



Community As Client: A Qualitative Descriptive Study of the Work of Midwives to Increase Access to Midwifery Care

La collectivité comme client : étude descriptive qualitative du travail des sages-femmes pour accroître l'accès à leurs soins

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ABSTRACT

Increasing access to midwifery care for disadvantaged groups was an explicit goal of the regulation of midwifery in Ontario. However, people of low socio-economic status (SES) remain less likely to receive midwifery care. We conducted a qualitative descriptive study to explore the work midwives do to make midwifery care accessible to people of low SES. We interviewed 13 Ontario midwives serving people of low SES, who practiced midwifery in settings ranging from a remote solo practice to a large urban practice. Participants described a broad range of ways in which they work to enhance the approachability, acceptability, availability and accommodation, affordability, and appropriateness of their services for people of low SES. We identified two distinct approaches to increasing access to care: [1] working to maximize the existing beneficial aspects of the midwifery model to whoever presents to care, and [2] stepping outside of the confines of the midwifery model, to provide what we call “community-centred care,” in which midwives are both a part of and responsive to the broader communities that they serve. The intentional, pro-active approach used by midwives providing community-centred care could be implemented more broadly to improve access to midwifery care for people of low SES.

KEYWORDS

midwifery; health services accessibility; social class; health care quality, access, and evaluation; community health services; health services; Indigenous

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RÉSUMÉ

L'accroissement de l'accès des groupes désavantagés aux soins prodigués par les sages-femmes constituait un objectif explicite de la réglementation de la profession en Ontario. Néanmoins, les personnes de statut socioéconomique faible demeurent les moins susceptibles de les recevoir. Nous avons réalisé une étude descriptive quantitative pour examiner le travail accompli par les sages-femmes afin de rendre leurs services accessibles à ces gens. Nous avons soumis à une entrevue 13 sages-femmes ontariennes qui desservent des personnes de statut socioéconomique faible dans des milieux allant d'un cabinet indépendant en région éloignée à un grand cabinet urbain. Les participantes ont décrit un large éventail de moyens par lesquels elles travaillent à l'amélioration de la facilité d'accès, de l'acceptabilité, de la disponibilité, de l'adaptation, de l'abordabilité et de la pertinence de leurs services pour les personnes de statut économique faible. Nous avons déterminé deux approches distinctes de l'élargissement de l'accès aux soins : [1] travailler à la maximisation des aspects bénéfiques existants du modèle de pratique sage-femme à quiconque se présente afin d'obtenir des soins; [2] sortir des limites du modèle de pratique sage-femme afin de fournir ce que nous appelons des « soins axés sur la collectivité ». Les sages-femmes font alors partie de la communauté élargie qu'elles desservent tout en étant sensibles à ses besoins. L'approche proactive intentionnelle adoptée par les sages-femmes qui prodiguent des soins axés sur la collectivité pourrait être généralisée afin d'améliorer l'accès des personnes au statut socioéconomique faible aux services des sages-femmes.

MOTS-CLÉS

pratique sage-femme; accessibilité des services de santé; classe sociale; soins de santé : qualité, accès et évaluation; services de santé communautaires; services de santé; Autochtones

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BACKGROUND

It is well established that socio-economic status (SES) is a reliable predictor of health status. People of low SES have poorer health outcomes generally, including an increased likelihood of adverse birth outcomes, most notably preterm births and babies who are small for gestational age.¹⁻⁴ Further, even in publicly funded health systems like Canada's, low SES is associated with poorer access to health care, including maternity care.^{5,6}

The Canadian midwifery model of care (which includes informed choice, choice of birthplace, continuity of care, flexible community-based care with longer appointments, and a nonjudgmental approach) can mitigate some of this double burden of poorer health outcomes and decreased access to care, both by increasing access to prenatal care and by improving outcomes.^{7,8} Recent evidence from British Columbia shows that for people of low SES, a midwifery-led continuity-of-care model, when compared to physician-led care, is associated with a lower risk of preterm birth and small-for-gestational-age babies.^{9,10}

Increasing access to midwifery care for marginalized women was a stated goal of midwifery regulation in Canada.¹¹ A 1999 survey of midwives, conducted 5 years after the regulation of midwifery in Ontario, reported that public funding had increased the diversity of the midwifery client population and that a notable proportion of midwifery-practice groups reported increased utilization by women of low income.⁷ However, recent evidence shows that, despite 25 years of regulation and public funding, clients of low SES continue to be underrepresented in Ontario midwifery care.¹²

To explore this issue further, we conducted a mixed-methods research program about access to midwifery care for people of low SES. (We have reported elsewhere on the barriers to midwifery care faced by pregnant people of low SES.)¹³ Our primary research question was, How do midwives work to make midwifery care accessible to people of low SES? Our objective was to explore the efforts of midwives to increase access to care for people of low SES. We approached this work [1] understanding SES as a multifaceted construct used to describe social inequality, based on factors

that include income, employment, occupation, and educational attainment, and [2] recognizing that SES reveals inequities that must be understood by taking into consideration intersectionality and the historical legacies of oppression and colonization.^{14,15} Much health care or service provision that strives to increase access for people of low SES focuses on particular communities whose members are disproportionately of low SES. We recognize that neither socio-economic groups nor racialized or ethnic communities are homogeneous, and we acknowledge that not all people of any given community are of low SES, nor are all people of low SES only from specific communities.

METHODS

We conducted a qualitative descriptive study using semistructured interviews.¹⁶ Ethics approval was obtained from the Hamilton Integrated Research Ethics Board.

Participants, Setting, and Recruitment

Our study participants were registered midwives in Ontario. We used purposive snowball sampling to recruit participants who practiced in a diverse range of settings and who were either actively engaged in work to increase access to care or working in a geographical area known to be economically depressed. Participants were approached directly by email or in person. Sample size was determined by achievement of thematic saturation of the data;¹⁷ two investigators discussed emerging themes as interviews were conducted, and it was determined that interviews would stop being conducted when no new themes, information, or insights were identified.

Data Collection

We developed a semistructured interview guide that included open-ended questions about the following: barriers to accessing midwifery and other health care; the context in which participants worked; ways in which participants facilitated access to care for clients of low SES; barriers faced by midwives in increasing access to care; changes that could improve access to care; and advice to other midwives seeking to increase access to care for people of low SES. A demographic survey was

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also administered to each participant. A research assistant (a masters student and registered midwife) conducted individual interviews by telephone or in person with all of the participants. The interviews, each lasting approximately 60 minutes, were conducted between January and June of 2018.

ANALYSIS

Interviews were audio-recorded and professionally transcribed. Transcripts were analyzed and managed using NVivo 12 [Boston, MA] software. Each transcript was read and reread to increase familiarity with the data. As per Sandelowski's description of qualitative descriptive analysis, analysis was conducted in stages, beginning with open coding to summarize and describe the data, then proceeding with focused coding to identify and categorize themes.^{17,18} After the initial stages of coding, we noted resonance between our descriptive codes and Levesque and colleagues' framework describing five dimensions of health care accessibility [Figure 1].¹⁸ At this point, we conducted the next round of coding in a way most accurately described as an "unconstrained directed qualitative content analysis."^{19,20} We grouped our descriptive codes according to the five supply-side dimensions of the Levesque framework but remained open to data that did not fit or which required refinement or adaptation of the five dimensions identified by Levesque: approachability, acceptability, availability and accommodation, affordability, and appropriateness. These five dimensions were congruent with our data, and we did not need to add or adapt the categories. Focused coding continued, identifying particular ways in which midwives worked to achieve each of these dimensions, including the

ways in which midwives and midwifery practices worked within and across the categories.

RESULTS

We interviewed 13 midwives working in practices across Ontario, ranging from a remote solo midwifery practice to a large, urban practice group comprising 19 midwives. Participants served clients from a variety of backgrounds, including, but not limited to, the following: young people, uninsured people, newcomers, Indigenous people, homeless people, people who use drugs, people with mental illness, people living with HIV, sex workers, people who have undergone recent incarceration, people with child protection service involvement, Amish and Mennonite populations, and low-income people living in rural and remote communities. Some participants worked in practices that predominantly or entirely served clients of low SES, while others worked with a more economically diverse clientele. Characteristics of the participants are shown in Table 1. The strategies used by midwives to increase access to care for clients of low SES are summarized and categorized with the use of Levesque's supply-side accessibility framework [Table 2].

Approachability: Education, Outreach, and Location

Levesque and colleagues conceptualized approachability as the degree to which services are identifiable as relevant to a person's health needs. Participants stated that increasing the approachability of their practice meant overcoming a lack of awareness of and misconceptions about midwifery services. For most midwives interviewed, this involved educating other providers and service

Table 1. Participant Demographic Information

Demographic	n
Years of practice as RM	
New registrant	0
1–5 years	3
6–10 years	3
> 10 years	7
Education programme	
Ontario Midwifery Education Program	11
International Midwifery Pre-registration Program	0
Michener pre-registration program	2
Aboriginal Midwifery Training Program	0
Other [e.g., trained in another province]	0
Caseload	
Full time	9
Part time	3
Not currently practicing	1
Catchment area*	
Urban	7
Rural	3
Rural/remote	1
Remote	2
Primary language spoken	
English	13
Other languages spoken	
French	5
Cree	1
Hindi	1
Urdu	1
Punjabi	1
Spanish	1

RM, registered midwife

*n >13 [some because some midwives work in more than one practice]

agencies about the benefits of midwifery services and creating strong and deliberate community networks. Education and networking created routes of entry, by way of referral, to midwifery care for clients who might benefit from this particular model of care but would not likely access midwifery on their own.

“And so I think a big part of what we do is constantly educating, constantly educating the community, constantly educating our care providers that we

work with, constantly educating the hospital. And we live that advocacy on a daily basis because we have to.”

Fewer participants described outreach that targeted clients directly—public education campaigns, such as a colouring contest featuring the practice’s name; volunteer clinical work at an uninsured walk-in clinic; or population-specific outreach, targeting international post-secondary students or residents in a maternity home for young mothers.

Another midwife described the broader work she does not only to inform the next generation of clients about midwifery but also to promote health literacy and empower young women.

“The outreach we do to the high schools is really important, you know, there’s a healthy dose of feminism, a healthy dose of equity and anti-oppression stuff, and that is something that goes beyond just the promotion of midwifery and the discipline about helping young people understand that they have agency, they have choice, that it’s not only about sexual and reproductive justice, it’s about so much more.”

Finally, the adage “location, location, location” denoted a strategy used by some midwives to increase the visibility of their services. Some participants talked about the importance of being close to referral sources, some locating their clinics within community health centres. Others talked about the importance of strategically locating their clinic near people they hoped to reach.

“We opened in our catchment area very deliberately and thoughtfully, knowing that we were serving [a particular neighbourhood], so very highly impoverished population, highly racialized population, a population that generally has difficulty accessing care overall.”

Acceptability: When You See Yourself Reflected in the Care You Receive

Acceptability denotes how culturally or socially acceptable the service appears to potential clients for a given health need. Most participants

Table 2. Alignment of Midwifery Strategies for Increasing Access with Levesque's Framework

Strategy	Approachability	Acceptability	Availability Accommodation	Affordability	Appropriateness	CCC
Informed choice						
Choice of birthplace						
Continuity/trust building						
Mobile care						
Networking referral routes						
Targeted client education						
Community education						
Strategic location						
Clinic atmosphere reflects population						
Diversity of clinic staff						
Cultural sensitivity/anti-racist care						
Translation						
Flexible communication						
Saving spots/prioritizing clients						
Uninsured MW fund						
Innovative use of operational funds						
Paying out-of-pocket for client needs						
Alternate funding models						
Advocacy/care coordination						
Continuing education						
Midwifery leadership						
Community consultation						

CCC, community-centred care; MW, midwifery

* Blue cells indicate what dimensions of access to care each strategy addresses.

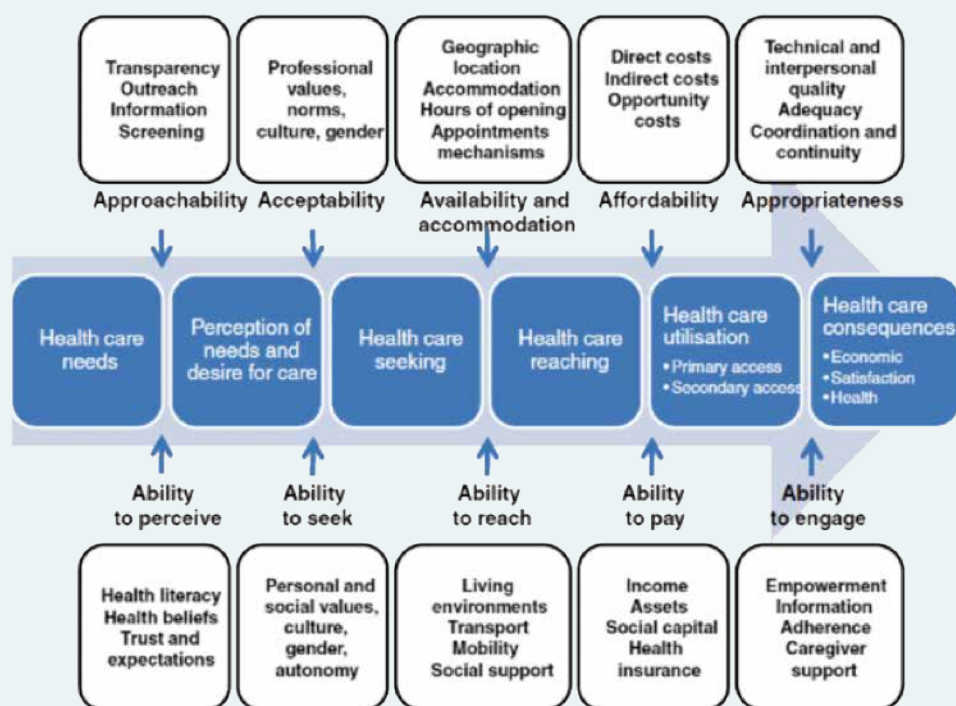
acknowledged the historic and ongoing lack of ethnic, cultural, and linguistic diversity among Ontario midwives. While careful not to equate this diversity directly with SES, participants pointed out that a lack of representation in their practice group served as a barrier at the level of acceptability. Some expressed a desire to intentionally increase the diversity of their practice group, while others described having engaged very actively in ensuring that their practice is reflective of the communities they serve, thus increasing the acceptability of midwifery care to particular communities.

“...to make sure that we have Indigenous midwives on staff and that our mandate is to grow Indigenous midwifery, because really that's the safe space for this community. When you walk in and you see yourself reflected in the face of your midwife or in the space itself, that's the first step to safe care. That's the first step to making that care more accessible. People are going to want to come back.”

Another participant described how the midwives in her practice sought to present themselves in a way that was culturally acceptable to the clients they serve.

“We dress very conservatively for work, so I usually wear a skirt below the knees. We make sure that we're covered, we never have bare arms....we're dressed very

Figure 1. Levesque Framework



Source: Levesque J-F, Harris MF, Russell G. Patient-centred access to health care: conceptualizing access at the interface of health systems and populations. *Int J Equity Health*. 2013;12(18):1-9.

modestly for home visiting, and it's meant in-kind to the population, but they really respect that we do that. And that really builds a reputation for cultural sensitivity."

To varying degrees, practices were able to overcome or lessen linguistic barriers to care. Some indicated that they relied on outsourced translation services, while others described the value of having multilingual midwives and hiring frontline staff from the communities they served.

"All of our frontline staff are immigrant women themselves, and they all speak Spanish. And we have a huge Spanish-speaking population, so the fact that people can pick up the phone and call and be able to speak to somebody without going through a translator or multiple phone calls makes a big difference."

Availability and Accommodation: You Have to Go Where People Are

Availability and accommodation relate to how easily clients can reach the care they need. Midwives talked about how the client-centred model of midwifery care inherently attends to this facet of access through the on-call model, home visiting, and home birth. Midwives described helping clients of low SES with complex and competing priorities to access care by seeing them at home and by providing clinic births. Participants described physically seeking out clients who could not be reached reliably by phone and capitalizing on the mobility in the midwifery care model to broaden the concept of home visiting to include meeting clients where they are, wherever that may be.

"In terms of what do I do to increase access for the folks with whom I'm working, I go to safe injection sites. You have to go where people are. If people are

under the bridge, I'll go under the bridge. I'm very hooked in. We're partnered now with I don't know how many social services. I don't wait for them to phone me. I go to the social services."

Midwives noted that many clients of low SES are less health literate, have complex priorities, and are therefore less likely to present for care early in pregnancy. The way in which the limited midwifery spaces available are quickly filled by those who have the knowledge, privilege, and capacity to call early in pregnancy was repeatedly identified as a structural barrier to access for clients of low SES that midwives sought to overcome.

"We were reserving 75% of our caseload; we just would not book intakes right away. Like, we would book up maybe one spot per midwife per month on the early side. So the typical midwifery consumer, as soon as they pee on the stick, will register for services and...then the people who maybe could benefit more from the care aren't getting it. So we were holding spots."

Affordability: Supporting People Who Cannot Pay

Affordability relates to client's ability to pay for health care services and needs. Midwives described the ways in which the structure and funding model of midwifery in Ontario allowed clients to access care that they could not access in other parts of the health care system. Ontario Midwifery Program funding for midwifery care of Ontario residents [regardless of Ontario Health Insurance Program [OHIP] status], for home birth kits, and for some laboratory and physician services for Ontario residents without OHIP coverage were cited as huge facilitators to providing care to clients of low SES.

Midwives also described measures they took above and beyond what these facilitators made possible. One midwife explained how the flexibility available to practices in how they choose to spend operational funds received per course of care could be better used to serve marginalized clients.

"The operational fees, you can spend it on bus tickets, you can spend it on food, you can spend it on prescription medication, you can spend it on socks; there's nothing

that says that you couldn't buy an outreach van and drive around the city with all your equipment in it."

Some midwives described providing supplies, medications, clothing, and food and formula to their clients either through practice- or community-coordinated donation programs. A couple of midwives described repeatedly paying out-of-pocket for client needs.

"Until I got [special] funding, I was paying for food, for formula, for, like, over-the-counter medication that's not funded by ODSP [Ontario Disability Support Program], for prescription that's not funded. And my clients have more need for those things because they're medically more complex."

Appropriateness: You Have to Think Outside the Box

Appropriateness refers to the overall fit between the service and the client, or how well the client's health needs are met and how much they like and benefit from the service. There are many ways in which midwifery care by its very nature is appropriate for clients of low SES. Midwives invariably described maximizing the potential within the philosophy, model, and core tenants of midwifery to provide care that was tailored to clients of low SES.

Midwives described many ways in which their clients of low SES were often stigmatized in the health care system. The relationship and trust building supported by the client-centred model of midwifery care, while not a panacea, helped midwives to help clients overcome some of their aversions to the health care system, accumulated in previous negative experiences.

"You might not see it during the course of the care that you're providing...that person might return for midwifery care the next time that they're experiencing another pregnancy, and so that might be the impact—that they've developed, not trust necessarily with you as a provider, but with midwifery as a profession."

Several midwives described the potential for midwifery to provide humanized care that increases

the appropriateness of care for marginalized clients.

"I think midwives have an opportunity to provide a kind of care that is missing for lots of people, but especially missing for people who don't fit well with the health care system as it currently is."

The union of clinical skills and social service work was described by one midwife as a unique contribution that midwives can offer to clients of low SES who might be socially high risk.

"[O]ne of the child protection workers said to me, 'I think one of the things that works the most is you have the clinical care to offer...like when I go into somebody's home or into their space at the shelter, when somebody's inviting me into their own little world, they can choose to talk to me or not talk to me about child protection issues, but we can listen to their baby together, and that part is really important to people.'"

Advocacy is integral to the practice of midwifery in Ontario, but some of the midwives we interviewed described a level of advocacy that they likened to taking on an additional role as a social worker, coordinating with Child Protective Services, housing, hospital billing departments, community health services, etc.

"CAS [Children's Aid Society] sent me a letter saying they felt like there were 12 babies who went home with their families who wouldn't have otherwise. So part of that's that negotiation and our relationship, and part of that has to do with just my ability to choose to go see somebody seven days in one week, if that's what's going to make the difference to the plan."

On the other hand, many midwives described not feeling that they or their colleagues had the expertise to provide care to some clients of low SES who may have had clinically and socially complex care needs. Midwives worked to overcome this barrier to meeting complex needs by engaging in continuing education in areas that were relevant to their clinical care. Some midwives described how

they had taken on programs of self- or collaborative study to become competent and even develop expertise in providing the clinically complex care required by some clients of low SES.

"I probably go to workshops and seminars or do online reading, probably a minimum...20 to 30 hours a month. And be prepared to pay for it all yourself; it's all volunteer. It's being there when the babies [are] born that's going to pay you to do the work."

Midwives often described feeling that their abilities to decrease barriers to care were constrained by the funding and practice model of midwifery care. Several midwives described how, with a great deal of work, they had created ways of providing care that stepped outside of the existing model, often in ways for which they were not compensated.

"But I also think the genius of midwifery is that we don't think in the box. And I worry the more legislated we get, the more in the box we get. And I think to truly serve marginalized communities, there is no box for them, and so I think you have to think outside the box because they don't fit in anyway."

Midwives described street outreach midwifery programs that provided mobile prenatal and postpartum care to people living on the extreme margins of society. They described providing care outside the standard course-of-care model, instead providing collaborative care based at a community health centre or an Aboriginal Health Access Centre, walk-in care for uninsured clients, or culturally appropriate supportive care for Indigenous clients flown into a tertiary care centre. They also described interprofessional models of care that supported the clinical, social, and geographic needs of their clients.

Community-Centred Care

In addition to describing how the elements of the work described by participants fit into each of the five dimensions of accessibility described by Levesque, our analysis revealed a unique approach to improving access to care described by some participants. These midwives described how midwifery practices

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[and less often individual midwives] had established or evolved their practice into an integrated and reflexive part of the community they serve, which invariably involved integrating all five dimensions of accessibility described by Levesque. This entailed expanding on the notions of person-centred care at the core of midwifery practice in Ontario to build and provide “community-centred care.” Midwives and midwifery practices providing community-centred care always referred to the community as something that they were both a part of and from which they took their lead.

"There's a lot of word of mouth in the community, so really just providing excellent services that the community is actually telling us they want. So it goes back to the community, like what kind of care consultation process, right? What kind of care do you want? What kind of care do you need? How do you need it? And how do you think we should provide it? So those are always the questions that we're trying to ask the community and screen back from the community."

Community-centred care (CCC) involved ongoing formal or informal consultation with the community but also an investment and genuine presence in the community.

"We really have a great outreach program at the [practice]. So we go to powwows and we go to community events and we participate strongly in community committees and we sit on boards at the city and we sit at boards at the hospital and we really want to try to have a well-rounded, wide-reaching feel for who's out there and what they want."

Midwives providing CCC described a shared intentionality or mandate within their practice group, whether it was part of their reason for founding the practice or whether it developed over time, to increase access to care. This meant that the structure and culture of the practice group was largely and proactively devoted to serving specific communities.

"We've made an effort to strongly hire with the bounds of looking for midwives who are really committed to doing this type of work. And it's a high priority when we interview for what we're looking for. And it's also what would help us retain midwives in our community."

Midwives who provide CCC also described the impact their services have had more broadly on the local health care system. Midwives described how their initiatives prompted advances in screening for and treatment of genetic conditions, ensured the availability of culturally competent care at busy tertiary care centres, and decreased the rates of people presenting to hospital without prenatal care.

"But what's interesting about our catchment area is that there are so many people who don't have insurance and are living kind of underground...many people who are just showing up at the hospital when it's time to give birth or when there's a complication. Our hospital absolutely, and I think this is a success story, the number of walk-in clients without health insurance has plummeted and that they very much attribute to our practice being around and being available."

Participants who provide CCC described the

work of their practice groups as much broader than providing clinical care to individuals. They described a deep respect for the client populations they serve and a keen awareness of the real and potential impact of their services. They also expressed humility regarding the privilege and responsibility of being a part of the community they serve. The most profound examples of this were described by two midwives in two separate practices working with Indigenous nations and communities.

"It's a community that really agitated and advocated for midwifery service in the first place, which is a great thing. But it is at the same time a community that's had the impact of out-of-community birth for several generations, and so there has to be, and there is, taking place this kind of like, confidence building and local births, which is again, confidence building is a little bit different than interest or belief or desire, like what the people really believe that birth is an integral part of the community."

"So in the Indigenous traditions, seven generations ahead, we're not doing things for us now. We do things looking forward seven generations. So where are my grandkids' grandkids' grandkids going to be? What will I leave them? And I think what we're learning, like in the light of residential schools, is that we can actually heal backwards now. Like that piece of intergenerational trauma, we can heal our elders, our communities, and what's gone before. So that's a big motivating factor, I think, in the Indigenous midwifery now is intergenerational healing, even looking backwards."

Finally, participants providing CCC described an urgency and value to their work that demanded that they take a leadership role. They described working with imagination, intentionality, and pride in the unique potential of the midwifery model and philosophy to decrease barriers to care. They insisted that midwives need to be at the table during the development of programs designed to increase access to prenatal care and in the design of the health system more broadly. One participant stated the following, with respect to being at the policy making table:

"This has to start happening now, where we're telling people that not only can we be there, we actually should be there, and that we deserve to be there."

DISCUSSION

Our research identified numerous ways in which midwives work to decrease barriers to midwifery care for clients of low SES. Their approaches fell into two distinct categories, variously focusing on and spanning the five supply-side dimensions of accessibility as described by Levesque.¹⁸ The first approach involved midwives who did a modest amount of outreach and/or simply found themselves caring for clients of low SES. These respondents described maximizing the features of the midwifery model to provide high-quality, person-centred care to those presenting for care. The second approach involved tailoring or breaching the confines of the midwifery model, to provide CCC. Most often, this involves an entire midwifery practice group rather than an individual midwife within a practice. It entails an approach in which midwives are a part of, and responsive to, their broader community, often working at the intersection of low SES and complex clinical and social needs. Participants working with a CCC approach invariably described the role of midwives as leaders in work to increase access. They conceptualized leadership as proactively identifying barriers to care, imagining and building collaborations to fill these barriers, resulting in changes to the provision of midwifery care and, sometimes, maternity care. The approach of CCC is one that sees the community as client and which often necessitates the ongoing development of unique expertise in order to provide appropriate clinical care.

Previous research has looked at how midwives experience caring for a subset of clients of low SES.^{21,22} There is some literature on why people of low SES or special populations do or do not choose midwifery care but little literature on what midwives do to increase the accessibility of their care for potential clients.²³ Our findings align with those of previous Canadian research, which found that informed choice, mobile care, funding of midwifery care for uninsured people, and midwives' advocacy work are important facilitators of access to care.^{24,25}

The global variation in midwifery models makes it difficult to make meaningful comparisons. However, international research endorses our findings of midwives as potential leaders in increasing access to care and thus improving maternal and neonatal outcomes.²⁶⁻²⁹ Aspects of care enshrined in the Ontario midwifery model and, more specifically, features of CCC are repeatedly cited as effective ways to reduce barriers to care and improve maternal and neonatal outcomes.³⁰⁻³²

The term “community-centred care” is not yet well defined in the literature. However, there are commonalities between CCC and the defining characteristics of Indigenous Primary Health Care Systems [Indigenous health services by and for Indigenous people].³³ Indigenous Primary Health Care Systems [IPHS] are described by Harfield and colleagues as accessible and flexible services designed through community participation and having a culturally appropriate and skilled workforce, providing holistic health care that engages with the social determinants of health.³⁴ In response to harms caused by colonization and colonial health systems, the recognition of the value of Indigenous medicine, and an affirmation of the right to self-determination, Indigenous peoples have been and are at the forefront of the development of primary health care systems founded in their own needs, desires, priorities, and approaches to health.³⁴⁻³⁷ It is no coincidence that participants in this study from midwifery practices that centred the provision of care to Indigenous peoples described some of the most comprehensive and established models of CCC.

CCC also has strong overlap with an approach to care called “community-oriented primary care” [COPC]. Originating in pre-apartheid South Africa and most thoroughly adopted in Cuba,^{38,39} COPC is the integration of “primary care practice and public health for a defined community.”⁴⁰ It is an equitable, evidence-based, comprehensive, multidisciplinary approach to the provision of care that engages the community, makes use of its assets, and prioritizes and intervenes in health needs.⁴⁰ It is similar to IPHS and CCC in that it is an iterative, community-dependent process with no ready-made recipe and that looks different from context to context. As stated by Mullan and Epstein, “The idea of community is

the core element and the point of departure for the COPC process,” and “COPC is adept at identifying gaps in health status and intervening to reduce those gaps.”⁴¹ Both IPHS and COPC originate from a core aim of increasing access to care and have been shown to reduce disparities in health.^{32,33,38,41}

A strength of this study is the variety of contexts in which participants worked, including urban, rural, and remote midwifery practices, serving populations with varying levels of ethnic and economic diversity. Although we conducted interviews with only 13 midwives, our participants represent more than 10% of the 101 midwifery practices in Ontario. Although we achieved data saturation in our interviews, we were unable to interview some midwives who were doing innovative work, and not all communities in the province were represented in our sample. It is possible that we may have missed some useful or important ideas or approaches regarding improving access to midwifery care for people of low SES. An important limitation of our work is that our research team did not include any members who identify as Indigenous. We did not set out to explore issues related to Indigenous health care, but the unique and important contributions of Indigenous midwives arose spontaneously in our data. We share our interpretation of these findings with humility and with the recognition that we are not experts in the work of Indigenous midwives.

Implications for Policy, Practice, and Future Research

Participants in this study identified practical approaches that midwives striving to increase access to midwifery care can begin to implement at the practice level almost immediately. This includes, but is not limited to, the following: building networks with community health and social service organizations as a means of increasing referrals and enhancing the visibility of the profession; reserving caseload for people who seek midwifery care late in pregnancy; prioritizing the intake of clients of low SES; creatively using practice resources to decrease barriers to care; and providing mobile care for people who have difficulty getting to a clinic.

Participants who take a CCC approach to their work highlighted the importance of, and potential for, midwives to step up and take a seat at the

policy table. While others have called for midwifery leadership in championing access to care in rural settings,⁴² our findings suggest that midwives have unique and valuable contributions to make in informing policy that will more broadly support equitable access to maternity care.

Future research could explore the concept of CCC in midwifery practice; further elaboration would be valuable in informing more-intensive approaches to improving access to care. It could also provide a framework to inform replication and scale-up of CCC models of practice. Evaluation of the impact of CCC models on access to prenatal care and maternal and newborn outcomes would also be valuable in directing policy.

Finally, much of what we have described here as innovation in access to care has long been practiced by Indigenous peoples.^{33,34} Both the Association of Ontario Midwives and the Canadian Association of Midwives have committed to the growth of Indigenous midwifery.^{43,44} Further, the Truth and Reconciliation Commission of Canada, in its *Calls to Action and Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls Calls for Justice*, implores Canadian health care providers and systems to rectify the past and ongoing injustices committed against Indigenous peoples.^{45,46} As Canadians, we are morally and legally obligated to support and respect Indigenous ways of knowing and healing. Further, we suggest that a commitment to the reparation of relations and the betterment of Canadian health care systems also compel Canadian and other settlers to learn from Indigenous peoples, to recognize Indigenous expertise, and to look to Indigenous peoples, past and present, as role models in creating accessible, inclusive health care systems.

CONCLUSION

Our research indicated that midwives and midwifery practices are working to increase access to care for clients of low SES within all dimensions of Levesque's access-to-care framework. There are many aspects of the existing model that can help increase access for clients of low SES. We have identified a practice of "community-centred care" to describe the most deliberate, innovative, and

intensive work being done by Ontario midwives to increase access to care. As the profession completes its 26th year of regulation in Ontario, our findings are a call for a celebration of midwives' contributions to the achieving of more-equitable access to midwifery care, and they give us pause to consider if and how midwives can most effectively move that mandate forward on a larger scale.

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