most appropriate for communities with no birthing services but a significant number of birthing families. It may also be appropriate for other settings, such as in communities with complex health and social needs where facilitating access and outreach may be priorities.

3.3.1. Deliverables

80-110 clients and their newborns per year per EFT

3.3.2. Additional considerations

The midwife or team functions with clearly identified obstetrical/medical support, whether this is within the community or outside of it. There are clear guidelines for providers and patients with regards to consultation and referral processes as when and where to access care.

3.3.3 Compensation

A starting point for compensation for this type of work organisation is comparison to a community health clinic nurse practitioners, given the similarities in role, workload, responsibilities and schedule.

Canadian Programs

Community-Based Programs

Collingwood Well Baby Clinic
(Collingwood, ON)

NorWest Community Health Centre
(Thunder Bay, ON)

Women's Health Centre and Midwifery Servies, All Nations Healing Hospital
(Qu"Appelle Valley, SK)

Hospital-Based Programs

Alongside Midwifery Unit at Oak Valley Health
(Markham, ON)

Early Discharge Program (London, ON)

Early Pregnancy Clinic at Michael Garron Hospital
(Toronto, ON)

Families and Babies Program
(Surrey, BC)

First Steps Pregnancy Triage Clinic
(Kamloops, BC)

North York General Midwifery Care Clinic
(Toronto, ON)

West Lincoln Memorial Hospital
(Hamilton, ON)

3.4 Midwives providing primary care

Many settings could benefit from midwives providing primary care. This type of organisation capitalises on the knowledge and skill midwives have to provide sexual and reproductive health care, breastfeeding support and infant care to members of the community. Care would include contraception, pap smears, STI screens, abortion and early pregnancy care, fertility treatments, and extended infant care. Some activities may be undertaken under the authority or delegation of a physician while most are within the midwifery scope of practice. This is a common work organisation for *Expanded Midwifery Care Models* (EMCM) in Ontario.

One example of an EMCM is Norwest Community Health Centre in Thunder Bay, ON. Midwives in this clinic provide care to pregnant people including those with complex medical and social needs while also providing services listed above. An example job posting from 2024 is available in Appendix C.

3.4.1. Deliverables

Deliverables for this type of work organisation would likely be similar to that of community health clinic nurse practitioners, given the similarities in role, workload, responsibilities and schedule.

3.4.2 Compensation

Compensation for this type of work organisation would likely be similar to that of community health clinic nurse practitioners, given the similarities in role, workload, responsibilities and schedule.

3.5 Midwives providing midwifery services and primary care

Another option of work organisation is midwives providing a combination of midwifery services and primary care. This is commonly found in rural and remote regions like northern Canada. Examples include practices in Hay River, NWT, and the Nunavik region of QC, where practices have been established for more than 20 years. In these communities, midwives provide caseload-style midwifery care to pregnant people who birth in the community, provide prenatal, postpartum and newborn care to those who birth outside the community, and provide aspects of primary care as described in the previous section. In some jurisdictions, midwives are further supporting the community by providing care to people who attend the local ER for pregnancy-related concerns or due to sexual assault.

A posting for a position in Hay River from late 2024 is available in Appendix D.

3.5.1. Deliverables

Deliverables for this type of work organisation would depend on the primary goal of this organisation.

3.5.2 Compensation

Compensation for this type of work organisation would likely be the similar to or higher than caseload midwifery given it is caseload midwifery with additional services. See the link provided in section on Unions for links to current contracts.

3.6 Hospitalists midwives

While hospital-based midwives are relatively new to the Canadian context, hospitalist midwives are common around the world. In many countries, antenatal, intrapartum and postpartum wards are staffed by midwives. Hospital-based midwives may also work in outreach programs such as prenatal education, early discharge programs and home phototherapy programs.

Some of the roles midwives can fill in hospitals include:

- Providing intrapartum care for people experiencing low- to medium-risk pregnancies
- Staffing early pregnancy assessment clinics
- Staffing post-birth early discharge programs
- Staffing home phototherapy programs
- Staffing in-hospital postpartum and newborn clinics
- Providing medication abortion care
- Forensic assessments (post-sexual assault care)

3.6.1. Deliverables

Deliverables will once again vary based on the goals of the programs in which the midwives are working. These could include reducing the length of postpartum stays, facilitating in-home care for infants, rerouting early postpartum and newborn care to a more appropriate setting.

3.6.2 Compensation

Compensation will be based on the level of responsibility and the type of care the midwife is providing. Some settings may choose to engage midwives to fill one role, others will fill multiple roles. Comparative compensation to caseload midwifery or physician assistants working in obstetrics would be appropriate. Examples of job descriptions can be found in Appendix B. One is for a midwife filling several roles including intrapartum care. The second is for a hospital-based postpartum midwife.

Key Steps

1. Identify a project lead
2. Establish a steering committee
3. Identify community health needs and map current services
4. Collect baseline data
5. Consider how midwives may meet identified need
6. Consultation and engagement activities
7. Community-specific consideration
8. Future steps
9. Example community need

Section 4: Designing new or improved service pathways

Every service delivery organisation will have its own process in how to determine the priorities of their organisation as well as project management skills and principles they wish to follow. Here is a suggested outline of some of the topics and steps you may consider when designing new or improved service pathways.

An example project is presented on p.28

4.1 Identify a project lead and key stakeholders

Identify and assign a project lead who will manage and coordinate the project. Help the project lead build a team with a variety of skills including project management, data management, and administrative skills incl. managing and coordinating meetings.

4.2 Establish steering committee

The next key step is identifying key stakeholders. These can include managers for relevant primary and acute care services, midwives, obstetricians, family physicians, paediatricians, Indigenous health representatives, and consumers.

4.3 Identify community health needs and map current services

A critical step is identifying your community's health needs and mapping current services to see where services could be improved and what services are missing.

Consider all aspects of care related to the reproductive and sexual health.

- Contraception (including IUD and implant insertions)
- Pap tests
- STI screening and treatment
- Assessment and management of menstrual issues
- Assessment and management of menopause symptoms
- Early pregnancy assessment and management
- Abortion services
- Fertility services incl. screening tests and intrauterine insemination services
- Prenatal care (for pregnancies of all risk levels)
- Intrapartum care

- Postpartum care to 2 years
- Breastfeeding support
- Pelvic pain and pelvic floor health

Consider infant and child healthcare needs

- Primary care for infants and children up to 5 years of age
- Infant feeding support incl. tongue tie releases

Consider public health and health education needs

- Immunization education and administration
- Prenatal, labour and birth, and postpartum education
- Infant feeding education
- Sexual and reproductive health education

When mapping the services, consider:

- How people know when and where to access the service
- Whether or not a referral is needed
- Barriers to care incl. hours and location of services, wait times, transportation and parking needs, childcare needs
- How needs might otherwise be met
- Impact of not meeting needs (physical and mental health consequences, financial repercussions for families and the healthcare system)

4.4 Collect baseline data

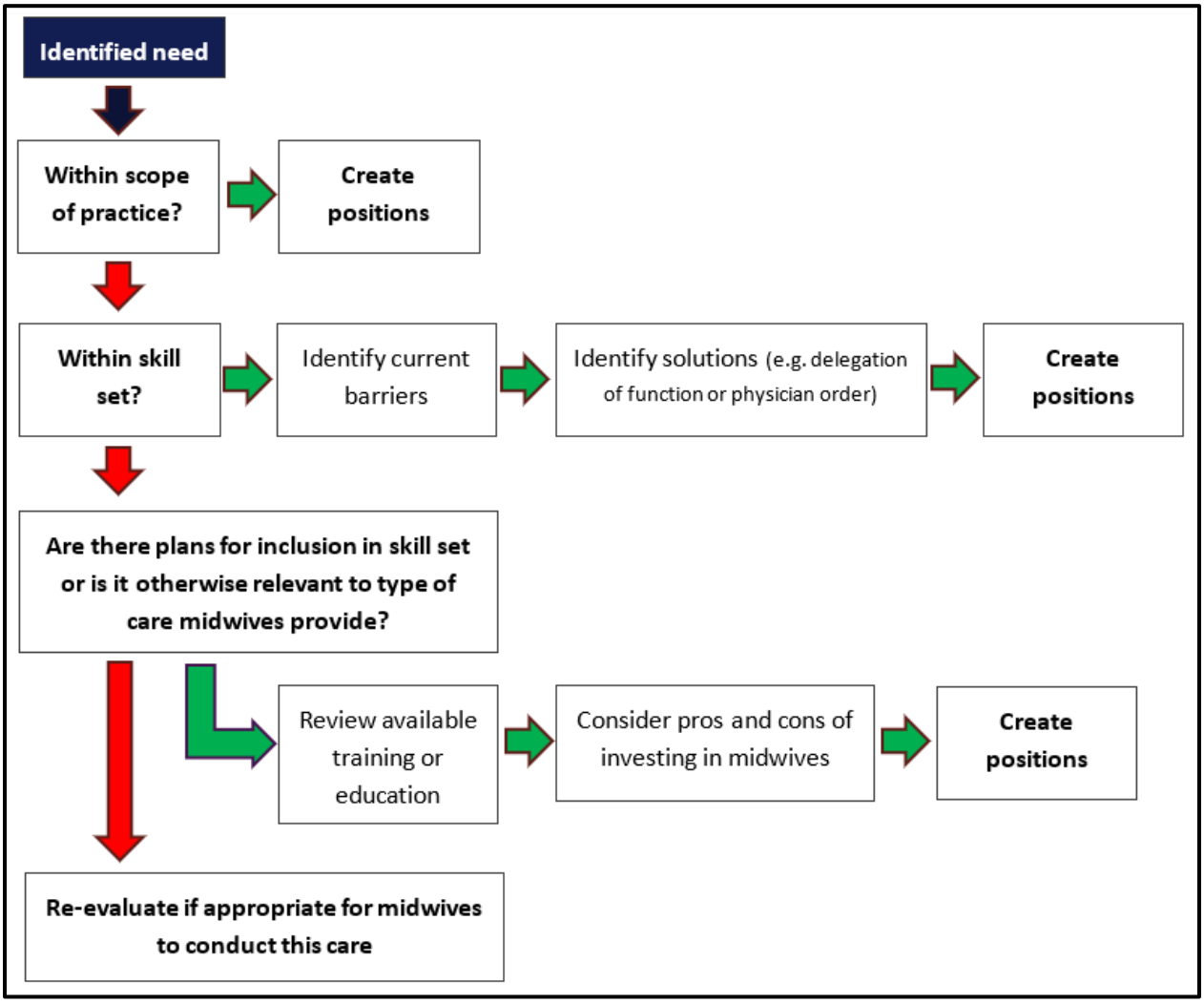
How your community's needs are identified will vary on the sources of information available to your organization. These may include:

- Availability of needed services (including diagnostic imaging and laboratories)
- Distance to needed services
- Comparison of capacity of obstetrical facility vs current usage
- Staffing concerns in facilities (e.g. surge protocols, being over capacity, patient wait times, staff not feeling confident providing intrapartum care)
- Surveys or needs assessments conducted
- Public feedback through letters, complaints, 'town hall' meetings
- Number or percentage of pregnant people who do not have access to a care provider
- Number or percentage of families from your catchment area who birthed in a different jurisdiction and potential reasons why (proximity to another jurisdiction, lack of care providers, lack of obstetrical services)
- Breastfeeding rates
- Rates of access to primary care provider (e.g. requests through Family Doctor Finder)
- Technological options (e.g. virtual visits)

4.5 Consider how midwives may meet needs

In many instances, creating positions for midwives to meet community needs is more straightforward than anticipated. As reviewed in sections on Structural barriers and Perceived and historical restrictions, many barriers and restrictions are either not applicable or can be circumvented.

Below is a suggested workflow to help determine if and how midwives may meet identified healthcare needs. It can be applied to both general work organisation and to specific program needs. While many examples are provided in section on Type of midwifery work organisations, examples of how specific needs may be met are also presented here.



4.5.1 Setting-based examples

Example 1: Rural/Remote community with few healthcare providers, without birth services

In less populous communities with no birth services, midwives could provide numerous aspects of care including prenatal, postpartum and infant care, infant feeding support and health education.

Depending on the size of the population and the number of providers, this could be combination of midwifery antenatal and postpartum service and midwifery primary care or a shared care model with additional responsibilities. This care is within the midwifery scope of practice and skill set. Aspects which are currently outside the midwifery scope, such as childhood vaccinations, can be circumvented through the use of physician orders and delegation of function.

An example of a job description for this type of role can be found in appendix B.

Example 2: Rural/Remote community with few healthcare providers, with birth services

In this setting, midwives provide care in a similar way as in the previous example, while also providing intrapartum care. An example of a job description for this type of role can be found in appendix C.

Example 3: Large obstetric hospital with staffing or volume concerns.

Hospitalist midwives may be considered in the setting of a large obstetric hospital experiencing difficulties due to staffing or volume of patients. Some of the challenges may include insufficient obstetrical providers for the volume of patients, need for diversion of patients to other services or hospitals, delays in patients being assessed, or delays in discharging patients. These midwives may facilitate births, assess and treat patients who attend obstetrical triage, or staff early discharge and home phototherapy programs.

Communities with this type of work are listed on page 21. An example of a job description for this type of role can be found in appendix A.

4.5.2 Population-based needs

Example 4: Population with complex health and social needs

Several midwifery and interprofessional programs have been established to meet the needs of a specific population. Often, these programs provide care for populations who are underserved and have complex health and social needs. One example is the PIIPC project, discussed on page 19.

4.5.3 Discrete aspect of care needs

Some communities may identify a specific aspect of care where needs are not currently being met. For example, early pregnancy care is not accessible for many Manitoba families. Early pregnancy assessment clinics (EPACs) have been established in many communities and have been shown to divert care from urgent care services, improve outcomes and increase patient satisfaction with care. The Early Pregnancy Clinic at Michael Garron Hospital (Toronto, ON) and First Steps Pregnancy Triage Clinic (Kamloops, BC) are examples of midwifery-led EPACs.

4.6 Consultation and engagement activities

Consumer consultation:

Engaging in consumer consultation will help guide structuring the service to best meet consumer needs. This can be accomplished through surveys, focus groups and by recruiting a consumer representative.

Workforce consultation:

Early consultation with the workforce enables engagement, buy and reduced resistance. This can be accomplished in both formal and informal ways with surveys, discussions and rounds or at team meetings, monthly emails or through focus groups.

4.7 Community-specific consideration

Challenges related to providing appropriate care to rural, remote and Indigenous communities are discussed in the introduction.

Additional considerations include structuring services to help prevent burnout and fatigue (e.g having adequate staffing, locums), ensuring adequate continuing education opportunities, and having clear escalation and referral pathways. Technological support, such as having consultants available via video chat, would also be beneficial.

4.8 Future steps

The next phases of designing new programming or services pathways may include:

- Writing a business case
    - Including sourcing space, equipment and supplies
- Establishing a management and leadership structure
    - Including midwifery leadership
- Writing an operational plan
- Creating and implementing a communication and marketing plan
- Recruiting staff
- Launching the service
- Evaluating the service
    - With staff
    - With stakeholders
    - With consumers

4.9 Example of community need: Early pregnancy services

4.9.1 Elsie's story

Elsie is a 24 y.o. woman who arrived in Canada 3 years ago. She lives in Arborg with her husband. She recently found out she is pregnant, having taken an at-home pregnancy test. She thinks she is about 7 weeks pregnant, based on her last menstrual period. She does not yet have a primary care provider.

One Friday evening at 9 pm, Elsie finds she has some light vaginal bleeding. She is worried and she doesn't know what to do. She goes online to try to find information. She finds information on bleeding in early pregnancy but still doesn't know what to do. There isn't any information available about Manitoba-specific services for early pregnancy assessment or possible miscarriage.

Elsie calls her sister Ruth, who has several children, and asks what she should do. Ruth tells her to go to Arborg Hospital. Unfortunately, there are no physicians at Arborg Hospital Emergency Department that day, and the Gimli Hospital Emergency Department was only staffed until 8 pm (as was the case on Friday 17 January 2025). Elsie's nearest option for care is the Selkirk Regional Health Centre Emergency Room, more than an hour's drive away. She could also wait until the next morning to be seen in Gimli.

Elsie decides to wait and see. She goes to bed but wakes up at 3 am with heavier bleeding and lots of cramping. She doesn't want to make the long drive to Selkirk but is worried. She asks her husband to drive her. Once at Selkirk ER, she waits 5 hours to get some blood work and an ultrasound completed. She is exhausted and heartbroken when the physician confirms there is no heartbeat and that the miscarriage will likely resolve on it's own. She is not offered medication or surgical options. She is sent home and told to see her primary care provider (which she does not have) for follow-up. Elsie is feeling very lost and doesn't understand what is happening or why. The physician at the ER was very busy and did not have time to explain.

Early pregnancy assessment services

Alberga H. Experts urge streamlined, more compassionate miscarriage care in Canada. Winnipeg Free Press. 2024.

Edwards S, Birks M, Chapman Y, Yates K. Bringing together the "Threads of Care' in possible miscarriage for women, their partners and nurses in non-metropolitan EDs. Collegian. 2018; 25:293-301

Glicksman R, McLeod S, Thomas J, Varner C. Services for emergency department patients experiencing early pregnancy complications: A survey of Ontario hospitals. Canadian Journal of Emergency Medicine. 2019; 21(5):653-8.

Larivière-Bastien D, de Montigny F, Verdon C. Women's experiences of miscarriage in the Emergency Department. J Emerg Nurs. 2019; 45(6):670-6

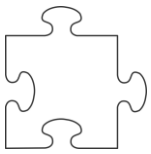
Mehra VM, Meng S, Murphy-Kaulbeck L, Tunde-Byass M. Time to Make Early Pregnancy Care a Priority in Canada. JOGC. 2024.

Memtsa M, Goodhart V, Ambler G, Brocklehurst P, Keeney E, Silverio SA, et al. Differences in the organisation of early pregnancy units and the effect of senior clinician presence, volume of patients and weekend opening on emergency hospital admissions: Findings from the VESPA Study. PLoS One. 2021;16(11):e0260534.

Pang P, Temple-Smith M, Bellhouse C, Trieu V, Kiropoulos L, Williams H, et al. Online health seeking behaviours: what information is sought by women experiencing miscarriage. Stud Health Technol Inform. 2018;252:118-25.

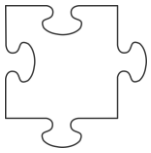
(Continued on next page)

4.9.2 Mapping services and data collection

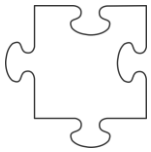


The **first obstacle** Elsie encountered is **the lack of available information** about early pregnancy assessment services in Manitoba, specifically about potential miscarriage. As of February 2025, searches for terms like 'early pregnancy bleeding' and 'miscarriage' do not lead to related services in Manitoba, other than the Dragonfly Support Program. This program is a support group led by Women's Health Clinic for families who have experienced a pregnancy or infant loss.

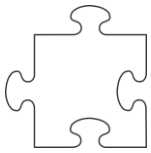
Considering that a significant proportion of Manitobans do not have a primary care provider, that 1 in 4 pregnancies end in miscarriage, and that an estimated 1 in 9 pregnant people in Manitoba seek care for early pregnancy loss, the lack of information and services is shocking.



A **second obstacle** faced by Elsie is the **lack of services in her community**. The service she can access is an hour away and requires access to a personal vehicle. Fortunately for Elsie, her husband is available to drive to the hospital and they do not have find care for children or other dependents.



Obstacle three is that the **only service Elsie can access is an emergency department (ED)**. EDs are often overwhelmed, leading to busy providers and long wait times. Numerous studies from around Canada and the world have shown the ED is not an appropriate service for early pregnancy. Many jurisdictions have opened early pregnancy assessment clinics (EPACs). Links to some of these studies are available on pp 30-31.



A **fourth obstacle** is the **lack of follow-up**. Elsie does not have a primary care provider. A final obstacle is that Elsie's physical, emotional and psychological needs have not been met.

Your team starts gathering information and data. This might include what services are available in the region, distance to and availability of the services, the number of ER visits related to early pregnancy concerns, length of time of ER visits related to early pregnancy, input from obstetrical providers and ER staff, consultation with the public, review of complaints, and other sources of information.

Early pregnancy assessment services

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4.9.3 Designing potential services

Your team concludes that early pregnancy services can be improved and starts considering options. Depending on resources and setting, options that could be explored include:

- A multi-disciplinary EPAC in hospital
    - BC Women's EPAC (Vancouver, BC)
    - Regina EPAC (Regina, SK)
- A midwifery-led, hospital-based EPAC
    - Early Pregnancy Clinic at Michael Garron Hospital (Toronto, ON)
- A multi-disciplinary, community-based EPAC
- A midwifery-led, community-based EPAC
    - First Steps Pregnancy Triage Clinic (Kamloops, BC)
- An on-call process for midwives to see patients who present to an ER with early pregnancy concerns
    - Midwives in a remote BC community are called in for any early pregnancy-related concerns for patients who present to the ER.
- A provincial, multi-disciplinary virtual clinic
    - Patients with early pregnancy concerns have virtual visits to talk about their concerns and receive information. Visits are available via phone or online and no referral is required. The providers organise appropriate care, usually blood work and ultrasound, for the patient in a community as close as possible. When needed, providers prescribe medication abortion or organise surgical intervention, or other appropriate follow-up.
- A combined virtual and physical multi-disciplinary EPAC
    - A combination of a provincial virtual service coordinating care across the province and a physical EPAC.

4.9.4 How midwives could meet the needs for early pregnancy assessment and care

In the potential service designs discussed above, midwives can provide most or all of the care. Midwives are already ordering lab work and ultrasounds, providing rehydration and anti-nausea medication, providing advice and organising appropriate referrals and follow-up for their clients. This type of service could be expanded, such as through a virtual clinic, to make it accessible to more people.

For more advanced levels of care, such as providing medication abortion or point of care ultrasound, these tasks could be undertaken through a delegation of function while awaiting legislative and regulatory changes to the midwifery scope of practice. This is how some of the clinics in other parts of Canada are functioning.

Conclusion

Throughout this introductory toolkit, various factors that had led to a lack of investment in and growth of the midwifery profession have been discussed. Some of factors include ongoing lack of understanding of the profession, scope of practice and skill set. The primary goal of this toolkit was to help identify the numerous ways many community health needs could be met by midwives. Optimization of midwifery skills and services would be beneficial for many settings and communities.

A planned second phase of this toolkit will provide further details on the project management aspects of optimizing services provided by midwives.

Thanks

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Multi-disciplinary programs

South Community Birth Program (Vancouver, BC)

High River Maternity (High River, AB)

Inlet Community Birth Program (Port Moody, BC)

Community-Based Programs

Collingwood Well Baby Clinic (Collingwood, ON)

NorWest Community Health Centre (Thunder Bay, ON)

Women's Health Centre and Midwifery Servies, All Nations Healing Hospital (Qu"Appelle Valley, SK)

Hospital-Based Programs

Alongside Midwifery Unit at Oak Valley Health (Markham, ON)

Early Discharge Program (London, ON)

Early Pregnancy Clinic at Michael Garron Hospital (Toronto, ON)

Families and Babies Program (Surrey, BC)

First Steps Pregnancy Triage Clinic (Kamloops, BC)

North York General Midwifery Care Clinic (Toronto, ON)

West Lincoln Memorial Hospital (Hamilton, ON)

Appendix A: Job description resources

The Canadian Association of Midwives website contains job listings for a variety of midwifery positions across the country. Examples are also provided below.

Appendix B:
Example job description – Hospitalist Midwife

Example 1

**HOSPITALIST MIDWIFE, ALONGSIDE MIDWIFERY UNIT –
FULL TIME, PART TIME, CASUAL (2018)**

Who we are:

Markham Stouffville Hospital (MSH) is one of Ontario's leading community hospitals. Across our two sites (Markham and Uxbridge) and Reactivation Care Centre (RCC), we provide high quality, patient-centred care to more than 435,000 patients each year. We offer diagnostic and emergency services and deliver clinical programs in acute care medicine and surgery, addictions and mental health, and childbirth and children's services. We are also proud to be part of the Eastern York Region North Durham Ontario Health Team (OHT).

Our 526 physicians, 28 midwives, 2,400 staff and 1,000 volunteers serve patients and families with an honoured to care mindset and are focused on delivering an extraordinary patient experience to the residents of Markham, Whitchurch-Stouffville, Uxbridge and beyond. We are dedicated to providing access to the right care, at the right time, in the right place by the right people and at the right cost. Are you ready to join us?

Who you are:

You are an innovative and patient centered individual who provides excellence within their profession

You are a team player with excellent communication, critical thinking and customer service skills

You have vision, flexibility, transparency, honesty and practicality

You are organized, accurate, able to multi-task and meet deadlines

You support the patient experience, your colleagues and others cultural and spiritual beliefs

You encompass MSH's core values and live the words of Respect, Trust, Commitment, Compassion and Courage

What we need:

The Hospitalist Midwife is responsible for the day-to-day clinical running of the AMU unit, including but not limited to prioritizing client needs, admission and discharge timing, communication with community midwives, consultants and other members of the healthcare team, supporting learners, planning for emergencies, reviewing outcomes, teaching, mentoring and providing support to the midwifery team and learners. The Hospitalist midwife has an important role to play on the AMU with respect to leadership and change management and will support the strategic directions set by the Governance Council and the Executive Director. The Hospitalist Midwife communicates and

facilitates communication with the other members of the interprofessional team to execute the best plan of care for each client

Compensation:

Band C: $50.56 - $63.24

Work Schedule:

The successful candidate would be required to work 12 hour days, evenings and weekend and holidays. Please note schedules may change due to operational needs.

What you bring to MSH:

- Current Certificate of Registration with the College of Midwives
- Post graduate certificate in surgical first assist for caesarean birth completed or in progress
- Masters level degree in midwifery, education or other appropriate program preferred, in progress or plan for undertaking is preferred
- Minimum 5 to 10 years of recent experience as a midwife working in a full scope hospital setting
- Minimum 5 years as a Clinical preceptor to midwifery students
- Demonstrated role as a resource and role model to junior midwives and learners
- Excellent physical assessment skills
- Proficient computer and writing skills
- Familiar with professional and hospital standards, guidelines and procedures
- Demonstrated commitment to a woman friendly /family centered care environment
- Demonstrated excellent critical thinking and problem-solving skills
- Demonstrated ability to work effectively within an interprofessional team as well as independently
- Excellent communication, interpersonal and teaching skills
- Excellent organizational skills with an ability to prioritize
- Experience in leading organization and team change
- Evidence of ongoing professional development, continuing education and leadership experience
- Demonstrated good attendance record with the ability to maintain this same standard

Markham Stouffville Hospital takes pride in serving some of Canada's most diverse communities. We are committed to fostering an environment of equity and inclusivity where every person can work and receive care safely, openly and honestly. All qualified applicants will receive consideration for employment without regard to race, colour, religion, gender, gender identity or expression, sexual orientation, nation of origin, genetics, disability, age, veteran status, marital or family status, belief system, or other factors related to one's personal identity and/or values. Furthermore, Markham Stouffville Hospital is committed to meeting the needs of all individuals in accordance with the Accessibility for Ontarians with Disabilities Act (AODA) and the Ontario Human Rights Code. Should you require accommodations during the recruitment and selection process, please contact Human Resources.

Example 2

Families and Babies Program - A Fraser Health Program
Position: Registered Midwife - Postpartum Clinic at Surrey Memorial Hospital

Position Overview:
The Families and Babies Program, launched in October 2023 at Surrey Memorial Hospital, is seeking a compassionate and skilled Registered Midwife to join our dynamic team. This innovative program provides specialized postpartum care for low-risk birthing families and their infants, ensuring a smooth transition from hospital to home with early discharge at 24 hours.

Midwives in this program play a vital role in delivering high-quality, supportive care to families during the critical first week postpartum. This includes providing in-home care and conducting follow-up appointments at our program clinic, located in the Children's Health Centre at Surrey Memorial Hospital.

Who You Are:

You are a patient-centered individual who consistently performs at an exemplary standard.
You are a team player with excellent communication, critical thinking, and prioritization skills, eager to collaborate with a multidisciplinary team at Surrey Memorial Hospital.

Position Summary:
This hospital-based integrated postpartum primary care midwife position will support early discharge from the Family Birthing Unit, providing clinical care to families post-discharge through home visits and follow-up clinic appointments.

What We Are Looking For:
Registration with the BC College of Nurses and Midwives
Currently privileged at Surrey Memorial Hospital or eligible for privileging
Minimum 2 years of recent experience as a midwife
Excellent physical assessment skills and proficiency in clinical care
Strong computer and writing skills
Knowledgeable in professional and hospital standards, guidelines, and procedures
Demonstrated commitment to person-centred, family-focused care
Strong critical thinking, problem-solving, and decision-making skills
Ability to work effectively both independently and as part of an interprofessional team
Excellent communication, interpersonal, and teaching skills
Strong organizational skills with the ability to prioritize effectively
Evidence of ongoing professional development, continuing education, and leadership experience
Good attendance record with the ability to maintain this standard

Work Schedule:
Approximately 7 twelve-hour shifts per month, including hospital visits, home visits, and clinic visits.
Home visits are scheduled 7 days a week, with midwives expected to conduct 2 to 4 home visits per shift.
Clinic hours are 3:30 pm – 6:30 pm, Monday to Friday, including statutory holidays.
No night shifts required.
Schedules may be adjusted for operational needs.
Remuneration:

$1,000 per 12-hour shift

How to Apply:
Please submit your CV and letter of interest to familiesandbabiesprogram@gmail.com by January 30, 2025. Only selected applicants will be contacted to arrange an interview.

Join our team and make a meaningful impact by providing exceptional care to new families during their postpartum journey. We look forward to hearing from you!

Families and Babies Program is committed to fostering a diverse and inclusive workplace. We encourage applications from individuals of all backgrounds and experiences.

Appendix C: Example job description – Primary Care Midwife

NorWest Community Health Centres
Centres de santé communautaire NorWest

Midwife - 1 FTE - Thunder Bay Site (2024)

One of a network of community health centres, the NorWest Community Health Centres is a community based, non-profit organization funded by Ontario Health, emphasizing access to primary health care and prevention programs and services.

We are currently seeking 1 FTE Midwife, who as a valuable members of the Community Health Centre team will provide services within their scope of practice at the Thunder Bay, Longlac, Armstrong and Kakabeka locations. There is a strong emphasis on disease prevention, health promotion and education and community partnerships.

There is no on call provided.

These positions have the Health Care of Ontario Pension Plan and an excellent group health benefit package.

QUALIFICATIONS:

- A General Registrant in good standing with the College of Midwives of Ontario and QAP up to date.
- Member of the Association of Ontario Midwives
- Up to date NRP, FHS, CPR, and Emergency skills certification.
- Minimum 5 years' experience working as a midwife.
- Demonstrated experience **not only** in the provision **of low-risk, but also complex** prenatal, intra-partum and post-partum care for pregnant clients and their babies, including experience with an expanded midwifery scope of practice such as performing and evaluating NST's, managing clients with GDM, managing epidurals, oxytocin, augmentation and induction of labour.
- Demonstrated practice of providing compassionate, respectful, non-judgmental and culturally sensitive care in an informed choice model.
- Highly motivated to work with high needs populations and open to working in a new model of care as an employee of NWCHC's.
- Awareness and sensitivity to socio-economic and cultural issues.
- Awareness of and sensitivity to health issues particular within populations who face barriers to accessing care (homeless, under housed, street affected, living with mental health illness, active or past drug use, complex health histories, 2SLGBTQI+, newcomers, non-insured).
- Creative thinker with the ability to generate new ideas and challenge assumptions.
- Demonstrated leadership skills.
- Program development experiences an asset.
- Proficiency in the use of computer technology/software (Microsoft Office, Outlook etc.)
- Clinical experience with 2SLGBTQIA+population an asset.
- Experience with contraceptive care (prescribing OCPs, inserting IUDs) an asset.

- Experience with fertility treatment (IUI or home-like insemination) with 2SLGBTQI+ clients an asset.
- Willing to obtain training and be involved in providing comprehensive birth control and reproductive options upon approval for inclusion within the “Midwifery Scope of Practice.”
- Experience using an Electronic Medical Record system (EMR) an asset.
- Successful candidate will be required to apply for, obtain, and maintain privileges at TBRHSC.
- Experience with utilizing BORN System is an asset.
- A current driver's license and access to a vehicle to travel to designated outreach clinics.
- There **may** be an opportunity for deliveries **(there will be no on call).**

Appendix D: Example job description – Caseload and Primary Care Midwife

Hay River Health & Social Services Authority
Hay River Health & Social Services Authority
Dec 2024

Midwife, Acute and Ambulatory Care
Salary: Range 20, $124,449 to $148,668 ($63.82 to $76.24/hour)
Status: Full-time, Indeterminate
Competition #: 089-22
Closing Date: Open until suitable candidate found
Effective November 1st, 2024, this position is eligible for a temporary Labour Market Supplement of $11,000 upon recruitment and may be eligible for an additional temporary Labour Market Supplement of $11,000 upon one year of continuous service. Terms and conditions apply*
The Registered Midwife is responsible to provide primary midwifery services to maternity clients to ensure safe and appropriate care that contributes to healthy pregnancies, safe births, and healthy beginnings for mothers and babies. The position advances a best practice approach to the provision of community-based maternity care within an integrated health service delivery model.
The Registered Midwife is a credentialed member of the Hay River primary community care team with admitting privileges and works collaboratively with other members of the Medical and Professional Staff and other healthcare providers. The position ensures the appropriate coordination of community-based maternity care with the territorial health services, and maintains regular communication with the Stanton Territorial Hospital perinatal team. At times, the Registered Midwife may be required to travel and work in other Health Authorities across the Territories in order to maintain proficiency or cover short periods of leave for other Authorities.
The Registered Midwife works as a member of the maternity care team that provides services to all maternity clients including approximately fifty complete courses of care to women and their babies, as well as partial courses of care to women in a variety of circumstances. The position assumes primary responsibility for and provides continuity of care to assigned clients.
Qualifications:
Knowledge of the NWT Midwifery Profession Act and the NWT Midwifery Practice Framework in order to practice in compliance with the model and standards of practice.
Knowledge of and an ability to apply, in a variety of settings, current evidence based midwifery theory and practice in order to provide safe and competent primary care to women and their families, in a manner consistent with the “General Competencies of Midwives in the NWT” (refer to NWT Midwifery Practice Framework).
Knowledge and ability to use tools and technology appropriately in order to provide safe and effective care to clients (including but not limited to fetal monitors, oxygen delivery, diagnostic sampling techniques, incubators, phototherapy equipment, and neonatal resuscitation and intubation equipment).
Demonstrated ability to communicate effectively with excellent interpersonal skills.
Knowledge of and an ability to apply health promotion principles and strategies, in order to provide education, health promotion and counselling to women, their families and the community.
Knowledge of and an ability to apply principles of adult education in order to participate in and deliver orientation and training to health professionals and allied health workers.
Skills and ability to identify and work collaboratively with resources within the Authority, the

community, and the territorial health and social services organization in order to ensure appropriate support to clients and their families.
Knowledge, skills, and ability to utilize a computer and the internet in order to acquire, manage, and disseminate information related to midwifery practice and the implementation of the midwifery-led maternity care program.

This level of knowledge, skills, and abilities may typically be attained through the completion of a Baccalaureate degree in Midwifery (Health Sciences), or assessed through a Prior Learning and Experience Assessment (PLEA) program within a Canadian province, with a minimum of 3 years' experience in delivering midwifery care as a primary care provider. The incumbent must hold, or be able to obtain prior to hire, current registration as a Registered Midwife with the Government of the Northwest Territories. The incumbent must be credentialed by the NWT Credentialing Committee and must be able to obtain, prior to hire, appointment as a member of the Professional Staff of the Authority. The incumbent must also possess a valid Class 5 license. The incumbent will be required, on an annual basis, to reapply for registration, credentials, and appointment to the Professional Staff. Current CPR certification, Neonatal Resuscitation (NRP) certification with intubation and UVC placement, and SOGC Alarm Course or Emergency Skills Workshop for midwives is essential.

In addition to an attractive salary, we offer a Northern Allowance of $2.73 per hour up to $5,332 per year. All job offers are subject to references, a satisfactory Criminal Records Check (including vulnerable sector search) and an Employee Health Risk Assessment. Only those candidates selected for an interview will be contacted.
The Priority Hiring ranks shall be as follows:

- Indigenous Canadian, meaning a member of a Canadian First Nation, or an Inuk or Métis person;
- Long-Term Northern Resident, meaning a person who has lived at least half their lives in the Northwest Territories;
- People living with disabilities as defined in the Northwest Territories Human Rights Act, or members of the LGBTQA2S community;
- Northern Residents, meaning persons who have resided in the Northwest Territories for at least twelve (12) continuous months at the time of application.

Candidates shall be invited to identify their eligibility for Priority Hiring in the job posting at the time of application.
For full job description, including required knowledge, skills & abilities, please see job posting/job description on our website at www.hayriverhealth.ca under the 'Careers' section.
How to apply:
Applicants should send their resume via email to hrhssa_competitions@gov.nt.ca or via Fax to (867) 874-8345