Excerpts from:
WRITTEN SUBMISSION
to Law Amendments Committee
regarding Bill No. 107 An Act Respecting Midwifery
November 20, 2006

By: Dr. Christine Saulnier and Marlo Shinyei from the Atlantic Centre of Excellence for Women's Health.

We are very pleased to have this opportunity to provide a written submission to the Law Amendments Committee regarding Bill 107 – An Act Respecting Midwifery. We want to commend the government for taking the first legal step to regulate and integrate midwives into the public health care system in Nova Scotia. We are very pleased with the legislation. We have three reasons for contributing this written submission: first, to demonstrate the depth and breadth of evidence in support of regulated and funded midwifery, and more specifically of home birth; second, to highlight why the current status of midwifery in the province of Nova Scotia is unsustainable for women and midwives; and third, to present our about the timing of its proclamation.

The evidence in support of regulated and funded midwifery

We feel it is very important to reiterate for the public record that the evidence is clear: midwifery offers high-quality, women-family-centred, community-based, collaborative care that has excellent outcomes for mothers and babies.

The Atlantic Centre of Excellence for Women's Health is dedicated to conducting policy-oriented research aimed at improving the health status of Canadian women by making the health system more aware of and responsive to women's health needs. By introducing this legislation, this government has demonstrated its willingness to do just that: be more responsive to the needs of women in this province who acutely experience the affects of the system everyday.

Current trends in maternity care are troublesome. More and more women travel long distances for their prenatal appointments and when they are in labour. Many women are faced with the stress of not knowing whether the closest hospital will be open -especially if they go into labour on the weekend. Many women do not have a regular family physician, and many family physicians no longer provide any obstetric care. This means when a woman suspects she might be pregnant, the first thing she has to contend with is finding a primary care provider. Regulated midwifery has helped to sustain very fragile maternity care services and even reintroduced them in some communities in Canada. For example, in Nunavik, northern Quebec, midwives have taken a leadership role in the provision of maternity care, working with physicians and nurses in the region to enable close to 92% of women to give birth in their own communities (Houd et al. 2003). And this, when the nearest institution with a c-section capacity is at least a 6-hour plane ride away.

The other troublesome part of maternity care is the rising intervention rates and trend toward making procedures and tests routine without the evidence-based to support such a move. I am not here to delve into specific interventions, but rather to point out that while these rates are rising, there is not a rise in efforts to support women to achieve natural birth. Natural birth - spontaneous vaginal births - is still the safest way for women to give birth and for a baby to be born. The decrease in the number of women who achieve this is worrying because each

intervention increases the chances that a woman will need more interventions-the cascade of interventions that repeatedly occurs. With a c-section rate above 30% in many areas of this province, this is something we should be concerned about. Alongside other initiatives, by moving forward with midwifery regulation and integration, this government could begin to address this situation. We know that women who give birth with the help of a midwife are much less likely to have a c-section and are much less likely to experience any interventions. In Ontario, for example, midwife assisted births in low risk pregnancies resulted in a 5.4% rate of operative vaginal deliveries as compared with14.41% for physician assisted births. Clients of midwives also have shorter postpartum hospital stays after a vaginal birth, and startlingly lower c-section rates (12.7% in 2002 versus 20.58% for the GP low risk cohort) (Ministry of Health and Long-Term Care, 2004). One other outcome I would like to highlight is the breasfeeding rate of women who are under the care of a midwife: the same study of midwifery in Ontario found 90.7% of women still breastfeeding at 6 weeks (compared to 71.5% of GP low risk cohort). The rates in Nova Scotia are much lower than this. There is evidence to support exclusive breastfeeding for the long term health of Nova Scotians - we know that breastfed babies have lower rates of obesity and diabetes for example - two chronic conditions that are particularly prevalent in Nova Scotia.

The evidence in support of home birth

We realize that not everyone is convinced by the evidence supporting midwifery especially when it comes to allowing midwives to assist women to give birth in their homes. We want to commend the government for including this possibility in the legislation. In anticipation of this opposition, it is useful to review the scientific evidence that supports this choice.

In the provinces where midwifery is regulated, all midwives are able to support eligible women in their choice to have a home birth. The numbers of women who choose home birth remain small – most women continue to give birth in hospital even in the provinces where midwifery is fully integrated into the healthcare system. However, for the women who choose to give birth in their homes, having this choice is extremely important, and is a pivotal part of the midwifery scope of practice.

In fact, according to their scope of practice (as defined in Nova Scotia's Bill 107 and in the Acts of other provinces), midwives are *required* to be available and skilled to attend home births. Because all midwifery regulators in Canada are signators to a Mutual Recognition Agreement (MRA) for labour mobility, for consistency across Canadian midwifery jurisdictions, it is imperative that Nova Scotia's Act Respecting Midwifery maintains Section 2 (i) as it is currently written describing the practice of midwifery "either within or outside of a hospital setting."

In addition to the issue of consistency across Canada, home birth should be included in the midwifery scope of practice as a matter of public safety. There will always be some pregnant women who choose to give birth in their own homes and midwives must be fully trained and equipped to attend them. For these women, their home is where they feel safest and consequently where their stress levels will be lowest and where they will be best supported to have a natural birth.

In the Netherlands, where the perinatal mortality rate is one of the lowest in the world, approximately 35% of all births take place at home. An integrated system of home birth services includes well-trained midwives who carry all necessary equipment, within a well-established system for emergency transport and the reception of home birth transfers in

hospital (BC Home Birth Statement).

The literature suggests that, under the circumstances listed below, the risks of home birth may be reduced as long as:

1. there are enforced criteria to determine who is a low risk candidate for home birth and who needs consultation or transfer prior to birth or during the birthing process;
2. there are clear guidelines and practice agreements guaranteeing smooth transition of care in the event of emergency; and,
3. transportation from home to hospital is not an impediment to timely care.

There are opponents who wrongly contend however that it is always necessary to have everything that a level 1 hospital has present at every birth. This would include the availability of blood and fresh-frozen plasma for transfusion; anaesthesia, radiology, ultrasound, continuous electronic fetal heart rate monitoring and laboratory services available on a 24-hour basis; a nursery; and other services that are not available in the home setting. There is no evidence to support this contention. In fact what is required for a safe delivery is access to adequate transportation for the small number of planned home births that will require emergency transfer to a hospital.

As stated earlier, every province that has regulated midwifery in this country has ensured that women have the choice to have a home birth and that midwives are skilled and trained to attend them. A review of the literature on the safety of home birth was undertaken for the government of Alberta prior to legislation and concluded that "with proper risk assessment, selection and care, low risk women may safely give birth at home."(Alberta Registrar of Health Disciplines, 1991). When the BC government decided to regulate midwifery it required all BC midwives to participate in the Home Birth Demonstration Project to determine how to best organize and administer home birth services in BC to ensure the safest possible care. The project's independent evaluation team conducted an analysis and evaluation of data from both midwife-attended home births and a comparison group of low-risk hospital births for 1998 and 1999. As a result of their evaluation they recommended that home birth services continue to be delivered by registered midwives to a well-screened low-risk population of BC women - in a province with a vaster geography than our own. Perhaps the strongest scientific evidence in support of home birth is that the largest study of home births attended by certified professional midwives found that there were far fewer interventions for planned home births than similar births for low risk patients in hospitals, with similar intrapartum and neonatal mortality (Johnson & Daviss, 2005). Regulated and funded midwifery must support home birth as a safe and viable option for women in Canada (Canadian Association of Midwives, Position Statement: Home Birth, 2001). Women have the right to make an informed choice about where they give birth.

Opponents of home birth do not have this kind of evidence base to back them up. Indeed, the only studies that have been uses to suggest that home births are unsafe are those that did not differentiate between planned and unplanned home birth or attendance by qualified versus unqualified attendants, and/or that do not clearly define appropriate inclusion criteria (American College of Nurse Midwives). In contrast, midwifery regulation in Canada has been informed by the evidence. Clear guidelines have been developed in each case to promote safe outcomes through appropriate client selection, attendance by a qualified provider, sound clinical judgment, and transfer to a receptive environment when necessary (American College of Nurse Midwives). All the evidence about regulated midwifery for planned home births tells us that these conditions are in place in Canada and that we can easily emulate them in our province.

The sustainability of midwifery

I would like now to return to my second point, which is how unsustainable the current situation for women and midwives in this province. Currently, a handful of midwives work in private practice either performing home births or serving as labour advocates in hospitals. Women pay for their services out of their pockets. The current situation has many implications not the least of which is that only a small number of women can access the service. Another implication is that women take unnecessary risks when they want to have a midwife as their care provider. I am not here speaking to the competence of the midwives who are currently practicing, but pointing out that women are having to assess credentials and figure out for themselves whether their midwife is a skilled provider. This function is best left to a mandated regulatory body.

As described above, the current lack of legislation presents a barrier for women who want to access the service, and as an apprentice-trained midwife who moved here from Alberta, Marlo Shinyei can attest to the fact that the lack of legislation is also a barrier for midwives who wish to practice in Nova Scotia. Although she pursued a career in midwifery here in Nova Scotia when I first arrived in 2003, it quickly became apparent that the lack of legislation made it impossible to do so. Ms. Shinyei uses the word impossible because despite the fact that there are practicing midwives in this province, she thinks that the passionate and dedicated women who have had the tenacity to maintain their midwifery practices in this province over the last several decades achieved the impossible.

We would like to support Bill 107 – An Act Respecting Midwifery – because it will eliminate one of the barriers to practicing and accessing midwifery in this province. However, we also want to make it clear that two additional barriers to the practice and access of midwifery exist – and these barriers must be addressed. These two issues are the need for public funding of the service, and the need for a midwifery education program. In order for the profession of midwifery to be successful and sustainable, Nova Scotia will need to develop an adequate mechanism for educating and training future midwives. A Bachelor of Midwifery is the standard educational program in Canada available in Quebec, Ontario, Manitoba (Aboriginal Midwifery Education Program) and BC. The Province of Manitoba did not have an education program for many years following legislation of the profession and still does not have one for nonaboriginal candidates. As a result there are insufficient numbers of practicing midwives to meet the demand for midwifery services.

Concerns about timing of proclamation

Now that we have addressed our first two points - publicly recording the evidence for midwifery and the unsustainability of the current practice environment - we would now like to turn to our specific concerns about the timing of proclamation and the date upon which this act will become law. We want to reiterate again that we support it coming into effect unless two conditions are met first:

1--Funding-We emphasize the need to make a public commitment to fund midwives. If midwifery is not publicly funded, the government will not achieve any of its objectives underlying the introduction of this Act. We realize that it is not standard practice to include stipulations about funding in the actual legislation. However, a public commitment is necessary. Without public funding the practice will not be sustainable; midwives will not be able to practice here and women will not be able to access their services.

2--Registration of Midwives- We emphasize the need to ensure that this legislation does not

receive Royal Assent and become law before midwives are duly registered and ready to practice. Midwives, who have practiced in this province under very stressful circumstances and without liability insurance - deserve to be reassured that they will not have to fear persecution should this bill be passed before they are legally able to practice.

In conclusion, we need to remember that childbirth is not a medical event. Most women can and do experience it without complications. It is a natural, normal life event that every woman and family has a right to experience within a context that respects cultural values, human dignity, and self-determination.

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Second Reading Debates

Bill No. 107 - Midwifery Act.

MR. SPEAKER: The honourable Minister of Health.

HON. CHRISTOPHER D'ENTREMONT: Mr. Speaker, I'm very pleased today to move this bill for second reading. Midwives are trained specialists who care for women throughout their pregnancy. They assist mothers and babies through low-risk births and, of course, through the following weeks, and they will help provide support to the health care system by working with family physicians and nurses and other primary health providers in delivering care to mums and families across Nova Scotia.

[3:45 p.m.]

Mr. Speaker, midwives in Nova Scotia are currently practising outside of a legislative mandate and are not integrated into the overall health care delivery system. We had them in the House yesterday at the introduction of this bill - and there are about 16 midwives practising across Nova Scotia of course outside this legislative mandate, and we did want to provide them with a piece of legislation and some regulations that they could work with within the health care delivery system. We've accepted recommendations from the primary maternity care working group to help legislate these midwives in Nova Scotia.

Pregnancy and childbirth are natural processes, and accessibility to primary maternity care is vital to healthy communities. Mr. Speaker, many of us have had the pleasure of having children - the guys say that's because I'm a guy, I'm sure women would probably say something a little different through their pregnancies - but I can say that I was there to provide a helping hand,

when I could, to my dear wife through the pregnancies of our two children. I can say that maybe some extra help, including a guidebook for children, probably would have come in handy too.

Providing the right health care services in communities across Nova Scotia is important, and we want to have health teams of professionals and providers work in communities supporting mums and families. We know that midwives can be key team players collaborating with team members, including family physicians and nurses, ensuring mums and families get timely access to maternity care. Adding midwives to our teams of health care professionals allows us to better meet the needs of mums and families across Nova Scotia. This Act will allow midwives to work to their full scope of their practice as they do in other provinces and territories across Canada where they are legislated. This Act will also ensure a consistent standard of care for all midwives working throughout Nova Scotia. Unlike other provinces and territories throughout Canada we've been able to include an option in this Act that allows midwives to work in research and policy development.