Toward Equity in Access to Midwifery: A Scan of Five Canadian Provinces

Vers un accès équitable à la pratique sage-femme : Survol de la situation dans cinq provinces canadiennes

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Abstract

This research project was created to support equitable access to midwifery care for the diverse populations of Saskatchewan women. Given the ongoing implementation and expansion of midwifery across diverse mixes of rural, urban, and aboriginal communities in the health regions of the province, we asked: How can midwifery care be implemented in an equitable and accessible way in Saskatchewan? The first phase of this research explored experiences with midwifery implementation around issues of accessibility through an environmental scan of five Canadian provinces (British Columbia, Manitoba, Ontario, Northwest Territories, and Nova Scotia). By analyzing policy and regulatory documents together with primary data generated through key informant interviews, we discovered an interesting compendium of provincial activities and policies in support of equity to access midwifery. We also identified several important areas in need of strengthening. In this article, we present a brief description of the best practices identified by each province, followed by an exploratory analysis of key thematic issues that are significant in creating equitable access to the full scope of midwifery care. These included funding models, interprofessional relationships, choice of birthplace and second attendants, risk designation, geographic dispersal, community integration, and midwifery human resources.

Keywords

midwifery, midwives, health services accessibility, and delivery of healthcare

This article has been peer reviewed.

Résumé

Ce projet de recherche avait pour but de découvrir la meilleure façon de faire en sorte qu'un accès équitable aux soins relevant de la pratique sage-femme soit offert aux diverses populations de femmes de la Saskatchewan. Compte tenu de la mise en œuvre et de l'expansion continues de la pratique sage-femme dans une gamme diversifiée de communautés rurales, urbaines et autochtones au sein des régions sanitaires de la province, nous avons posé la question suivante : Comment les soins relevant de la pratique sage-femme peuvent-ils être mis en œuvre de façon équitable et accessible en Saskatchewan? La première phase de cette recherche s'est penchée sur les questions d'accessibilité entourant la mise en œuvre de la pratique sage-femme, et ce, par l'intermédiaire d'une analyse environnementale menée au sein de cinq provinces canadiennes (C.-B., Man., Ont., T.N.-O., N.-É.). Par l'analyse des documents traitant des politiques et des règlements, ainsi que par celle des données primaires obtenues au moyen d'entrevues menées auprès d'intervenants clés, nous avons découvert un recueil

intéressant d'activités et de politiques provinciales soutenant l'équité dans la mise en œuvre de la pratique sage-femme. Nous avons également identifié plusieurs domaines importants dans le cadre desquels un renforcement s'avère requis. Dans cet article, nous présentons une brève description des meilleures pratiques identifiées dans chacune des provinces, le tout étant suivi d'une analyse exploratoire des aspects thématiques clés qui comptent une importance significative dans la création d'un accès équitable à l'éventail complet des soins relevant de la pratique sage-femme (parmi ceux-ci, on trouve : les modèles de financement, les relations interprofessionnelles, le choix du lieu de naissance et des deuxièmes assistantes à la naissance, la désignation du risque, la répartition géographique, l'intégration communautaire et les ressources humaines dans le domaine de la pratique sage-femme).

Mots-clés

Pratique sage-femme, sages-femmes, accessibilité des services de santé, prestation des soins de santé

Cet article a été évalué par des pairs.

INTRODUCTION

Canada's maternity care environment is burdened by problems that include a high attrition rate for physicians, difficulty in attracting new practitioners because of demanding lifestyle issues, practitioners' litigation fears, and payment models.[1–3] Rural, aboriginal, remote, and northern communities are particularly affected by practitioner shortages,[2,4,5] and many studies have illustrated the negative effects of the concomitant policies of evacuation[6,7] and rural facility closure[3,4] that force women to leave their home communities to give birth. Women who have a low income, are periodically homeless, suffer from mental illness, or have addictions suffer additional consequences due to their greater maternity care needs.[3,8,9] Aboriginal women face other barriers to accessing culturally specific maternity care,[6,10] as aboriginal practitioners are particularly scarce both on reserve and off.[11] Overall, Canadian maternity care is uneven in both quality of care and access to different providers for distinct groups of women.[1,2,6]

Like access to physician care, access to midwifery care is uneven. In Manitoba, British Columbia, Ontario, the Northwest Territories, and Quebec, studies have shown that there are various barriers to access to midwifery care and that these barriers are related to legislation and organization.[2,12–14] In British Columbia, for example, midwifery has struggled with insufficient funding for training opportunities, insufficient numbers of registered midwives, interprofessional tensions, and a lack of targeted governmental support.[10,15] Wait lists for midwifery services exist in the majority of midwifery practices in Canada, and calls for the expansion of midwifery by researchers,[15–17] midwifery professional associations,[6] and traditionally excluded groups of women[3,18] continue to rise.

The recent introduction of midwifery in several Saskatchewan health regions has presented challenges similar to those faced by other provinces. A team of midwives, researchers, and midwifery advocates undertook a two-part research project seeking to develop a strategy for an equitable rollout of midwifery services in the province. This article reports on the first phase of that study, which involved an environmental scan of policies, practices, and strategies that address questions of equitable access in five political regions where midwifery care is offered.

ACCESSIBILITY AND EQUITY: DEFINITIONS AND DETERMINANTS

Midwifery is usually considered a service within primary health care. Some of the tenets of primary health care definitions of accessibility are: (1) the opportunity or right to receive health care; (2) the ability of a person to receive health care services, including the availability

of personnel, supplies, and adequate funding; and (3) equitable access to culturally relevant services and resources.[19] Equity, in turn, is defined as the absence of systemic barriers and disparities.[20] Important, equity is not just about access to services but is also about the quality of care once services are accessed.[1,9,21] Equity and access to care are inextricably linked, as both are rooted in the social, economic, and political contexts of the system in which service is delivered.[20,22,23]

As noted above, studies have shown that various determinants to equitable access to midwifery care in Canada are related to legislation and organization,[2,12–14] scope, standards, and practice arrangements.[2,5] There are also social determinants of health that shape women's lives, such as ethnicity and language, geographic location, socio-economic status, age, education, and physical and mental abilities.[24,25] Studies of pregnancy and birth experiences of diverse groups of Canadians suggest that socio-economic status, culture, and geographic location have a profound impact in limiting equitable access to quality maternity care, including midwifery services.[5,21,26–29] Although geography and physical distance to services are important determinants of access,[1,2,9,26,30,31] social and cultural fit have proven to be exceptionally important for both aboriginal[5,6,32] and socially marginalized women.[2,5,9,21,26] Culturally appropriate services have been shown to have an impact both on birth outcomes and on the quality of birth experiences.

PURPOSE, METHODS, AND FRAMEWORK

While midwifery research in North America and internationally has offered ample evidence of efficacy, there is scant Canadian midwifery research on the determinants and effectiveness of implementation strategies for assuring equitable access. As Saskatchewan began to implement midwifery across various health regions, this research sought to inform this process by seeking answers to one overarching research question: how can midwifery care be implemented in an equitable and accessible way in Saskatchewan? To explore this question, research was divided into two phases.

We began by exploring midwifery implementation across Canada, specifically examining practices and policies aimed toward equitable access in five Canadian political jurisdictions. The specific objectives for the first phase of this research were to (1) identify legislative policies and organizational strategies that influence access to midwifery care for diverse populations of women, and (2) within those, identify and examine best practices for establishing equitable and accessible midwifery care.

The data gathering occurred throughout 2011 and focused on two main activities: (1) reviewing documents (including policy and regulatory documents) and (2) interviewing informant midwifery professionals and key policy-makers in British Columbia, Manitoba, Nova Scotia, the Northwest Territories, and Ontario. The policy documents relate to midwifery implementation and legislation and include regulatory documents, ethics statements, models of care, and statements of missions, values, and beliefs. We identified policy documents and key informants through a "snowballing" technique[33] wherein midwifery informants identified researchers and key policy actors (both from midwifery associations and from provincial governments) in each chosen jurisdiction. In turn, policy actors assisted in identifying what they considered to be significant documents. Important, there was significant variation in the kinds of documents reviewed, partially due to availability (Table 1).

The interview data were subject to qualitative analysis using NVivo software (QSR International, Burlington, MA), and the policy documents were subject to a documentary analysis that included identifying themes generated from the research questions, extensive thematic coding, and further analysis and classification within a modified version of the equity and access framework proposed by Gulliford et al., who suggested that equitable access can be assessed within three categories: (1) service availability; (2) utilization of services and barriers to access; and (3) relevance, effectiveness, and access.[34] For our analysis, "service availability" refers to the ability of health consumers to access services where and when they want. We analyzed the data from each province, specifically in reference to what service availability looked like for vulnerable populations. Under the category "utilization of services and barriers to access," we identified issues and factors that might prevent equitable access to midwifery services by vulnerable populations. As Gulliford et al. stated, a population may have access to services but, for various personal and organizational reasons, find it difficult to use them. The data available for this project were unsuitable for analysis using the third category put forth by Gulliford et al. (i.e., relevance, effectiveness, and

Table 1. *Documents Reviewed in Study, by Jurisdiction*

Ontario	British Columbia (BC)	Manitoba	Nova Scotia (NS)	North West Territories (NWT)
College of Midwives of Ontario: *Mission Statement*	College of Midwives of BC: *Midwives Regulation*	College of Midwives of Manitoba: *Role of the College of Midwives of Manitoba*	Midwifery Regulatory Council: *Bylaws*	Midwives Assoc. of NWT and Nunavut: *Code of Conduct*
College of Midwives of Ontario: *Bylaws*	College of Midwives of BC: *Model of Midwifery Practice*	College of Midwives of Manitoba: *Philosophy of Care*	Midwifery Regulatory Council: *Mission, Values*	Midwives Assoc. of NWT and Nunavut: *Practice Framework*
Assoc. of Ontario Midwives: *Diversity Statement*	College of Midwives of BC: *Ethics Statement*	College of Midwives of Manitoba: *Model of Care*	Midwifery Regulatory Council: *Midwifery Regulations*	Midwives Assoc. of NWT and Nunavut: *Standards of Practice*
Assoc. of Ontario Midwives: *Mission, Vision and Values*	College of Midwives of BC: *Bylaws*	College of Midwives of Manitoba: *Core Competencies*	Midwifery Regulatory Council: *Philosophy of Midwifery Care*	Midwives Assoc. of NWT and Nunavut: *Continuing Competency*
Ontario Midwife (newsletter) *Summer 2010;3(2)*	College of Midwives of BC: *Proposed Bylaw Changes*	College of Midwives of Manitoba: *Ethics*	Midwifery Regulatory Council: *Scope of Practice*	Midwifery Profession Act: *Midwifery Profession General Regulations*
	College of Midwives of BC: *Philosophy of Care*	College of Midwives of Manitoba: *Midwifery Act*	Midwifery Regulatory Council: *Code of Ethics*	
		College of Midwives of Manitoba: *Bylaws*	*Report of External Assessment Team (Evaluation)*	
		College of Midwives of Manitoba: *About*	NS Dept. of Health: *Implementation Evaluation*	
			Midwifery Coalition of NS: *Response to Evaluation*	

Assoc. = Association

access); greater clarity in this area remains a goal of future research.

It is important to note that the environmental scan was not intended to be comprehensive, but rather was intended to increase our understanding of how other jurisdictions have experienced implementation and to identify best practices. As a result, nuances may have been missed and documents overlooked, or other accidental omissions may have occurred. Given the exploratory nature of the research, such errors are acknowledged. Overall, despite vastly different implementation practices, policy frameworks, and institutional supports in each province, common organizational factors affect equitable access to midwifery.

RESULTS

Provincial Snapshots and Interprovincial Comparisons

This section highlights some of the best practices for ensuring equitable access to midwifery services that were identified in each of the five political jurisdictions studied. It is neither comprehensive nor representative of each region; rather, it presents a collection of promising practices and policies that were noted in our data.

In Ontario, we encountered an impressive variety of ways in which equitable access for vulnerable groups is promoted through regulatory and policy documents, promotional materials, and health care supports. For example, Ontario midwives support the immigrant population and improve its access by (1) providing translations of web and printed material and visually representing multiple ethnic groups on promotional materials, (2) providing midwifery care to recent immigrants who do not yet have provincial health care coverage, and (3) promoting a "diversity statement" within the Association of Ontario Midwives.

In some Northwest Territories communities, midwives are the only maternity care providers available and provide care to all women in these communities. According to key informants, this highly equitable yet anomalous situation is a product of the geographic isolation of the health authority (which is in a contained region) and excellent interprovider relationships. The isolation and small number of health human resources also contribute to a much wider scope of practice and extended roles for midwives in the communities in which they reside. Practices and policies that have influenced this positive and equitable state of affairs include the following:

- Development of trusting interprofessional relationships
- Community engagement and extended roles for midwives in communities
- Health authority support for the full (and extended) scope of practice for midwives

In Nova Scotia, midwifery was only a few years into implementation at the time of this study, yet principles of equity were highly visible in all policy and regulatory documents, and a platform of equity was quite evident. The small number of midwives and uneven implementation strategies (which included three different pilot projects) was contributing to difficulties in the enactment of such principles at the time of the study. Still, Nova Scotia instituted a fundamental building block for equity.

In contrast to Nova Scotia and in comparison with other provinces, British Columbia Ministry of Health documents are relatively unclear regarding equity principles; the policy documents that were reviewed revealed few to no references to tenets of equity. Nonetheless, several midwifery practices employed innovative and notable strategies to identify and target clients from vulnerable groups. The best practices within those arrangements included the following:

- Use of community development principles of outreach and engagement to identify clients in need
- Innovative practice arrangements (such as the South Community Birth Project) that target and prioritize vulnerable populations

In Manitoba, we found a plethora of ways in which the province, the midwifery association, and regulatory bodies are promoting equitable access. Although not all experiments were equally successful, the following were among the best practices:

- Legislated supports and explicit intentions to integrate aboriginal midwifery and provide service to aboriginal populations
- Existence of standing committees on issues related to midwifery care for aboriginal women
- Extensive community consultation with underserved populations prior to and in the early years of implementation
- Establishment of a target (50%) for attention to priority populations

A number of these best practices, policies, and strategies were shared by more than one province. Our analysis of factors that seem to matter across provinces showed that sometimes those factors exist together with

differing opinions about them. The following section outlines some of those crosscutting themes, discusses why the informants thought they mattered to equity, and gives a sample of the views presented.

Crosscutting Themes and Observations

In the thematic analysis of the data, six organizational and policy factors appeared to be considered most significant in influencing equitable access to the full scope of midwifery care: flexibility of the funding models, the state of interprofessional relationships, the choice of birthplace and the availability of second attendants, geographic dispersal, risk designations, and midwives' approach to community integration and outreach. Overarching concerns included those about midwifery shortages and related human resource issues (recruitment, retention, education, and certification).

Funding Models

Provincial and territorial midwifery programs across Canada vary greatly in their funding structures. In general, provincial midwifery programs can be classified as salaried or as fee for course of care. Key informants identified different funding models as being particularly helpful or detrimental to equitable midwifery care, yet there was no consensus on which model promotes equity better.

In Ontario, which boasts a well-established and comparatively extensive program, midwives are remunerated on the basis of a unique course-of-care model. Due to a concentrated effort to address issues of equity in midwifery services, the province provides additional funding to midwifery practices working with priority populations. Manitoba has also addressed equity issues in its funding model; midwives are salaried workers, which allows them to provide flexible services to diverse populations that may require greater time commitments. As one key informant operating in Manitoba noted,

> *It was felt that the fee-for-service model, or the fee for course of care, would not support vulnerable populations who might come late for care, who might have higher social risks and require more hours of care, and we wanted the midwife [to] be able to work with the range of the population.*

These models contrast with that of British Columbia, where midwives are paid on a fee-for-course-of-care model, generally through private practices. The British Columbia Ministry of Health provides no additional support to practices that target marginalized populations. One key informant reasoned that,

> *If you choose to be paid that way, it kind of swings around just as it is for physicians, on fee for service. Some patients take more time than others.*

The free-market principles of this model offer their own advantages, preventing geographic limitations on the establishment of new midwifery practices and ensuring a degree of autonomy not necessarily experienced in the salaried model—that is, midwives have greater flexibility and fewer bureaucratic barriers to establishing midwifery practices in diverse geographic settings.

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Although there was universal agreement on the importance of funding models in affecting equity, there was disagreement over which funding model better enables midwives to care for diverse populations. To our knowledge, there is no clear evidence that definitively supports one over the other.

Interprofessional Relationships

The document analysis in this study reflects midwives' deep commitment to interprofessional collaboration and collaborative care. Nova Scotia's document on midwives' scope of practice, for example, specifies that a midwife: "recognizes and respects the unique and overlapping scopes of practice of other members of the team; establishes collaborative relationships and networks with other health professionals and the community; [and] acts as a role model and mentor to midwifery colleagues and other healthcare providers within the team." These sentiments were echoed in the guidelines of other provinces, often in multiple areas.

While various practice guidelines clearly elaborate on inter-professional aims, the integration of midwives into primary health care settings has been almost uniformly difficult. Key informants stated that other health

professionals (i.e., nurses and physicians) have difficulty grasping the scope of care provided by midwives. Midwives sometimes encounter challenges based on pre-existing arrangements, as noted by one Nova Scotia midwife, who argued that:

> *Culturally, one of the things that is quite predominant in the health care system and in other projects is the very established hierarchy.*

Even in the NWT, where interprofessional relationships are reportedly good, midwives described their entry into the health care system as being, in the words of one,

> *[It's] an adjustment, you know, because it meant some other provider would relinquish some aspects of care and coming to understanding that the new model was going to be, perhaps, an improvement in terms on the care women would receive.*

Ongoing interprofessional tensions influence the provision of equitable midwifery services in both obvious and more diffuse ways. For example, hospital privileges can be granted, blocked, or revoked, effectively hindering the emergence of certain forms of practice and affecting access for certain populations of women. Examples of ongoing tensions were plentiful, but midwives also noted strategies for overcoming them.

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Key informants from the NWT, BC, and Ontario argued that the process of integrating midwives into the primary health care system requires ongoing efforts on the part of midwives to educate other health professionals about the role of midwives and the benefits—for all parties—stemming from their participation in maternity care. As one midwife in BC described her struggles in this area:

> *It has been ongoing work to ensure that outreach nurses know about our services, and downtown health clinics know about our services, and the Friendship Centre knows about our services, and the public health nurses know about our services, and so there was quite a lot of work, I guess, to ensure that those who might be making the referrals knew about us.*

Less obvious in the documents we reviewed were health system–directed efforts to "smooth" the integration of midwives into pre-existing teams.

Choice of Birthplace and Second Attendants

A key tenet of midwifery care is choice of birthplace. Yet—depending on the size, scope, and type of midwifery or collaborative care available in a particular region—choice of birthplace is not always available to women. Evidence from our key informant interviews indicates that larger midwifery practices in urban centres are more likely to offer women the choice of birthplace, whereas provinces with newly established midwifery programs (and rural regions in many provinces) are unable to do so because of regulatory complexities or a paucity of midwives and other qualified human health resources. Promising exceptions exist; one informant noted that a small number of physicians in certain rural regions of Manitoba actively serve as second attendants at home births.

Informants also identified incompatibilities between funding models of midwives and other health professionals as barriers to home birth. Midwives in Canada are paid on either a course-of-care or salary model, with irregular and sometimes complex rules for compensating other health professionals serving as second attendants. An external assessment of the three midwifery programs recently established in Nova Scotia identified the lack of funding for second birth attendants as a major cause of fatigue for the two practicing midwives offering home births. At the time of the study, both midwives were required to attend each home birth, alternating as primary and secondary birth attendants. The Northwest Territories and Nunavut have addressed this issue by adding the role of second birth attendant to the job description of nurses, a policy that also provides liability insurance to nurses.

The regulatory issue of second birth attendants is often a murky one. For instance, one Manitoba informant asserted that regulations require the presence of a second birth attendant but do not specify the professional qualifications for the role:

> *We've always supported and left provisions—it doesn't say you can have a non-midwife second attendant but doesn't describe the second attendant. Our legislation and regulations do not require that the second attendant be a midwife or a nurse.*

Risk Designation

Our document analysis and key informant interviews reflected a complicated relationship between midwives, client risk designation, and scope of care. A number of the regulatory documents included in this analysis make specific reference to midwives' expertise in overseeing low-risk births. For example, the Mission, Vision and Values statement of the Association of Ontario Midwives states, "Midwives are experts in the provision of primary care for women anticipating normal, low risk pregnancy and birth." Similarly, the standards of practice document of the Midwives Association of the Northwest Territories and Nunavut delineates very clear circumstances under which midwives must either seek consultation with a physician or relinquish care altogether.

Risk designation is of significant relevance to midwives' ability to provide equitable care to vulnerable populations that may be classified as at higher risk for reasons such as geography or socio-economic status. In isolated regions in the Northwest Territories, there is some evidence that midwives have been very successful in providing care to both low- and high-risk women as a result of access to multidisciplinary teams via Telehealth, but this study provided few other examples of how midwives can influence the assignment of risk designations or their own scope of care to allow them to care for individuals who fall outside the "low risk" designation.

Geographic Dispersal

Lack of availability of human health resources in midwifery was consistently identified as a major limitation of both the discipline's growth in Canada and its ability to meet the growing demand for its services. Midwives interviewed for this study often spoke of having to refuse service to many clients as a result of chronically full caseloads. They also acknowledged that rural women are often the most underserved populations, since midwifery practices are frequently clustered in urban settings.

In response to an implementation evaluation of the Nova Scotia midwifery programs, the Midwifery Coalition of Nova Scotia released a report summarizing two dozen letters it received from women across the province regarding their desire for more extensive midwifery service availability in the province. In particular, rural respondents argued that they were being treated unfairly in being denied access to midwifery services. One woman wrote:

> *Please don't underserve rural women, Department of Health. We already have less access to health care services and have to travel much more than 30 km in many cases. If we have to come into the hospital anyway, why not have the choice of a midwife? Please make midwife care more accessible.*

The report blames "urban favouritism" for overlooking the maternal care needs of rural women.

Both Ontario and Manitoba have addressed this issue through policies that encourage midwives to practice in rural communities. In both provinces, funding for midwives is geographically bound, meaning that jobs are created only where there is a demonstrated need for services.

Community Integration

Both the policy documents and key informant interviews included in this study highlight the critical importance of community involvement in the implementation process and ongoing success of a midwifery program. The Midwifery Model of Practice in Manitoba document states, "Community input is fundamental to the development and evaluation of midwifery practice across all settings. Community participation must be structured into the midwifery system during the development and ongoing planning of midwifery services and education." One midwife practicing in Manitoba argued that the province's relative success in addressing the maternal and infant care needs of aboriginal women is due to early efforts to consult aboriginal women's groups during the program's implementation process.

The Midwifery Coalition of Nova Scotia report, created in response to an implementation evaluation of the province's midwifery program, stressed that consumers should be involved in every step of the planning and maintenance of the program to ensure its success. One consumer quoted in the report wrote:

> *We hope to be involved in shaping midwifery care implementation for the Valley because it is so important to us that the authenticity of midwifery care remain intact and the quality of care that we have previously received has a place within the new model.*

Key informants also demonstrated a commitment to community by engaging in outreach activities with local community groups, public health workers, and social

workers. These efforts were made to ensure that vulnerable populations were made aware of the services available to them.

Midwifery Human Resource Issues

An overarching and repeated theme we found in the data involved human resource issues such as recruitment, retention, education, and certification. The paucity of midwifery human resources exacerbates the challenges of integrating midwifery services into Canadian primary health care and, by extension, curbs the potential of many promising routes toward equitable access to midwifery services. The small number of midwives in most provinces and the resultant heavy caseloads make it difficult for midwives to engage in the extensive and ongoing lobbying needed to improve access. Without concentrated efforts in support of midwifery, particularly in the absence of strong community-driven advocacy and lobbying, neither interprofessional tensions nor policy-level issues (such as the absence of second attendants) can be addressed.

Human resource issues are unlikely to be addressed in the short term, given that Canada boasts a limited number of midwifery baccalaureate programs. These programs are not large enough to produce sufficient midwives, given the growing desire for midwifery services across the country. The difficulties faced by internationally educated midwives (IEMs) in gaining certification to practice in Canada further hinder efforts to address human resource shortages. IEMs in Ontario must complete the International Midwifery Pre-Registration Program at Ryerson University in Toronto; this is followed by a supervisory period that may last up to one year.[35] IEMs in British Columbia, Alberta, the Northwest Territories, Saskatchewan, and Quebec have access to the recently introduced Multi-Jurisdictional Midwifery Bridging Project, a seven-month program with online and clinical components. Bourgeault et al. assert that the costs associated with these programs pose a significant barrier to IEMs and thus affect the growth of midwifery human resources through certification.[35] Clearly, more educational opportunities are needed throughout Canada.

Lingering Questions and Future Research

There are limitations to this study that preclude broad-based conclusions on best practices for the equitable implementation of midwifery services. Sources of data were limited to readily available (usually web-based) documents and reports; hence, some official policy documents are not represented. The considerable variation of documentation related to bylaws, regulatory policies, statements of purpose, vision, values, or philosophy available in each province also prohibits truly fair comparisons. Additionally, although both the study participants and documents provided a broad background and examples of issues related to access for diverse women, they did not focus on specific issues related to specific groups of women or on geographic particularities. Hence, issues related to specific communities of women as well as to aboriginal midwifery remain important areas to examine in the future.

Notwithstanding these limitations, a number of intriguing insights and potentially useful approaches, strategies, practices, policies, and statements emerged from this research. The various midwifery programs in the five jurisdictions that this study examined provide a rich and varied source of data that have already been used for discussion with the Saskatoon Health Region, other health regions, and First Nations Health Facilities. Questions generated by this report have begun to mould the directions of our future efforts. Many more questions remain to be answered, including the following:

- Is there a correlation between the factors identified in this report (interprofessional relationships, second attendant availability, community integration, etc.) and greater overall equity in service provision?
- Does a greater emphasis on these factors result in a more diverse client base for Canadian midwives?

CONCLUSIONS

This study was an environmental scan of equitable access to midwifery as seen in the reviewed provinces and territories. While exploratory, the study illuminated a number of key factors influencing Canadian women's access to midwifery services and the extent to which geography and provincial policies mediate their access. We found that there is no single model of midwifery care that is best for all of Canada for addressing equity and access issues and that no single funding model is clearly more equitable than another. Each province or territory has therefore determined the best approach for itself, dependent on a variety of factors. Answering the many lingering questions this study has raised will require various kinds of additional comparative pan-Canadian research and will require client demographic and health

outcome data from both past midwifery clients and those who are on waiting lists. Future research might allow us to develop a much more comprehensive understanding of the relationship between midwifery policies and legislation and the sociodemographic characteristics of midwifery clients within and between provinces, allowing us to determine what "works" to foster equitable access.

The next steps, already taken, involve an ongoing analysis of Saskatchewan-based data on equitable implementation to date. We hope the second phase of this research will inform the development of strategies and policies to promote an equitable rollout of midwifery services together with a "road map" for assessing our efforts. Other provinces have helped guide our understanding of what is possible and advisable. Perhaps they will be able to learn from us in the future.

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College of Midwives of British Columbia

is seeking a Registrar and Executive Director

The College of Midwives of BC seeks a strategic and visionary individual to serve as Registrar and Executive Director and lead the College in fulfilling its legislated mandate under BC's Health Professions Act - to serve and protect the public interest by regulating the practice of midwifery - providing leadership in the spirit of our mission statement: *"We are dedicated to ensuring that women and their families receive a high standard of midwifery care."*

The Role

The Registrar and Executive Director provides strategic and operational leadership in the overall management of the College including strategic planning, financial management, overseeing matters related to legislation, regulation, standards, and policy development. The Registrar reports to the Board, advising and supporting the Board and its Committees on matters related to registration, inquiries and discipline, quality assurance and standards of practice. Internally the Registrar manages a talented staff collaboratively as an inclusive and supportive leader. Externally the Registrar maintains important relationships with government and provincial boards and agencies working on matters related to maternal newborn care in British Columbia, while effectively championing the College's mission, vision, and values.

The Ideal Candidate

The successful candidate will possess well-developed strategic leadership and management skills and have strong knowledge of legislation and health professional regulatory frameworks. Ideally she/he has senior leadership experience in Canadian health care, including familiarity with regulated midwifery and the midwifery profession in Canada. Strong communication and relationship building skills are required, as well as a proven track record working successfully with boards and committees, and experience working with government and external stakeholder groups and with strategic planning and organizational and financial management. Experience working as a Canadian registered midwife is a definite asset.

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