ARTICLE

Facilitating the Implementation of Midwifery Services: The Case of Montérégie, Quebec

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ABSTRACT

Objectives: This study analyzed midwifery services implementation in one region (Montérégie) of Quebec. The objectives were to determine whether services were implemented as planned and to identify factors that facilitated or impeded implementation. The aspects studied included organizational components; types of midwifery services provided; levels of interprofessional collaboration among midwives, physicians, nurses, and community organizations; and training activities offered to perinatal care providers and students.

Methods: This is a qualitative case study of one implementation experience and is based on three data sources: individual interviews and focus groups; policy and administrative documents related to the implementation; and a database compiled by the midwives on services provided. Data were collected and analyzed between July 2012 and March 2013.

Results: The implementation of midwifery services in Montérégie was successful and largely accomplished as planned. Its success was due to the alignment of two categories of favourable conditions. The first category consisted of appropriate policies and regulations, demand from service users, and support from front-line professionals. The second category concerned the implementation process and governance and included effective governance structures and mechanisms, dedicated resources, and leadership from champions.

Conclusion: The lessons from this study can be usefully applied to the introduction of midwifery services in jurisdictions where they are not currently present. They may also inform the implementation of other publicly funded health services or professionals in other jurisdictions.

KEYWORDS

midwifery, perinatal care, implementation factors, delivery of health care, integrated

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ARTICLE

Comment réussir l'implantation de services de sage-femme? L'expérience de la Montérégie au Québec

par by Nathalie Clavel, MSc, PhD(c); Caroline Paquet, MSc, PhD(c); and Régis Blais, PhD

RÉSUMÉ

Objectifs : Cette étude a analysé l'implantation des services de sages-femmes en Montérégie (Québec). Les objectifs étaient de déterminer si les services ont été mis en œuvre comme prévu et identifier les facteurs qui ont facilité ou entravé leur implantation. Les éléments étudiés comprenaient: les composantes organisationnelles; les types de services de sages-femmes prévus; le niveau de collaboration interprofessionnelle entre les sages-femmes et les autres professionnels en périnatalité; les activités de formation offertes aux professionnels et aux étudiants en périnatalité.

Méthodes : Cette étude de cas qualitative repose sur trois sources de données: entretiens individuels et groupes de discussion, documents légaux et administratifs et une base de données compilées par les sages-femmes sur les services fournis. Les données ont été recueillies et analysées entre Juillet 2012 et Mars 2013.

Résultats: L'implantation des services de sages-femmes a été accomplie en grande partie comme prévu. Ce succès s'explique par l'alignement de deux types de conditions favorables. Le contexte d'implantation constitue le premier type de conditions : politiques et règlements appuyant la pratique sage-femme, forte demande des femmes, soutien des professionnels concernés par l'implantation des services. Le processus d'implantation et la gouvernance constituent la seconde catégorie de conditions : structures et mécanismes efficaces de gouvernance, allocation de ressources et leadership exercé par un ensemble de professionnels.

Conclusion : Les leçons tirées de cette étude peuvent être appliquées à l'introduction de services de sages-femmes dans d'autres régions du Québec et du Canada où ces services ne sont pas implantés.

MOTS CLÉS

pratique sage-femme, soins et services périnataux, conditions d'implantation, intégration des soins et services.

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INTRODUCTION

Many studies have shown that, compared to services provided by physicians, services offered by midwives are associated with lower rates of obstetric interventions (i.e., cesarean section, labour induction, spinal anaesthesia, and episiotomy), higher rates of maternal satisfaction, and similar perinatal mortality rates.[1–4]

Despite this long-established evidence, Canada was one of the last industrialized countries to legalize the profession of midwife in the 1990s. Midwifery practice was first regulated in Ontario (1993), then in British Columbia (1998), Alberta (1998), and Quebec (1999). Other provinces and territories legalized midwifery practice in the 2000s. Manitoba (2000), the Northwest Territories (2005), Saskatchewan (2008), Nova Scotia (2009), New Brunswick (2010), and Nunavut (2010) legalized midwifery practice, whereas Prince Edward Island, Newfoundland and Labrador, and Yukon Territory have yet to do so.[5] Even in provinces in which the profession is officially recognized, midwifery services are not offered everywhere. For example, in Nova Scotia, midwifery practice is legally limited to three hospital sites in three out of nine health districts.[6,7] Similarly, in Quebec, midwifery services are available in only 13 of 95 local health areas and in only one northern territory (Nunavik).[8,9] Although Quebec's perinatal policy recently supported the implementation of additional midwifery services throughout the province,[10] many local health areas have not yet set up a midwifery practice.

Quebec's perinatal policy envisions the implementation of midwifery services in all regions.

This uneven coverage, both in Quebec and across Canada, raises the question of why some provinces, regions, and local health jurisdictions have successfully implemented midwifery services, whereas others have encountered opposition or difficulties. Indeed, little is known about the factors that impede the implementation of midwifery services or—more important—the factors that contribute to the successful implementation of such services. Most research on midwifery implementation in Canada has focused on factors that influence the legalization of the profession itself and more specifically on the political processes and forces leading to this legalization.[11–14]

In the field of health care in general, there is an extensive literature on factors that facilitate the implementation of new services.[15–18] These factors can be classified into two broad groups. The first group refers to health care innovation or new services, a supportive implementation context being an important condition for innovation. Three types of facilitating conditions for innovation have been identified: appropriate policies and regulations, demand from service users, and support from front-line professionals.[15,17] The second group refers to the processes involved in successful implementation, including governance strategies, mechanisms and structures supporting the innovation,[16,19] dedicated resources,[15,17] and leadership from champions.[15,16,20,21]

OBJECTIVES

The purpose of this study was to analyze the implementation of midwifery services in Montérégie, a region of Quebec, and more specifically the local health area covered by the Centre de santé et de services sociaux Haut-Richelieu-Rouville, one of the region's health and social services centres (CSSSs). The study's objectives were to determine whether these services were put into effect as planned and to identify factors that facilitated or impeded their implementation. The study examined organizational components; types of midwifery services offered; levels of collaboration between midwives, physicians, nurses, and community organizations; and training activities offered by midwives to perinatal care providers and students.

OVERVIEW OF MIDWIFERY SERVICES IN QUEBEC

Midwifery services were legalized in Quebec in 1999[22] following positive results from the evaluation of midwifery pilot projects put into effect in the early 1990s.[23] At the time of legalization, seven birthing centres offered midwifery services; since then, new birthing centres and services have opened. Even so, 15 years after the legalization of midwifery, only 13 of 95 local health areas and one northern territory offer midwifery services. All 13 CSSSs provide perinatal midwifery services and the option of birth at home; 10 are at birthing centres, and 10 also offer hospital birth. However, Quebec's perinatal policy envisions the implementation of midwifery services in all regions.[10]

Regions are divided into local health areas. In each area, most publicly funded health services have been merged into a CSSS, which coordinates and oversees the activities of local community health centres (CLSCs), other health

facilities, and usually at least one hospital. Montérégie, the region south of Montreal, is where one in five births in the province of Quebec occur and has the second highest number of births annually, after the region of Montreal. In Montérégie, there are 11 CSSSs serving approximately 1.5 million people.[24] Until 2011, there were no midwifery services in Montérégie despite a fast-growing population and a high demand for maternity services. In 2011, the Agence de la santé et des services sociaux de la Montérégie, the regional health agency of Montérégie, decided to put into effect midwifery services within one of its CSSSs (Haut-Richelieu-Rouville), offering health services to a population of 150,000. This provided the opportunity to study the implementation of midwifery services and to draw lessons for other jurisdictions that were considering setting up such services.

METHODS

This study was a qualitative implementation case study[25] based on three sources of data. The first and main source consisted of individual semistructured interviews (n = 12) and focus groups (n = 3) with midwives, physicians, nurses, and managers involved in putting midwifery services into effect in Montérégie. Participants were selected following snowball sampling. First, we contacted and interviewed a key informant (the project manager for the implementation of midwifery services), who then directed us to other key persons to be interviewed, and so on. All interviews were recorded and transcribed and then coded with NVivo 9 software. Then we performed a thematic analysis to assess the level of implementation of the different midwifery service components and to identify the factors facilitating and impeding the implementation of those components.

The second data source consisted of policy and administrative documents related to putting midwifery services into effect. The documents included plans and reference frameworks, agreements with obstetric services at hospitals and with emergency transportation services, minutes of the various implementation committees' meetings, and various other working documents. These documents provided a better understanding of the structures, organizational components, and processes of implementation.

The third data source was a database (compiled by the midwives) on the provided services, containing information on the number of women who requested these services, the number of follow-ups by midwives, and the distribution of births by place of birth during the implementation phase (September 2011 to March 2013). Data were collected between July 2012 and March 2013. The data from the three sources were analyzed and aggregated in accordance with the research objectives.

The study received approval from the University of Montreal's Health Research Ethics Committee.

RESULTS

Implemented Services Compared to Planned Services

We compared what was planned to what was actually implemented in terms of four aspects of midwifery services: organizational components, types of services, levels of interprofessional collaboration, and training activities offered by midwives to perinatal care providers and students. The main organizational components of midwifery services were implemented as planned. First, a strategic regional advisory committee composed of representatives of different professions in perinatal care (midwives, nurses, family physicians, obstetricians, managers) was set up. This committee conducted a year-long consultation of stakeholders (physicians, nurses, managers, community organizations, etc.) in Montérégie that led to a consensus on the value of implementing midwifery services in the region. On the basis of several criteria, the committee identified the local health area served by the CSSS of Haut-Richelieu-Rouville (CSSS-HRR) as the most appropriate area in which to put these new services into effect, then developed the main procedures to plan and implement the services. The committees' activities included developing a regional plan for the deployment of midwifery services in Montérégie and a framework for the functioning of those services and future such services in the other CSSSs. The committee also drew up several regional agreements to set standards and create mechanisms for collaboration and continuity of care between midwives and other perinatal care providers, including an agreement with emergency transport services. A model for regional agreements on medical consultations and transfers from midwives to obstetricians was also developed.

On the basis of the regional strategic advisory committee's recommendations, three local committees were set up to plan the integration of midwifery services into the existing perinatal care services offered by the CSSS-HRR. The first was a programming committee whose role was to ensure that midwifery services were implemented and linked with the perinatal services that were already offered in the CLSCs. The second was a clinical committee mandated to adapt the strategic committee's model

agreement on medical consultations and transfers and to apply it to the obstetric services of the two local hospitals. The third committee was in charge of the technical aspects of implementation; it planned and monitored the construction of a birth centre and ensured that the centre's location and set-up met the relevant patient safety criteria.

For the midwifery service of the CSSS-HRR, six midwives were hired (four full-time midwives and two part-time midwives). In accordance with the law regulating midwifery practice in Quebec, these midwives offered a full range of perinatal services for low-risk pregnancies: prenatal consultations in the birth centre; births at the birth centre, at home, and in hospital; and postnatal care for up to six weeks at the birth centre. As planned, midwifery services were offered to both vulnerable (n = 2) and nonvulnerable women (n = 190) living in the CSSS-HRR area. However, very few vulnerable women (i.e., pregnant women under 20 years of age and pregnant women living in poverty) used midwifery services. Collaboration varied greatly between midwives and other perinatal care professionals but was very good between midwives and hospital obstetric professionals (nurses and obstetricians). Respondents felt that the agreements on medical consultations and transfers from midwives to hospital obstetric teams were effective in ensuring coordination and continuity of care. However, in cases of hospital birth after a medical transfer, even though midwives' presence was encouraged by the agreements between obstetricians and midwives, the midwives did not always accompany their clients, for reasons that included fatigue after hours spent assisting the client, lack of time, and (sometimes) a feeling of unease in the hospital setting.

Collaboration between midwives and perinatal nurses working in CLSCs was initiated through a series of meetings that respondents viewed as positive. This collaboration centred around midwives' clients' access to perinatal services such as breastfeeding clinics and baby clinics offered in CLSCs. In the follow-up of vulnerable women and their babies, close collaboration also developed between midwives and the interdisciplinary CLSC perinatal teams (composed of nurses and other health care providers such as nutritionists, psychologists, and social workers). However, although the planning committees hoped to avoid duplication of perinatal services, there was no collaboration between nurses and midwives in the follow-up of nonvulnerable women. Midwives provided a full set of perinatal services, which overlapped with what nurses offered.

Because of time constraints, no collaboration was established between midwives and community organizations offering social services for vulnerable women and children, even though this had been proposed by the programming committee.

Finally, under the supervision of two midwives, two midwifery students completed their internships in the birth centre. However, because of the time required to implement midwifery services and the priority given to consolidating the midwives' team, the plan for midwives to provide training to obstetricians, medical residents, and other perinatal professionals was not carried out.

Factors Facilitating the Implementation of Midwifery Services

Because the implementation of midwifery services in Montérégie was successful, we essentially identified only facilitating factors and no significant impeding factors. The success was due to the alignment of various conditions and facilitating factors, which we divided into two groups related to the context and process of implementation.

Certain key factors contributed to the successful implementation of the first midwifery services in Montérégie. At the local level (region and local health area, [i.e., CSSS]), there was a high and growing demand among women and families for midwifery services, along with support from several key front-line perinatal professionals, including obstetricians. Indeed, two major facilitating factors were (1) the activism of a regional citizens' group (Mouvement Maison de Naissance en Montérégie) advocating the creation of midwifery services and (2) the support of managers and clinicians within the CSSS. At the government level, the perinatal policy supported the development of midwifery services across the province. This policy upheld midwives' key role in perinatal services, particularly in a context of physician shortages.

With regard to the implementation process, the facilitating factors were related to governance (strategies, mechanisms, and structures), dedicated financial and human resources, and leadership from champions. In terms of governance, the one-year consultation prior to services being brought into effect was a key facilitating strategy because it produced a general consensus on the value of introducing midwifery practice and allowed all perinatal care professionals to be involved in the decision to deploy midwifery services. Dedicated governance structures played a key role in planning and monitoring the implementation of all aspects of midwifery services. All three implementation committees (programming, clinical, and technical)

recommended integrating midwifery services into hospital obstetrics teams and CLSCs and also supported the technical aspects of setting up the birth centre.

The full funding of services by the Ministry of Health, which initially consented to cover only 50% of the costs, was another facilitating factor, as was the support of a CSSS-associated private health care foundation that funded the construction of the birth centre. The expertise of designated managers and coordinators at both the regional and local levels also played an important role in midwifery services' deployment, functioning, and integration within existing local perinatal services. The Agence de la santé et des services sociaux de la Montérégie (ASSSM) specifically recruited a full-time project manager midwife for a one-year position. This expert consultant advised the three departments of the ASSSM (medical, health and social services, and public health) that were involved in implementing the medical, health and social, and public health services that represent the expertise required for the integration of midwifery services.

Leadership from both medical and managerial champions was another major facilitating factor. Essentially, the head of obstetric services at the main hospital convinced obstetricians of the value of introducing midwifery practice and of collaborating with midwives.

DISCUSSION

Key Factors for the Successful Implementation of Midwifery Services

This study showed that the successful implementation of midwifery services in Montérégie was due to two favourable factors: the implementation context and the implementation process and governance.

From a general perspective, our findings are consistent with the literature on factors that influence the implementation of new services in health care settings. The supportive implementation context was an important condition for innovation. We observed three main favourable factors in our study: appropriate policies and regulations, demand from service users, and support from front-line professionals.[15,17] The implementation of midwifery services also benefited from favourable environments at both local and higher levels.[15] Finally, dedicated resources,[15,17] leadership from champions (especially from the heads of obstetric services),[15,16,20,21] and governance mechanisms and structures supporting the innovation[16,19] were also key factors.

These findings can be compared to the contextual factors that either facilitated or impeded midwifery pilot projects in Quebec in the 1990s. First, the government at that time demonstrated political support and engagement by fully funding the pilot projects as defined in the Act respecting the practice of midwifery within the framework of pilot projects.[26] Second, several health care organizations showed interest in setting up midwifery services.[3,26] Third, there was a high demand from organized women's groups advocating the right to receive holistic care from pregnancy to birth. However, the unwillingness of some maternity care providers (especially members of physicians' associations) was a major impediment, prompting the government to pilot-test midwifery practice instead of directly recognizing the profession.[3,12,26] The introduction of midwifery services raised sensitive issues around sharing professional territories and defining the respective roles of the various perinatal care providers.[26,27] In the Quebec pilot projects, the relative weakness of governance mechanisms and structures was partially responsible for the poor integration of midwives into the perinatal health system. Lack of coordination between the new settings (midwife-staffed birth centres) and the conventional perinatal settings resulted in limited opportunities for midwives to interact and collaborate with other perinatal providers (i.e., physicians and nurses).[26]

> Agreements on medical consultations and transfers from midwives to hospital obstetric teams were effective in ensuring coordination and continuity of care.

The pilot projects and the Montérégie experience highlight the importance of clear coordination and collaboration agreements established through effective governance structures and mechanisms. Effective coordination requires a clear definition of each profession's responsibilities,[26] including referral procedures (i.e., medical transfers and consultations). Successful midwifery implementation and governance also require that all relevant stakeholders be engaged through ongoing consultations.[3,26] In the pilot projects, midwifery services were successfully integrated only when all facilitating conditions were aligned,

in terms of both context and processes, with clearly spelled-out referral agreements and well-defined responsibilities of each profession. The experiences of the Montérégie and pilot projects have shown that all critical conditions have to be met for the successful implementation of midwifery services.

Implementation of Midwifery Services in Other Canadian Provinces: Facilitating and Impeding Factors

The successful implementation of midwifery services in Ontario indicated favourable contextual conditions, which included high demand and strong lobbying from women's groups and midwives' associations, the commitment of government, and an open attitude among physicians toward midwifery practice.[12,28] As mentioned by Vadeboncoeur et al. and Bourgeault, [12,28] this combination of key factors could explain why midwifery services were fully legalized earlier in Ontario (1994) than in Quebec (1999), even though Quebec was the first province to put midwifery services into effect.

The successful implementation of midwifery services in Ontario ...included high demand and strong lobbying from women's groups and midwives' associations, the commitment of government, and an open attitude among physicians toward midwifery practice.

In contrast, in Nova Scotia, restricted implementation of midwifery services has been reported, and the factors that impede full implementation have been examined.[29] The main limitations to implementation were at the political and organizational levels. At the political level, there was no strong formal government commitment to the integration of midwifery. At the organizational level, the impeding factors included (1) lack of clear objectives for implementation and integration; (2) delegation of implementation to local bodies or institutions, without coordinated and integrated actions from higher levels of governance (the government and the Department of Health and Wellness); (3) lack of leadership from local bodies that were responsible for implementation; and (4) lack of dedicated funding to local bodies.[29,30] These impeding factors stand in direct contrast to the facilitating factors we found in Montérégie.

Issues for the Long-Term Success of Midwifery Services

We identified four issues that can have an impact on the long-term integration of midwifery into existing perinatal care services and that can particularly affect interprofessional relationships.

First, situations in which midwives do not accompany their clients in cases of hospital birth after a medical transfer are an important impeding factor for the successful integration of midwifery, because such situations reduce the opportunities for collaboration with the hospital's obstetric professionals.

Second, lack of support among family physicians for midwifery also affects its long-term integration. This and the collaboration challenge could be addressed by joint training courses for obstetricians, medical residents, family physicians, and other perinatal professionals. Such joint programs could facilitate exchanges on practices and strengthen communication and collaboration.

Third, collaboration between perinatal nurses (within CLSCs) and midwives in regard to nonvulnerable women was difficult because of the overlap between midwives' full set of perinatal services and nurses' services. More thought should be given to the alignment of both practices and to ways of strengthening collaboration.

Fourth, because of the difficulty in reaching them, the number of vulnerable women served by midwives is limited. This issue might be addressed by strengthening the collaboration with community organizations that offer social services to vulnerable women and children.

Study Limitations

This study has two main limitations. First, the results are based on a single case study of one successful implementation rather than on a multiple case study. Some caution is advised in generalizing those results to other settings, since they could depend on the specific context of perinatal care in the studied Quebec region. Still, the similarities between our findings and the results of midwifery implementation in other contexts (e.g., Quebec pilot projects and other provinces' midwifery projects) or of

other health care innovations provide some validity to our conclusions.

Second, our respondents did not necessarily represent all views, because they participated voluntarily and had a rather positive opinion of the midwifery services' implementation, an opinion they perceived to strongly contrast with the opinions of certain other stakeholders. Indeed, they reported that the general practitioners (whom we did not interview) were generally not in favour of midwifery services or the birth centre and had decided not to collaborate with midwives.

CONCLUSION

The successful implementation of midwifery services in Montérégie was attributable to a favourable context and an effective implementation and governance process. The lessons drawn from this study can be useful for the introduction of midwifery services into jurisdictions that have none, and they can also inform the introduction of other professionals or publicly funded health services into other jurisdictions. For example, nurse practitioners and physician assistants are hardly present in many jurisdictions, including parts of Canada.[31] It is likely that putting these professionals' services into effect would require the same facilitating conditions as those found to be required for midwives' services.[32] Finally, it would be useful to systematically document and evaluate the facilitating conditions for midwifery services as well as for new publicly funded health services in order to better support their implementation.

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