maternity care
PRIORITIES IN ALBERTA

"Three reasons problems are inevitable; first, we live in a world of growing complexity and diversity; second, we interact with people; and third, we cannot control all the situations we face."

~ John C. Maxwell ~

Final Report on a Listening Campaign

Conducted by

MCAN
MaternityCare Consumers of Alberta Network
ADVOCATING BIRTH CHOICES

MATERNITY CARE PRIORITIES IN ALBERTA
EXECUTIVE SUMMARY

The MaternityCare Consumers of Alberta Network (MCAN) conducted a Listening Campaign from April through August, 2014, involving almost 1,400 Albertans and found that:

- Alberta's maternity care system is in the midst of a crisis, unsustainable (particularly in rural and remote settings), and not meeting families' needs.
- There are not enough low risk maternity care providers to meet the demand.
- Universal rights of childbearing women are not always being acknowledged and supported.

MCAN is calling for the development and implementation of a maternity care strategy for Alberta.

A healthy baby and a healthy mother are desires universally shared by everyone involved in birth. The childbirth continuum (from pregnancy through birth and infant care) is a deeply personal time that can be a profoundly empowering or disempowering season of a woman's life. It is also a time when respectful maternity care is essential and when the universal rights of childbearing women ought to be upheld.

In September 2014, the World Health Organization issued a statement calling for women's right to dignified, respectful care in pregnancy and childbirth (World Health Organization, 2014). Recently, the Prime Minister of Canada spoke to the United Nations General Assembly calling the world to improve maternal and child health. In Alberta, stakeholders are echoing these calls and asking for a province-wide maternity care strategy.

There are two key concerns. The first is that maternity care conditions in Alberta do not ensure women's rights to freely choose where, how, and with whom they birth. Second, current maternity care system constraints are escalating, negatively impacting care, and creating inefficiencies. However, babies cannot wait for the system to catch up before being born. Our maternity care system is in crisis. It is not meeting families' needs and is unsustainable.

Pregnant women in Alberta find it extremely difficult to find primary caregivers of their choice especially in remote, rural, and aboriginal communities. A critical shortage of obstetricians has loomed for years, fewer family doctors are providing maternity care, and the demand for midwives far exceeds the number of registered midwives. Additionally, while it is recognized that obstetricians are extremely skilled and essential for high-risk pregnancies, with fewer family doctors practicing maternity care and not enough midwives to meet the demands, obstetricians are taking on more low risk clients. Not only does this place an unnecessary financial burden on taxpayers, it is a contributing factor to the key concerns set out above.

To better understand the maternity care landscape, the MaternityCare Consumers of Alberta Network (MCAN) undertook a project to identify and understand maternity care priorities in our province. A Listening Campaign took place from April through August 2014 and included nine focus groups held in urban, remote, and rural communities, as well as an online survey that received 1,235 responses, several informal interviews, and a number of unsolicited written submissions.

This report describes the Listening Campaign and provides historical context around North American birthing culture along with women's health theory and woman-centred ethics. It also presents findings and makes recommendations on improving Alberta's maternity care system. Specifically, this report recommends that a multi-stakeholder, interdisciplinary team with at least 25% consumer representation be appointed to develop a province-wide maternity care strategy that recognizes and addresses women's desire for autonomy over their bodies, the importance of informed, evidence-based decision-making, and the rights of women to give birth where, how, and with whom they want.

Our recommendations align with Alberta's Primary Health Care Strategy that defines three strategic directions: enhancing the delivery of care, changing the culture of health care, and creating the building blocks for change.

We offer two key points to developing a maternity care strategy that bolsters autonomy in decision-making and moves towards equitable access to care. First, a comprehensive leadership approach is needed across the system (consumers, primary caregivers, other health professionals, government policy makers, administrators, professional organizations, academia, unions, and media). Second, to develop a maternity care strategy, a system of change is needed that focuses on remediation of the whole (instead of constituent parts) and relies on leverage points that are linked and interconnected. Our recommendations are based on Wexler's (2005) Cosmopolitan Leadership and Doppelt's (2010) seven sustainability leverage points.

It is our hope that the findings and recommendations in this report will encourage and embolden Alberta's political leaders to improve the maternity care system so that it is wholly integrated with inter-disciplinary collaboration and where leadership is strategic, health professionals have balanced and rewarding careers, and maternity care consumers enjoy the type of care, setting, and caregiver of their choice.

DEDICATION

> "Birth is not only about making babies. Birth is about making mothers . . . strong, competent, capable mothers who trust themselves and know their inner strength."
>
> ~ Barbara Katz Rothman ~

To future generations of mothers.

May our work contribute to your ability
to trust yourself and know your inner strength.

And may you freely choose where, how, and with whom you birth.

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> "If we are to heal the planet, we must begin by healing birthing."
> ~ Agnes Sallet Von Tannenberg ~

Giving birth is a powerful, unique, and potentially transformative experience, with a desire for a healthy baby and mother universally shared by everyone involved in birth. The childbirth continuum (from pregnancy through birth and infant care) is a deeply personal time that can be a profoundly empowering or disempowering season of a woman's life and have enormous impact on her and her child's health and wellness (Odent, 2002). As such, respecting birthing women's autonomy, choices, and bodies is essential.

The childbirth continuum is also a channel for transmitting cultural values (Davis-Floyd, 1992). Yet, we live in a complex world of accelerated change where cultural values are in flux and contemporary values around technology, consumerism, and convenience may negatively impact birth. In some cases, the connection among biological (body), psychological (mind), and social (community, global) domains may be under-valued, which can diminish the possibility of a transformative birth experience. The importance of women having autonomy to choose how, where, and with whom they birth may not be highly regarded, something that prenatal and perinatal psychology has been exploring for a half century.

This report explores maternity care in Alberta based on two key concerns of maternity care consumers. The first concern is that current maternity care conditions do not ensure women's rights to freely choose where, how, and with whom they birth. Section 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (commonly referred to as the United Nations Women's Convention), (1979) states that participant countries "shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period". Despite the fact that Canada is a participant in the UN Women's Convention, maternity care conditions in Alberta provide few women with free choices for what we consider to be "appropriate services" in the Canadian context. In this regard, there is emerging international recognition that birthing women's fundamental human rights to physical integrity, self-determination, privacy, family life, and spiritual freedom must be upheld (Human Rights in Childbirth, 2014), calling into question the ethical relationships among maternity care actors.

The first concern is amplified by the second concern. The current maternity care system's constraints are escalating, negatively impacting care, and creating inefficiencies. However, babies cannot wait for the system to catch up before being born. Our maternity care system is in crisis. It is not meeting families' needs and it is unsustainable.

In Alberta, as far as we can tell, there is no province-wide maternity care strategy. The result is a shortage of primary caregivers and inequitable access to a caregiver of choice in a birthing woman's choice of setting. With these forces in play, the maternity care landscape has seen a host of difficulties. Increasingly, headlines point to issues in maternity care:

"Canada's doctor shortage worsening" (The Canadian Encyclopedia)

"Big demand for Alberta midwives leads to long waits" (CBC News)

"C-section main reason Canadians hospitalized for surgery" (CBC News)
"Premature births highest in Alberta" (Metro Edmonton)
"Banff hospital closes obstetric services" (Straight Goods News)
"Health-care system taxed during Fort McMurray's baby boom" (Maclean's)
"Birth experiences often fail to meet mothers' expectations" (University of Lethbridge News)

Alberta Health's vision for primary care is a "system that supports Albertans to be as healthy as they can be" (Alberta Health, 2014a). In September, 2014 Alberta's Health Minister, the Honourable Stephen Mandel, stated, "We need to do more listening and less talking when it comes to health care." (Alberta Health, 2014b). MCAN agrees with this simple yet powerful approach. That is precisely what we did and what this report is about – a Listening Campaign.

Maternity Care in Alberta

The forces described above are a call for change, particularly in light of a major 2014 report by the Alberta Treasury Board and Finance that projected that Alberta's population would expand by 2.2 million by 2041. The report further stated that the fertility rate has been rising for almost a decade and projected the annual number of births would grow by 28% by 2041 as a result of an increase in the number of childbearing women (Alberta Treasury Board and Finance, 2014). This has serious implications for a maternity care system that is already in trouble.

While it was promising to see Alberta's Primary Health Care Strategy published earlier this year with its references to family planning, pregnancy, maternal and child services, and family doctors, there were no references to obstetricians or midwives, both of whom are providing primary care to pregnant women. Nor does there appear to be representation of these professions in the working group that developed the strategy (Alberta Health, 2014a).

Pregnant Albertans find it extremely difficult to find primary caregivers especially in remote, rural, and aboriginal communities. While obstetricians are extremely skilled and essential for high risk pregnancies, with fewer family doctors providing maternity care and not enough midwives to meet the demands, obstetricians are taking on more low risk clients. With a critical shortage of obstetricians looming, this may not be the best use of highly-trained experts and has financial implications. Family doctors and obstetricians operate under Alberta Health's fee-for-service model without any limitation on the number of clients and procedures they can bill while the funding model for midwifery is based on courses of care (from pre-conception to six weeks postpartum) and allocates a set number of courses of care province-wide.

For low risk pregnancies, midwives are cost-effective. A 2010 Alberta Health and Wellness study found that the cost implications supported integrating midwifery into the maternity care system without increasing health care costs (O'Brien, Harvey, Sommerfeldt, Beischel, Newburn-Cook, & Schopflocher, 2010). Yet, midwifery funding has been implemented unevenly across the province, creating inequitable access and increasing demand on caregivers whose provision of care is not capped (obstetricians and family doctors).

The desire to address these concerns is not new. For over 40 years, consumers have advocated for women to freely choose where, how, and with whom they birth. In the 1970s and 1980s, consumer groups were formed. One of those groups was the Alberta Midwifery Task

Force (subsequently renamed the Midwifery Consumers of Alberta Network or MCAN) which went dormant in the early 1990s when its objective of legalizing midwifery was accomplished.

In 2013, consumer angst around the supply deficit of primary caregivers culminated and it became clear that addressing these challenges would take concerted and collaborative effort. In October 2013, maternity care stakeholders from several Alberta regions participated in a stakeholder dialogue in Edmonton. A briefing note was published with one of the recommendations being that MCAN be revived. MCAN held its first meeting in December 2013 where it was easily decided that its mandate and name be broadened to "maternity care". Shortly after, MCAN developed its vision, mission, objectives, and a statement about how it conducts its work. A copy is attached as Appendix A.

MCAN is the provincial body that represents consumers on maternity care health policy and other initiatives. It supports consumers in making informed choices and having equal access to publicly funded, quality maternity care of their choosing in their community (whether provided by family doctors, midwives, or obstetricians). Once MCAN's governance framework was in place, it undertook a project to identify maternity care priorities in Alberta.

Introducing the Listening Campaign

The project was launched by conducting a Listening Campaign from April through August 2014 that asked stakeholders one question: *What are the burning issues in maternity care in Alberta?* The Listening Campaign was comprised of nine focus groups, an online survey, informal interviews, and unsolicited written submissions. The survey ran from May 5 to July 31, 2014 and received 1,235 responses. The focus groups took place in July and August.

The question includes three assumptions. The first is that Alberta Health's intention is to align its actions with its espoused principles (person-centred, accessible, continuity of care, proactive, collaborative, accountable, sustainable, quality, and equitable [Alberta Health, 2014a]). The second is that the maternity care system can function more efficiently. The third is that decision-makers will respond to Albertans' desires and develop a maternity care strategy.

Organization of this Report

This report is organized to explain how the Listening Campaign was executed and analyzed. We make recommendations about how a maternity care strategy for Alberta can be developed and advanced. We start with an overview of the Listening Campaign and define key terminology. Then we provide historical context around birthing culture and explore women's health theory and woman-centred ethics. Next, we describe the design framework for the overall Maternity Care Priorities Project and explain the data analysis strategy.

Our findings are presented by triangulating data from the focus groups, online survey, informal interviews, and written submissions. They are depicted through the tri-fold lens of MCAN's vision of "Alberta women freely choose where, how, and with whom they birth." In other words, into three key areas: birth setting (where); maternity care choices (how); and primary caregivers and other health caregivers (whom).

We use Wexler's *Cosmopolitan Leadership* (2005) to discuss the leadership needed to align Alberta's Primary Health Care Strategy principles with what is happening in practice. Finally, we apply Doppelt's *System of Change* (2010) to the findings and to organizing our recommendations. We finish with our reflections.

Terminology

We use several terms and phrases for ease of reference. These include:

Canadian Model of Midwifery Practice: Principles of midwifery practice including:

- respecting pregnancy and childbirth as normal physiological processes;
- promoting wellness and taking the social, emotional, cultural, and physical aspects of a woman's reproductive experience into consideration;
- respecting women's right to make informed choices by providing them with complete, relevant, and objective information in a non-authoritarian manner;
- being autonomous care providers who make decisions in collaboration with their clients and, when conditions require care that is outside of their scope of practice, making referrals to other care providers, continuing to provide supportive care and collaborating with other health professionals to ensure clients receive the best possible care;
- working in partnership with women in their care and spending time to build trust and provide individualized care;
- respecting women's right to make an informed choice about birth setting including home, birth centres, and hospitals; and
- having evidence-based practices and staying up-to-date with regard to research on maternity care issues (Canadian Midwifery Regulators Consortium, n.d.).

Cosmopolitan Leadership: A contextual approach to leadership in which a masterful leader develops an awareness and ability to apply varying leadership styles (Wexler, 2005).

Maternity Care: Care for a woman and baby throughout pregnancy, birth, and in the early weeks after the birth (Women and Health Care Reform, 2007).

Society of Obstetricians and Gynaecologists of Canada (SOGC): a national medical society representing obstetricians/gynecologists, general practitioners, nurses, midwives, and allied health professionals whose stated core beliefs include:

- women should have equitable access to optimal, comprehensive, culturally-safe health care provided with integrity and compassion;
- women should have the knowledge they need to make informed choices about their health;
- SOGC members have the right to practice in a safe and supportive environment;
- the practice of obstetrics and gynaecology must be based on the best scientific evidence available;
- the Society has a responsibility to facilitate change in relation to health system issues affecting the practice of obstetrics and gynaecology;
- every woman has the right to optimal care during pregnancy and childbirth to ensure the health and safety of both the mother and her baby (SOGC, 2012)

Stakeholder: Any group or individual who can affect or is affected by the achievement of an organization or system's objectives (Freeman, 1984).

Systems Thinking: A way of seeing inter-relationships rather than linear cause-and-effect chains, and in seeing processes of change rather than snapshots (Senge, 1990).

Maternity care in Alberta has become more complex in recent years. Policy makers and administrators are challenged to meet increased needs with limited resources, no province-wide maternity care strategy (that we could find), a shortage of primary caregivers, and inequitable access to caregivers and choice of birth setting. We are in a crisis state of affairs that is calling for change. This report offers a way forward.

NORTH AMERICAN BIRTHING CULTURE

Most people would agree that childbirth is much more than producing a living baby and mother (Levesque-Lopman, 1988). It is profoundly life-altering since it affects how women see themselves, others, and their place in society. When treated as a powerful, transformative life event, childbirth is deeply personal. Yet, that which is personal is also political (Sprague, 2005). In recent decades, childbirth has become an increasingly political issue with systemic difficulties. Equitable access has become a major issue. Not all women are free to choose where, how, and with whom they birth. Over the past century, pregnancy and birth have gone from being a natural event in a woman's life to one that is medicalized and not necessarily family-centred.

Around the globe and for time immemorial, rites of passage were how cultural beliefs were transmitted particularly when it comes to life-changing events like childbirth (Davis-Floyd, 1992). In contemporary North America, birth is rarely seen as psychologically transformative. The irony is that two current psychological concerns are postpartum depression and psychosis. Today, standard medical procedures are the new rites of passage that have become the norm, putting the caregiver at the centre instead of the woman who becomes subservient to the conditions. These rites may go unquestioned, do not necessarily stand up to empirical scrutiny, unnecessarily increase costs, and may increase risk to the mother and baby's well-being.

Cultural anthropologist, Robbie Davis-Floyd (1992) identified three medical models: Technocratic, Humanistic, and Holistic (see Appendix B). While health care systems may appear to apply the Humanistic Model, in practice the medicalization of childbirth has created a dichotomy by pitting the Technocratic Model against the Holistic Model.

Historically, birth took place among women who were seen as healers and elders. Over time though, the domain of birth that was exclusively held by midwives slowly eroded. Developments that took place were not necessarily based on empirical science. The advent of "natural childbirth" saw birthing women trained to co-operate with the Technocratic Model by breaking down and analyzing stages of pregnancy and birth (Levesque-Lopman, 1988). In the 1950s, obstetrician Emmanuel Friedman developed the Friedman Curve which was subsequently interpreted to mean that dilation during labour should progress at one centimeter per hour (Block, 2007). Fifty years later, women are still put on the clock to "perform" based on this criterion. If they do not progress quickly enough, negotiated or coercive application of interventions ensues (Block, 2007). Birthing women, in turn, place expectations on their bodies

to comply with these requirements. If things do not go as planned, women may experience disappointment and even see themselves as failures, which can have negative repercussions on themselves as well as their families.

Other remnants of this history remain in place for some consumers including the mindset of the Technocratic Model (Malacrida & Boulton, 2013) which continues to disconnect the biological, psychological, and social aspects of women's lives. Reliance on technology, for example, results in health caregivers privileging a particular type of knowledge (which gets encoded as objective knowledge) and not valuing women's ways of knowing and experience (Levesque-Lopman, 1988). Further, the Humanistic Model has also been criticized for creating confusion since, rather than empowering choices, it gives the illusion of choice because it is rooted in the primary caregiver taking charge and treating the body as a machine.

Resistance to medicalizing childbirth started in the 1830s with the genesis of the Popular Health Movement at the same time that the feminist movement was first being organized, with both movements emphasizing women's health and access to medical training (Ehrenreich, 1973; Feldhusen, 2000). Despite this resistance, the Technocratic Model was becoming entrenched and many women simply went along with it. Resistance increased in earnest in the 1970s.

> The concept of "health care as a matter of right, not privilege" captured the spirit of the time better than any other single idea. Concerns of the new health rights movements included such rights in health care as the right to informed consent, the right to refuse treatment, the right to see one's own medical records, the right to participate in therapeutic decisions. . . A movement developed to "deinstitutionalize" the dependent and "demedicalize" critical life events, such as childbirth and dying. (Feldhusen, 2000).

In *Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization*, Pauly Morgan (1998) describes the critical role of the Women's Health Movement in contesting medicalization. This contestation involved at least two complex and related theoretical projects: (re)claiming subjectivity and (re)claiming epistemic power. Reclaiming subjectivity involves resisting the notion of the "ideal patient", who is

> reasonably (but not too) intelligent, enthusiastic about but only sufficiently informed about medical institutions, procedures, and technology to satisfy minimum legal consent conditions, cooperative with respect to the paternalistically motivated medically directed use of medical technology, convinced that institutionalized medicine and medical technology provide the best health care in a larger macro-institutionalized setting where medicine enjoys pride of place, highly compliant with respect to following medical orders, and cheerfully responsible with respect to medicalized self-management (Morgan 1998; Sherwin 1992; Weiss 1997, as cited in Pauly Morgan, 1998, p. 109).

Pauly Morgan (1998) explains that to reclaim subjectivity

> it is important for us to fight for recognition of the knowledge women have as healers, as knowledgeable informal and formal providers of health care, and as critical subjects who can take up a variety of political positions in relation to medicalization (p. 110).

She asserts that it is important that medical knowledge be demystified and democratized so that "credentialed experts" are not the sole purveyors of knowledge (p. 113).

Belenky, Clinchy, Goldberger, & Tarule (1997) identified five categories of women's ways of knowing: *silence* where women see themselves as mindless, voiceless, and reliant on external authority; *received knowledge,* where women see themselves as receiving and articulating knowledge but not able to create it; s*ubjective knowledge,* where women's concept of knowledge is personal and intuitive; *procedural knowledge,* where women can objectively learn and apply ways of getting and sharing knowledge; and *constructed knowledge,* where women see knowledge as contextual and that they are creators of it. Through increased knowledge, women were encouraged to develop their voices and allow their knowledge from lived experience to emphasize connection, understanding, and collaboration (Belenky et al., 1997).

These women's ways of knowing may be rooted in the sharing of knowledge that women have about lived female body experiences (pregnancy, childbirth, menstruation, and menopause) (Levesque-Lopman, 1988). As women pushed for valuing intuition and their knowledge of their bodies and their health, their voices have been amplified and there's been movement towards greater equality and reclaiming power (Belenky et al., 1997). In Alberta, this desire to reclaim power had its genesis in the 1970s and 1980s when maternity care consumers organized to advance change that emphasized the reintroduction of midwives into the mainstream health care system. Today, midwives demonstrate outstanding care and outcomes. One Canadian five year study found comparable outcomes between physician-attended hospital births and midwife-attended hospital and homebirths, and that midwife-attended homebirths had reduced interventions and fewer adverse maternal outcomes (Janssen, Saxell, Page, Klein, Liston, & Lee, 2009). Similar results can be seen in *What Mothers Say: The Canadian Maternity Experiences Survey*, conducted by the Public Health Agency of Canada (2009).

An area of growing concern is maternal mental health as more women describe mental disturbance after birth. A recent study explored 726 peer reviewed papers on birth trauma (Elmir, Schmied, Wilkes & Jackson, 2010). The analysis was distilled to ten papers with six themes describing how women perceived and experienced traumatic birth: feeling invisible and out of control; a desire to be treated humanely; feeling trapped; a rollercoaster of emotions; disrupted relationships; and strength of purpose in succeeding as a mother (Elmir, Schmied, Wilkes & Jackson, 2010). Another study found that one in three women had the presence of three symptoms of trauma and over 5% met DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) criteria for acute post-traumatic stress disorder (PTSD) (Creedy, Shochet & Horsfall, 2000). PTSD among women who have birthed is not well recognized and the study sees PTSD being caused by a combination of obstetric interventions and dissatisfaction with care. Due to ambiguity of the definition of birth trauma and the criteria constituting PTSD, diagnosis of PTSD may be delayed or missed (Elmir, Schmied, Wilkes & Jackson, 2010). The study also acknowledged that some health professionals may not even be aware that some women experience birth trauma (Creedy, Shochet & Horsfall, 2000).

With the knowledge that birth is seen by women as a meaningful lived experience, health caregivers must not simply respect a patient's autonomy and do them no harm; they should also contribute to their well-being (Melchert, 2011). These principles are held up in bio-medical ethics and include: autonomy (right to body and self-governing), informed consent (knowledge), harm reduction (birth trauma and long term implications on community, women and children), and that services be beneficial to supporting well-being (Beauchamp & Childress, 2009).

Vulnerability is part of the rite of childbirth that does not discriminate on the basis of: ability, accomplishment, material wealth, level of confidence, socio-economic status, race, sexuality, or level of education. Women must also take responsibility for birth outcomes and satisfaction. Many birthing women rely upon caregivers and institutions to help them navigate the vulnerability inherent in birthing, yet caregivers and institutions may not be fully informed or may apply dated attitudes (Block, 2007). Over two decades ago, Davis-Floyd (1992) suggested creating more options and realizing cultural change by applying systems theory.

Currently, consumers across North America are creating an ever-expanding network to advance choices in childbirth. The advent of social media is accelerating this. Yet, knowledge of choices in childbirth needs to be increased not simply as "nice to haves" but as reproductive rights pursuant to United Nations conventions, World Health Organization statements, and international expectations around the universal rights of childbearing women. This does not mean that medical science is rejected to promote the Holistic Model. Rather, it means that primary caregivers and other health professionals need to be aware of personal bias and to understand the importance of supporting all choices, whether they are ones that they would personally make or not. This type of change calls for progressive leaders.

The current challenges of Alberta's maternity care system were likely never anticipated. Solutions need to be rooted in shifting from an individualized snapshot approach to a contextually-based process with system-wide implications. Contemporary leaders can let go of dated Technocratic approaches and apply a Holistic mindset, comprehensive leadership, and a change process targeted to the whole system.

PROJECT DESIGN

The design framework for the project was Fair Process, a model that takes into account that people care about both the outcomes and the process used to create outcomes. Fair Process is rooted in the idea that, for people to see decision-making as fair, they have to believe that the process involved in arriving at the decision was fair (Chan Kim & Mauborgne, 1997; Wu, Loch & Van der Heyden, 2007).

The five steps of Fair Process are set out in the following table, along with the purpose of each and specific actions we are taking with this project.

Table 1
Fair Process: Five Steps

Timeline	Step	Purpose	MCAN's Actions
April-August, 2014	Engage	Understand maternity care issues and opportunities	Listening Campaign: ● Focus groups ● Online survey ● Informal interviews ● Written submissions
September, 2014	Explore	Discuss options and commit to a plan	Leadership Face to Face session
October-November, 2014	Explaining	Communicate the plan; build trust	Publish Briefing Note and report
November 2014-August, 2015	Executing	Take action on the plan	Initiatives, campaigns, programs (government, health care settings, professional associations, unions, educational institutions, consumers)
September, 2015	Evaluating	Feedback, learning and improvement	Leadership Face to Face session

The objective of the Listening Campaign was to identify and understand the burning issues in maternity care in Alberta. An exploratory approach was undertaken. The data collection and analysis approach was twofold: First, it was to gather input from stakeholders (consumers, physicians, midwives, nurses, lactation consultants, doulas, childbirth educators, academics, students, and others) on maternity care priorities. Second, it was to understand the leadership philosophy of the system and how the various elements interact.

Data Analysis

The data analysis strategy had two aims. The first was to determine how broadly Alberta's Primary Health Care Strategy's principles of person-centred; accessible; continuity of care; proactive; collaborative; accountable; sustainable; quality; and equitable are reflected across maternity care practices. The second was to organize the findings around the three domains of MCAN's vision for maternity care (where, how, and with whom birth takes place).

Participants for both the survey and focus groups were invited to participate through social media including the MCAN Facebook page as well as the MCAN website. Some stakeholders, including physicians, were contacted directly with invitations to participate. In some communities, flyers were posted in the community. Individual MCAN members and leaders also shared the information across their personal social media platforms.

Focus Groups

Nine focus groups were held in urban, rural and remote communities, with each organized by the local MCAN representative who secured a venue, promoted the session,

informed the media, and played a leadership role. All nine focus groups were facilitated by Dr. Laura (Lolly) de Jonge and asked, *What are the burning issues in maternity care in Alberta?*

Each focus group lasted approximately two hours and included a presentation that introduced MCAN and the project and provided information about Systems Thinking that included a five minute video by Dr. Peter Senge entitled *Navigating Webs of Interdependence* (http://www.youtube.com/watch?v=HOPfVVMCwYg). A description of the Listening Campaign was provided including an explanation of Fair Process. Before discussing the burning issues, focus group participants were asked to identify their role in maternity care, where they reside, how they heard about the focus group, and their purpose in participating.

Focus group participants hailed from Banff, Brooks, Calgary, Canmore, Cardston, Cochrane, Edmonton, Edson, several First Nations, Fort McMurray, Grand Prairie, Lethbridge, Lloydminster, Okotoks, Peace River, Red Deer, Spruce Grove, Wainright, Whitecourt, and Wood Buffalo. They were primarily consumers (pregnant women, women who will become pregnant, and women who have been pregnant), with some having their partner or a parent accompany them. The following disciplines were also represented: physicians, midwives, lactation consultants, nurses (hospital, public health), doulas, prenatal educators, prenatal yoga instructors, hypnotherapists, early childhood development professionals, pre and post-natal mental health professionals, fertility support personnel, prenatal massage therapists, local union leadership, postpartum parent support outreach workers, pharmacists, academics, and students. Although in some communities, invitations were hand delivered or emailed to physicians, there was only who attended a focus group that self-identified, although we had informal interviews with an obstetrician and a family practitioner who performs caesarean sections.

The focus group discussions were visibly recorded. Before the session ended, all of the recording was fed back to the group to ensure accuracy and determine if anything had been overlooked. Following the focus groups, the newsprint recordings were transcribed by the facilitator and sorted by location and by "where", "how", and "with whom". The attendance lists were scanned and indicated that there was a total of 138 participants.

After the first six focus groups (Lloydminster, Calgary, Edmonton, Lethbridge, Whitecourt, and Fort McMurray/Wood Buffalo), consistent themes were being found, along with location specific findings. Besides the standard delivery, the last three focus groups (Red Deer, Banff, and Peace River) were used to validate the common themes that were found in the first six. After the data from the focus groups were analyzed and documented, they were synthesized with the survey data which were compiled and analyzed as described in the next section.

Survey

The survey also sought to understand burning maternity care issues; yet it was not intended to identify statistical information. In other words, it did not attach any weight to each concern. Since information about specific demographics and locations was not sought, there is no way to know what the breakdown is. As such, the data are not representative nor do they paint an exact picture. Rather, the data identify themes about priorities in maternity care. Theoretical and philosophical issues can be drawn from the data and these are explored later.

The online survey identified the respondents' role in the maternity care system and burning maternity care issues. The question about their role offered respondents a number of categories. Not all of the 1,235 survey participants answered by selecting one of the categories offered. The responses for those who did answer are comprised of the following:

- 752 Consumers who were pregnant or planning to become pregnant
- 311 Consumers planning no further pregnancies
- 24 Midwives
- 66 Doulas
- 3 Lactation Consultants
- 38 Nurses
- 10 Physicians
- 3 Traditional Birth Attendants (TBAs)
- 2 volunteers with a birth organization

There were 1,209 respondents who selected one of the above categories. Following the respondents' indication of their role, there was a comment box. There were 26 respondents who did not select a box and 58 individuals who elaborated in the comment box. In some instances, the comments noted additional roles to the response indicated in the question about their role (for example, the respondent indicated they were a consumer in the role question and then indicated in the comment box that they were also a doula). In other cases the comment box was used in lieu of selecting a category from the list offered. Other roles identified included the following:

- Non-parent
- Non-parent with intention to have children
- Queer partner to woman receiving care
- Childbirth Educator
- Lactation Educator
- Undecided on having more children
- Chiropractor
- Midwifery Student
- Adoptive Parent
- Grandparent
- Placenta Encapsulator
- Acupuncturist
- Maternity Massage Therapist
- Maternity Yoga Instructor
- Aspiring Midwife
- Midwifery Administrator
- Holistic Nutritionist
- La Leche League Leader
- Hypnobirth Instructor
- Social Worker
- Researcher

Besides determining the respondents' role in the maternity care system, the survey asked participants the same question as the focus groups, *What are the burning issues in maternity care in Alberta?* There were 1,216 completed responses (19 participants skipped this question). To analyze the survey data, methods were used as described by Rivas (2012) in her work titled *Coding and Analysing Qualitative Data*.

The question required in-depth analysis. Responses were reviewed twice by the analyst to become familiar with the data and types of responses submitted. At that point, the analyst decided that it would not be possible to include the prioritization scheme the participants were

asked to utilize in their responses since many responses were not structured that way (some responded with a single comment and others included full commentary on their experiences).

The responses were then coded using open-coding in which each response was coded comment-by-comment to ensure that each new idea was labelled as a separate code (Rivas, 2012). Once approximately half of the comments were coded and the majority of unique codes created, the codes were then sorted based on the three sections utilized here: where, how, and with whom. The categorization was based on what the focus of the given code was. For example, "need more midwives" was categorized as a "whom" comment, whereas "need fewer interventions" was coded as a "how" comment. Very unique comments were sorted into 'other' categories within each section as appropriate (including comments on maternity care leave benefits, for example). Once the codes that far had been categorized, the remaining responses were reviewed and any new unique codes were added into the appropriate section.

As the data were sorted into codes, constant comparison was used, meaning that data were being compared against same-category and different-category responses to ensure that the categorization scheme was still adequate as new data were being added (Rivas, 2012).

Informal Interviews and Unsolicited Written Submissions

At the local level, several MCAN representatives arranged for informal meetings between the facilitator and various stakeholders. In addition, for fact checking purposes, there were discussions with several individuals who provided background or additional information on certain system aspects and/or confirmed or refuted perceptions about the system that were offered by some participants. These individuals were assured their input was without attribution.

Unsolicited written submissions came in through several channels. Some were provided to the local focus group organizer, some were emailed to MCAN or one of its leaders. The maternity care priorities in these submissions were consistent with the findings of the focus groups and surveys, with some also including stories of personal experiences.

Limitations

Although steps were taken to obtain a full picture of maternity care in Alberta, the Listening Campaign had limitations. Participants were primarily reached through social media and word-of-mouth. Another limitation is the seeming lack of diversity among participants because we did not ask for demographic information. Because the re-emergence of MCAN as a consumer group was the result of citizens who share an affinity for midwifery, data may have also been potentially missed from populations that are not connected to that community. Another limitation is that the Listening Campaign was aimed at simply identifying what the primary maternity care issues are rather than a full quantitative assessment of maternity care outcomes. The collection of data was limited by the project being a voluntary consumer-led initiative; health care professionals had little social and professional pressure to participate. Further because the scope of the Listening Campaign primarily drew consumers in, it was not possible to verify findings through disciplines that were invited to participate but were under-represented including: family doctors, obstetricians, and nurses.

The Listening Campaign provided a rich, interdisciplinary view of Alberta's maternity care system that touches on the components of maternity care in which we are concerned: where, how, and with whom women birth. While not exhaustive, the Listening Campaign provides insight and an opportunity to assess the alignment between Alberta Health's espoused principles and what is happening in practice. It also enables a preliminary look at the nature of leadership in the health care system and how a systems approach might support improving it.

FINDINGS

Participants identified "burning issues" that were synthesized into three themes: where birth takes place, the approaches used in maternity care, and the types of caregivers women access (primary caregivers and other health professionals). These three areas are described in this section.

Where They Want

Three key themes were emphasized around the subject of where women want to birth: choice of birth setting, systemic barriers, and challenges in the hospital setting.

Choice of Birth Setting

Depending on where a woman lives, her choice of birth setting varies. Although consumers in urban settings are more likely to have a wider range of choices of where they birth, they are still limited by available caregivers. If a pregnant woman in an urban setting is not able to obtain midwifery services due to the shortage of midwives, the woman is limited to birthing in a hospital or birthing at home, either unattended or by hiring a traditional birth attendant.

Participants in all locations decried the limited choice of birth setting for rural and remote consumers. Some hospitals do not deliver via caesarean section and many will not allow vaginal birth after caesarean (VBAC) due to perceived risks and/or lack of available personnel to support surgical deliveries. Where VBAC is available, women may be discouraged from trying or are "put on the clock" due to restrictive hospital policies. Even under regular labour and birth conditions, some respondents reported being rushed to deliver and then leave the hospital. This was reported by consumers, primary caregivers, and nurses.

Concerns were raised about the need to improve facilities and restrictive hospital policies. Areas mentioned included NICUs in northern regions; additional staff and equipment; and other options including using the same room for labour and delivery, private postpartum rooms (shared rooms force partners to leave overnight and prevent women from sleeping well), use of birthing tubs (most hospitals do not allow women to labour in water and/or birth in water), and eating in labour. Even seemingly minor policies like only allowing two people at the birth proved to be a barrier for some. For example, girls who were surrendering their babies for adoption had to choose between having family members (who offer trusted support) or adoptive parents (who want to bond with their baby) attend the birth. There were calls for hospitals to adopt the Mother-Friendly Childbirth Initiative and the Baby-Friendly Hospital Initiative.

In several locations, the granting of hospital privileges was noted as an issue. There were reports of seemingly qualified primary caregivers being denied privileges including registered

midwives, family doctors, and internationally trained physicians. Participants noted that when a midwife transfers a client from home to a hospital where she does not have privileges, she must transfer care which doesn't give the client continuity of care nor allow the midwife to practice her full scope. There were accounts in more than one location of women birthing in the emergency room either due to rooms being unavailable or to unusual admitting procedures being applied when a non-privileged caregiver transfers from a planned out-of-hospital birth.

The choice of planned out-of-hospital birth is limited because the only primary caregivers who attend women for these births are approximately 90 registered midwives (who have been legally recognized in Alberta for over twenty years, are regulated by the College of Midwives of Alberta, and whose fees are covered under Alberta Health Care). When it comes to home birth after caesarean (HBAC), some midwives will not take on clients. Participants called for more free-standing birth centres and for more providers to offer postpartum home visits. Between the focus groups and the online survey, only one participant did not think homebirth should be a legal option and one participant suggested that traditional birth attendants should be outlawed.

There are traditional birth attendants (TBA) practicing in Alberta who will attend women for home births. In some lesser developed countries, the majority of primary maternity care in rural, remote, or under-served communities is provided by TBAs who are typically well-respected (Sibley, Sipe, Brown, Diallo, McNatt & Habarta, 2007). In Alberta, TBAs are considered lay practitioners, are not regulated, do not have hospital admitting privileges nor are their services publicly funded. Some women plan to birth at home without any primary caregiver - unassisted childbirth (UC) or freebirth. Typically, individuals who use TBAs or who freebirth are private about their choice. This is due to the lack of a regulatory framework for TBAs and difficulties encountered by some families, such as being reported to the police and interrogated when follow up care is sought through a physician or hospital.

Systemic Barriers

Primary caregivers are funded out of separate pots of money (physicians by Alberta Health with no cap on the number of patients they can take and midwives by Alberta Health Services with a limited number of courses of care for the entire profession province-wide). These funding schemes set up financial disincentives that can result in physicians keeping a stronghold on the number of births they attend and limiting the granting of hospital privileges to other primary caregivers. (Note: how privileges are granted remains opaque to us). In addition, because of these funding schemes, one physician reported that some physicians think that midwives receive greater compensation yet the physician did not recognize the distinctions in practice between obstetricians and midwives. In at least one instance at a regional level, a closed group of medical professionals set practice guidelines without including other practitioners and which may run counter to professional standards. A major systemic barrier is the lack of interdisciplinary involvement and consumer representation in key decision-making bodies such as workforce planning committees, professional associations, and others.

Due to the shortage of primary caregivers, especially midwives, women opt for other choices. Some leave their community to receive the care they desire. Some regularly travel 4½

to 5 hours for prenatal visits, uproot themselves from their community late in pregnancy, and live away from home for five or six weeks. Some women in larger settings choose to go to smaller communities to increase the likelihood of knowing their caregiver. On the other hand, women in remote communities may be displaced from their community to birth in a hospital because they do not have the option to birth out-of-hospital where they live. These system barriers force some women to freebirth or have a TBA birth when they might not otherwise. This is difficult to verify since there is no central registry tracking TBA attended births or freebirths.

Challenges in the Hospital Setting

The challenges in choice of setting were amplified when we heard from physicians and nurses about the shortage of resources that are needed to do their jobs and to make it easier for women in labour and birth. There were several accounts from physicians and nurses that requests for improvements to the physical conditions of the labour and delivery unit, better staff training, or even inexpensive purchases like birthing balls were denied.

There were reports of a disconnection between administration and policies that specifically affected the hospital-based workforce: high turnover among staff, job dissatisfaction, opacity of policies, attraction and retention, burn-out, and lack of support for career development. In some instances, we were told, the College & Association of Registered Nurses of Alberta (CARNA) had to get involved to support staff in addressing these problems.

Participants expressed concerns that, because of the high birth rate in many communities, other obstetric-gynecological issues are not being addressed in a timely fashion and that non-maternity care patients are increasingly accessing emergency services since physicians are busy attending births. As such, the constrained maternity care system ends up having a domino effect across the broader health care system resulting in even more inefficiencies.

How They Want

Participants raised many issues relating to how women experience care, including specific practical issues (such as intervention rates and the availability of birth pools), as well as more philosophical issues such as the attitudes, knowledge, and beliefs about maternity care.

Model of Care and Woman-Centred Ethics

One of the most frequently made points relates to the model of care delivered. While there seems to be a desire to move away from the Technocratic and Humanistic Models to the Holistic Model, it was not being practiced consistently. Espoused intentions do not seem aligned with practice; in some cases, we were told that caregivers reverted to the Technocratic Model.

There was a strong sentiment that women's autonomy over their bodies and choices was not always respected. Women want personalized care that empowers them and fosters trust in the caregiver's competence. We repeatedly heard of instances where birthing women were called selfish or a bad mother or, as was articulated in several focus groups, "thrown the dead baby card" when they questioned or wanted to refuse interventions. There was a great deal of emphasis around rude and inappropriate behaviour (some even called it bullying) in hospital

settings by physicians and other health caregivers. The need for respect was repeatedly stated. In some instances, there was blatant rage and even tears as women expressed their pain and, as one stated "despair" despite the fact that birth is a time that "should be celebrated in one's life". There was consternation about a lack of awareness among some primary caregivers about matters that are extremely important to consumers such as birth being a function of women's sexuality, the impact of prior sexual trauma or abuse, and the frequent incidence of birth trauma and lack of available support systems.

Some women were told that they had no choice or were not allowed certain choices. In addition, consumers were not always presented with all of the choices nor was informed consent always obtained for interventions or the presence of students. There were concerns about whether internationally trained physicians were acculturated to the principles in Alberta's primary care strategy, especially regarding informed consent. Participants reported seeing the standard for induction of labour going from 14 days after the due date to 5 days without an explanation, particularly as it relates to risk.

Concerns about diversity were raised including care and attitudes towards marginalized or impoverished populations, aboriginals, immigrants, LGBTQ, neurodiverse, adolescents, and differently-abled. It was reported that little consideration is given to regional context such as communities that have high immigrant or transient populations. In some instances, where typical social supports such as family may not be available and/or there are language barriers, poverty or lack of access to transportation, there may be difficulties in accessing services.

Some participants suggested that there are systems barriers to learning and that there are few mechanisms in place to connect the various parts of the system.

There was also a strong desire around improving mindsets to support attachment, bonding, and physiological practices including delayed cord clamping and skin-to-skin care.

The participants pointed to the need for birthing women to better trust themselves and to have primary caregivers and other maternity care professionals encourage and support them.

Continuity of Care

A primary feature of the Holistic Model that many consumers desire is continuity of care from pre-conception through the postpartum period. Consumers and primary caregivers talked about maintaining continuity of care and taking a shared-care approach when care is transferred from a physician or midwife to an obstetrician (which has financial implications). Participants emphasized that, once a woman has already gone into labour, she develops a bond with her nurse or primary caregiver and that the relationship throughout plays an important role in the birth.

Evidence-Based Practice

Issues in evidence-based practice were raised often. It was pointed out that the Society of Obstetricians and Gynaecologists of Canada's (SOGC) guidelines on VBAC are often not followed nor is risk being properly communicated (for example, consumers being treated as though a VBAC is a high risk birth when it is not considered so by the SOGC). In addition, there is a lack of knowledge of the Canadian Model of Midwifery Practice particularly among family

doctors and nurses. One participant noted that a physician told her that midwives were not funded even though they have been for five years. Another said that her physician advised her that she may be denied care if she chooses midwifery care and needs to transfer to hospital. There was limited knowledge around doulas in some communities. Breastfeeding was an area that participants thought needed increased knowledge of empirical evidence among nurses and primary caregivers and that formula should not be offered in hospitals or physicians' offices.

Awareness and Support

Participants would like policies to be developed and for caregivers to be better at providing informed consent and to support undisturbed birth, vaginal birth for twins and breech babies, breastfeeding, tongue and lip ties, and, most importantly, women's rights and autonomy over their bodies. Concerns were raised around maternity benefits to accommodate more families, make the transition to parenthood easier and increase flexibility for women who return to work outside of the home.

Participants said that caregivers need to improve their awareness and training about prenatal loss, fertility difficulties, and mental health issues during the postpartum period or in cases of abortion. Besides new mothers experiencing trauma, some primary caregivers and other health care professionals may suffer vicarious (secondary) trauma and support is lacking. Participants felt that grassroots support initiatives can assist with these challenges but these initiatives are often started by young mothers and lack program resources, which may threaten longevity. Participants noted that support systems work best when different channels are utilized such as online discussion groups, moms' nights out, and face to face gatherings.

Participants reported that cultural factors can impact consumers in the postpartum period where there may be a push to get back to day to day living rather than gradually making the transition to parenthood. Even though we live in the information age, some women have difficulty accessing support. It was felt that educating children at a younger age and throughout K-12 (especially updating the sex education curriculum) were important, along with the media keeping maternity care at the forefront.

Overriding all of this, participants pointed out systemic issues. The system lacks accountability, transparency, and an inter-disciplinary approach. Funding systems are not set up to make the maternity care system efficient and restrict access to resources. The system increasingly prevents respectful maternity care, choices, and human rights in childbirth.

With Whom They Want

This section is broken into two subsections: primary caregivers and other health care professionals. The most frequently cited response in this category was the insufficient supply of midwives to meet consumers' demands.

Primary Caregivers

Without exception, participants agreed that all three primary caregivers (family doctors, obstetricians, and midwives) are important. When choosing a caregiver, participants' greatest

concern was the lack of equitable access to the caregiver of choice. The result is that women are forced to deliver in ways and in places that they do not wish.

Resoundingly, we heard that consumers want more midwives. Yet, in some communities, there are either no midwives or very few, midwives are not operating at capacity due to a lack of privileges, or there is a limited number of courses of care. Even in urban centres where there are midwives, access is limited with some participants talking about "winning the midwifery lottery". There were also concerns about how the client selection process for midwives lacks transparency and accountability. Some participants were concerned about restrictions that some midwifery practices place on HBAC, multiple births, and gestational diabetes with the view that the decision to care for clients should be based on the individual client rather than blanket policies by a particular practice.

On the other hand, some primary caregivers felt that they should be able to choose whether or not they want to work with clients with certain risk factors. There is a lack of understanding by other primary caregivers and consumers of how the midwifery funding models works and how it differs from other jurisdictions. There were concerns about a move away from traditional midwifery practice towards a more Technocratic approach. There was a call for Alberta Health Services to commit to the sustainable growth of midwifery and integrate all aspects of the profession (education, administration, regulation, funding, and recruitment).

Participants called for health care funds to be used more efficiently. They would prefer obstetricians, who are highly trained specialists and surgeons, to care for high risk rather than low risk women. Some participants reported that obstetricians were running their clinic contemporaneously with being on call. In some instances, an obstetrician would run their clinic in the hospital triage area (where, due to the environment, pregnant women overhear high risk issues being dealt with, which can breed fear and breech privacy). Some reported being treated more respectfully and presented with fewer scare tactics when their male partners attended prenatal visits.

In some communities, there is a lack of obstetricians. Some participants expressed a desire to have more obstetricians available and that they support normal variations in birth such as vaginal delivery of twins and breech babies. In some communities, family doctors no longer attend births because there are so many other practice demands. In some instances when family doctors are practicing maternity care, they are part of a large practice (up to 12 physicians) and women run the risk of giving birth with a doctor they have never met. This is something that many consumers do not want to happen because they feel they are vulnerable and that a trusting relationship with a primary caregiver is important to optimal birthing.

Participants recognized that primary caregivers are under a great deal of stress, with many working long hours because of the high birth rate and lack of resources. In some communities, it appeared to be standard for family doctors to care for pregnant women until 36 weeks and then refer them to an obstetrician, sometimes not letting them know beforehand and the woman assuming her physician would provide continuity of care. Some participants felt that they should also be able to self-refer. There were reports of inconsistency of care from one

primary caregiver to another and even among individual caregivers with the same woman from one pregnancy to another.

It was felt that physicians had good intentions but that local conditions were driving care. Appointments with physicians are short (10 minutes in some cases). There are long wait times at appointments (up to 2 hours), to make appointments (up to 2 weeks) or to reschedule appointments (up to 3 weeks) if a physician is called away when on call while running their clinic. Participants want to see more family doctors practicing maternity care. In one community, participants reported waiting four to six hours in an obstetrician's clinic (sometimes with a toddler in tow) when the doctor was called away. They wait because they do not want to reschedule due to lengthy waiting periods. Physicians do not have wait lists and midwives do, resulting in transfer of care concerns that can create difficult dynamics inter-professionally and force some women to be dishonest with their physicians to avoid being denied care.

Some communities reported high turnover in caregivers because of better opportunities elsewhere. Through our informal interviews, we thought this may also be because of entrenched powers in some communities making it difficult for those primary caregivers who were not part of the power base to practice in the way they want.

A concern raised was the difficulty in having more primary caregivers due to the cost of higher education. There are recruiting barriers at the local level due to Alberta Health Services administrative barriers and a lack of incentives to practice in rural settings and to practice labour and delivery. It was felt that there should be better ways for internationally trained midwives to become accredited and for TBAs to practice without legal repercussions.

There were some concerns raised about the Mount Royal University (MRU) Bachelor of Midwifery program, specifically regarding the granting of application interviews. Some participants suggested that the interviews should not be granted based solely on GPA. They would like to see an entrance exam and a personal statement. Participants did not appear to be aware of the challenges that MRU faces in the early years of offering its program.

There was a call for enhanced communication, increased cooperation and greater respect among health care professionals, and a move away from the politics of maternity care.

Other Health Professionals

Participants reported that hospital maternity care nurses offer a broad yet inconsistent range of skills and knowledge. Some questioned whether all nurses are familiar with natural, intervention-free birth. It was felt that hospital-based nurses were overworked and that there is a shortage of nurses in maternity wards. There were concerns about demographics particularly a gap in the number of nurses between the ages of 33 and 48. In other words, there is an impending shortage as the "older" nurses retire. This is impacted by potential changes to pension schemes which may be forcing some nurses to retire early. This is particularly risky since the "younger" demographic is in the childbearing season of life that may take them out of the workplace for periods of time, resulting in an even greater shortage of nurses.

In some small hospitals, when a woman presents in labour, a nurse may be assigned who is not up to practice or not keen on labour and delivery. There was some concern that some

nurses lack friendliness, compassion, civility, and patience. Some respondents attribute this to being overworked and under-resourced yet assert that such behaviour is not acceptable.

Many communities lack breastfeeding support with few lactation consultants in hospitals and communities (whether health care system-based or independent). In some communities, there is only one part time lactation consultant with 6 to 7 week wait lists, large territories to cover, or other work-related duties that limit the time they can spend offering breastfeeding support. Other well-intentioned professionals offer breastfeeding support but may lack training. It was noted that the first support a woman gets for breastfeeding birth is the most important.

In several communities, it was reported that public health nurses are over-extended. Some participants thought that there was little awareness about other health care modalities such as cranial-sacral therapy, chiropractic, or acupuncture and how they can complement care. It was felt that more community-based prenatal education and postpartum support would be helpful. There was a desire for prenatal education and support mechanisms focusing on women's vulnerabilities and empowerment rather than on teaching compliance. Other suggestions included increased public education, media attention, and authoritative discourse on reproduction, prenatal development, postpartum recovery times, breastfeeding, midwifery, out of hospital birth, doulas, and unassisted birth.

There were concerns raised about the lack of access and/or long waiting lists to see certain practitioners especially in remote and rural locations (e.g. ultrasound, pediatricians, availability of physicians for births, lack of midwives).

All of the focus groups talked about mental health issues including the lack of personnel specializing in birth trauma, post-partum depression, and other maternity care mental health issues. There are long wait times and some professionals may not even know what questions to ask to determine if their clients need services. Birth trauma was one of the primary themes in the focus groups yet participants thought that few health caregivers realize the extent of it. It was felt that there needed to be greater appreciation for how birth experiences impact women, babies, and breastfeeding outcomes. In only one community, there was a dedicated (part time) postnatal mental health professional who works closely with primary caregivers to provide support.

Some participants felt that there should be full or partial coverage of other services such as doulas or hypnotherapists, with increased respect by health caregivers and better integration. On the other hand, several primary caregivers and hospital-based nursing staff commented on the lack of consistency in how doulas practice and how some practice out of scope or created animosity with primary caregivers and other health caregivers.

Overall, when it came to who women birth with, there was a strong desire to see silos break down and an increase in interdisciplinary practice and inter-professional learning across all professions to increase understanding and foster collegial relationships from those who serve consumers from pre-conception through to early childhood development.

Clearly, there are pressing issues and room for improvement to ensure that Alberta women can freely choose where, how, and with whom they birth. The findings provide a

comprehensive understanding of the burning issues in maternity care, the current type of leadership, and aspects of the system that may not be aligned with espoused principles.

DISCUSSION, RECOMMENDATIONS AND REFLECTIONS

Our recommendations align with Alberta's Primary Health Care Strategy that defines three strategic directions: enhancing the delivery of care, changing the culture of health care, and creating the building blocks for change (Alberta Health, 2014a).

We offer two key points to developing a maternity care strategy that bolsters autonomy in decision-making and moves towards equitable access to care how, where, and with whom a woman chooses. First, a comprehensive leadership approach is needed across the system (government policy makers, administrators, professional organizations, academia, unions, consumer groups, and media). Second, to develop a maternity care strategy, a system of change is needed that focuses on remediation of the whole (instead of constituent parts) and relies on leverage points that are linked and interconnected. Our recommendations are set out below.

Our clarion call is that a multi-stakeholder, interdisciplinary team with at least 25% consumer representation be appointed to develop such a strategy that recognizes and addresses women's desire for autonomy over their bodies, the importance of informed decision making based on evidence, and the universal rights of childbearing women. While this report encompasses the broader maternity care picture, it was glaringly obvious from the nine focus groups, 1,235 survey responses, interviews, and written submissions that, by far, equitable access to midwifery services in urban, remote, and rural settings was the strongest theme. While some might argue that acceptance of midwifery is lacking, we did not find that to be the case. In one rural setting where there are no midwives practicing, one physician acknowledged that midwives would be welcomed to "share the load". As one nurse with over two decades of experience who serves as a local union leader stated, "We're all in this together".

The following discussion captures how Wexler's *Cosmopolitan Leadership* and Doppelt's *System of Change* can lay the foundation for a strategy to support the alignment of maternity care practice with the principles in Alberta's Primary Health Care Strategy.

Leadership

To address the changing context of maternity care in Alberta, contemporary leaders face an array of increased expectations. Whether primary caregivers, health care professionals, policy makers, or administrators, leaders have had to adapt. Contemporary leadership has evolved from being an individual characteristic to a complex social dynamic (Avolio, Walumbwa & Weber, 2009). Besides supporting positive health outcomes, leaders are expected to have high patient satisfaction, maximize use of financial resources, and keep employees engaged.

Maternity care leaders have to question their prevalent leadership philosophy. Because the world is moving so quickly, they also need to be nimble and adaptive. Yet, the pace of change is sometimes very slow. For example, adoption of the Baby Friendly Hospital Initiative has not been forthcoming even though it was launched in 1991. It was suggested that the Society of Obstetricians and Gynaecologists of Canada (SOGC) is not keeping pace with the American

Congress of Obstetricians and Gynecologists' (ACOG) clinical guidelines. There needs to be alignment between the health care system's espoused guiding principles for primary care and what is happening in maternity care practice. However, there need not be a trade-off between a principles-based approach and a service delivery driven one (George, 2003, Driver, 2006).

A comprehensive leadership approach is needed for Alberta's maternity care system. In *Leadership in Context: The Four Faces of Capitalism,* Wexler describes four worldviews that, taken collectively, offer a wide-ranging approach called Cosmopolitan Leadership. The four worldviews are Entrepreneurial (focused on maximizing use of financial resources), Regulatory (focused on uncertainty/risk reduction), Communitarian (focused on meaningful existence), and Network (focused on collaboration and innovation) (Wexler, 2005).

The subtitle *Four Faces of Capitalism* refers not to the political economy but to the worldviews and how "time, energy, passion or capital" are deliberately invested to achieve results (Wexler, 2005, p. 2). Context is essential to understanding leadership based on two assumptions: Each person makes sense of reality based on their worldview that they consider rational and leaders can learn to understand and apply more than their own worldview (Wexler).

The key to becoming a Cosmopolitan Leader who can take a systems view is for the individual leader to understand their own worldview, determine to what extent their leadership skills are lacking, and reinvent themselves as Cosmopolitan Leaders (Wexler, 2005). Otherwise, they are limited to being a *Local Leader* who will have difficulty dealing with change.

We assert that an effective maternity care system that wishes to authentically engage with Albertans would do well to take a Cosmopolitan Leadership approach.

The Entrepreneurial Worldview – The "Money Talks" Story

The Entrepreneurial Worldview is focused on taking action, creating results, and maximizing use of financial resources. The ethic of this worldview is wealth generation through winning. While maternity care services are not about generating wealth, they do require efficient use of financial resources. By virtue of the way that maternity care services are currently funded, our system is rooted in the Entrepreneurial Worldview with the other worldviews marginalized. This results in competition among some primary caregivers. That is not to say that responsible stewardship of financial resources should not happen. Rather, it is to say that financial mechanisms need to adapt to the changing context particularly funding of primary caregivers.

The current system generates what economics refers to as perverse financial incentives (Heath, 2014). To reduce queues, physicians would have to forego some patients along with the fees that they would receive for their care. This could open the system to fund courses of care for midwives in communities where there are none. But there is no financial incentive to do this, particularly since the two professions are funded out of separate funds. Somehow the funding of maternity care services needs to be centralized with oversight mechanisms put in place.

Instead, pregnant women are getting induced at earlier and earlier gestation even when there is no medical indication. In fact, induction may be happening so early as to run the risk of prematurity particularly if a woman is unsure of her dates (Fleischman, 2010). We were told that inductions may take place so that physicians can accommodate their long queue of clients and

women are agreeable because it prevents them from having a stranger attend their birth. As a preventative measure to counter these effects, the strategy of forming practice groups to pool patients has taken place. However, this has problems particularly with practices with up to 12 partners (midwifery teams have a maximum of four) thus diminishing continuity of care and increasing the chance that a woman will end up birthing with a stranger. The rationale for this may include preventing burnout, preserving family life, or having scheduling control. This creates a challenge for everyone.

Change also necessitates maintaining the significant role of the Communitarian Worldview that calls many practitioners to become health caregivers in the first place – a desire to serve others and do no harm.

The Communitarian Worldview – The "Cooperation Pays" Story

The Communitarian Worldview is interested in dialogue, shared values, authenticity, and trust. Honouring one's word is the ethic of this worldview. The de-coupling of the Entrepreneurial and Communitarian Worldviews was a deeply concerning finding during the Listening Campaign. The extent of lack of compassion, respect, patience, and civility was unexpected as was the degree of fear mongering described by participants. Our system needs to return to a dual approach of old. Specifically, the underpinning principle of respecting women's autonomy over their bodies and choices needs to be upheld while remaining mindful of limited resources and making sure regulations and professional standards are maintained.

The Regulatory Worldview – The "Built to Last" Story

Planning, certainty, and reliability are some of the hallmarks of the Regulatory Worldview. Abiding by rules and traditions is this worldview's ethic. More emphasis needs to be put on systems and strategy because of the increasing birth rate, limited resources, and a shortage of primary caregivers. When it comes to privileging the past, our view is that it should take into account the time centuries ago when women were seen as healers and elders.

The Regulatory Worldview is also relevant because the professions are so heavily regulated. The "Built to Last Story" and its need for strategy, planning, systems, and policies means finding new ways of delivering maternity care – writing a new story without losing the importance of best practices from the past. This notion leads us to the final worldview.

The Network Worldview – The "Portal to a New World" Story

The Network Worldview is knowledge-centred and focuses on possibilities, alliances, and creativity. Its ethics are innovative and emergent. This worldview offers the maternity care system an opportunity to extend that commitment in various ways with particular emphasis on coupling the Entrepreneurial and Communitarian Worldviews.

In considering the "Portal to a New World" story, collaboration may be the most innovative approach to take. If the decision is made to develop and implement a maternity care strategy for Alberta, it should be a multi-stakeholder, interdisciplinary process with representation from primary caregivers (family doctors, midwives, and obstetricians), other

health care professionals (hospital-based nurses, public health nurses, lactation consultants, doulas, childbirth educators, mental health professionals, early childhood professionals), other sectors (academia, educators, students, union) and, most importantly, a high level (at least 25%) of consumer representation (women who are pregnant, will become pregnant, or have been pregnant). The multi-stakeholder, interdisciplinary group should also reflect diversity by having representation among its members: aboriginals, youth, elders, differently-abled, immigrants, LGBTQ, etc. In the remainder of this report, the multi-stakeholder, interdisciplinary group that we are proposing will be referred to as McStAR (Maternity Care Strategy for Alberta Representatives).

As Wexler (2005) points out, leaders with the greatest reach are those who can customize their story to achieve success. By considering Cosmopolitan Leadership, Alberta's maternity care system can customize its story by taking a progressive and concept-driven approach. To do so, a systems approach is needed to counter barriers that are currently embedded in the system.

Systems Change

Advancing maternity care can be viewed through a Systems Thinking lens by taking an interdisciplinary view of how different parts or groups of the maternity care system can work as a whole (Senge, Smith, Kruschwitz, Laur, & Schley, 2008; von Bertalanffy, 1969). This is needed because of the host of disciplines within the maternity care system that work together including. Doppelt (2010) asserts that effective governance systems facilitate information exchange, decision-making, and distribution of finances and other resources. He identifies blunders to change that can be counteracted by leverage points that are progressively linked and interconnected. Our recommendations are organized around these ideas, as set out below.

Table 2

Doppelt's (2010) System of Change: Blunders, Levers and MCAN's Recommendations

Blunders	Levers	MCAN Recommendations
Patriarchal Thinking	Change the Dominant Mindset	Change the Dominant Mindset
Silo Approach to Issues	Re-arrange the Parts	Fund Maternity Care Services by User
No Clear Vision	Alter the Goals	Adopt a Province-wide Maternity Care Strategy
Confusion over Cause and Effect	Restructure the Rules of Engagement	Align People and Processes
Lack of Information	Shift the Flows of Information	Enhance the Flows of Information
Insufficient Mechanisms for Learning	Correct the Feedback Loop	Become a Continuous Learning System
Failure to Institutionalize Change	Adjust the Parameters	Increase Accountability and Transparency

Systems change is messy and the weak application of any of the levers can disrupt the change process (Doppelt, 2010). There must be a heartfelt desire among all stakeholders to recognize their own mental models, rise above the dominant mindset and existing conditions, and believe in the possibility of change. One of the reasons why system changes fail is that the final leverage point of changing the parameters (in the case of MCAN's recommendations increasing accountability and transparency) is over-emphasized to the exclusion of the other leverage points. In doing so, the complexity of the system is over-looked and the inter-relations of the various elements of the system are not taken into account (Doppelt).

Applying a systems approach to Alberta's maternity care landscape will also address von Bertalanffy's (1969) view that structural similarity exists between various fields, reflected in the statement, "We are widely scattered and do not know each other, so difficult is it to cross the boundaries of the disciplines" (von Bertalanffy, 1969, p. 14). We found that structural similarity exists in Alberta's maternity care system. Participants indicated that they were not aware of some of the local issues or the services that were available. For example, community-based parenting support professionals indicated that they didn't realize the challenges facing their local hospital because of a baby boom and hospital-based professionals were not aware of the prevalence of birth trauma once women left the hospital setting.

System parts are in mutual interaction and the best way to change a system is not to consider the various parts individually but to regard the system as a whole. Solutions need to be sought by emphasizing the remediation of the whole rather than the constituent parts. The following are our recommendations.

Changing the Dominant Mindset

Based on our findings, the dominant mindset in maternity care has to shift to recognize women's psychological and emotional needs along with their physical needs. Such an approach will align with the following: Canada's commitment to the United Nations Women's Convention and Alberta's Primary Health Care Strategy. It will also uphold the universal rights of childbearing women.

Action:	Shift the dominant mindset to the Holistic Model
Who:	Government policy makers, health care administrators, primary caregivers, other health care professionals, unions, consumers, media, university educators (academic staff, course developers)

Funding Maternity Care Services by User

Because primary caregivers are financed out of separate finance pools, mechanisms should be put in place to provide centralized oversight of how maternity care services are financed, with a view to embedding continuity of care, seamless service delivery, and accountability for taxpayer dollars. Funding of maternity care services should follow the user

not the practitioner and utilize innovative models to support the best outcomes (Gulliford, Naithani & Morgan, 2006).

Action:	Design and implement a centralized oversight mechanism for maternity care funding
Who:	Alberta Health and Alberta Health Services

Action:	Enhance continuity of care
Who:	Primary caregivers

Adopt a Province-wide Maternity Care Strategy

At the highest level, there needs to be a clearly articulated commitment to improve maternity care. This should entail the Premier and Minister of Health appointing a heterogeneous team who can bring a variety of perspectives to establish a clear vision for the future and develop a maternity care strategy for Alberta that encompasses all families (including rural, remote, diverse, and vulnerable populations).

Action:	A clearly articulated commitment to improve maternity care
Who:	The Premier, Minister of Health

Action:	Appoint McStAR through a consultative process
Who:	Minister of Health

Action:	Develop a maternity care strategy for Alberta
Who:	McStAR

Align People and Processes

Respect for women's autonomous choices and their bodies needs to increase, including ensuring informed consent and being transparent and forthcoming to birthing women about all choices pursuant to international human rights in childbirth standards, including their rights to:

- Freedom from harm and ill treatment
- Information, informed consent and refusal, respect for choices and preferences, including the right to companionship of choice wherever possible
- Confidentiality, privacy
- Dignity, respect
- Equality, freedom from discrimination, equitable care
- Timely health care and to the highest attainable level of health

- Liberty, autonomy, self-determination, and freedom from coercion (The White Ribbon Alliance, 2011).

Primary caregivers and nursing staff need to be provided with the physical and human resources they need to do their jobs, meet their standards of practice, and develop professionally. Childbirth educators, consumer groups, and mental health professionals can work to support women in finding, using, and amplifying their voices in birth.

Action:	Education on informed consent and respect for choices
Who:	Primary caregivers, other health care professionals, bodies that recruit internationally trained primary caregivers

Action:	Improve opportunities to process birth experiences including: ● Increasing awareness around birth trauma; mechanisms for dealing with trauma for women and for birth professionals ● Increasing safe debriefing and dialogue between women and caregivers without fear of being sued or discounted
Who:	Public health, consumer groups, mental health professionals, media

Action:	Empower women to find and use their voices
Who:	Consumer groups, mental health professionals

Action:	Provide adequate physical and human resources in hospital and community settings for staff to fulfill their duties
Who:	Alberta Health Services, professional associations

Enhancing the Flows of Information

More effort needs to be put into instilling evidence-based practice, increasing awareness, and improving transparency around a number of identified areas such as reinforcing Society of Obstetricians and Gynaecologists of Canada guidelines and understanding the Canadian Model of Midwifery Practice. There needs to be enhanced understanding about: natural physiological birth, prenatal loss, fertility challenges, waterbirth, vaginal birth after caesarean, breastfeeding, birth trauma (whether situational or iatrogenic), and other mental health concerns. In addition, new modes of outreach to diverse and vulnerable populations need to be pursued.

Action:	Review, update, and implement knowledge management programs and platforms
Who:	Alberta Health Services, professional associations

Action:	Increase knowledge and awareness of maternity care issues
Who:	Alberta Education, Alberta Teachers' Association, SOGC, Alberta Medical Association, Alberta Association of Midwives, consumer groups, aboriginal communities, academics, media

Becoming a Continuous Learning System

A commitment is needed at a high level to make the maternity care system a continuous learning system. This will entail moving beyond traditional approaches to overcome barriers, promoting learning as valuable, and employing more knowledge creation and dissemination mechanisms, such as MOREOB (Managing Obstetrical Risk Efficiently), which was noted in several instances as a good tool albeit with limited licenses currently available in Alberta and reliant on local leadership for application.

One of the aims of the multi-stakeholder, interdisciplinary group (McStAR) that will develop the maternity care strategy for Alberta will be to identify silos, find ways to remove barriers and put mechanisms in place to increase interdisciplinary learning.

Action:	Increase interdisciplinary learning
Who:	McStAR as part of the maternity care strategy, professional associations, academia

Action:	Commit to the maternity care system being a learning system
Who:	Minister of Health, Alberta Health Services, McStAR

Increasing Accountability and Transparency

Despite the complexity of our maternity care system, alignment across and through the system - strategically, administratively, and operationally - needs to be a priority. Sophisticated tools will need to be developed to set performance improvement targets and measure progress. Accountability mechanisms and increased transparency will need to be put in place as well as seeking and applying best practices.

Action:	Identify accountability mechanisms; increase transparency
Who:	McStAR, Alberta Health, and Alberta Health Services

Action:	Implement accountability mechanisms
Who:	Alberta Health and Alberta Health Services

Reflections

Alberta's maternity care leaders are challenged due to a lack of a strategy, a shortage of primary caregivers, and inequitable access to choice of caregiver and birth setting. Despite this, we were heartened by the sincere desire for change by those who participated in the Listening Campaign whether they were consumers, primary caregivers, other health care professionals, academics, students, or simply interested taxpayers. We found participants to be passionate about maternity care and genuinely concerned not just about the conditions of where, how, and with whom birth takes place. Many were concerned with the shortage of primary caregivers and the impact that system constraints are having on the well-being of health caregivers and how high stress levels may be contributing to compromised care, a lack of compassion for patients, and treating patients "like a number". MCAN's greatest desire is to have a maternity care strategy for Alberta developed and implemented.

Our hope is that, by taking a comprehensive leadership approach and applying a system of change to maternity care, Alberta's principles around primary care and the universal rights of childbearing women will be better upheld. We recognize that this is a daunting dream and that there is no set path to accomplish it. We do not purport to have all of the answers nor make any suppositions that there will not be bumps along the way.

In essence, we are suggesting a balance of Wexler's four worldviews. We are optimistic that, through applying Systems Thinking and developing a maternity care strategy, we can see a shift to greater caring and compassion (Communitarian Worldview) where client/patient choices are heard, respected, and valued. We also recognize the importance of remaining diligent and fiscally responsible with limited health care resources (Entrepreneurial Worldview). All of this should be tempered by the Regulatory Worldview that has become increasingly necessary because of maternity care risk and complexities. Finally, we call for a commitment to be innovative and continuously learn by taking a Network Worldview and to find better ways to practice, manage care, and engage with stakeholders.

Scientia Cordis (Science of the Heart)

These lofty goals will only be possible based on two key ideas. First, the world has changed. As a result, how maternity care services are delivered requires an expanded repertoire in terms of collaboration, how services are funded, and how consumers are engaged in advancing the system. There is a plethora of website information, videos, tutorials, journal articles, forums, etc. that specifically address the changing times surrounding childbirth. The demand for change is high; yet actual change is minimal and the pace is slow. We assert that the Holistic Model is the dominant mindset that is required to uphold the universal rights of childbearing women.

The challenge is that, while employing a rights-based philosophy is a process that is worth pursuing by the maternity care system, it is not fully attainable. Our maternity care system faces structural impediments to realizing this type of social justice, particularly as a result of constrained financial resources (Borwick, 2004). Furthermore, a maternity care system that is supportive of a rights-based approach may be reliant on exceptional individuals who use their

positions to advance their personal beliefs (Borwick, 2004). This might be at a government level, health care setting level, practice level, education level, or consumer level. Such efforts, while admirable, may not be sustainable when there are changes in leadership. Nonetheless, these considerations should not diminish the efforts that policy makers or, indeed, primary caregivers or any other stakeholders take in pursuit of a rights-based approach to maternity care.

The second key idea is that caregivers must hold tight to that which called them to maternity care in the first place. As one physician stated, "We do this because we love it." Consumers' voices must be heard, honoured, and respected; not belittled, disregarded or, even, outright refuted as indicated in our findings. This need is supported by Elmir, Schmied, Wilkes and Jackson (2010), stating that

> Healthcare professionals must recognize women's need to be involved in decision-making and to be fully informed about all aspects of their labor and birth to increase their sense of control (p. 2,142).

By doing so, a context will be created which can move all of us that much closer to a system that aligns practice and principles and positions Alberta as a leader in maternity care.

The first sentence in Mark Wexler's book, *Cosmopolitan Leadership* is, "We know leadership when we see and admire it" (2005, p. 1). MCAN wants to see and admire maternity care leadership and we saw glimpses of it throughout our Listening Campaign. The participants' voices and hearts which informed this Listening Campaign were deeply committed to advancing change. The stories that we heard and read were stories of real human beings. Many broke our hearts. Others inspired optimism.

Wexler (2005) also wrote about reflexivity being integral to leadership and emphasized the importance of being open to others' worldviews. French geologist Xavier Lepichon described how common humanity or fundamental unity occurs the more that our hearts open up and we become compassionate (Vanier, 1998). The Romans called this *scientia cordis*, the science of the heart that allows us to be vulnerable, accepting, and understanding of others, while listening to their needs, and challenging them when necessary (Vanier, 1998, p. 88).

Our desire is that the maternity care system evokes *scientia cordis* by taking the desires we heard in our Listening Campaign and operationalizing them so that all stakeholders can be empowered to become all that they can be as the great Canadian Jean Vanier (1998) described:

> To become fully human is not a question of following what everyone else does or conforming to social norms, or of being admired and honoured in a hierarchical society, it is to become free to be more fully oneself, to follow one's deepest conscience, to seek truth and to love people as they are. (p. 95).

Giving birth can be one of the most empowering or disempowering experiences of a woman's life. By shifting the focus to one where birthing women can be their greatest selves even when their birth experience is difficult or does not turn out the way they wanted, our maternity care system will create the transformative experiences that we described at the outset.

However, wanting a life-altering and satisfying birth experience is not just for the sake of feeling good. It results in better outcomes and enhanced well-being for families which, in turn,

keeps health care costs down both from physical and mental health perspectives. All of this contributes to family bonding; builds trust with the health care system; gives women self-respect, dignity and pride; increases community involvement; and strengthens society. From an economic perspective, a healthy woman (in mind and body) has a healthy baby. In turn, society does not have to bear the costs for a mother or baby who are not thriving.

Our hope is that the findings and recommendations in this report will encourage and embolden Alberta's political leaders to improve the maternity care system so that it is wholly integrated with interdisciplinary collaboration and where leadership is strategic, health professionals have balanced and rewarding careers, and women freely choose where, how, and with whom they birth. In doing so, healing birth in Alberta will begin, which can ultimately contribute to healing the planet.

Appendix A – About the MaternityCare Consumers of Alberta Network

MISSION

The MaternityCare Consumers Network of Alberta (MCAN) is the provincial body that represents Alberta consumers on important maternity care health policy and other initiatives.

VISION

Alberta women freely choose where, how, and with whom they birth.

OBJECTIVES

The objectives of the MaternityCare Consumers of Alberta Network (MCAN) are to:

- Advocate fair, equitable, efficient and effective access to maternity care services; and
- Support consumers in engaging in the development, improvement and expansion of maternity care and related services in Alberta.

WE DO OUR WORK BY

- Employing a rights-based philosophy that emphasizes the right of consumers to make informed choices and have equal access to publicly funded, quality maternity care of their choosing in their community (whether provided by midwives, physicians or obstetricians)
- Developing knowledge and understanding of provincial maternity health care agenda, reforms and emerging issues and their impact on consumers and communities
- Empowering and equipping leaders in the maternity care consumer community to be informed, amplify their voices and be effective in their work at local and provincial levels
- Maximizing consumer participation in relevant bodies and groups that develop maternity health care policy, planning, decision-making, service delivery and evaluation (e.g. regulatory agencies, professional organizations, health care settings)
- Convening fora and developing programs to encourage collaboration and cooperation to advance MCAN's mission and vision
- Being a respected and credible voice for Alberta maternity care consumers

PROJECT TEAM

The project is being overseen by Dr. Laura (Lolly) de Jonge, the primary author of this report who collaborated with Nicole Hill and Jennifer Summerfeldt. Claire MacDonald provided editorial guidance. Dr. de Jonge is a maternity care leader with senior management experience and over 25 years of community leadership involvement. Her doctoral studies were in human and organizational systems. Ms. Hill is a researcher on women's reproductive experiences and is completing a Masters of Arts in Integrated Studies focusing on equity and social justice. Ms. Summerfeldt is a women's life transition and birth coach and working toward a Master of Arts in Counselling Psychology with emphasis on birth trauma and postpartum depression. Ms. MacDonald is the Editor-in-Chief of Birth Issues magazine and a doula since 1999. The Project Team's multi-disciplinary background enabled a complementary approach to the data collection and analysis. They received no compensation for their work and declare that they have no competing interests.

Appendix B – The Technocratic, Humanistic and Holistic Models of Medicine

Technocratic Model	Humanistic (Biopsychosocial Model)	Holistic Model
Mind-body separation	Mind-body connection	Oneness of body-mind-spirit
The body as machine	The body as an organism	The body as an energy system interlinked with other energy systems
The patient as object	The patient as relational subject	Healing the whole person in whole-life context
Alienation of practitioner from patient	Connection of caring between practitioner and patient	Essential unity of practitioner and client
Diagnosis and treatment from the outside in (curing disease, repairing dysfunction)	Diagnosis and healing from the outside in and from the inside out	Diagnosis and healing from the inside out
Hierarchical organization and standardization of care	Balance between the needs of the institution and the individual	Networking organizational structure that facilitates individualization of care
Authority and responsibility inherent in practitioner, not patient	Information, decision-making and responsibility shared between patient and practitioner	Authority and responsibility inherent in each individual
Supervaluation of science and technology	Science and technology counterbalanced with humanism	Science and technology placed at the service of the individual
Aggressive intervention with emphasis on short-term results	Focus on disease prevention	A long-term focus on creating and maintaining health and well-being
Death as defeat	Death as an acceptable outcome	Death as a step in the process
A profit-driven system	Compassion-driven care	Healing as the focus
Intolerance of other modalities	Open-mindedness toward other modalities	Embrace of multiple healing modalities
Basic underlying principle: Separation	Basic underlying principle: Balance and connection	Basic underlying principle: Connection and integration
Type of Thinking: Unimodal, left-brained, linear	Type of Thinking: Bimodal	Type of Thinking: Fluid, multimodal, right brained

Source: Davis-Floyd (2001)

ordering information:

Copies of this report, a condensed version in a Briefing Note, a list of references and list of acknowledgements can be downloaded from www.maternitycarealberta.com

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