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Implementation of Midwifery In Nova Scotia

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Nova Scotia Department of Health &
Reproductive Care Program of Nova Scotia

Final

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Preamble

This report presents a qualitative evaluation of the implementation of midwifery in three model sites in Nova Scotia, primarily focusing on the time period since legislation. The evaluation was led by the Midwifery Evolution in Nova Scotia (MEINS) Committee which is overseeing the implementation process. The MEINS Committee contracted an experienced research and evaluation firm, Research Power Incorporated (RPI), to conduct the evaluation and provide guidance and input into all aspects of the evaluation process (e.g., feedback and approval of key informants and data collection tools, review of draft reports, and input into the conclusions and recommendations). Members of the MEINS committee are:

Co-Chairs:

- Judy Chisholm, Interdisciplinary Team Coordinator, Primary Health Care, DOH
- Cheryl Purcell- Cotnam, Manager of Operations, Primary Health Care, DOH
- Bob Van Dine, Manager of Development, Primary Health Care, DOH

Members:

- Rebecca Attenborough, Reproductive Care Program, DOH
- Mariah Battiste, Aboriginal Midwifery Project, Tui'kn
- Valarie Campbell, Healthy Beginnings, Public Health (Alternate: Karen Blanchard)
- Lynda Campbell, Physician Services, DOH
- Jan Catano, Midwifery Coalition of Nova Scotia
- Sharon Davis-Murdoch, Diversity and Social Inclusion, DOH
- Jan Hanifen, Manager Perinatal Services, GASHA
- Anne Jackman, Registrar, Midwifery Regulatory Council
- Catherine Knockwood, Maternal Child Health Program, Confederacy of Mainland Mi'kmaq
- Hilary Marentette, Family Resource Centres

- Leslie Niblet, Association of Nova Scotia Midwives
- Dr. Heather Scott, Obstetrician, IWK
- Jennifer West, Manager Childbirth Services and Midwifery, IWK
- Marlene Wheatley, Manager, Primary Health Care, SSDHA

Corresponding member:

- Dr. Patsy Menard, Family Physician, GASHA

In addition to this evaluation report, there is a second report entitled *Uncomfortable Positions: Consumer Comments of Midwifery Implementation in Nova Scotia*. This report was undertaken by the Midwifery Coalition of Nova Scotia (MCNS) at the request of the MEINS Committee to describe the experiences of women in areas of the province where there are no midwives in practice. Since the focus of the implementation evaluation was on the model sites, seeking feedback from women living in other areas of the province was beyond the scope of the evaluation. The MCNS used their networks to solicit written submissions from women who were unable to access midwifery care and compiled the feedback in the *Uncomfortable Positions* report. This report provides an additional perspective that is relevant to the future of midwifery in Nova Scotia.

Acknowledgements

We would like to thank a number of people and organizations who have contributed to Evaluation of the Implementation of Midwifery in Nova Scotia. Thank you to the MEINS Committee (see page iii for committee membership) for their invaluable guidance, input, dedication, time and support throughout the evaluation process.

We gratefully acknowledge all of the women who participated in the focus groups for taking the time to openly share their opinions, experiences and points of view. Thank you also to the health care providers and stakeholders from the model sites as well as provincial stakeholders for taking the time to participate in the evaluation process and thoughtfully reflecting on their experiences with the implementation of midwifery in Nova Scotia.

Executive Summary

Background

In November 2006, Bill 107, the Midwifery Act, was passed in the House of Assembly. Over the next two and a half years provincial committees addressed a wide array of policy and clinical issues and oversaw introducing regulated midwifery in three model sites in Nova Scotia including: Guysborough-Antigonish-Strait Health Authority, IWK Health Centre and South Shore Health. Midwives working as employees and with primary maternity care teams began practicing in the three model sites between April and August 2009. The purpose of this report is to present the findings of a qualitative evaluation of the implementation of midwifery in Nova Scotia (since legislation). The findings are intended to inform future planning and implementation of midwifery in Nova Scotia.

Methodology

Data collection gathered information from the following key stakeholders: health care providers within the three model sites, provincial stakeholders involved in the planning and implementation of midwifery, and clients (women living in a model site who used midwifery services, and women who were unable to access midwifery services). Focus groups were conducted in person and most interviews were conducted via telephone with some conducted in person. For each group of stakeholders, an interview/focus group guide was developed (and approved by the MEINS Committee) to ensure all areas of interest were covered. All interviews and focus groups were audio-recorded (with participants' permission), transcribed verbatim and thematically analyzed. The findings were synthesized and compiled into this report.

Considerations for Readers

Considerations and observations of the evaluators are presented to help provide context for readers in reviewing and interpreting the findings:

- It is important to differentiate between the women's and the key stakeholder's perspectives as these groups were asked different questions. The women's focus group guide primarily focused on obtaining feedback on women's experiences with the midwifery services they received. Their experiences are important to consider, even though the evaluators and the MEINS Committee members realized that women could not comment specifically on the implementation process.
- Stakeholders had varying levels of involvement in implementation and may have been engaged at different times, which contributed to their level of knowledge and perspective about the implementation process.
- The evaluators noted that within and across model sites there were misperceptions or opposing views on some issues between stakeholders and stakeholders groups (e.g., within a focus group at a model site participants raised concerns about a particular issue while in another focus group within the same model site a different provider group was unaware of the issue).
- Issues presented through the thematic analysis were generally found across all model sites; very few were site specific. In addition, findings were found across care provider groups and administrators versus specific to one type of provider or stakeholder group.

Findings

❖ *Women's Experience with Midwifery*

- Women, both those who accessed the service and those who were unable to do so, were interested in midwifery for the continuity of care, philosophical approach to birth (e.g., natural, low intervention, etc.), choice of birth place, longer appointments, post-natal follow-up, and breastfeeding support.
- For many of the women, their experience with midwifery was positive. Women described receiving personal care from their midwife; felt empowered and confident in their abilities to give birth and to be a good mother; were involved in all decisions

related to their pregnancy and birth, felt comfortable asking questions, discussing their options and making decisions free of judgment; received women centred care (e.g., midwives were respectful of women's bodies, etc.); and the midwives included and involved their partners in the pregnancy and birth process.

- A few women indicated that the midwifery services received did not match their expectations. Some women sensed tension between the midwife and other health care providers at the hospitals which was stressful and distracting during birth; they felt their midwife was not as attentive to them as they had hoped; felt that the care they received from the midwife was inadequate; post-partum care did not meet their expectations; and the visits were shorter than anticipated.
- For women who wanted but were unable to access midwifery services (IWK site), they were dissatisfied with the care received (feeling not involved in decision making, received invasive interventions, struggling with breastfeeding, unable to have a home birth, did not have somebody to advocate for their needs) and felt that their overall experience would have been improved had they been able to access a midwife.

❖ *What was Done to Support Midwifery Implementation*

- Model sites have done several things to support the implementation of midwifery including: strategies to build an understanding of the role of the midwife (e.g., information on websites, welcoming parties, meetings and presentations with individual departments/providers, etc.); provision of an orientation to the system for the midwives; use of provincial supports (e.g., guidelines, toolkits, guest speakers from other provinces, the provincial funding provided to support implementation, courses made available to the midwives, etc.); and using a consultative/participatory process to involve a range of stakeholders in implementation (e.g., committees, etc.).

❖ *Issues Associated with Midwifery Implementation*

The three model sites are very different in the approach they have taken to integrating midwives into the system; however, most of the issues and challenges identified were common across model sites as well as across provider groups:

- *Collaboration:* There are significant differences in how each model site functions (e.g., location of midwife, sharing patients, etc.) and varied perspectives on how this impacts collaboration. While some felt co-location and sharing patients was important, others felt this was unnecessary to ensuring effective interprofessional collaboration and may not be in keeping with the traditional approach to midwifery in Canada.
- *Philosophical differences:* The philosophical differences between midwifery and traditional maternity care was a notable issue as there continues to be a lack of understanding, trust and respect for midwifery practice among a range of providers. Some providers appear unclear about their role in working with midwives and some do not support home birth, perceiving it to be unsafe.
- *Resources and sustainability:* Issues related to resources and sustainability were described including a lack of sufficient number of midwives to support effective midwifery practice and principles in each of the model sites; issues of access (e.g., waitlist, midwifery only available in three sites in the province); underestimated administrative support needs; the need for a cost-benefit analysis of midwifery (evidence to support that midwifery is beneficial given that it is a costly service); and questions and fears surrounding long-term sustainability of midwifery.
- *Reaching and providing services to vulnerable groups:* Midwifery services are predominantly used by women who tend to be more out spoken and with higher education, and outreach efforts are not adequate to reach vulnerable groups. The challenges of offering midwifery services to vulnerable groups include a tendency for these groups to have conditions/risks which preclude them from being considered a low risk pregnancy (thus they would not be candidates for midwifery services) as well as the location of midwifery services which can affect the uptake among vulnerable populations who may be intimidated, feel less welcomed or may be unable to easily access services.
- *Remuneration and call time:* Physicians were hopeful that midwifery would provide some reduction in their on-call time, and although this has happened at some model

sites, on-call time has remained unchanged at others. In addition, the funding model has created concerns for some providers as midwives are paid via a salary and have expenses covered, whereas many physicians work within a fee-for-service model and must cover their own expenses.

- *Working within the system:* The issue of midwives working within the health care system included the willingness and challenge of midwives to work within the system, and on the flip side, the willingness and challenge of the system to incorporate midwifery.
- *Governance and accountability:* Issues related to governance and accountability included the employment model (under an employment model, midwives must work in a system that places restrictions on overtime hours, with many organizational policies and procedures, some of which may be inconsistent with midwifery practices, etc.); reporting structure (midwives reporting to nursing creates issues); policies and standards, some of which were developed without the input of midwives and may not reflect midwifery practices; and lack of true consumer representation/voice.
- *Timing:* Not enough time was allocated within the implementation process to engage providers and build understanding of midwifery. The short timeline meant that midwifery was implemented prior to having the appropriate policies, etc. in place.

❖ ***Accomplishments of the Implementation of Midwifery***

- All model sites and provider groups consistently discussed the fact that introducing a new health care provider into the system is no small feat, and therefore having legislation and regulated midwives practicing within the system is a significant accomplishment.

Conclusions & Recommendations

The findings reveal that incorporating/ integrating a new health care provider into the existing health care system is a complex task that requires substantial support including an investment of time and resources (financial and people). This is not a surprising finding given that the philosophical beliefs and underpinnings of the midwifery profession are quite different from the traditional medical model. Further, the health care system is undergoing transformation with greater investments being made within primary health care – this is a potential opportunity to effectively support the integration of midwifery programs and services, but is also a challenge, as midwives are being introduced into the system when many changes and developments are underway.

❖ *The Model and Vision for Midwifery*

- Clearly define and communicate the model of midwifery being implemented in Nova Scotia. Terms such as ‘continuity of care’ and ‘collaboration’, which are integral to the Canadian Model of Midwifery, are used by many provider groups. More detail about what these principles mean in the context of midwifery is needed to address current lack of understanding among providers as well as philosophical differences in interpretation of some terms.
- Develop a plan for implementation of midwifery throughout the province including a vision and timelines.

❖ *Standards and Accountability*

- Build awareness and understanding among key stakeholders about the regulatory and policy framework that governs midwifery practice in Nova Scotia to help support the interprofessional relationships and development of accountability and reporting structures at the local level that ensure safe ethical midwifery practice.
- Continue to monitor the midwifery implementation process and ensure alignment with the standards of practice for midwifery in Nova Scotia.

- Align midwifery programs and services with Primary Health Care programs and services (e.g. Community Health Centres, Birthing Centres, etc.).
- Review district policies related to midwifery and identify current and future policies that have the potential to be provincial in scope, and determine responsibility for monitoring compliance.

❖ ***Diversity and Social Inclusion***

- Develop and implement local culturally specific action plans/strategies for midwifery programs and services to reach underserved, marginalized populations, and monitor effectiveness and annually report on outcomes.
- Continue to provide cultural competence and cultural safety training in an interprofessional learning environment.

❖ ***Support for Implementation and the Integration of Midwives into the System***

- Continue to provide supports to facilitate the integration of midwives, and to support the building of effective collaborative care teams including:
 - conducting regular interprofessional team meetings in District Health Authorities/IWK to build awareness and understanding of approaches and roles and responsibilities;
 - implementing the *Building a Better Tomorrow*¹ modules to foster and support team development; and
 - exploring other team building initiatives such as *MOREOB*² to foster and support team development.
- Convene a working group to conduct a comprehensive review of the orientation processes for the midwives, and develop standards and a planned

¹ Building a Better Tomorrow Together (BBTT), a series of continuing education models for health care providers, facilitates the development, integration, and support of interdisciplinary teams. The program was informed by the evaluation of the initial BBT program, a survey of primary health care managers, competencies for interprofessional collaboration, and provincial cultural competency guidelines.

² MOREOB (Managing Obstetrical Risk Efficiently) is a Canadian patient safety, professional development, and performance improvement program for caregivers and administrators in hospital obstetrics units.

approach; this should include (but is not limited to) ensuring content related to primary health care within the orientation process, and hiring midwives in a non-practicing role during the implementation phase.

- Convene a working group to review and revise/update the contents of the *Getting Started Toolkit*.
- Include consumer and midwifery representatives on implementation committees and other structures established to support the integration of midwives, and provide support to ensure a safe and supportive environment for participation and meaningful involvement.

❖ ***Financial Resources and Sustainability***

- Increase the number of midwives within each model by one full-time equivalent position prior to establishing additional sites.
- Provide resources to support the expansion of midwifery into other DHAs.
- Increase the administrative support provided to midwives (a half-time position per midwife).
- Until midwifery is available in all District Health Authorities, explore interim solutions to help make midwifery services accessible to more women in the province beyond the three model sites (e.g., self-employed funded practice).
- When midwifery programs and services are disseminated throughout the province, ensure a sufficient number of midwives are hired within DHAs to help maintain the principles of midwifery services based on the Canadian model (e.g., continuity of care, choice of birth place).
- Convene a working group to address physician remuneration issues identified in this evaluation (e.g. remuneration for consult or collaboration with midwives).

- Gather Canadian data about cost effectiveness and work with health economists to develop and test cost effectiveness models to inform long term planning and sustainability of midwifery programs and services.
- Provide resources to support cultural competence and cultural safety training for interprofessional providers and to support community outreach strategies.

Moving the recommendations to action will be a shared responsibility of the many stakeholders impacted by the introduction of regulated midwives into the health care system including women and their families, midwives, community groups, other providers, District Health Authorities and the Nova Scotia Department of Health. Just as this shared responsibility was important in developing legislation for midwifery, so too will it be critical for successful implementation of midwifery programs and services across Nova Scotia.

Background

In November 2006, Bill 107, the Midwifery Act, was passed in the House of Assembly. Over the next two and a half years provincial committees addressed a wide array of policy and clinical issues and oversaw the introducing of regulated midwifery in three model sites in Nova Scotia. A call for model sites was issued for District Health Authorities (DHAs) interested in introducing midwifery. Only three sites

Midwifery in Nova Scotia

(Source: Midwifery Regulatory Council)

The “clinical practice of midwifery” means the provision of antepartum, intrapartum, postpartum and newborn care as a primary care provider. Midwives have the necessary competencies and qualifications to provide the complete course of low-risk prenatal, intrapartum, postnatal and newborn care, including physical examinations, screening and diagnostic tests, the prescription of certain medications and the conduct of vaginal deliveries. As primary care providers, midwives may be the first point of entry to maternity services and are fully responsible for clinical decisions and the management of care within their scope of practice. This responsibility includes identifying abnormalities and conditions that require consultation or referral to specialists or other health professionals.

expressed interest and were therefore selected including:

- Guysborough-Antigonish-Strait Health Authority (GASHA)
- IWK Health Centre
- South Shore Health (SSH)

Legislation was proclaimed on March 18, 2009. Midwives working as employees and with primary maternity care teams began practicing in the three model sites between April and August 2009.

Canadian Model of Midwifery Practice

(Source: Canadian Midwifery Regulators Consortium)

While there are provincial/territorial differences in how midwifery is legislated, organized, and practised, the basic model of midwifery practice is the same across all regulated jurisdictions in Canada. Midwives provide care from early pregnancy through to at least six-weeks postpartum to women and their infants.

Health and Well-being

Midwifery care in Canada is based on a respect for pregnancy and childbirth as normal physiological processes. Midwives promote wellness in women, babies, and families, taking the social, emotional, cultural and physical aspects of a woman's reproductive experience into consideration.

Informed Choice

Canadian midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner.

Autonomous Care Providers

Canadian midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients. When midwives identify conditions requiring care that is outside of their scope of practice, they make referrals to other care providers and continue to provide supportive care. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care.

Continuity of Care

Canadian midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualized care. Individual or small groups of midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A midwife known to the woman is available on-call throughout her care.

Choice of Birth Setting

Canadian midwives respect the right of each woman to make an informed choice about the setting for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals.

Evidence-based Practice

Canadian midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care.

Purpose of this Report

The purpose of this report is to present the findings of a qualitative evaluation of the implementation of midwifery in Nova Scotia (since legislation). The evaluation was conducted by a team of evaluators from Research Power Inc. (RPI). The report presents the findings of key informant interviews and focus groups conducted with midwifery

clients (women living in a model site who used midwifery services, and women who were unable to access midwifery services) and stakeholders involved in the implementation process provincially and at the three model sites.

It is important to state that the purpose of this evaluation is not to compare model sites, and reiterate that the purpose of the evaluation is to describe the lessons learned from the implementation process. The report highlights successes, facilitators and issues for consideration in implementing midwifery programs and services, and the findings are intended to inform future planning and implementation of midwifery in Nova Scotia.

Methodology

Recruitment & Data Collection

Data collection focused on gathering information from the following key stakeholders: health care providers within the three model sites; provincial stakeholders involved in the planning and implementation of midwifery; and clients (women living in a model site who used midwifery services, and women who were unable to access midwifery services). Focus groups were conducted in person and most interviews were conducted via telephone with some conducted in person. For each group of stakeholders, an interview/focus group guide was developed to ensure all areas of interest were covered. The guides were reviewed and approved by the Midwifery Evolution in Nova Scotia (MEINS) Committee (copies of the guides are provided in the appendices of this report). With participants' permission, the focus groups and interviews were audio recorded (PLEASE NOTE: In several instances, participants requested that the audio-recorders be shut off and asked to speak off the record. To ensure confidentiality, information collected while the recorders were off was not presented in this report).

❖ *Health Care Providers (Model Sites)*

The MEINS Committee was interested in gathering the perspective of a variety of health care providers at each of the model sites to gain their input into the successes, challenges and lessons learned in the implementation of midwifery. To accommodate the large number of stakeholders at each model site, both focus groups and one-on-one interviews were conducted. With the assistance of the managers accountable for midwifery, a list of key stakeholders was developed for each site.

The following table summarizes the key informants who were interviewed or who participated in a focus group from the three model sites.

Model Site	Health Care Provider
GASHA	<ul style="list-style-type: none"> ▪ Pediatricians (n=1) ▪ Obstetricians (n=2) ▪ Nurse Manager Children and Women's Health Unit & Ambulatory Care (n=2) ▪ VP Patient Care (n=1) ▪ Chief of Staff (n=1) ▪ Nurses (Children's & Women's Health Unit) (n=5) ▪ Family Physician (n=1) ▪ Chief of Family Practice (n=1) ▪ Prenatal Nurses (n=2) ▪ Midwife (n=1)
South Shore Health	<ul style="list-style-type: none"> ▪ Nurse Practitioner (n=1) ▪ Clinical Nurse Manager (n=1) ▪ Midwives (n=2) ▪ Obstetricians (n=3) ▪ Anesthesiologist (n=1) ▪ Pediatrician (n =1) ▪ OBS Clinic Physicians (n=4) ▪ Nurses (Children's & Women's Health Unit) (n=5) ▪ Manager PHC (n=1)
IWK Health Centre	<ul style="list-style-type: none"> ▪ VP Patient Care (n=1) ▪ Director Women's & Newborn (n=1) ▪ Manager Birth Unit & Midwifery (n=1) ▪ Consumer Representatives (n=2) ▪ Midwives (n=3) ▪ Med Lead- Obstetricians (n=3) ▪ Med Lead- Head Family Practice (n=1) ▪ Obstetricians (n=7) ▪ Clinic Nurse Lead (n=1) ▪ Birth Unit Nurse (n=1) ▪ Public Health (n=1) ▪ Administrative Support (n=1) ▪ Director Risk Management (n=1) ▪ Family Physician (n=1)

❖ *Provincial Stakeholders*

The MEINS Committee identified provincial key informants who were sent a letter of invitation to participate in an interview. Key informants were then contacted by Research Power Inc. to determine interest in participating and to arrange interview logistics. The following provincial key informants were interviewed for this evaluation:

Provincial Stakeholders

- Primary Health Care, Department of Health (n=3)
- Consultant to support Midwifery Implementation, Nova Scotia Department of Health (n=1)
- Reproductive Care Program of Nova Scotia (n=2)
- Legislation & Policy, Nova Scotia Department of Health (n=2)
- Midwifery Coalition of Nova Scotia (n=1)
- Midwifery Regulatory Council of Nova Scotia (n=1)
- Association of Nova Scotia Midwives (n=1)
- College of Nurses of Nova Scotia (n=1)
- College of Physicians & Surgeons of Nova Scotia (n=1)

❖ *Women*

To gather the perspective of those who have used midwifery services (since legislation), focus groups were held with women in each of the model sites. The midwives at each of the sites were tasked with contacting and inviting women to participate in a focus group. Interested women were asked to contact RPI. Due to the overwhelming response from women at the IWK Health Centre site, two focus groups were held. All participants received an honorarium for their participation in the focus group. Total number of participants included:

- GASHA: 6 women
- IWK Health Centre: 25 women
- South Shore: 11 women

Due to a wait list to receive midwifery services at the IWK Health Centre, the MEINS Committee felt it would be important to hear the perspective of women who wanted a midwife but were unable to access the service. A focus group was held with nine women who fit this criterion.

Data Analysis & Trustworthiness of the Findings

Data analysis was completed by consultants from RPI. All interviews and focus groups were audio-recorded (with participants' permission) and then transcribed verbatim. Once transcribed, the interview and focus group data was coded, that is, broken into meaningful pieces related to emerging themes and categories. Coding was done using the qualitative software package NVivo (version 7). The findings were synthesized and compiled into a report.

Trustworthiness of the findings was assured through the use of well-established qualitative research procedures by the evaluation consultants conducting the interviews/focus groups and analysis. Trustworthiness was assured through:

- Regular peer debriefing with the team of analysts;
- Independent and systematic coding and data analysis;
- The use of verbatim quotations/excerpts from the interviews and focus groups and sufficient descriptions of themes to illustrate the findings; and
- Completion of a log of methodological decisions made throughout the analysis process.

Qualitative methods, including interviews and focus groups, are exploratory in nature and thus provide rich and valuable insight into people's views and feelings, but results are not intended to be generalized or quantified.

Considerations

As illustrated by the methodology employed by this evaluation, data was collected from a large sample of stakeholders. This report provides the facilitators, successes and issues/challenges related to the implementation of midwifery across model sites. Through the focus groups and interviews it was apparent that there is great passion for midwifery and key informants provided thoughtful reflection about the implementation process, although as previously mentioned some discussions were requested to be off the record.

Findings

Considerations for Readers

Considerations and observations of the evaluators are presented to help provide context for readers in reviewing and interpreting the findings (some of which have been noted in the previous section):

Evaluation Purpose:

To describe the lessons learned from the implementation. The findings are intended to inform future planning and implementation of midwifery in Nova Scotia. The evaluation cannot serve as a 'road map' to implementation of midwifery in every DHA as each area has unique features. However, the report highlights successes, facilitators and issues for consideration.

- The findings related to women's experiences with midwifery services are presented in the first section of the report followed by the results from the interviews and focus groups with provincial and model site stakeholders. It is important to note and differentiate between the women's and the key stakeholder's perspectives as these groups were asked different questions. The implementation process was the focus of the provincial and model site stakeholder interviews/focus groups. The women's focus group guide primarily focused on obtaining feedback on women's experiences with the midwifery services they received. Their experiences are important to consider, even though the evaluators and the MEINS Committee members realized that women could not comment specifically on the implementation process.
- Although not specifically asked about implementation, some of the responses from women addressed successes and challenges resulting from the implementation to some extent. Where appropriate/relevant/available, the women's perspectives have been inserted in a textbox within the provincial and model site stakeholder findings to illustrate the perspective of women on particular issues.
- Stakeholders had varying levels of involvement in implementation and may have been engaged at different times, which contributed to their level of knowledge and perspective about the implementation process.

- The evaluators noted that within and across model sites there were misperceptions or opposing views on some issues between stakeholders and stakeholders groups (e.g., within a focus group at a model site participants raised concerns about a particular issue while in another focus group within the same model site a different provider group was unaware of the issue and in fact noted it as a success versus a challenge; or there were perceptions that one model site had very few challenges with implementation when in fact several challenges were identified by various stakeholders in that model site).
- Issues presented through the thematic analysis were generally found across all model sites; very few were site specific. In addition, findings were found across care provider groups (e.g., nurses, family physicians, obstetricians and midwives) and administrators versus specific to one type of provider or stakeholder group.
- Quotations are provided throughout to illustrate findings. In order to protect the confidentiality of participants, the quotes are not identified by site or stakeholder/provider type.

The findings are presented within four main sections including: women's experiences with midwifery, what was done to support midwifery implementation, the issues associated with midwifery implementation, and the accomplishments of midwifery implementation. As previously noted, the findings related to the women's experiences with midwifery are presented first followed by other stakeholders' perceptions regarding implementation (i.e., supports, issues and accomplishments). Where appropriate/relevant, women's experiences are included within the supports, issues and accomplishments sections (although these sections primary reflect the perspective of providers, and administrative and consumer representatives from the model sites and province).

Women's Experiences with Midwifery

Focus groups were conducted with women who made use of the midwifery service in each of the model sites to explore their experience with the service. A focus group was also conducted with women who wanted but were unable to access midwifery services (at the IWK site) to examine the impact of this on their pregnancy, birth and post-partum experience.

❖ *How Women Heard About Midwifery*

During the focus groups, women were asked where they heard about the midwifery service in the province. The following mechanisms were cited:

- Word of mouth (friends, family, co-workers in the community who had used/heard of the service, etc.)
- Referral (e.g., family physician, naturopath, chiropractor, etc.)
- Family Resource Centres and other community organizations
- Local media/promotion (e.g., article about midwifery in local paper, hospital websites, etc.)
- Had used a midwife prior to legislation and regulation

❖ *Why Women Wanted Midwifery Services*

Women, both those who accessed the service and those who were unable to do so, were asked why they were interested in receiving the services of a midwife. The following table provides a summary of the findings, including a description of each theme as well as supporting quotes.

Theme	Description	Quotes
<i>Continuity of Care</i>	<ul style="list-style-type: none"> - Women were interested in having the same health care provider throughout pregnancy, birth and post-partum - Continuity was important in building a trusting, personal relationship with their maternity care provider 	<p><i>It was pretty nice to have someone consistent, someone that you built up a trust with, and then someone there afterwards. You could call public health but it would be a different nurse each time, so it was good to have someone whose opinion you already trusted.</i></p> <p><i>I was kind of turned off by the clinic. I really like the nurses, but the fact that it could have been any one of [the] doctors [delivering my baby]. ... I wanted that personal relationship with someone that was going to spend so much time with me, and I wanted to be comfortable with them</i></p>
<i>Philosophical approach to birth</i>	<ul style="list-style-type: none"> - Women felt that the midwifery approach to birth was more ‘natural’ and focused on low intervention - Women wanted a provider that would respect and trust their bodies to do what they are physiologically designed to do 	<p><i>I wanted to use as little intervention as possible, and I thought that going with a midwife, that that would be the way to go.</i></p> <p><i>I think just generally the philosophical difference that I felt with the midwife, she believed that I could do it, that my body could do it.</i></p> <p><i>To have the least amount of intervention as possible. I just knew that I wanted to try and do it as natural as possible if the pregnancy all went well.</i></p> <p><i>Because the [midwifery] attitude is that, it’s something a woman can do, you can do it naturally.</i></p>
<i>Choice of birth place</i>	<ul style="list-style-type: none"> - Women wanted midwifery as it allowed for the choice of birth place - Some were interested in having a home birth 	<p><i>I really wanted to have a home birth.</i></p> <p><i>My first child I had with my GP, and I had an expectation of natural childbirth, and I have nothing bad to say about my GP. And I had a natural childbirth at the hospital [for this pregnancy] but I really wanted a home birth.</i></p>
<i>Longer appointments</i>	<ul style="list-style-type: none"> - Women liked the longer appointments in midwifery, which they felt would allow for increased opportunity to ask questions and provide input into decisions 	<p><i>I felt with an obstetrician that I wasn’t really able to ask the questions, or didn’t have the time to ask the questions that I wanted to ask. I needed more support they couldn’t give.</i></p>

Theme	Description	Quotes
<i>Post natal follow-up & breastfeeding support</i>	- Some women wanted midwifery for the post-natal support (e.g., alleviating fears of being a new mother, breastfeeding support, etc.)	<p><i>I changed from my doctor to the midwife around 36 weeks, and one of the reasons was, I like that they check up on you afterwards, with the six week check up.</i></p> <p><i>The breastfeeding support is huge, because midwives come so frequently after they have the babies for the first little bit, and recognize that the breastfeeding support that's required when you're first starting out in nursing a baby is huge.</i></p>

❖ ***Women's Experience with Midwifery***

For many of the women, their experience with midwifery was positive. The following summarizes the positive experiences of these women (including supporting quotes):

- ***Received personal care:*** Many of the women described the personal care provided by their midwives. These women had built strong rapport and trusting relationships with the midwives and the women felt that the midwives took the time to get to know them as well as their families which helped the midwives to understand their wants and needs.

I was calling my midwife, Auntie [name], that was the relationship that I felt. It was pretty nice to have someone consistent, someone that you built up a trust with.

From six weeks pregnant to six weeks after, the development of the relationship that you create with your midwife. And for me, that relationship helped in the labor process, like it felt like my friend was in the room.

- ***Empowerment & Confidence:*** Several of the women noted that midwifery services empowered them and provided them with the confidence in their abilities

Just the confidence. I find with midwives it's trusting yourself, trusting your instincts, trusting your body, [and] trusting yourself as a parent.

I feel so empowered, and proud of myself, like I feel like I can do anything. And I know a lot of friends that come out of births feeling just kind of battered, like – that was not my experience. I feel like I can do anything.

to give birth and to be a good mother. Many noted that the midwives built their confidence to trust their bodies to give birth. Further, many

described a sense of accomplishment and pride in their ability to give birth the way they were hoping to with the support of the midwives.

- *Informed decisions:* Several women described being highly involved in all decisions related to their pregnancy and birth. Many indicated that with the midwife they felt comfortable asking questions,

I felt that you get much more input into the process, you got much more involved in your pregnancy.

Not feeling judged, turning down certain tests or not wanting to do things that maybe your doctor would, or my doctor would have really frowned upon.

I felt very entitled to ask the questions I had, whereas with my family doctor I really didn't. She explained things a lot better than the doctor.

discussing their options and making decisions free of judgment. Further, the women often felt that the midwife was better able to explain things in a manner which was easy to understand, compared to their physician. Overall, women described feeling “more involved” in their whole pregnancy and birth.

- *Women-centered:* Some of the women noted that they experienced a very women-centered approach from the midwife. Women highlighted that the

The difference for me was the respect that I felt the midwives gave to my body.

midwives were very interested in them as people and were respectful of their bodies.

- *Supports for partners:* Some of the women highlighted the attention the midwife gave not only to them, but also to their partner (e.g., husbands, significant others, etc.). It was noted that the midwife worked to include and involve their partners in the pregnancy and birth process (e.g., asking questions, provide reassurance of their concerns, birth process, etc.).

It was really great to have my husband involved in the process, and I think the midwifery system really kind of focuses on that. My husband actually delivered the baby, the midwife delivered the head and shoulders, and then he pulled him the rest of the way out.

I think that the midwives also provide great care for husbands. My husband thoroughly enjoyed the experience, and he came to a lot of the meetings with the midwife and he asked a lot of questions.

Although women in the focus groups were generally satisfied with their experience with midwifery, a few were not and indicated that the midwifery services they received did not match their expectations. These are summarized below:

Tension: Some women sensed tension between the midwife and other health care

So professionalism, it would be breaking it down to professionalism between the staff and the midwives. ..., like as much on the midwives' side as on the staffs' side, because you're feeling stressed out, and you will need to concentrate and those kind of friction situations really just elevate levels of stress.

I felt as though there was just tension between the managers and the nurses, [and the midwives].

providers at the hospitals. Women told stories where their midwife got into disagreements and often had to 'defend' what they were doing to other health care providers. These women found the conflicts stressful and distracting during their birth experience.

Mixed attention: A few women felt that their midwife was not as attentive to them as they had hoped. Some women noted that the midwife tended to be very busy and over worked and found that their attention sometimes strayed from their birth to other distractions (e.g., blackberry, taking notes, etc.).

My nurse, she was great. She actually helped me more than the midwife, who was on her Blackberry writing down notes the entire time. She came over to check me occasionally, and that was it.

Inadequate care: A couple of women in a focus group felt that the care they received from the midwife was inadequate. They noted that the appointment with the midwife was sometimes un-focused and that their health concerns were not adequately addressed. Further, a few commented that the care they received during and after birth was below their expectations.

[The midwives] were very laissez-faire about everything. ...My appointments were really like, three quarters of my appointments would be like chit-chatting about completely unrelated things. Which was fine, except that there were various things that came up that I would mention concerning health concerns I had during my pregnancy that were kind of like, oh yeah, it's fine, you're fine.

Home visits: A few women commented that the post-partum care they received did not meet their expectations and the visits were shorter than they anticipated. Further, some

I have a two year old, so I always had to drag her and we lived in [name] to see [the midwife], and she wasn't as willing to come to me, which was disappointing.

noted that because of where they lived, the midwife did not make any home visits during their care.

❖ *Experiences of Women's Who Could Not Access Midwifery Services*

A focus group was held with women who wanted but were unable to access midwifery services (IWK site). Generally, these women were dissatisfied with the care they received and felt that their overall experience would have been improved had they been able to access a midwife.

Decision-making: Several women in the focus group commented that they did not feel as involved in decision making during their pregnancy and birth as they would have liked.

Many noted that their options were not well explained and that they did not feel comfortable or had the opportunity to clarify or ask questions.

I think with midwifery care, it would have been a lot different, [the information] would have been presented very differently, it would have been a much more collaborative process, and I would have been part of that decision versus being told that that was what I had to do.

Interventions: Many women felt that they received more invasive interventions than if they had been under the care of a midwife. Several of the women in the focus groups did independent research to inform themselves on what procedures they wanted or did not want, but inevitably many still received interventions they were not interested in. It was noted that although some felt these interventions may have been necessary, under the care

I ended up having a c-section. Chances are, even with a midwife it could have possibly happened as well, but, I had this obstetrician in my face telling me that I had to have a c-section. And I was totally not prepared for that, it felt like an emergency, it felt like it was something that I had to do, and I ended up doing it. But looking back on it now, had I had a midwife, it would have been presented very differently, there was no reason it needed to happen so quickly.

of midwife, they felt they would have received a better explanation and been more informed on the need for intervention.

Breastfeeding: Some women described struggles with breastfeeding and were challenged in finding support to assist with breastfeeding. They believed that the post-partum care provided by a midwife would have served as a much needed support for breastfeeding and would have prevented some from enduring prolonged breastfeeding challenges.

Breastfeeding, that's something else that midwives do support a lot. I think from the breastfeeding aspect, although the medical staff pushes it a lot, I don't think they push it as strongly as midwives do.

I had always intended on at least exploring the option of the home birth, and that was completely out of the window.

Home birth: Some women noted that they were interested in home birth and without access to a midwife, they had no choice in their birth place.

Advocacy: Overall, the women in the focus group noted that a key role they wanted the midwife to play in their care was to help advocate for their needs. Many felt that they were left out of decision making processes and that even when they expressed concern or dissatisfaction, their voice was not heard. Several of the women made use of a doula and felt that the doula provided them with much of the support they were hoping to receive from a midwife although the doula was unable to advocate as strongly as a midwife would have been able to.

[The midwife] was going to be your advocate ... So you didn't have to go into your birth worried about things kind of changing. You knew that your midwife was going to deal with it, and knew that your wishes were going into it.

What was Done to Support Midwifery Implementation

The focus groups and interviews with provincial and model site stakeholders revealed that the models sites have done several things to support the implementation of midwifery including: strategies to build an understanding of the role of the midwife; provision of an orientation to the system for the midwives; use of provincial supports; and using a consultative/participatory process to ensure a range of stakeholders were involved in implementation. These themes are described further in this section.

❖ *Building an Understanding of the Role of the Midwife*

All model sites described efforts to build an understanding of the role of the midwife among providers. This included the provision of midwifery information on websites for both providers and the public, and hosting informal welcoming parties to build collegiality and provide health care providers with the opportunity to get to know the midwife or midwives and ask questions about their role. The midwives at several of the sites also worked to build others' understanding about their role by taking the time to meet with individual departments/provider groups. Some midwives also did presentations to departments and individual providers to share their role, responsibilities and scope of practice. Many stakeholders felt it was important to give health care providers an opportunity to ask questions as there were concerns among some about the impact of midwives on the roles/responsibilities of other team members (e.g., some nurses had concerns about their role in supporting a midwife and her client during and after labour and delivery, etc.). These opportunities to build awareness of the role also provided the chance for the midwives to highlight their knowledge/credibility which facilitated building respect for their profession.

It was noted that although these “meet and greets” and presentations were done when the midwives first started, various provider groups continue to be at different levels of understanding/acceptance of midwifery practice. It was suggested that building an understanding of the role does not simply mean doing a one-time presentation, but

requires an ongoing process to gradually and continually build providers' understanding and support for midwifery. For example, at one model site a system was set up whereby providers can write midwifery related questions on a board which are then addressed/followed up by the midwife.

Well the challenge was getting acceptance of both obstetricians and nurses, in fact I was quite surprised there were a lot of nurses that were challenged and threatened by their presence. [It helped] to get those groups together and have those kinds of meetings and set the parties in question and answer sessions where they could sit down and actually see the [midwife/midwives] face-to-face, another person that has good training and excellent training, a different kind of training.

If you're going to do it, respect midwifery, respect its model of care, respect its role as a primary maternity care provider, respect the abilities of those practitioners and respect the women who want those services. ... recognize that in your organization many people have never worked with a midwife, that your doctors, your nurses, your pharmacists, your radiologists. They don't know who this person is and they don't know what her skills are. You have to make sure they know and they're in the loop and they've met the [midwife/midwives] and they understand what [she/they does/do] and you have to keep those communication channels open for a long time.

❖ *Orientation to the System*

Several stakeholders from the model sites commented that midwifery has traditionally worked “outside” of the health care system. As such, taking the time to orient the midwives to the system and its processes was critical to implementation. At some model sites, the midwives participated in an orientation whereby they worked shifts in various areas of the hospital to build familiarity and their understanding of working within the system. However, a few midwives commented that although they saw the value in being oriented to the system and departments, they felt the orientation was overwhelming and should focus more on primary care providers and more practical information about working within the system. The midwives noted that it has been a learning curve getting used to ‘working within the system’ including paperwork requirements, protocols for developing forms, referral processes, etc.

[The midwife/midwives] worked in different departments. They did actual shifts... I think that was a big, big help in integrating them into the health care system [at the hospital], so they knew what resources that they had available to them. And who they could make phone calls to if they needed consults.

... our orientation was three days sitting at the [hospital], and an anesthesiologist for example came to tell us something about when clients need an epidural during labor. I mean, we don't need this. I think orientation would be helpful if it would be with primary care providers, they show us, if you discharge a woman then that's what you have to do. Or if you have to write a consult to the prenatal clinic, that's the

process until you get an appointment for the consult. Or for example, for the lab, if you have to send a woman for a certain kind of sugar testing, that's the process ...So I think there's really practical things, how to work in the system.

I mean, getting used to the paperwork was a challenge because every hospital you go into, or another province, or another country, have different paperwork. So, how they want things filled out. Initially for example, ultrasounds, I was putting a lot of information down and even some words, like she has an XC pregnancy, they didn't know what I meant. [So for] me understanding what they wanted written on the request as well, so that was a bit of a learning curve.

❖ **Provincial Supports**

During the interviews and focus groups, several provincial supports were highlighted as facilitators to the implementation of midwifery. Supports such as guidelines (e.g., transfer of care) and the toolkit were generally viewed favorably. For one site, the toolkit was not helpful and therefore they relied on resources from other jurisdictions. A few commented that the amount of information is overwhelming and needs to be further filtered. It was suggested that these supports may need to be revisited and revised on an ongoing basis to ensure relevance and applicability to the implementation process.

I think the toolkit was very well done, I must say, congratulations. It could be tweaked, but really, for us it was a nice blueprint to really start.

We've developed the toolkit to help with the implementation, and I think that was a good idea in terms of setting out, as much as we could, anticipate what would need to be done. ... what the toolkit tried to do was anticipate these changes for the implementing institutions so that they wouldn't stumble, and it would be as seamless a process as possible. And I think that's a good idea and part of this evaluation is in fact to improve those toolkits so that subsequent DHAs will have even better information to start with.

The toolkit was looked at by the members of the committee, and then a very conscious decision was made to put it aside. So it wasn't particularly helpful, so I think if the department of health is interested in coming up with another one, it should be revised to be a little bit more useful. A lot of it looked like it was coming from a different plan, a different place, a different time...the BC document was very helpful.

Other provincial supports which were described as being helpful to the implementation process included having guest speakers from other provinces come to present about their experiences with midwifery, the provincial funding provided to support implementation, courses made available to the midwives (e.g., Advanced Life Support in Obstetrics [ALSO], Acute Care of At Risk Newborns, cultural competence workshop, etc.), and Reproductive Care Program (RCP) time and resources devoted to implementation,

availability to answer questions, data capture form developed in collaboration with the Association of Midwives, etc.

I think all the midwives took the ALSO course...and they've also done the ACoRN course, it's RCP that organizes and puts it on.

Another support was RCP period. Because a lot of the RCP people, sat on the initial implementation committee as well, but they had their annual conference and so they put the whole midwifery on their agenda for the conference.

I think it did work well that RCP was involved with, was that little road show. We put together and RCP facilitated this, a panel of people who, there was a family doctor from here, a nurse from Manitoba, Winnipeg, and a midwife from McMaster and a maternal/fetal medicine specialist from Toronto, really trying to cover the range of care providers who are going to be affected by midwifery. ...And I thought that was a really good thing to do, and we got a lot of positive feedback about that, and a lot of interest, really good turnouts, and tons of questions. It was an opportunity for people to ask questions, so I think that was a good thing.

I know the province also have committed funding. They pay not only [the midwives] salaries, but liability, so I mean obviously it wouldn't be possible without it, so that's huge.

❖ **Consultative/Participatory Process**

It was noted by both respondents at the provincial and model site level that the implementation process was consultative/participatory and included a diverse range of stakeholders on various implementation committees. These committees facilitated communication and ensured that all key stakeholder groups had an opportunity to voice opinions and concerns. Although generally most felt that the implementation process was consultative, there were a few providers such as family physicians, who would have liked more input into the process given the impact this new provider had on their work.

I think another big accomplishment was the steering committee and the members that sat on the steering committee. Because there was community representatives from a variety of organizations, there was public health, there was consumers, and reproductive care program, so I think every member had a voice in the steering committee that gave advice as to how to make this a success. And so that input was beneficial.

So part of the problem is that they kind of changed the delivery of prenatal and postnatal care without actually bringing in the people who were doing it, which is the family doctors.

Issues Associated with Midwifery Implementation

The interviews and focus groups revealed several complex issues related to the implementation of midwifery services including collaboration, philosophical differences, resources and sustainability, reaching vulnerable groups, remuneration, a new way of working, governance and accountability, and timing. These are described in greater detail in this section.

❖ *Collaboration*

Respondents were asked to reflect on collaboration between the midwives and other health care providers, and the findings reveal varied issues and perspectives. In reflecting on collaboration, the difference in how each model site functions was consistently discussed. There were divergent and varied views of the way in which the model chosen impacted collaboration and coordination of services. In two of the model sites, the midwives are located in community-based locations and not co-located with other perinatal health care providers. In one site the midwife is co-located with other providers in the perinatal clinic. Some key informants felt that co-locating the midwife with other team members and working closely together facilitated collaboration and coordination of services. It was felt that more direct contact helped to build relationships, trust, networking and sharing, and is consistent with changes/enhancements to primary health care to build interdisciplinary teams.

For others, having the midwives practice in an acute care setting and sharing patients with other providers was felt to be unnecessary to establish a well functioning team, and is not in keeping with the traditional approach to midwifery in Canada. It was noted that midwives provide services for women that are considered low risk, and they collaborate with other providers as needed but being co-located and working together on a daily basis is not required to ensure that women receive good care. It was also noted that mechanisms such as inter-disciplinary team meetings, rounds, etc. help to build relationships and facilitate coordination.

I personally think it's great to have [the midwife/midwives] right in our unit, because she's easily accessible, and it's all about team building as well. For me personally, I like having her here because, and again, right inside the case room, I think it's great. And then the clinic is right there, she's visible to the public, I just think it's great to have her right [in the hospital].

I'm just thinking that actually I couldn't imagine [the midwife/midwives] being outside of the hospital, because I think again what you're doing is having a silo system. You are not working as part of a team at that point, because she's somewhere else. She's something separate then, and if you want to really work as a collaborative care team, you need to all be together.

[There] is an ongoing sort of review process for the midwives to bring cases that they need reviewed and decisions made about, should there be consultation or not, that's also a multidisciplinary committee. [But] there isn't a lot of collaboration right now, with the care of patients, ...we don't work really closely right now with the midwives. In part, because the midwives are looking after a very different patient population, especially from what [obstetricians] might be looking after, who are high-risk patients.

When I thought about midwifery initially, when we sat down and started going into this, was the physical space and collaboration model that I had in my mind was, obstetricians, family docs and midwives working side-by-side in an environment. ...We talk about low risk women, but one of the groups that we're actually targeting with midwives are priority populations. And priority populations are the populations that tend to have some of the highest risk factors for obstetrics... there are some patients who may not even want to come to the hospital, and may need to be accompanied by the midwives to come to the hospital to sort of get their care. ...And that's the true collaboration. That's true collaboration where you can also say, I don't really need to be here, or someone saying, listen, you know what, I still need you to be involved with this.

Some respondents discussed the concept of locating midwives within the community and having other health care providers such as obstetricians, nutritionists, social workers, etc. providing services periodically at the community site. Placing midwives within existing primary health care teams was also discussed by some key informants, although it was noted that in some cases this was not possible as these primary health care teams are in the early stages of development.

I think being attached to primary health care ...probably protects the actual essence of midwifery.

I think those are the patients [facing difficult circumstances] where a collaborative model where midwives could actually do a lot of the care ... in that [community] location, bring them in and give them that nurturing that they need, the education, and yet have immediate access to an obstetrician or doctors, to have the feedback, the back up for their high risk component.

❖ *Philosophical Differences*

Philosophical differences between midwives and other health care providers emerged during the focus groups and interviews. The lack of understanding among providers of the philosophical approach of midwifery and divergent views about home birth were discussed.

Lack of Understanding & Trust for the Practice of Midwifery

An issue highlighted by many key informants was the philosophical differences between midwifery and traditional maternity care. The findings revealed that although efforts have been made to build an understanding of the role of the midwives and midwifery practices, there continues to be a lack of understanding, trust and respect for midwifery practice among a range of providers. It was noted that a lack of trust challenges collaborative work between providers.

Women's Perspectives

- Some women sensed tension between the midwife/midwives and other health care providers at the hospitals (e.g., their midwife got into disagreements, often had to 'defend' what they were doing to other health care providers, etc.).
- These women found the conflicts stressful and distracting during their birth experience.

“ *So professionalism, it would be breaking it down to professionalism between the staff and the midwives. ..., like as much on the midwives' side as on the staffs' side, because you're feeling stressed out, and you will need to concentrate and those kind of friction situations really just elevate levels of stress.*

I felt as though there was just tension between the managers and the nurses, [and the midwives]. ”

The more they can do to sort of build up that trust, develop that trusting relationship, sooner rather than later is better, because it's a whole introducing a new person, a new practice into an area, that's been working with an existing practice for so long. It's really difficult, so if they can introduce people and form that trusting relationship earlier on, it will work, it's going to work better.

I think the biggest thing [is for others to] model respect. I think that sometimes it's forgotten that the midwives are bringing something pretty special and pretty unique, and that their standards are different because their knowledge is different. It just needs to be more that, and less of answering the assumption that everything that is different is a problem.

For the system to deal and sustain working with midwives and working collaboratively, there has to be a certain level of understanding and comfort between those professionals. They have to trust each other and at the moment, they don't. And no collaboration is possible without trust, and there's no trust possible without that mutual trust and respect for each others' skills.

Unclear Roles & Responsibilities

Some providers appear unclear about their role in working with midwives. For example, some nurses expressed uncertainty regarding their responsibilities with a midwifery patient (e.g., what tasks the midwife will complete versus those they expect nursing to complete) and challenges in completing nursing duties while caring for the midwives' patients. Others, such as Public Health, commented that they were unclear on what supports the midwives provide in comparison to the supports and services they provide. It was noted that a clearer understanding and a stronger relationship between midwives and Public Health would ensure that services and supports are provided to women but are not duplicated.

Just getting used to the scope, [midwifery is] new here, so it was a big challenge for the nurses. Not that they were against it at all, they were very interested, but what their role was in conjunction with a midwife, where did they fit in, in the case room, what's the nurses role?

I think one of the biggest challenges has been when we have a delivery in house and everything is done, and then the midwife goes home, and the biggest challenge is the accountability, how much are we [as nurses] accountable for when they're gone, their charting that they have or have not done, who does it, when they're coming back, when they say they're coming back and again, that comes to how we are as nurses trying to get all our ducks in a row, getting all that paperwork done, everything done.

[Public Health is] not really sure exactly what women are getting in the home visits with the [midwife/midwives]. And I've had a couple of clients say they don't want any contact with Public Health at all, so we don't go in at all. ...[We're not] sure whether or not [midwives are] just forwarding people after the six weeks ...what's sort of going on with public health, midwives. ...If we can find out what they do exactly, so that we know what they're doing with every person, if it's the same for everyone, then we wouldn't duplicate services. That's our biggest concern. ...some people say, I have a midwife, but I still want public health, right, so I guess if we knew more clearly what each other was doing, then we'd know.

Home Births

The philosophical differences are epitomized by home birth. In two model sites home birth was not available from the outset. Choice of birth place, including home birth, represents a key principle of Canadian midwifery but one of the more contentious issues surrounding midwifery practice. Although there have been efforts made to build understanding and support for home births, the

Women's Perspectives

- Some women wanted midwifery as it allowed for the choice of birth place
- Some were interested in having a home birth

“ *I really wanted to have a home birth.*

My first child I had with my GP, and I had an expectation of natural childbirth, and I have nothing bad to say about my GP. And I had a natural childbirth at the hospital [for this pregnancy] but I really wanted a home birth.

”

interviews and focus groups revealed that some providers do not support home birth perceiving it to be unsafe. These providers fear complications and question the skills of the midwife should complications arise.

... home births, I don't agree with them. I really don't see why they're necessary. ... To be perfectly honest, I think it's ridiculous. ...I'm totally against it.

... all of us have in the background of labor/delivery, it's really hard to understand why anybody would want to go out in the home and do a delivery

I think because it's something new, and [other providers] see a lot of the bad, because it's a hospital. They see a lot of the sad cases, the post-partum hemorrhages or the cord prolapses or whatever, and I'm thinking, oh my god, what if that happens at home?

❖ *Resources & Sustainability*

During the focus groups and interviews the issue of resources and sustainability were described including lack of sufficient number of midwives, issues of access, administrative support, the need for a cost-benefit analysis of midwifery, and questions and fears surrounding midwifery sustainability. Each is described further below.

Lack of Sufficient Number of Midwives

It was consistently noted that there are currently an insufficient number of midwives to support effective midwifery practice in each of the model sites. The lack of midwives challenges their ability to maintain the principles of practice. For example, having a second attendant (who may or may not be a midwife, although non-midwife second attendants have yet to be formalized) is a requirement for home birth thus sites with only one midwife can not offer home birth as an option (thereby compromising midwifery principles) and for the other sites with only two to three

midwives, home births draw on the full complement of midwives limiting their ability to attend to other clients. Further, the low complement of midwives challenges continuity

Women's Perspectives

- Women were interested in having the same health care provider throughout their pregnancy, birth and post-partum
- Continuity was important in building a trusting, personal relationship with their maternity care provider

“ *It was pretty nice to have someone consistent, someone that you built up a trust with, and then someone there afterwards. You could call public health but it would be a different nurse each time, so it was good to have someone whose opinion you already trusted.*

I was kind of turned off by the clinic. I really like the nurses, but the fact that it could have been any one of [the] doctors [delivering my baby]. ... I wanted that personal relationship with someone that was going to spend so much time with me, and I wanted to be comfortable with them ”

of care (another principle of midwifery- whereby the patient is followed by a midwife throughout pregnancy and six weeks post partum) as the number of midwives practicing cannot provide 24/7 service. Many stakeholders noted that the midwives show unquestionable commitment to the women in their care and dedication to providing a comprehensive service and having so few midwives at each site results in midwives working substantial overtime, and the potential for burnout is high.

The problem is making sure that clients get the [midwives'/midwife's] full range of services that they're entitled to. Two midwives are required to attend home births. If one of us is unavailable, if one goes into labor, according to the system the way it is now, she can't have a home birth.

I would make sure that the next District Health Authority who embarks upon this to do so learning from the experiences of the three model sites. And one of those big leanings is that if you are going to offer a service you need to offer 100% of that service. You can't offer it half way.... Like that, that's not midwifery. [For the DHA] to do this they need to have ample time and ample funding to get ready and then as soon as they're ready the midwives go and they practice 100% to their capacity.

It requires continuity of care which means the same midwife takes care of you during your pregnancy, she's there for your birth and she does your post-partum. Now most midwives work with partners or they work in small practices, and so the client chooses her midwife and she meets the other people, and if she chooses a home birth the midwife will come with a secondary midwife.

A midwife can't be on call 24 hours a day, seven days a week. ...a midwifery practice, in order for it to function and be sustainable requires a minimum of 4-6 midwives.

Access

As previously noted, the allocation of funding towards midwifery by the Department of Health has meant that the service is now more accessible to a range of women who would otherwise be unable to pay for the service (e.g., low income, teens, etc.). According to respondents in the model sites, the service is well used by women and demand for midwifery continues to be high. However, issues of access were consistently highlighted including a waitlist at one of the model sites and therefore midwifery services are not available to all low-risk pregnant women. Further, the implementation process (to begin with three model sites) has meant that midwifery services are currently only available in three sites in the province. Some expressed concerns that should the model sites fail in the implementation process, no women in the province would have access to midwifery services.

I think people underestimated the popularity and the use of the [midwife/midwives], and if they can only take eight to nine patients per month, when there are certainly 30 to 40 to deliver in [this area] on a monthly basis, then you know, they're going to be overstretched very quickly, and they're going to be very limited. And so then it puts a lot of pressure on the program to provide care to the masses, and the more people that come, and if they can't get in then I think you're going to have disgruntled people wanting that choice. If you're offering the choice, you need to be able to provide the service.

...this is a vast fear. It's a legal profession now and before it was legalized, you could get a midwife anywhere in Nova Scotia. Now you can't, and if these model sites close or fail, you're not going to be able to get a midwife anywhere. ...We are desperate for these models to succeed; we want them to be an enormous success so that other District Health Authorities are eager to replicate that great success. Otherwise we're not going to have midwifery, we'll be back to the days when we did underground midwifery and we don't want that, it's not safe for anybody.

Administrative Support

Although several key informants felt it was beneficial to engage the midwives early on in implementation prior to them offering clinical services, it was noted that much of their time was spent on administrative tasks. Several of the model sites commented that the amount of administrative support required for midwifery was underestimated and therefore under budgeted. Long-term sustainability of midwifery services, particularly as it continues to grow, will require increased resources for administrative support.

They need to have administrative supports. You can't run programs like that without admin support. You have to have somebody who can answer the phone, book the appointments, do the charts. Otherwise, you're paying midwives to do it and that's a very expensive admin assistant.

[The midwife/midwives] don't have really as good a clerical support as [she/they] could have. It does limit [her/them] somewhat, so I think it would have been a better implementation had [there been] a little more financial support from the department of health, district, I don't care where the monies come from, but if you want to set up a program, you really need to have the ability to have the support people in place. ...make sure that you have adequate staffing from day one, because in the beginning I don't think they were even thinking we'd need a secretary.

Cost-Benefit Analysis

Some key informants noted that evidence is needed to support that midwifery is resulting in benefits as it appears to be a costly service to offer, and one in which significant financial resources have already been invested. It was suggested that a cost-benefit analysis is needed to build the evidence surrounding the benefits prior to the continued growth and expansion of midwifery in the province.

I don't think there's any question that midwifery needs to be an option, that it provides an option of high quality care, but whether it provides the cost effective care for a system that's falling apart with no money – that's the question.

There isn't a mechanism in place to really look at cost effectiveness, and that needs to be developed. ... When you look at the cost savings of midwifery, an example, ...the cost savings when a woman doesn't have a cesarean section, has an early discharge or doesn't go into the hospital are massive. It pays for the [midwifery] program in a handful of clients. [People say] midwifery has cost us this much so far and they've had how many clients? That's expensive. ... So some mechanism where the department of health has an interest in looking at overall cost effectiveness rather than micro cost effectiveness. [Another example is] the breastfeeding rates, [midwives] had a 90 plus rate of breastfeeding mothers at six weeks after the birth, which if you compare it to the rest of the district, is only about 40%.

The ideal would be that you have enough midwives that it then does shorten length of stay in hospital, decrease the rates of intervention, decrease epidurals ...But that's never going to happen when there are only [a few] midwives. ...it's an expensive model. It would be a little more cost efficient probably if we had a few more midwives.

Questions & Fears for Midwifery Sustainability

Many expressed fear and concern regarding the long term sustainability of midwifery in the province. It was noted that more clarity is needed in terms of the long term plan or “vision” for midwifery in Nova Scotia (e.g., clarity regarding the model, etc.) as well as a commitment by the Nova Scotia Department of Health to bring the plan to fruition.

Midwifery resources in all the model sites are just barely enough to survive. And that means you can have no changes or the whole thing is in jeopardy. ... so in terms of did we create something sustainable, I don't think we did.

I think there are real opportunities there, but you know in the absence of a commitment to incrementally increase the number of people, they're not even going to be able to sustain. If you look at the average age of the midwives right now, many of them are probably within five years; the average person is probably within five years of retirement.

❖ Reaching & Providing Services to Vulnerable Groups

Many key informants highlighted the potential advantages of midwifery for those in ‘at-risk’ or vulnerable groups (e.g., teenagers, low income women, etc.) as it was believed that they would benefit from the continuity of care, the relationship building and longer appointments provided by midwives. Currently, some work around cultural competence and outreach to vulnerable groups is being done at model sites such as participation at multicultural health fairs and cultural competence workshops; promoting midwifery to family resource/women’s centres, sexual health centres and other community based organizations for vulnerable groups; and providing prenatal care services in Aboriginal

Communities. In some cases, midwifery spots are purposefully held for those in vulnerable groups to ensure their access to the service.

However, many stakeholders commented that midwifery services are predominantly used by women who tend to be more out spoken and with higher education, and that outreach efforts are not adequate to reach vulnerable groups. Some described the challenges of offering midwifery services to vulnerable groups as they tend to have conditions/risks which preclude them from being considered a “normal” low risk pregnancy and thus would not be candidates for midwifery services. Some key informants also noted that the location of midwifery services (e.g., in a hospital) may affect interest and uptake among vulnerable populations who may be intimidated, feel less welcomed or may be unable to easily access services (e.g., transportation, etc.). Key informants also indicated that a trusting relationship needs to be built through being visible in communities such as African Nova Scotian and Aboriginal populations before these groups will feel comfortable making use of midwifery services. However, resources for midwifery are stretched to the limit and therefore a lack of time prevents many of the midwives from doing outreach work and building relationships with these communities.

We've been trying to figure out the best way of doing it because we've been trying to get people who are obviously low risk, but also try to pick people from priority populations. That hasn't always worked out, so it's been difficult.

If we're targeting a priority-based population, that group theoretically is going to have the poorest nutrition, perhaps the highest rates of diabetes, the biggest smokers, etc. So they theoretically are going to have risk factors from the start and the midwives are bringing them into the medical care they need, or getting them into the system. The question is... is the supportive care that a [midwife/midwives] provides necessary beyond bringing them in. I think that's a case-by-case basis, that each patient may need that supportive care.

It takes time to do that outreach, and certainly we were working on collaborating with [the African Nova Scotian community], but you need a presence out there. ...So a recommendation would be that the next group of midwives [that] they place them in a community like [the African Nova Scotian community].

❖ *Remuneration & Call Time*

Physician remuneration and call time (i.e., on-call) was identified as a challenge in the implementation of midwifery by some respondents. Physicians were hopeful that midwifery would provide some reduction in their on-call time, and although this has happened at some model sites, on-call time has remained unchanged at others. In addition, the funding model has created concerns for some providers. Midwives are paid via a salary and have expenses covered, whereas many physicians work within a fee for service model and must cover their own expenses. Some of the issues/challenges discussed include:

- Midwifery services are “taking away” patients from physicians: Family physicians’ incomes are impacted by the introduction of midwifery services which has diverted away some of their patient population.
- Inequity in pay structure and services provided: Due to differences in pay structure, midwives are able to provide longer appointments to their patients. The provision of longer appointments would negatively impact the amount of patients a physician can see and in turn would decrease their salary (although many physicians noted that they would love to provide longer visits, it is just not economically feasible).
- There are potential financial implications for fee-for-service providers when a new primary maternity care provider is introduced.
- Lack of payment for fee-for-service physicians in supporting midwives: physicians do not get remunerated for time spent in discussion or client review with midwives.

Work is underway at some model sites to address the issue of remuneration potentially through an alternative funding arrangement. It was noted that it is important for the remuneration issues to be addressed to facilitate a collaborative relationship between physicians and midwives and help to ensure that family physicians continue to offer obstetrical services.

We said early on that funding models and mixing funding models is a problem for collaboration. I think it would be a very rare person who would be willing to take an income cut for any length of time. ...I think at all levels that's something that we need to, again looking at how this is all rolling out and the sustainability of it. ...all the obstetricians are on fee-for-service, what happens then when either a family doctor or a midwife requests the advice and services of an obstetrician? What happens then, and this would be the same thing that family doctors were not certain how they would be reimbursed for any kind of consultation that they did for the midwives. Say an obstetrician provides advice and consultation, and will be sort of there throughout labor and available for assistance, well the bottom line is that the money that you get is primarily for delivery and you don't get that if the midwife catches the baby. And that's the same thing with the family doctors.

Our docs still do their call. The midwives are separate. But the midwives follow their patients, you know, I think maybe in the back of our mind we had hoped that with the introduction of midwifery in the district, that it would be a help to our physicians ... [the midwives] have helped in that they have 80 patients, so those are 80 patients that would ordinarily come to the clinic. So in a way it has lessened the workload to a certain extent, but by doing that, it has also lessened their income.

I think what we're alluding to is the unintended consequences. I think a really potentially destabilizing the clinic for the physicians economically, has been the major result. So that their volume, because they're fee-for-service based, their incomes have dropped substantially. And of course, now they're looking for money.

❖ **Working within the System**

The issue of midwives working within the health care system was a consistent theme with two perspectives identified: the willingness and challenge of midwives to work within the system, and on the flip side, the willingness and challenge of the system to incorporate midwifery.

Respondents discussed the fact that for many years midwifery was unregulated and midwives practiced independently and “outside” the system. As previously noted, some midwives are challenged working within a system with many policies and procedures to follow given their history of working as autonomous health care providers, and (at times) fighting the system. It was also noted by some that it is challenging for midwives to integrate within a system which tends to be “risk focused” with a more medical approach to patient care. Some respondents indicated that the fact that the system is facing many stressors and in need of change further challenges the incorporation of midwifery.

They're fiercely independent, but I think they're very willing to work collaboratively. I think they will fight for their principles and to maintain what they believe is the core of midwifery. I think they've had to, I think in a lot of jurisdictions they've been seen as who knows what ...

I've done some collaboration with them over patients, ...I've gotten phone calls for advice and it's all really good. But then behind the scenes, there's a real inability for them to integrate into a system. I find it a little bit surprising because I knew off the bat that was the model.

Implementing midwifery is a complex endeavor because you are implementing midwifery in a system that has had little or no exposure to it. It's been something that has been practiced in the province, but off to the side. So the formal health system has known of its existence, but really hasn't brushed up against it in a professional way and interacted with it. So all of a sudden now, you're trying to integrate this new creature if you will, into this big formal system that's a bit of a machine.

... a health care provider who had not worked within a system into a system. And bringing them in at a time when our system was very sick. We're introducing SAP and it was not easy; it was extremely rough. A lot of our internal systems were not set up to support community, and we're seeing that in our other primary health care sites, that the institution itself is not organized to be able to support, so we had trouble with IT, we had trouble with materials management, [etc]. And we need to make that shift to support our primary health care initiatives as well. There needs to be a system shift around supporting creation of community sites. ... it was very frustrating for the midwives and very frustrating for us as well.

❖ **Governance & Accountability**

Several issues related to governance and accountability were noted during the interviews and focus groups including the employment model, reporting structure, policies and standards, and consumer representation.

Employment Model & Physical Location of Midwives

Several key informants highlighted issues with the midwives working under an employment model. As previously described, midwives have traditionally worked as autonomous providers (some described them as “entrepreneurs”) and therefore had the ability to provide unrestricted care (e.g., hours) to women. However, under an employment model, key informants noted that the midwives must work within the system that places restrictions on overtime hours and they must work within organizational policies and procedures, some of which may be inconsistent with midwifery practices. Some commented that the impact of regulation and working under an employment model was not adequately or clearly communicated. It was suggested that more collaboration is required between the midwives and their employers to clearly articulate and build an understanding of the employer/employee relationship. These challenges are even more pronounced in the case of one model site where midwives are employees of a tertiary care centre that has high risk clients which influences the focus. Some suggested that

midwifery would be better positioned within Primary Health Care, which is more aligned with midwifery practice.

...there could have been a lot more work up front and a lot more communication around what does it mean to be regulated. ...we weren't all in the same room to hear- this is what it means to be regulated or this is what it means to be an employee. And so I think it was a bit bumpy to start because I guess the model that the province chose was not really accepted and embraced by midwives. And understandably, they were coming from very independent, non –regulated practices to be regulated and also then being an employee. I don't think there was a shared understanding of what that means, and it's hard when you are an independent professional to also be an employee because your employer can dictate how you practice to some extent. So I don't think there was - that was ever communicated.

I think being hired by the IWK as opposed to Capital Health may possibly have been a big mistake. The challenges of being hired by a health centre as opposed to a district, I think are too great. [Midwifery should be] under primary health... because [they] are primary health providers, and they're more community-based, and [midwives are] community-based.

One of the challenges, was that it's a tertiary care centre and they have basically "tercerized" the whole process. ...And of course [the IWK is] wonderful at tertiary care. There is no question about that. But when it comes to midwifery and to primary care there is a whole different phenomena. Pregnant women do not need to be treated like they're a bomb waiting to explode. Why do [midwives] need to be integrated into a tertiary care model? They don't. I use the same example of family physicians [who] live in the communities, come to the hospital to deliver babies. We do know that intervention rates go up when you are in a tertiary care centre compared to either secondary or primary care. The midwives are no different and if they are completely connected to the tertiary care program, you are going to start seeing their care shift towards that end. So, I think that if you want to maintain the good and the low risk and the uncomplicated and the non-intervention work that the midwives do, you need to put them in a supportive environment to do that.

Reporting Structure

Several key informants highlighted the issue of the current reporting structure at the model sites where the midwives report to nursing. Having the midwives report to nursing creates some issues including: variability in the nurses' level of understanding of midwifery practices, principles and scope; needing other mechanisms to discuss concerns regarding clinical issues and other providers' practices; being managed by a provider with different philosophical views (medical model); and a sense of being monitored by a profession that does not fully understand midwifery practice. Further, it was suggested that it would be beneficial for any midwifery department head to be an active practicing clinical midwife.

The greatest challenge is the fact that nurses are managing midwives, and that nurses are judging midwives' practice by nursing standards. And there is a real failure to understand that midwives have a scope of practice. ...In fact do not share so much of the scope of registered nurses as midwives.

I have really questioned this employment model. I don't know if it's right for the midwives to have to answer to the nurse manager from the birth unit. That has been a source of irritation and when they have an employment model, that's how it works.

Policies & Standards

It was noted in the focus groups and interviews that several institutional policies and standards were developed and/or revised to incorporate midwifery. However, as previously noted, some policies were developed without the input of midwives and may not reflect midwifery practices. Currently there is also some lack of understanding regarding the role of the Midwifery Regulatory Council and lack of clarity regarding who is responsible for the development of midwifery standards (the district versus the Midwifery Regulatory Council). Although a few noted that it was positive that there was recognition of the uniqueness of each model site, some expressed concern regarding the lack of accountability between the Department of Health and the DHAs. It was noted that many of the recommendations developed over the last ten years (accepted by the Department of Health), including maintaining the principles of midwifery are not being upheld at the DHA level, but there is no mechanism currently in place to monitor that the recommendations are being followed.

Some respondents noted that provincial support for policy development at the local level would have been helpful. Some recommended that the development of policies such as support for home birth should fall under the mandate of the Reproductive Care Program. Some respondents acknowledged that there is a need to balance provincial standardization/policies with allowing for customization of the model based on the uniqueness of districts/model sites. As previously described, the evolution of midwifery in Nova Scotia has resulted in three quite different models of midwifery leading to concern among some key stakeholders that some models differ from the traditional approach to midwifery in Canada.

That the three sites are true to what our original intention was, in that [each model site is] very different, and that was intentional to try and mirror the context and the needs of the locales that they were in. And that's okay.

I think how the [Midwifery Regulatory Council] works is really misunderstood. The [Districts and IWK] thinks that they can develop midwifery standards. They write a policy, and they think that it overrides [the

Councils] *regulatory obligations, we're continually reminding them that that's in conflict with regulatory obligations. That needs to be clearly articulated. [The DHAs] can't do anything they want.*

The fact that some of these policies, procedures, protocols and scopes of practice weren't clarified as a province. ...When you have the Reproductive Care Program for example, that's a program that could be vested with developing provincial approaches. [For example] what are the criteria for home birth, easily could have been established as something that would have been applicable across the province.

... one of the challenges that the council is facing is the discrepancy between the approach to midwifery care and the model of care in Nova Scotia, as compared to the Canadian model, which is seen in other jurisdictions. ...It was the intent of the department to not have a model of care that reflects practice in other provinces, and to allow flexibility to respond to the needs of particular district health authorities. ...The midwifery model varies quite a lot from one area to another, so that the expectations of what a midwife does may be different from one area of the province to another, which is unusual.

Consumer Representation

During the focus groups and interviews, it was revealed that there was consumer representation on several of the implementation committees at the model sites. However, it was suggested by some that the consumer voice was often 'silenced' at meetings and was not actively sought. It was believed by some that the inclusion of consumer representatives was one of "tokenism" and their opinions were not truly valued. It was also suggested that the committees with consumer representatives had little involvement with decision-making processes (e.g., location of midwives). Further, it was noted that there was no mechanism in place for ongoing consumer representation beyond the initial implementation phase.

I was also under the understanding that [consumer rep] might have more involvement in the hands on choosing of the site and also how that site could be created to become a space that worked well for the women and the families it. It didn't end up being so much the case. ...[There was little] input on decisions being made.

[The consumer rep] position on the Steering Committee was one of tokenism. [The consumer rep was] always dismissed very quickly because [they] held that title of 'consumer representative' and was patronized because [they] didn't have clinical knowledge.

The community voice was not being heard. Decisions were being made by the powers that be, behind closed doors. And the consultation process was a bit of window dressing.

❖ *Timing*

Some respondents noted that not enough time was allocated within the implementation process to engage providers and build understanding of midwifery (that the midwives

were simply ‘introduced’ and insufficient time was devoted to building an understanding of their role, etc.). Others commented that the short timeline meant that midwifery was implemented prior to having the appropriate policies, etc. in place such as a home birth policy, which then resulted in significant challenges for the DHA/IWK and midwives, as well as concern and anxiety among clients. A lesson learned highlighted by some at one model site was the importance of initially hiring the midwives in an advisory role rather than a clinical role, to support setting up policies, etc. prior to the provision of services.

One of the huge challenges I think was, and there was no way of getting around this, and this is a one-off thing, so it was just with this implementation. And it was the same I think everywhere, was that suddenly midwifery was regulated, and boom. You know, we had to be up and running, and it was really difficult to get the timing right for things. And then of course, everybody was scrambling and working long hours and very quickly to try to pull things together. And then we came under criticism because we got all of that up and running, and still didn't have all of the policies in place for home birth, and there was a community outcry about the fact that we didn't have home births.

The situation was that the way the whole implementation and proclamation was set up, was that we didn't really have a substantial period of time where a clinic was set up before we were doing clinical work. The implementation period within the district was so short. ... I think what the learning is to allow some time where the midwives do not do clinical work that are just employed to maybe set up the clinic. And in many respects the midwives are the best people to do that work. I mean, because we know intimately what our needs are, what our specific needs for equipment ...although the time commitment was pretty huge for sure.

Accomplishments of the Implementation of Midwifery

The interviews and focus groups explored the successes/accomplishments of the implementation of midwifery to date. The findings revealed the following accomplishments: legislated midwifery services, access to midwifery services for women, and the ability for providers to learn from one another. Each is described in detail below.

❖ *Legislated Midwifery Services*

A key accomplishment highlighted by several key informants was the fact that midwifery has been successfully legislated in Nova Scotia, and that midwives are practicing in a regulated environment in the province. Many highlighted that the introduction of a new health care provider into the system is no small feat, and therefore the fact that implementation has occurred was deemed a success. It was noted that implementation was complex and included the establishment of several new processes and structures (e.g., policy, regulatory body, etc.). Some key informants highlighted the commitment of many stakeholders to the planning and implementation process, and the years of advocacy, lobbying and ‘fighting’ for midwifery. Therefore, to have it implemented in the province is a major accomplishment. Further, midwifery services appear to be well used by women and families (e.g., there is high demand for the service in the model sites). Many key informants noted that the implementation thus far is a “good start” but cautioned that more work is still required to fully implement the service provincially.

Probably the main accomplishment I would see would be a political one, to regulate the profession of midwifery. That’s a major step for Nova Scotia, it’s the first Atlantic province to regulate midwifery, and so I think the main issue was showing the political wherewithal to actually proceed with regulations.

We have [midwives] in [regulated] practice in Nova Scotia now, and we didn’t before. I think that’s the major coup, considering how long the midwifery coalition has lobbied to have midwives in practice in Nova Scotia. And the midwives themselves have lobbied obviously over the years, but you know, it would have been wonderful had it been available to every woman in Nova Scotia.

I think the commitment of the Department of Health, I think the commitment of the midwives, and certainly the other stakeholders like the College of Physicians and Surgeons [and College of Nurses]. We gave a fair amount of our time, donated a tremendous amount of time drafting the legislation. So I think the commitment of the key players was one of the main facilitators.

❖ *Access*

A success highlighted by many key informants was that women now have access to midwifery services, have the choice of maternity care provider, and choice of birth place. Since the legislation, women who would have been unable to pay for midwifery services are now better able to access the service.

I think [an] accomplishment, is providing midwifery care to people that didn't have access to it before. Because you know, it was expensive; people couldn't pay out of pocket for it.

I think one of the key accomplishments is that it's offering a choice for the client, and she can deliver with a [midwife/midwives] at home, deliver with a [midwife/midwives] in hospital or come in and have the normal delivery within acute care setting.

❖ *Learning from One Another*

Some key informants at the model sites noted that a success of the implementation of midwifery has been the mutual learning that has occurred between health care providers and midwives. Some health care providers have embraced midwifery noting that they have learned a great deal about natural/low intervention birth and are open to learning about midwifery techniques. Some have noticed that providers have incorporated midwifery techniques into their practice. Further, a few of the midwives commented that they too have learned about the practices of other providers.

I think some of what I'm doing [as a midwife] is rubbing off on [other providers], and I'm learning a lot from them too, about cases and the things that turn abnormal. I'm learning about that too; it's a learning experience for us all. And we have weekly meetings ... to talk about cases, and it's amazing what I'm learning.

One of the benefits is actually both physicians and nurses actually have learned a few good techniques from the [midwife/midwives]. There's been certainly some things that I think they've brought to bear in the way we do things, and we could learn from it and have learned from it.

Well there's been learning on both sides. [The midwife/midwives] learned a lot from us and I've certainly, personally I feel I've learned a lot. We've gotten more proactive in position changes and being open to different laboring positions in the case room.

Conclusions & Recommendations

Conclusions

The purpose of the current evaluation is to contribute to the understanding of the process for implementing midwifery in Nova Scotia. This qualitative evaluation included interviews and focus groups with women and a range of provincial and local stakeholders involved in the implementation process.

The findings reveal that incorporating/ integrating a new health care provider into the existing health care system is a complex task that requires substantial support including an investment of time and resources (financial and people). This is not a surprising finding given that the philosophical beliefs and underpinnings of the midwifery profession are quite different from the traditional medical model. Further, the health care system is undergoing transformation with greater investments being made within primary health care – this is a potential opportunity to effectively support the integration of midwifery programs and services, but is also a challenge, as midwives are being introduced into the system when many changes and developments are underway.

The three model sites are very different in the approach they have taken to integrating midwives into the system, however, most of the issues and challenges identified were common across model sites as well as across provider groups. In addition, all model sites and provider groups consistently discussed the fact that introducing a new health care provider into the system is no small feat, and therefore having legislation and regulated midwives practicing within the system is a significant accomplishment.

Recommendations

❖ *The Model and Vision for Midwifery*

- Clearly define and communicate the model of midwifery being implemented in Nova Scotia. Terms such as ‘continuity of care’ and ‘collaboration’, which are integral to the Canadian Model of Midwifery, are used by many provider groups. More detail about what these principles mean in the context of midwifery is needed to address current lack of understanding among providers as well as philosophical differences in interpretation of some terms.
- Develop a plan for implementation of midwifery throughout the province including a vision and timelines.

❖ *Standards and Accountability*

- Build awareness and understanding among key stakeholders about the regulatory and policy framework that governs midwifery practice in Nova Scotia to help support the interprofessional relationships and development of accountability and reporting structures at the local level that ensure safe ethical midwifery practice.
- Continue to monitor the midwifery implementation process and ensure alignment with the standards of practice for midwifery in Nova Scotia.
- Align midwifery programs and services with Primary Health Care programs and services (e.g. Community Health Centres, Birthing Centres, etc.).
- Review district policies related to midwifery and identify current and future policies that have the potential to be provincial in scope, and determine responsibility for monitoring compliance.

❖ *Diversity and Social Inclusion*

- Develop and implement local culturally specific action plans/strategies for midwifery programs and services to reach underserved, marginalized populations, and monitor effectiveness and annually report on outcomes.
- Continue to provide cultural competence and cultural safety training in an interprofessional learning environment.

❖ *Support for Implementation and the Integration of Midwives into the System*

- Continue to provide supports to facilitate the integration of midwives, and to support the building of effective collaborative care teams including:
 - conducting regular interprofessional team meetings in District Health Authorities/IWK to build awareness and understanding of approaches and roles and responsibilities;
 - implementing the *Building a Better Tomorrow*³ modules to foster and support team development; and
 - exploring other team building initiatives such as *MOREOB*⁴ to foster and support team development.
- Convene a working group to conduct a comprehensive review of the orientation processes for the midwives, and develop standards and a planned approach; this should include (but is not limited to) ensuring content related to primary health care within the orientation process, and hiring midwives in a non-practicing role during the implementation phase.

³ Building a Better Tomorrow Together (BBTT), a series of continuing education models for health care providers, facilitates the development, integration, and support of interdisciplinary teams. The program was informed by the evaluation of the initial BBT program, a survey of primary health care managers, competencies for interprofessional collaboration, and provincial cultural competency guidelines.

⁴ MOREOB (Managing Obstetrical Risk Efficiently) is a Canadian patient safety, professional development, and performance improvement program for caregivers and administrators in hospital obstetrics units.

- Convene a working group to review and revise/update the contents of the *Getting Started Toolkit*.
- Include consumer and midwifery representatives on implementation committees and other structures established to support the integration of midwives, and provide support to ensure a safe and supportive environment for participation and meaningful involvement.

❖ *Financial Resources and Sustainability*

- Increase the number of midwives within each model by one full-time equivalent position prior to establishing additional sites.
- Provide resources to support the expansion of midwifery into other DHAs.
- Increase the administrative support provided to midwives (a half-time position per midwife).
- Until midwifery is available in all District Health Authorities, explore interim solutions to help make midwifery services accessible to more women in the province beyond the three model sites (e.g., self-employed funded practice).
- When midwifery programs and services are disseminated throughout the province, ensure a sufficient number of midwives are hired within DHAs to help maintain the principles of midwifery services based on the Canadian model (e.g., continuity of care, choice of birth place).
- Convene a working group to address physician remuneration issues identified in this evaluation (e.g. remuneration for consult or collaboration with midwives).
- Gather Canadian data about cost effectiveness and work with health economists to develop and test cost effectiveness models to inform long term planning and sustainability of midwifery programs and services.
- Provide resources to support cultural competence and cultural safety training for interprofessional providers and to support community outreach strategies.

Moving the recommendations to action will be a shared responsibility of the many stakeholders impacted by the introduction of regulated midwives into the health care system including women and their families, midwives, community groups, other providers, District Health Authorities and the Nova Scotia Department of Health. Just as this shared responsibility was important in developing legislation for midwifery, so too will it be critical for successful implementation of midwifery programs and services across Nova Scotia.

Appendices

Focus Group Guides

Evaluation of Midwifery Implementation in Nova Scotia *Key Informant Interview/Focus Group Guide – Provincial*

PURPOSE OF THE INTERVIEW

The purpose of the interview is to gather the perspective of provincial key stakeholders to help inform the evaluation of the implementation of midwifery in Nova Scotia. This evaluation is focused on the implementation process within three model sites in Nova Scotia. Specifically the interview will examine the following:

- The successes, challenges & facilitators of the implementation of midwifery overall
- Selection and readiness of model sites
- Supports to facilitate the incorporation of midwives within the organization and team, including governance and accountability mechanisms

PURPOSE OF THE GUIDE

This document will be used by the interviewer to guide the interview discussion and help inform the evaluation of midwifery implementation in Nova Scotia.

INTRODUCTION & CONSENT

In November 2006, Bill 107, the Midwifery Act, was passed in the House of Assembly. Over the next two and a half years provincial committees addressed a wide array of policy and clinical issues and oversaw the introduction of midwifery in three model sites. Legislation was proclaimed on March 18, 2009. Midwives working as employees and with primary maternity care teams began practicing in South Shore Health (SSH), Guysborough-Antigonish-Strait Health Authority (GASHA), and the IWK Health Centre in April/ May and August 2009.

The purpose of the interview is to gather the perspective of key stakeholders to assist in the evaluation of the implementation of midwifery in the three model sites in Nova Scotia. Specifically, during this interview we will be discussing: the successes, challenges and facilitators to the implementation process overall; district/ organizational readiness to implement midwifery; supports and challenges to the incorporation of midwifery within the district/ organization and local team; collaboration and partnerships; and

governance and accountability. The evaluation findings will be shared with others in the province with the aim of helping to guide other DHAs in the implementation process.

Participation in this interview is voluntary, all the information provided will be kept confidential and answers will not be associated with any names in any reports written. To help with the analysis of the information, I would like (with your permission) to audio-record and transcribe this interview. The responses that you provide will only be reported in aggregate, and although individual responses may be used as quotations, no one will be personally identified. Do you have any questions before we start the interview?

Do you consent to participate in the interview?

Yes No

Do I have permission to audio-record this interview?

Yes No (If no, ask if notes can be taken)

INTERVIEW QUESTIONS

The interviewer will begin the interview using the scripts and questions outlined below. Items printed in italics are scripts for the interviewer.

General

I'd like to begin by asking some general questions about implementation of midwifery in Nova Scotia.

1. In your opinion, what are the key accomplishments of the implementation of midwifery to date?

Probes:

- Are you satisfied with the implementation process? Why or why not?
- What has helped or facilitated the implementation process?

2. In your opinion, what have been the greatest challenges to the implementation of midwifery to date?

Probes:

- How, if at all, were/can these challenges be addressed?
- What have been the greatest lessons learned?
- What advice would you give other jurisdictions who were about to implement midwifery programs and services?

Selection of Model Sites

3. How were the model sites selected?

Probes:

- What were the criteria to become a model site?
- What are the essential “components” or elements that need to be in place to support the implementation of midwifery? (what ground work needs to be laid)?
- What would you recommend to another jurisdiction/ province that was thinking about implementing midwifery in terms of what they should consider and/or have in place to ensure effective implementation?

Incorporation of Midwifery within the Organization and Team

Now, I'd like to ask some questions about the supports provided to facilitate the incorporation of midwifery within organizations (e.g., DHAs) and the incorporation of the midwifery positions within the PHC team.

4. What was done to support the integration/incorporation of midwifery within the model sites (e.g., the panel of consultants from other jurisdictions that went to the model sites to share their learnings and expertise about the implementation of midwifery programs and services; development of the document to address multidisciplinary review, consultation and transfer, “Getting Started” Toolkit)?

Probes:

- How effective were these supports? How could they be improved? What else is needed?
- What were the challenges to the incorporation of midwifery within the model sites?

If not mentioned explore the following:

- What ***governance and accountability mechanisms/ structures/ processes*** were developed at a provincial level to support the implementation of midwifery in Nova Scotia? How effective were these mechanisms and processes? How could they be improved? What else is needed?
- What supports were provided from a provincial level to support ***culturally competent midwifery programs and services***? How effective were these supports? How could they be improved? What else is needed?

5. What was done at a provincial level to support the integration of the midwife positions within the maternity care team (versus within the organization)?

Probes:

- How effective were the supports? How could they be improved?
- What were the challenges to the incorporation of the midwife positions within the maternity care team?

6. What was done at a provincial level to support collaboration within the broader multidisciplinary team (beyond the maternity care team – allied health

professionals such as physio, diagnostic testing, anesthesia, etc.) to ensure the provision of coordinated primary maternity programs and services (that now include midwifery positions)?

Probes:

- How effective were the supports? How could they be improved? What else is needed?
- In your opinion, what needs to happen in the future to support effective collaboration?

CLOSING

That is the end of the formal questions. Do you have any other feedback on the implementation of midwifery to help future planning that you would like to add?

Thank you for your time and thoughtful input. A report of the findings will be developed and available through Primary Health Care, Nova Scotia Department of Health.

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## **Evaluation of Midwifery Implementation in Nova Scotia Key Informant Interview/Focus Group Guide – Model Sites**

### **PURPOSE OF THE INTERVIEW**

The purpose of the interview is to gather the perspective of key stakeholders to help inform the evaluation of the implementation of midwifery in Nova Scotia. This evaluation is focused on the implementation process within three model sites in Nova Scotia. Specifically the interview will examine the following:

- The successes, challenges & facilitators of the implementation of midwifery overall
- Readiness to become a model site
- Incorporation of midwives within the organization and team
- Collaboration and partnerships
- Governance and accountability
- Program and service delivery

### **PURPOSE OF THE GUIDE**

This document will be used by the interviewer to guide the interview discussion and help inform the evaluation of midwifery implementation in Nova Scotia.

### **INTRODUCTION & CONSENT**

*In November 2006, Bill 107, the Midwifery Act, was passed in the House of Assembly. Over the next two and a half years provincial committees addressed a wide array of policy and clinical issues and oversaw the introduction of midwifery in three model sites.*

*Legislation was proclaimed on March 18, 2009. Midwives working as employees and with primary maternity care teams began practicing in South Shore Health (SSH), Guysborough-Antigonish-Strait Health Authority (GASHA), and the IWK Health Centre in April or May of 2009.*

*The purpose of the interview is to gather the perspective of key stakeholders to assist in the evaluation of the implementation of midwifery in the three model sites in Nova Scotia. Specifically, during this interview we will be discussing: the successes, challenges and facilitators to the implementation process overall; district/ organizational readiness to implement midwifery; supports and challenges to the incorporation of midwifery within the district/ organization and local team; collaboration and partnerships; governance and accountability; and programs and services. The evaluation findings will be shared with others in the province with the aim of helping to guide other DHAs in the implementation process.*

*Participation in this interview is voluntary, all the information provided will be kept confidential and answers will not be associated with any names in any reports written. To help with the analysis of the information, I would like (with your permission) to audio-record and transcribe this interview. The responses that you provide will only be reported in aggregate, and although individual responses may be used as quotations, no one will be personally identified. Do you have any questions before we start the interview?*

*Do you consent to participate in the interview?*

Yes  No

*Do I have permission to audio-record this interview?*

Yes  No (If no, ask if notes can be taken)

## **INTERVIEW QUESTIONS**

The interviewer will begin the interview using the scripts and questions outlined below. Items printed in italics are scripts for the interviewer.

### **General**

*I'd like to begin by asking some general questions about implementation of midwifery in your organization.*

1. In your opinion, what are the key accomplishments of the implementation of midwifery in your [district or the IWK Health Centre] to date?

Probes:

- Are you satisfied with the implementation process? Why or why not?
- What has helped or facilitated the implementation process?

2. In your opinion, what have been the greatest challenges to the implementation of midwifery in your [district or the IWK Health Centre] to date?

Probes:

- How, if at all, were/can these challenges be addressed?
- What have been the greatest lessons learned?
- What advice would you give to other DHAs who were about to implement midwifery programs and services?

### **Readiness to Implement Midwifery**

3. How did your organization decide that it was ready to support the implementation of midwifery?

Probes:

- How did you engage stakeholders within the organization and ensure their readiness?
- How did you engage community stakeholders and ensure their readiness?
- What are the essential “components” or elements that need to be in place to support the implementation of midwifery? (what ground work needs to be laid)?
- What would you recommend to another district that was thinking about implementing midwifery in terms of what they should consider and/or have in place to ensure effective implementation of midwifery?

### **Incorporation of Midwifery within the Organization and Team**

*Now, I'd like to ask some questions related to the incorporation of midwifery within your organization and the incorporation of the midwifery positions within the PHC team.*

4. What was done within the [DHA or IWK Health Centre) system to support the integration/incorporation of midwifery?

Probes:

- How effective were these supports? How could they be improved? What else is needed?
- What were the challenges to the incorporation of midwifery within [name of DHA or IWK Health Centre]?

5. What was done at a provincial level to support the integration/ incorporation of midwifery within your district/ organization (e.g., the panel of consultants from other jurisdictions that went to the model sites to share their learnings and expertise about the implementation of midwifery programs and services; development of the document to address multidisciplinary review, consultation and transfer)?

Probes:

- How effective were these supports? How could they be improved? What else is needed?

6. What was done to support the integration of the midwife positions within the maternity care team?

Probes:

- How effective were the supports? How could they be improved?
- What were the challenges to the incorporation of the midwife positions within the maternity care team?

7. Do you think the maternity care team is functioning effectively to support primary maternity programs and services? Why or why not?

Probes:

- What could be done to improve team functioning?
- Are you clear on the roles and responsibilities of team members? What, if anything, needs to be done to improve role clarity?

### **Collaboration and Partnerships**

8. What was done to support collaboration within the broader multidisciplinary team (beyond the maternity care team – allied health professionals such as physio, diagnostic testing, anesthesia, etc.) to ensure the provision of coordinated primary maternity programs and services (that now include midwifery positions)?

Probes:

- How effective were the supports?
- How effective is the collaboration?
- What are the challenges to collaboration?
- What can be done to overcome the challenges? What needs to happen in the future to support effective collaboration?

### **Governance and Accountability**

*Now, I'd like to ask a few questions related to governance and accountability.*

9. What governance and accountability mechanisms/structures/processes (were developed to support the incorporation of midwifery within the organization, including policy (e.g., the document to address multidisciplinary review, consultation and transfer, midwifery implementation toolkit, local Steering Committee)?

Probes:

- How effective are these mechanisms/ structures? If not effective, why not? How could they be improved?
- What was the membership of your Steering Committee, how did you recruit participants? Did you have a consumer representative? Why or why not?
- Are there any other governance and accountability mechanisms/ structures needed? If so, please describe.

### **Programs and Services**

*The next questions are about the provision of primary maternity care programs and services that incorporate midwifery [practice]?*

10. In your opinion, what were the greatest successes in terms of the delivery of midwifery programs and services?

Probes:

- Maintaining midwifery principles such as choice of birth place, continuity of care, ensuring access?

11. In your opinion, what were the greatest challenges in terms of the delivery of midwifery programs and services?

Probes:

- Maintaining midwifery principles such as choice of birth place, continuity of care, ensuring access?

12. How does the PHC team support the provision of culturally competent (culturally and socially inclusive) midwifery programs and services?

Probes:

- What are the challenges to the provision of culturally competent midwifery programs and services? How have you overcome these challenges or what additional supports do you need to overcome these challenges?

## CLOSING

*That is the end of the formal questions. Do you have any other feedback on the implementation of midwifery within your organization and/or input to help future planning that you would like to add?*

*Thank you for your time and thoughtful input. A report of the findings will be developed and available through Primary Health Care, Nova Scotia Department of Health.*

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Evaluation of Midwifery Implementation in Nova Scotia **Evaluation of Midwifery Implementation in Nova Scotia** *Women's Focus Group Guide*

PURPOSE

This document will be used by the moderator of the focus group with clients of midwifery programs and services to help evaluate the implementation of midwifery in three model sites in Nova Scotia.

PRIOR TO THE MEETING

As participants arrive for the focus group, the moderator will welcome them individually.

Welcome and Introductions

The moderator will introduce herself and ask participants to introduce themselves. The moderator will explain the purpose of the focus group as follows:

The purpose of this focus group is to help assess the implementation of midwifery programs and services in Nova Scotia. As an individual who has received midwifery programs and services, your feedback is greatly valued and will help in making improvements to the implementation of midwifery in the future, and help to ensure the best possible experience for women. To help with the analysis of the information, I would like to tape record and transcribe this focus group. The responses that you provide will only be reported in aggregate (summed together), and although individual responses may be used as quotations, you will not be personally identified. Do you have any questions?

Do you consent to participate in the focus group?

Yes No.

Do I have your permission to tape record this focus group?

Yes No. Ask if you can take notes if permission to tape record is not given

- The moderator will outline the process for the remainder of the session.
- The moderator will review guidelines for the focus group (e.g. what is said in the focus group is confidential and should not be shared outside the group, all views/feedback is welcomed, respectful of all opinions, etc.)
- The moderator will begin the focus group discussion, using the scripts and questions outlined below. Items printed in italics below are scripts for the moderator.

We will now move into discussing midwifery programs and services. Because of our limited time together, I may need to move the discussion along on occasion, just to ensure that we have time to cover all of the questions.

QUESTIONS

1. Why did you choose midwifery care?

Probes:

- How did you hear about midwifery care/ services?

2. Were you satisfied with the midwifery care? Why or why not?

Probes:

- What is it that you found particularly valuable?
 - What did you like best?
 - Was the care you received what you expected?
3. Did you experience any challenges related to midwifery programs and services?
Probes:
- How could midwifery care be improved?
 - Are there any other supports you would like to see provided through midwifery programs and services? Please describe.
4. What difference did the midwifery care you received make in your total birth experience? What was the impact?
Probes
- How about the difference midwifery care has made in your relationship with your newborn and/or helping you to care for your newborn?
 - How about the difference midwifery care has made in your family's life in general? In the long term?
5. Is there anything that we have not covered that you would like to share that would help us evaluate the implementation of midwifery programs and services in Nova Scotia?

Thank you very much for your participation in the focus group. Your input is very important as we continue to work to refine and improve the implementation of midwifery programs and services.

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**Evaluation of Midwifery Implementation in Nova Scotia**  
***Women's Focus Group Guide***  
*(those who wanted but could not get MW services)*

**PURPOSE**

This document will be used by the moderator of the focus group with women who wanted midwifery programs and services but were unable to receive the service. This information will help evaluate the implementation of midwifery in three model sites in Nova Scotia.

**PRIOR TO THE MEETING**

As participants arrive for the focus group, the moderator will welcome them individually.

**Welcome and Introductions**

The moderator will introduce herself and ask participants to introduce themselves. The moderator will explain the purpose of the focus group as follows:

*The purpose of this focus group is to help assess the implementation of midwifery programs and services in Nova Scotia. As an individual who wanted midwifery programs and services but were unable to receive them, your feedback is greatly valued and will help in making improvements to the implementation of midwifery in the future. To help with the analysis of the information, I would like to tape record and transcribe this focus group. The responses that you provide will only be reported in aggregate (summed together), and although individual responses may be used as quotations, you will not be personally identified. Do you have any questions?*

*Do you consent to participate in the focus group?*

\_\_\_Yes \_\_\_No.

*Do I have your permission to tape record this focus group?*

\_\_\_Yes \_\_\_No. Ask if you can take notes if permission to tape record is not given

- The moderator will outline the process for the remainder of the session.
- The moderator will review guidelines for the focus group (e.g. what is said in the focus group is confidential and should not be shared outside the group, all views/feedback is welcomed, respectful of all opinions, etc.)
- The moderator will begin the focus group discussion, using the scripts and questions outlined below. Items printed in italics below are scripts for the moderator.

*We will now move into discussing midwifery programs and services. Because of our limited time together, I may need to move the discussion along on occasion, just to ensure that we have time to cover all of the questions.*

## QUESTIONS

1. Why did you want midwifery care?

Probes:

- How did you hear about midwifery care/ services?
- What did you hope to get from midwifery care?

2. Since you were unable to get midwifery services, where did you receive your prenatal/post natal care?

Probes:

- Were you satisfied with the care received? Why or why not?

- Was the care you received what you expected?
  - How do you think this care differed from the care you would have/hoped to receive from a midwife?
3. What difference do you think not having a midwife make in your total birth experience? What was the impact?
- Probes
- How about the difference not having midwifery care made in your relationship with your newborn and/or helping you to care for your newborn?
  - How about the difference not having midwifery care has made in your family's life in general? In the long term?
4. Are you hoping to make use of a midwife for future pregnancies/births?
5. Is there anything that we have not covered that you would like to share that would help us evaluate the implementation of midwifery programs and services in Nova Scotia?

*Thank you very much for your participation in the focus group. Your input is very important as we continue to work to refine and improve the implementation of midwifery programs and services.*