



CHANGING CHILDBIRTH

in British Columbia

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changing-childbirth-in-british-columbia](http://www.birthplacelab.org/changing-childbirth-in-british-columbia)

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EXECUTIVE SUMMARY

Patient-centred care was described in the 2014 British Columbia Ministry of Health's strategic plan as a key priority for the provision of healthcare; yet very little is known about how women, especially disadvantaged women, experience maternity care in BC. In addition, since the inclusion of midwives, there have been limited opportunities for women to evaluate their experiences of maternity care or access to different models of care.

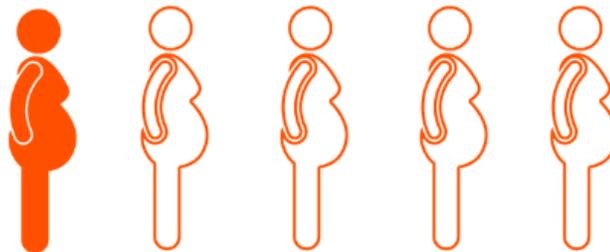
We used a community-led process to design the *Changing Childbirth in BC Study* (CCinBC) that examined experiences and outcomes of maternity care across diverse communities. This is the first provincial study to elicit person-centred outcomes of pregnancy and childbirth. Our team included consumers, researchers, clinician leaders and community partners. There was robust participation by a geographically and socioeconomically representative sample of women in this mixed methods study (survey n=4083, 20 focus groups). In the current report, we describe preferences, experiences, and outcomes of care among BC women with varied socio-demographic and obstetric characteristics.

Person-centred care values the preferences and cultures of patients, supports informed decision-making, and is linked to improved outcomes and reduced healthcare costs. By contrast, lack of involvement in decision-making and mistreatment during the course of pregnancy and birth can adversely impact postpartum mental health and parenting success. The CCinBC study resulted in the development and validation of two new patient-designed quality measures: the **Mothers Autonomy in Decision Making (MADM)** scale [1], and the **Mothers on Respect (MOR) index** [2]. The National Quality Forum awarded these tools the 2017 Innovation Prize for patient-centred health care measurement. MADM and MOR scores can indicate the level of autonomy and/or respect that women experience; both are described as important health outcomes in the global literature [3,4].

Below we summarize key findings and recommendations, flagged according to current priority areas for health system improvement: **effectiveness, accessibility, appropriateness, acceptability, safety, and efficiency**. Many of the key findings correspond to two or more priority areas.

KEY FINDINGS

- Having a provider who is a good match for what **the patient values and wants** was the most important factor when choosing a prenatal care provider. **ACCEPTABILITY**
- **One in five women struggled to find a doctor or midwife to care for them during pregnancy.** Women from vulnerable populations (e.g. recent immigrants, refugees, or a history of incarceration, homelessness, poverty or substance use) were almost twice as likely to report that they were not able to access care (37 % versus 20%). **SAFETY**



1 IN 5 WOMEN
STRUGGLED TO FIND A MATERNITY CARE PROVIDER
(midwife or physician)

- **Lack of access** to maternity care (and **specifically midwifery care**) was a recurrent theme. The primary reasons for lack of access were no midwives in the community and midwives and doctors not accepting new clients. **ACCESSIBILITY/SAFETY**
- Almost all women said that it was **important or very important that they lead decisions** about pregnancy, birth, and baby care. **ACCEPTABILITY/SAFETY**

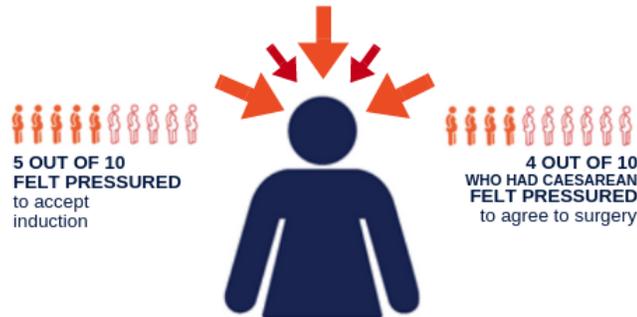


95% OF WOMEN
said it was **IMPORTANT**
or **VERY IMPORTANT**
that **THEY LEAD**
DECISIONS

- **One in three participants were not informed about the advantages /disadvantages of different care options** by their maternity care provider. One in four were not given enough time to thoroughly consider their options. **SAFETY/APPROPRIATENESS**

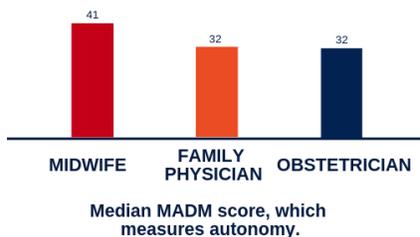
- **Pressure to accept interventions reduced women’s sense of autonomy.** Of the women who had their labour induced, 54 % felt pressured to accept the intervention. Among women who had a caesarean, 38% reported feeling pressure to agree to surgery. **APPROPRIATENESS/EFFECTIVENESS/SAFETY**

PRESSURE FOR INTERVENTIONS LOWERS AUTONOMY

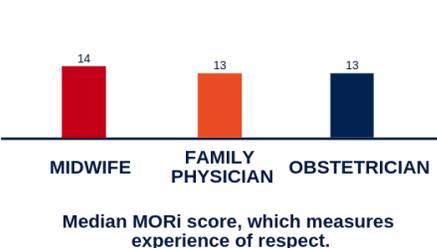


- One in seven felt **coerced** into accepting options their care provider suggested (9.7% of midwifery clients, 19.4 % of family physician patients and 23.8% of OB patients). **APPROPRIATENESS/ACCEPTABILITY/SAFETY**
- **Disadvantaged women**, women without postsecondary education and women of colour were more likely to report **very low autonomy (MADM) and respect (MOR) scores.** **SAFETY/ACCEPTABILITY**
- **Type of care provider and birth setting strongly influenced levels of autonomy and respect.** Midwifery clients reported consistently higher levels of autonomy and respect; MOR and MADM scores were lower for hospital births than home births. **APPROPRIATENESS/SAFETY/EFFICIENCY**

MIDWIFERY CLIENTS FELT MORE INVOLVED IN DECISION MAKING.



MOST WOMEN REPORTED EXPERIENCING HIGH LEVELS OF RESPECT.



- Women with medical or social risk factors, those who delivered by caesarean section, and women who were transferred from home to hospital reported less respectful care. **SAFETY/EFFICIENCY**
- Many women expressed an interest in community-based birth options (home births and freestanding birth centres). **ACCEPTABILITY**
- Women who had never experienced pregnancies reported a strong interest in midwifery care, and many respondents expressed a preference for midwifery care and home birth. **ACCEPTABILITY/EFFECTIVENESS**
- Women identified factors that are most important to them: having a **trusting relationship** with the care provider, having enough **time to ask questions** and discuss options, leading decisions, having support people present for labour and birth, and **not being separated from their baby** after birth. **ACCEPTABILITY/SAFETY**
- While 1 in 3 women who saw physicians found that prenatal appointments were too short, less than 2% of midwifery clients found appointments too short. **EFFECTIVENESS**
- Patients with **longer prenatal appointments** reported **higher autonomy and respect**. **EFFECTIVENESS**
- 55% of respondents rated having only **one maternity care provider as very important** and 79% said the same about having no more than 4 care providers. **ACCEPTABILITY**

POLICY RECOMMENDATIONS

Care Provider Education

- Improve education for care providers on how to support patient autonomy, patient-centred care, and informed decision making. Enhancement of skills and competencies to improve communication and respectful interactions will require upskilling in both current clinicians and for new health professional trainees. **ACCEPTABILITY/EFFECTIVENESS**
- Expand training for maternity care providers on Trauma Informed Care. **SAFETY/ACCEPTABILITY**
- Expand training and resources for care providers on how to identify, manage and refer women with mental health conditions. **APPROPRIATENESS/EFFECTIVENESS**

Health Services: Access and Scope of Practice

- Implement MADM and MORi as quality measures of experience of care at the institutional Scores can inform quality improvement initiatives and surveillance across health authorities. **EFFECTIVENESS**

- Increase access to patient-centred maternity care in rural and underserved communities, this need identified in our results reflects recommendations from the SOGC Joint Position Paper on Rural Maternity Care and MABC Vision Reports [5,6] **ACCESSIBILITY**
- Expand midwifery scope to include care of vulnerable populations, including immigrants, refugees, incarcerated pregnant women, and women with social barriers. Examine successful, cost-effective models for collaborative care programs serving vulnerable populations in other provinces. **ACCEPTABILITY /APPROPRIATENESS**
- Consider policy revision to the scope of practice for maternity care providers, particularly those practicing in rural locations that would allow women to continue to receive treatment with the provider of their choice for certain conditions that currently require transfer of care. **EFFECTIVENESS/SAFETY**

Health Systems Change

- Implement mechanisms in the health system and payor model to ensure that providers are able to spend enough time with clients so they are able to make informed and unhurried decisions about their care. **EFFICIENCY/APPROPRIATENESS/EFFECTIVENESS**
- Implement the new patient-designed MADM and MOR quality measures of respect and autonomy in maternity care into quality and safety monitoring across the Health Authorities. **ACCEPTABILITY/SAFETY**
- Consider waiving the waiting period for accessing MSP in BC for maternity care. **ACCESSIBILITY/EFFICIENCY**
- Pilot birth centre and alongside midwifery-led units (e.g. rural birth centre in Northern BC). **ACCESSIBILITY/APPROPRIATENESS**
- Expand access to funded doulas for vulnerable populations. **ACCESSIBILITY/SAFETY**
- Support additional research with Indigenous, Aboriginal, First Nations and Metis populations; given the noted health disparities experienced by these groups and communities of colour. Using the new validated instruments, repeating this mixed-methods study in these populations should be a priority. **ACCESSIBILITY/APPROPRIATENESS/SAFETY**

Public Information

- Develop patient information factsheets and provider guidelines that explain options for care (eg. types of providers, where to access free clinics); and choices and rights to care, (eg. right to refuse, patient autonomy). Ensure accessibility to these resources through online and print dissemination at community-based locations (eg settlement centres, clinics, pharmacies, food banks etc). **ACCEPTABILITY**
- Develop decision aids for families that explain options for place of birth and support informed choice. **EFFECTIVENESS/ACCEPTABILITY**

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