INTRODUCTION AND METHODOLOGY

The College of Midwives of BC and the Midwives Association of BC jointly contracted a researcher and consultant to support the BC Midwifery Scope and Model of Practice Review. The researcher of this report is a Registered Midwife practicing in a rural community in Northern British Columbia. Prior to training as a midwife, she worked as a legislative researcher and policy analyst in the Parliament Buildings in Victoria, BC.

In July 2013, the research undertaken began with a comparison of midwifery scope and model of practice across both Canadian and selected international jurisdictions; which also included a comparison of regulation, legislation, standards, policy, funding models, liability insurance mechanisms, as well as midwifery outcomes.

The inclusion criteria for the selected international jurisdictions was based on jurisdictions where midwives are autonomous primary care providers and have similar or easily comparable models and scopes of midwifery practice to BC and the majority of Canadian regulated jurisdictions. We focused on countries where the midwives were providing care to similar populations as would be seen in Canadian settings. The selected jurisdictions were New Zealand, Australia, the United Kingdom, the Netherlands, Sweden and Norway. Denmark and Germany were later added.

The demographics, maternity care and midwifery outcomes across BC and Canada were reviewed. An identified challenge to obtaining information about current functioning of and trends for maternity care in smaller communities in BC is how quickly the viability of service changes[1]. In some smaller settings, one or two providers leaving a community or taking leave can quickly destabilize the maternity care options available in that community. For that reason, absolute current information can be challenging to come by. To obtain demographic information about communities, the author looked at Canadian Institute of Health Information reports, Perinatal Services BC data, and Statistics Canada demographic trends.

The duties and objects of the College of Midwives of British Columbia are set out in BC's Health Professions Act. The College regulates the profession of midwifery with a mandate to serve and protect the public and to exercise its powers and discharge its responsibilities in the public interest. Advocating for the interests of practicing midwives in British Columbia is the mandate of the Midwives Association of BC. However, in the real world the public interest, and in particular the health and safety of childbearing women, cannot easily be separated from the sustainability and viability of the midwifery profession that cares for those women. Thus, in assessing current conditions and projected trends affecting both childbearing women and midwives in BC, and reviewing the scope and model of practice for midwifery in the Province of British Columbia in light of those conditions and trends, it made sense for the College and the Association to partner in a review that hopes to point the way to the most appropriate scope of practice, clear and effective standards of practice and policies, and more flexible and sustainable systems to better ensure childbearing women's access to safe, effective and relational care, while also supporting midwives in fully utilizing their skills to effectively care for women in rural, remote and urban environments, collaborating with their maternity care colleagues, and responding to

ongoing changes in practice environments, advances in technology and other emerging issues in health care.

The purpose of this project is to set the groundwork for consultations with both childbearing women and practicing midwives by gathering current data, information and trends regarding the current model and what best serves the public interest here in BC and in other jurisdictions, as well as identifying where potential gaps in services or other challenges lie, and what trends are demonstrated by the demographic information. We also look at the demographics of the currently practicing midwife population in British Columbia. This will set the stage to ask childbearing women what matters to them most about their maternity/midwifery care and the care available for their newborns, as well as ask registered midwives themselves (in rural, remote and urban settings) what is working well and what they see as the challenges and barriers to serving women and to successful, sustainable, life-long practice.

As a registered midwife herself, in full-time practice, the principal author has the unique perspective of having graduated from the UBC midwifery program, introduced and integrated midwifery into a small rural BC community, and later worked in a busy regional referral center in the North. She is also acutely aware of the challenges of work/life balance in practising sustainable midwifery.

INTERPROVINCIAL COMPARISON

The provinces and territories reviewed were British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Québec, New Brunswick, Nova Scotia, Newfoundland, Northwest Territories, Yukon and Nunavut. With each province/territory, we looked at scope, model of practice, the funding model, the insurance mechanism, and available maternity care and midwifery outcome data.

Province or Territory	Year Midwifery Regulation was Implemented
British Columbia	1998
Alberta	1998
Saskatchewan	2008
Manitoba	2000
Ontario	1994
Quebec	1999
New Brunswick	2010, regulation brought into force, not yet implemented
Nova Scotia	2009
Prince Edward Island	2010, not regulated – task force
Newfoundland	2010, not regulated
Nunavut	2011
Northwest Territories	2005
Yukon	2007, not regulated – government investigation , 2010 and 2013 public consultations

Table 1. “Legal Status of Midwifery in Canada,” adapted from Canadian Midwifery Regulators Consortium, last revised February 2014

In the legislation and/or regulation, common definitions include the role of the midwife and what the practice of midwifery encompasses[2 3 4 5 6 7 8 9 10 11]. The legislation or regulation usually describes both the midwife's role and the midwife's scope of practice, including the assessments , restricted activities and invasive procedures the midwife may undertake in the course of her practice (these may be exclusively reserved for midwives or be a part of a shared scope of practice with other regulated health professionals in that regulating jurisdiction), as well as the drugs or categories of drugs that the midwife may prescribe, order and administer, and the screening and diagnostic tests the midwife may order and interpret. Also described may be the model under which the midwife practices, including the standards and code of ethics that determine how she must practice, and requirements such as offering women choice of birthplace and continuity of care.

The over-arching philosophy for the practice of midwifery is that pregnancy, labour and birth and early parenting are significant and profound life experiences to women and their families. Midwifery is grounded in the normalcy of pregnancy and birth and its place as a natural life process. Important are the concepts and tenets of informed choice and respect for the childbearing woman's autonomy. Across Canada midwifery has been rooted in continuity of care which includes time for relationship-building between small practice groups of midwives and the women in their care. Also key is the central idea of midwives as autonomous primary healthcare providers[12], working as part of a team with other health care providers[13], with full responsibility for provision of care within their scope of practice. Key to this is the idea that midwives use their clinical judgement and clinical indications to assess when a woman or newborn's care is outside their scope of practice and if that is determined, they refer them into another appropriate provider's care while remaining available to provide supportive care[14].

The midwife's scope of practice is similar from province to province across Canada, as is the model of practice. However, there are small but significant differences in items such as the degree of laceration severity of tear that midwives may repair and what diagnostic tests may be independently ordered and interpreted, or what medications may be prescribed, ordered and administered[15].

Also the liability insurance requirements, including the minimum required coverage that a midwife must have in place in order to practice, are quite similar across the country, and are set out in legislation, regulation or the bylaws of the provincial or territorial regulatory body[16].

In each jurisdiction, a College of Midwives or other designated regulatory authority sets the standards of practice under which midwives practice. Across Canada this most often includes standards regarding continuity of care, client informed choice and choice of birth place[17]. There is a great deal of consistency regarding these issues and recognition of their importance to childbearing women across the country[18].

All Canadian jurisdictions that regulate midwifery also fund midwifery services through the public health care system. However, funding models across Canadian jurisdictions, as well as compensation levels, can differ significantly. For example, in Alberta, after midwives were regulated they remained privately funded for a number of years, until the government decided to fund midwifery services under a funded "course of care model" similar to the models used in BC and Ontario. Alberta midwives are capped at 40 courses of care annually, but the fee per full course of care is currently higher than in other provinces[19]. In many provincial and territorial jurisdictions (i.e. Nova Scotia, Quebec[20], Manitoba, Saskatchewan,

Northwest Territories[21], Nunavut[22]), a salaried employee model is in place and overhead expenses, including office equipment, supplies and professional insurance are paid for by the employer, which is often a health region, hospital or community health centre (CLSC in Quebec). In the independent contractor model (i.e. Ontario[23], BC, Alberta) some jurisdictions (e.g., Ontario) provide midwives with a specific allocation for administrative support, equipment, supplies and professional insurance[24], while others assume this is included in the course of care fee schedule.

Midwives in the salaried model have access to life insurance, disability and extended health and dental and pension plans as employees, while midwives in independent practice have access to similar benefits through benefits programs offered through their professional associations, which may also include RRSP contributions instead of a pension plan (e.g. as in Ontario).

Under the salaried model midwives are paid for statutory holidays and have paid vacation of 3-6 weeks per year, while independent midwives who are paid on a course of care model generally have a higher negotiated rate of compensation. This results in fairly similar levels of compensation across the country, although the different models can make comparisons difficult. In some jurisdictions where midwives are employees they are also unionized[25]. In both employee and independent contractor funding models compensation may be based on a fee scale related to level of experience or years of service, or on a fee schedule that applies to all midwives, regardless of their experience[26].

In the Manitoba, Saskatchewan and Nova Scotia, private practice midwifery is also possible, although this option is not much used. Midwives in private practice are paid directly by the woman and are responsible for paying all of their own expenses and liability insurance coverage[27].

New Brunswick has passed midwifery legislation[28] but does not currently have a funding model and has not yet registered any midwives[29].

In 2010, the Newfoundland and Labrador Health Professions Act, under which midwifery will be governed, received royal assent[30].

Prince Edward Island and the Yukon Territory have not yet regulated midwifery. Prince Edward Island has created a task force to study the issue[31].

Overall midwifery is a growing profession across Canada, with a small but steadily increasing percentage of midwifery-involved birth each year. Midwifery-involved birth and its benefits both to women, and in cost savings for the government, are well-demonstrated. Research from Ontario looked at the benefits of midwifery to the woman planning a vaginal birth after cesarean. The repeat c-section rate in Ontario was 84.3% (2006/2007) and amongst midwifery clients (2003-2008) was 46.1%, a very significant difference[32].

In British Columbia in 2011/2012, there were 1060 homebirths in British Columbia attended by Registered Midwives[33]. From 2007, in which there were 647 home births assisted by midwives, and 2011, in which there were 1057 births assisted by midwives, we saw an increase of 38% in the raw number of home births. However, the overall midwife-involved birth rate also grew from 2,716 to 4,924

over the same time period, an increase of 44%[34]. With new supports for home birth, we may see home birth numbers increase.

From 2002/03 to 2011/12, the rate of midwives as delivery care provider in BC (rate per 100 deliveries) has grown steadily from 3.6/100 to 10.9/100[35] and by 2011; the percentage of total births delivered by registered midwives in BC had increased to 11.2%[36]. This growth trend seems to be stable and likely to carry on into the future. As we integrate new graduating midwives into the system each year and as the profession and number of midwife-involved birth grows, policy and guidelines and funding may also need to be reassessed.

Midwife % of deliveries 2007/08 to 2011/12[37]	Rural Residents	Urban	Total Births 2011[38]
British Columbia	10.5%	9.8%	44,129
Alberta	0.6%	1.4%	51,040
Saskatchewan	0.3%	0.6%	14,271
Manitoba	3.8%	4.2%	15,620
Ontario	7.6%	6.8%	140,135
Quebec	-	-	88,583
New Brunswick	0%	*	7,124
Nova Scotia	1.2%	0.5%	8,862
Prince Edward Island	0	0	1,436
Newfoundland	4.2%	*	4,478
Nunavut	0.3%	*	837
Northwest Territories	5.8%	3.6%	690
Yukon	*	0	431

Table 2
*results suppressed due to small sample size

Province/Territory	Number of Registered Midwives Active Practice
British Columbia	218 (Jan 7, 2014)[39]
Alberta	69 (Mar, 2013)[40]
Saskatchewan	37 (Mar 31, 2013)[41]
Manitoba	55 (Aug, 2014)[42]
Ontario	441[43]
Quebec	146[44]
New Brunswick	n/a
Nova Scotia	9[45]
Prince Edward Island	n/a
Newfoundland	n/a
Nunavut	21(Mar 31, 2014)
Northwest Territories	3
Yukon	2

Table 3. Number of Midwifery Registrants in Active Practice

INTERNATIONAL COMPARISON: SELECT JURISDICTIONS

As noted in the introduction, the jurisdictions for international comparison and review were carefully selected with an eye to jurisdictions that had a similar model and scope of midwifery practice to the BC setting. As well, we focused on countries where the midwives were providing care to similar populations as would be seen in the Canadian setting. The selected jurisdictions were Australia, Denmark, Germany, the Netherlands, Norway, New Zealand, Sweden, and the United Kingdom.

Country	Australia	Canada	Denmark	Germany	The Netherlands	Norway	New Zealand	Sweden	United Kingdom
Midwives (practising) per 100,000[46] 2010	-	-	27.99 (2009)	23.24	15.72	51.75	-	77.46	52.78
Midwives graduated per 100,000[47] 2010	-	-	2.85	0.73	0.79	1.82	-	1.96	2.29
% Births by cesarean section[48]	31.6 (2010)	26.9 (2011)	21.2 (2012)	32.1 (2011)	17 (2010)	17 (2011)	23.6 (2010)	17 (2011)	20-25 (2013)[49]
Neonatal Deaths (per 1000) 2012[50]	1	1	0	2	0	0	0	0	2
Maternal mortality ratio (per 100,000 live births) 2013[51]	6	11	5	7	6	4	8	4	8

Table 4. Select Comparisons by Country, source: European Health for All Database, WHO Global Health Observatory Database

In all the jurisdictions reviewed, there is a universal recognition of normal, physiologic birth as the ideal, and that midwifery has a role to enhance and protect normal birth[52],[53]. The International Confederation of Midwives and the International Federation of Gynecology and Obstetrics joint statement states that "prescribing a midwife" is an effective way for OBs to ensure better care for women and their babies[54].

Midwifery has a long history in European countries, with a much more integrated approach in most settings due to the length of time for which midwives have been providing core maternity care services. For example, in Sweden, the regulation of midwifery began in 1711[55]. The benefits of this long history can be seen in some settings with improved outcomes and low neonatal and perinatal death rates[56],[57], but challenges can also be identified, especially seen in settings where optimal staffing levels and interprofessional collaboration have been under pressure[58]. Also of benefit for data analysis is the large number of midwives providing care in these settings. We may have much to learn from both the successes demonstrated and the challenges seen in these settings.

Country	Norway	Sweden	United Kingdom
Number of Midwives in Practice	3489* registered midwives	7720	35 889 ** intention to practice
Number of births/year	60 000	109 301	787 057
Number of births/midwife/year	17.2	14.2	21.9
Duration of midwifery training	2 years, after RN	18 months	3 yrs or 18 months

Table 5: Survey of European Midwifery Regulators Selected Data (Norway/Sweden/UK), 2nd issue, February 2010, Ordre des sages-femmes

In the United Kingdom, it was calculated that there was a "2,300 shortfall in midwives in 2012, calculated using a widely recognised benchmark of 29.5 births per midwife per year[59]." The Royal

College of Midwives (RCM) has an even stricter standard and uses a minimum ratio of one midwife for 28 births per year[60]. With the reality of these staffing pressures, the Royal College of Midwives drafted a guidance paper in 2011 to look at refocusing the role of midwife. Within any reform of the midwives role, the Royal College of Midwives is clear that any review has to be carefully paced and transparent. There is risk that any changes "could have implications that are not immediately apparent[61]." However, if units are considered understaffed and midwives considered overworked, the temptation may be to delegate core tasks. The Royal College of Midwives is clear that there are essential midwifery skills that were not felt to be suitable for delegation.

Box A: Essential midwifery skills
While suitably qualified doctors working in maternity care may carry out any of these functions, in the UK they are usually considered as appropriate activities for the midwife. All midwives should be competent in these areas of activity, and should carry the primary responsibility for ensuring they care carried out.
• Full clinical assessment and history-taking of social, psychological and physical circumstances; determination of risk factors
• Planning care in partnership with the woman
• Appropriate referral to other professionals, care givers and agencies
• Monitoring the progress of pregnancy, including maternal and fetal health, emotional, psychological and social wellbeing; providing primary advice and information and referring as appropriate
• Diagnosis of the onset of labour
• Monitoring the progress of labour and maternal and fetal wellbeing
• Facilitating physiological labour and birth
• Maximising normality for women in high dependency care
• Where necessary, resuscitation and management of emergencies such as haemorrhage, shoulder dystocia, fetal malpresentation
• Recognising deviations from the normal, making appropriate referral, and working as equal partners in a multi-disciplinary team
• Examination, monitoring and care of the newborn, including resuscitation
• Assessment, monitoring and care of the woman after birth
• Pain management and analgesic support
• Maintaining perineal integrity and undertaking perineal repair
• Appropriate postnatal transfer
• Monitoring maternal and infant wellbeing in the postnatal period
• Notification of birth
• Discharge and handover of care to appropriate professional
• Record keeping
• Supervision and support of students
• Contributing to the development of service provision that is appropriate for, and responsive to, individual and community needs

Table 6: FROM The Royal College of Midwives, Guidance Paper 26A, Refocusing the Role of the Midwife, February 2011

In any review and update of policy for the British Columbia setting, it may be useful to identify and protect our own essential midwifery skills. In international health, there is increasingly promoted the concept of "task shifting" to deal with shortages of health care professionals. In a developed country, with high resource settings but staffing shortages, it may be required to look at redefining the scope of practice of members of the health care team[62].

However, from a client perspective, equally important may be the concepts of continuity of care and having a known midwife. A 2012 survey from the Royal College of Midwives found that "47 per cent of respondents would have liked to have spent more time with their midwife during pregnancy" and "despite two-thirds of women stating they knew the name of their midwife, nearly a third said they always saw a different midwife during pregnancy and postnatal care.[63]"

In a large 2010 study involving 64,538 low-risk women in the UK, for multiparous women at low risk of complications, planned birth at home was the most cost effective and (demonstrated as a) safe option[64]. Despite the good outcomes seen for planned home birth with these women, midwives in the UK may still face challenges with the perception of homebirth, from their interprofessional colleagues. Midwives surveyed were generally supportive of the government's plans to increase home birth rates, GPs and OBs were neutral and pediatricians/neonatologists were generally negative both about home birth and any government plan to expand it[65]. Given staffing pressures and busy units[66] in the UK setting, it may be ideal to try to expand access to home birth. In May 2014, draft advice was released from the National Institute for Health and Care Excellence (NICE), stating that "women who had few complications during their pregnancy would be urged to stay away from traditional labour wards, leaving them free for difficult cases" and to instead use "specialist units led by midwives to prevent over-intervention" or be "encouraged to consider giving birth at home, especially if they have given birth before." The Royal College of Midwives welcomed the proposals but were clear that investment is needed to increase numbers of midwives in the profession and to develop facilities[67].

In the Netherlands, there is high home birth rate of 23.4% ('08-10), however this is a decline from the 29.4 % rate seen previously ('05-07). The evidence in the Netherlands supports the safety of home birth, and that women can safely choose where to give birth if the health care system is "well-equipped for homebirths.[68]" Of the 2,612 active midwives in 2011, only 27% worked in a hospital. There is a principle idea in the Netherlands that a healthy woman with a healthy pregnancy is best taken care of by a midwife. Dutch midwives have not trained as nurses, rather, they train in a 4-year, stand alone program. The Perinatal and maternal morbidity and mortality rates are low[69]. Every woman in the Netherlands "has the right to Midwifery care.[70]"

In Norway, students have to complete a bachelor's degree in nursing before admission to a 2 year midwifery program. There are approximately 60,000 deliveries annually, of which 18,000 take place in smaller, low-risk, midwifery led units[71]. In Norway, evidence supports that it is cost-effective to organize care in midwifery led units for low-risk women[72].

In Sweden, the scope of midwifery covers pregnancy, labour, birth and the post-partum, but also encompasses more holistic, well-woman care such as "support of parenthood including the dignity and autonomy of the individual, counselling and care concerning fertility control and sexuality, health care information concerning reproductive health including menopausal counselling, and care in connection with gynaecological health problems[73]."

In New Zealand, midwifery was redefined as a separate, autonomous profession in 1990[74]. According the New Zealand College of Midwives, Midwifery care is fully funded in New Zealand and free for all eligible, pregnant women. Midwives cannot charge the woman for care and fees are set and paid for by the government. 70% of women register with a midwife (aka Lead Maternity Carer) in the first three months of pregnancy, who will provide them with care until six weeks after the baby is born. Midwives can be self employed providing community based care or in hospital based maternity services as core employed midwives[75]. There are currently 2,800 midwives in New Zealand and no current shortage[76].

On paper, midwifery in Australia has a similar scope and standards of practice as seen in other midwifery settings. However, home birth outcomes are much poorer, which may be secondary to geography or need to revise guidelines and practice to optimize safety in the out of hospital setting. In a large population-based study using South Australian perinatal data on all births and perinatal deaths during the period 1991-2006, the study authors found that planned home births accounted for 0.38% of 300,011 births in South Australia. They had a perinatal mortality rate similar to that for planned hospital births, but a seven-fold higher risk of intrapartum death and a 27-fold higher risk of death from intrapartum asphyxia. Review of perinatal deaths in the planned home births group identified "inappropriate inclusion of women with risk factors for home birth and inadequate fetal surveillance during labour." The authors concluded that safety of Australian home births may be "improved substantially by better adherence to risk assessment, timely transfer if indicated, and closer fetal surveillance[77]."

In looking at the international jurisdictions, the universal messages support the need to continually protect and enhance normal birth, support safe out of hospital birth, work interprofessionally and collaboratively, expand midwifery scope, protect core and essential midwifery skills, and to consider the benefits of midwifery-led units.

The Lancet published a comprehensive set of articles in June 2014, looking at midwifery. The series concluded with a set of recommendations regarding how midwifery fits into the health care system and what to focus on in an expansion of midwifery services.

These recommendations are:

- Provision of accessible quality midwifery services that are responsive to women's needs and wants should be part of the design of health-care service delivery and should inform policies related to the composition, development, and distribution of the health workforce in all countries.
- Efforts to scale-up quality maternal and newborn care should include effective measures to identify and tackle systemic barriers to high-quality midwifery - e.g., the low status of women, interprofessional rivalries, poor understanding of midwifery care and what it can do, and unregulated private sector maternal and newborn health care.
- To recognise and enable the important contribution of midwifery to improve health in both mothers and newborn infants is important for national, regional, and global health programmes, initiatives, and institutions.
- Midwifery can lead to positive health outcomes, especially in settings in which midwifery services are valued and respected, community-based, and integrated effectively into a functioning health system.
- Expansion of equitable coverage and improvements in the quality of midwifery care will be challenging for many countries, especially those in which the number of births per year is projected to rise.
- Women and communities should be included in decision making to improve midwifery services.
- Midwifery care can be cost effective, affordable, and sustainable; national governments should invest in deploying midwives and national health plans should have a strategy to scale-up midwifery.

- More investment is needed (by countries and development partners) in relevant research and routine collection of data for quality maternal and newborn care and on the reproductive, maternal, and newborn health workforce.
- The coverage and quality of midwifery care should be monitored regularly and be used to hold stakeholders, including providers and programme managers, accountable[78].

In comparing multiple countries and provinces it is striking the number of different ways the regulators support, promote and regulate midwifery. Differences in outcome could well be related to differences in the approach to regulation, as well as to funding models. The Lancet series outlines what the focus for optimal midwifery care expansion could be. Their approach supports not only midwifery care, but also comprehensive data collection and the timely analysis of that data; to support change, enhance care and improve outcomes in an evidence-based manner.

They also speak to the importance of midwifery as an integrated part of the health care system, and to the importance of a culture of respect and acceptance for midwifery from other members of the health care team. Continued expansion and integration of midwifery in the Canadian context may benefit from looking at the Lancet recommendations moving forward.

As more women learn about the midwifery model of care in the Canadian setting, the demand will only grow. Since the cost-savings and improved outcomes with midwifery care are well documented in the Canadian setting, it only makes sense for levels of government to continue to not only fund expansion and support of midwifery, but also education around and the promotion of same. Midwives as a rule are a motivated, passionate profession and the system can only benefit from engaging them in any process to expand and enhance midwifery care. We have come far in a short period of time and there is much knowledge and wisdom to mine from those who have come before and practiced in other jurisdictions.

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2013-2014

CMBC/ Interprovincial Legislative and Regulation Comparison

Sarah Hilbert-West

May 2014

Canadian Midwifery Model:

While midwifery legislation and regulations are specific to each province/territory, the midwifery model of care is essentially the same across the country. Fundamental to the Canadian model is woman and family centred care that meets individual needs, promotes the healthy, normal process of pregnancy and birth, and values the profound meaning of the childbearing experience in women's lives. Other central principles of this model include:

• Continuity of care: Midwifery care is provided on a continuum throughout pregnancy, labour, birth and the postpartum period, enabling clients and midwives to build a relationship of mutual understanding and trust. Practices are organized so that a midwife known to the woman is available to attend the birth.

• Informed choice: The woman is encouraged to make informed choices about her own care. Midwives contribute their knowledge and evidence-based recommendations in a non-authoritarian manner and support the woman as the primary decision-maker. Midwifery visits allow adequate time for open, interactive discussion and education.

• Choice of birthplace: Midwives respect the woman's right to choose where she would like to give birth and are prepared to provide intrapartum care in hospital and out-of-hospital settings, within professional standards and guidelines.

Midwives generally carry caseloads of 40 clients per year and work in partnerships or group practices. Prenatal and postnatal care is provided in midwifery clinics and community health centres and includes home visits; births take place in hospitals, birth centres or at home. Collaboration and consultation with other health care providers is integral to the scope and practice of midwifery.

Unique practice arrangements involving multidisciplinary teams and shared care have also developed in response to population needs, for example in the South Community Birth Program in Vancouver, Stony Plain Shared Care Maternity Program near Edmonton, Thunder Bay Maternity Centre, and La Maison Bleue in Montreal. Other models of collaborative practice are being explored in efforts to help address shortages of maternity care providers and ensure women's access to maternity services, particularly in rural and remote communities.

http://www.canadianmidwives.org/DATA/DOCUMENT/FACT_SHEET_modelsoutcomes_EN_final%2009_09.pdf

Province and Regulatory Body	Scope	Model of Practice	Funding Model	Insurance
British Columbia College of Midwives of BC www.cmbc.bc.ca	Health Professions Act [RSBC 1996] Chapter 183, the Midwives Regulation BC Reg 155/2009	Bylaws for the College of Midwives of BC (CMBC Bylaws), Part VIII Standards of Practice	Course of care	CMBC Bylaws, Part V, S 58 Liability Insurance
Alberta College of Midwives of Alberta www.college-midwives-ab.ca	Reg Sect. 8. Schedule 1&2	Act Sect. 9(1)	Course of care	Act Sect. 12
Saskatchewan Saskatchewan College of Midwives http://www.saskmidwives.ca/	Reg. Sect. 17, 23		salaried	Act Sect. 46(1)
Manitoba College of Midwives of Manitoba www.midwives.mb.ca	Act Sect. 2(1) & (2), Reg 12, 13, 14. Sched A, B,C	Act Sect. 2(3), Reg 15, Reg 4(3)	salaried	Reg. 16(1) & (2)
Ontario College of Midwives of Ontario www.cmo.on.ca	Midwifery Act 1991, reg 884/93		Course of Care	Reg. 168/11 Sect. 11
Quebec Ordres des Sages Femmes du Quebec http://www.osfq.org/	Act Sect. 6, 7, 8, 31		salaried	Sect. 14. A.29, S 3. 1999 C 24, S 14, Health Insurance Act
New Brunswick	Act Sect. 2(1) & (2)		Not funded	Act Sect. 31(1)
Nova Scotia Midwifery Regulatory Council of NS www.mrcns.ca	Act Sect. 2(i)		salaried	Reg. 9(i)
Prince Edward Island	n/a		Not funded	
Newfoundland and Labrador	n/a		Not funded	
NWT	Act Sect. 2(1)		salaried	Act Sect. 13
Nunavut	Act Sect. 2 & 3	Act Sect. 4, 6(1)	salaried	Act Sect. 16
Yukon	n/a		Not funded	

CMBC Model of Practice Review 2013-2014 | **Table 1 Interprovincial Comparison Legislation and Regulation**

Province	Canada	BC	Alberta	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	PEI	Newfoundland	Nunavut	NWT	Yukon
Number of Deliveries Annually 2011/2012[1]	378,762	43,781	51,685	14,466	15,764	140,932	88,311	7,101	8,859	1,442	4,460	841	686	434
Midwife % of deliveries 2007/08 to 2011/12[2]	Rural Residents: 4 % Urban Residents: 5.7%	Rural Residents: 10.5 % Urban Residents: 9.8%	Rural Residents: 0.6 % Urban Residents: 1.4%	Rural Residents: 0.3 % Urban Residents: 0.6%	Rural Residents: 3.8 % Urban Residents: 4.2%	Rural Residents: 7.6 % Urban Residents: 6.8%	Not found	n/a	Rural Residents: 1.2 % Urban Residents: 0.5%	n/a	Rural Residents: 4.2 % (Labrador-Grenfell) Urban Residents: 0%	Rural Residents: 0.3 % Urban Residents: n/a	Rural Residents: 5.8 % Urban Residents: 3.6%	Not found
# of registered midwives per CIHI Health Personnel Database 2009[3]	826	146	27	7	42	441	139	n/a	9	n/a	n/a	n/a	3	2
# of registered midwives per provincial bodies		218 (Jan 7, 2014)[4]	69 (Mar, 2013)[5]	37 (Mar 31, 2013)[6]	42 (Jan 7, 2014)[7]	Close to 700 (2013) [8]	Not found	n/a		n/a	n/a	n/a		Not found
% hospital deliveries 2011[9]	371, 461 98.3%	42,893 97.19%	50,086 98.1%	14,147 99.13%	15,402 98.6%	137,039 97.79%	88,213 99.58%	7,098 99.63%	8,822 99.55%	1,434 99.86%	4,458 99.55%	780 93.18%	665 96.37%	424 98.37%
% non-hospital/home deliveries[10]	6166 1.6%	1,235 2.79%	952 1.86%	121 0.84%	217 1.38%	3,096 2.2%	370 0.42%	26 0.36%	40 0.45%	2 0.14%	20 0.45%	57 6.81%	24 3.47%	6 1.39%
C-Sec rate[11]	27.1	30.8%	27.4%	23.1%	21.4%	28.6%	23.6%	27.3%	26.5%	28.9%	30.6%	11.3%	21.9%	25.0%
Midwife c-sec rate	n/a	18.3%[12]	n/a	n/a	n/a	15%[13]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

CMBC Model of Practice Review 2013-2014 | Table 2 Interprovincial Statistical Comparison Outcome

[1] Statistics Canada Summary Tables births, estimates by province/territory 2011/2012
[2] Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Canadian Institute of Health Information
[3] Canadian Institute for Health Information, Health Personnel Database. Canada's Health Care Providers, 2000-2009, pg 123
[4] British Columbia: http://www.cmbc.bc.ca/pdf.shtml?List-of-Registrants
[5] Alberta: http://www.college-midwives-ab.ca/find-a-midwife/
[6] Saskatchewan: http://www.saskmidwives.ca/assets/Documents/Annual%20Report%202012%202013/SCM%20Annual%20Report%202012-2013%20-%20FINAL.pdf
[7] Manitoba: http://www.midwives.mb.ca/Website%20list%20of%20Practising%20Midwives%20Jan%206%202013.pdf
[8] http://www.ontariomidwives.ca/news-room/kit/faq#sthash.AjuLhKrE.dpuf
[9] Statistics Canada Table 102-4516 2011 Live births by place of birth (Hospital non-hospital) Canada, provinces and territories
[10] Statistics Canada Table 102-4516 2011 Live births by place of birth (Hospital non-hospital) Canada, provinces and territories
[11] Statistics Canada / CIHI Health Indicators 2013, pg 56
[12] Annual Report Midwifery Care in BC, BC Perinatal Database Registry April 1, 2011, March 31, 2012
[13] http://www.newswire.ca/en/story/911583/promote-normal-birth-and-the-c-section-rate-will-decrease-say-ontario-midwives

Province	BC	Alberta	Saskatchewan
Summary	Midwifery is regulated in British Columbia under the Health Professions Act [RSBC 1996] Chapter 183, the Midwives Regulation BC Reg 155/2009, and the College Bylaws. Since the implementation of regulation in January 1998, all midwives must be registered with the College of Midwives of British Columbia to be permitted to practice. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, last revised January 2012	Midwifery is regulated in Alberta under the *Health Disciplines Act RSA 2000, H-2* and the *Midwifery Regulation, Alta. Reg. 328/1994*. Midwifery is in the process of coming under the *Health Professions Act, R.S.A.2000, c. H-7*. Since regulation in July 1998, all midwives must be registered with the Alberta Midwifery Health Disciplines Committee in order to practice. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is regulated in Saskatchewan under the *Midwifery Act, Chapter M-14.1* and *The Midwifery Regulations*, *The Midwifery Administration Bylaws*, and *The Midwifery Regulatory Bylaws*. Since the implementation of regulation in March 2008, all midwives must be registered with the Saskatchewan College of Midwives to be permitted to practice. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*
Scope	The Midwives Regulation defines the role and scope of the midwife.as "..a person provides the following services during normal pregnancy, labour, delivery and the post-partum period" including: a) Assessment, monitoring and care for women, newborns and infants, including the carrying out of appropriate e1mergency measures when necessary; b) Counseling, supporting and advising women, including provision of advice and information regarding care for newborns and infants; c) Conducting internal examinations of women, performing episiotomies and amniotomies and repairing episiotomies and simple lacerations; and d) Contraceptive services for women during the three months following a birth. Health professional regulation in BC defines restricted activities for 23 regulated health professions. Under the Midwives Regulation midwives may: a) Make a midwifery diagnosis identifying a condition as the cause of signs or symptoms of an individual. b) Perform procedures on tissue below the dermis or below the surface of a mucous membrane, for the purposes of: performing episiotomies or amniotomies; repairing episiotomies or simple lacerations; taking a swab or specimen required for a screening or diagnostic test. c) Perform venipuncture for the purpose of collecting a blood sample. Administer a solution by irrigation for the purpose of wound care during the postpartum period. d) Administer a substance by injection, inhalation, or parenteral instillation for the purposes of pain relief, preventing or treating dehydration or blood loss, resuscitation or other emergency measures, or other purposes as required for midwifery practice. e) Put an instrument, hand or finger beyond the point in the nasal passages where they normally narrow, for the purpose of suctioning a newborn; beyond the pharynx, for the purpose of intubating a newborn; beyond the opening of the urethra, for the purpose of catheterization of a woman during	Sect. 8. Schedule 1&2 Section 9 AR 328/94 8 MIDWIFERY REGULATION A midwife may: (a) provide counselling and education related to childbearing, (b) carry out assessments necessary to confirm and monitor pregnancies, (c) advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk, (d) identify the conditions in the woman, fetus or newborn that necessitate consultation with or referral to a physician or other health professional, (e) care for the woman and monitor the condition of the fetus during labour, (f) conduct spontaneous vaginal births, (g) examine and care for the newborn in the immediate postpartum period, (h) care for the woman in the postpartum period and advise her and her family on newborn and infant care and family planning, (i) take emergency measures when necessary, (j) perform, order or interpret screening and diagnostic tests in accordance with Schedule 1, (k) perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum and urethra, (l) prescribe and administer drugs in accordance with Schedule 2, and (m) on the order of a physician relating to a particular client, administer any drugs by the route and in the dosage specified by the physician. Autonomous practice and medical consultation (1) In respect of normal pregnancy, a midwife may, (a) engage in the practice of midwifery as a primary health care provider, and (b) Provide services in a variety of settings. (2) If medical conditions exist or arise during the course of midwifery care that may require management by a physician, a midwife shall consult with a physician. (3) If the result of the consultation is a determination that management by a physician is required, the midwife shall	Sect. 23 The Midwifery Act Authorized practices 23(1) Subject to the terms and conditions of that member's licence, a member may perform the following authorized practices: (a) assess and monitor women during normal pregnancy, labour and the post-partum period; (b) conduct the spontaneous normal vaginal delivery of a baby; (c) provide care to a woman and her healthy baby during a normal pregnancy, labour and post-partum period; and (d) for the purposes of clauses (a) to (c): (e) prescribe, dispense or administer drugs in accordance with the regulations, the regulatory bylaws made pursuant to this Act and The Drug Schedules Regulations, 1997; (ii) order, perform or interpret diagnostic tests in accordance with the regulations, the regulatory bylaws made pursuant to this Act and The Medical Laboratory Licensing Act, 1994; and (iii) Perform invasive procedures that are prescribed in the regulations and the regulatory bylaws made pursuant to this Act.

	labour or the postpartum period; beyond the labia majora, for the purposes of conducting internal examinations of women, performing episiotomies or amniotomies, repairing episiotomies or simple lacerations, or beyond the anal verge, for the purposes of assessing perineal repairs, administering a substance, or assisting in the emergency delivery of a baby; Manage labour or a normal, spontaneous vaginal delivery. f) Apply ultrasound for the purpose of fetal heart monitoring. Give an instruction or authorization for another person to apply, to a named individual, ultrasound for diagnostic or imaging purposes, including any application of ultrasound to a fetus. <u>Prescribing Ordering and Administering Drugs</u> A midwife may compound, dispense or administer a federally controlled drug, barbiturate, narcotic or targeted substance if prescribed by or on the order of a medical practitioner. A midwife may independently prescribe, order, compound, dispense or administer a drug included in a category and for the purposes set out in Schedule A to the Midwives Regulation under the CMBC Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs. • A midwife may order, compound, dispense or administer a drug included in a category in Schedule B to the Midwives Regulation on the order of a physician. <u>Limits, Conditions, Restrictions on Performing Restricted Activities</u> Under the Midwives Regulation midwives must be certified to perform the following specialized practices after successfully completing a certification program required and approved by the College: • Insert acupuncture needles for the purpose of pain relief during labour or the post-partum period. • Put an instrument, hand or finger beyond the labia minora for the purpose of conducting a vacuum-assisted emergency delivery of a baby; or • Put an instrument, hand or finger into an artificial opening into the body for the purpose of assisting in the surgical delivery of a baby; • Prescribe, order, compound, dispense or administer a drug included in a category in Schedule B to the Midwives Regulation (e.g. oral contraceptives, abx for vaginal infections). Midwives must consult with a medical practitioner or nurse practitioner (where appropriate) regarding any deviations from the normal course of pregnancy, labour, delivery and the postpartum period that indicate pathology and transfer responsibility for care to another health professional when necessary or appropriate. These requirements are further defined in the CMBC's *Indications for Discussion, Consultation and Transfer of Care.*	transfer primary responsibility for care, or aspects of care, to a physician and may engage in the practice of midwifery in collaboration with the physician, to the extent agreed to by the client, physician and midwife.	

Model of Practice	CMBC bylaws: Standards of Practice and Code of Ethics: The CMBC's Midwifery Model of Practice describes how midwives provide autonomous, community-based primary care to women throughout pregnancy, labour and birth, and the postpartum, including newborn care, based on principles of continuity of caregiver, client informed choice, choice of birth setting, collaborative care, accountability and evidence informed practice according to the Standards of Practice and the Code of Ethics set out in the College's bylaws, and the BC midwifery Philosophy of Care. Community-Based Practice As autonomous primary caregivers midwives must acquire hospital privileges and offer women the choice of hospital or out-of-hospital birth. Working in small group practices, midwives share 24 hour call for their clients who have had the opportunity to get to know them during pregnancy. Early postpartum is generally provided at home visits. Primary Care As primary caregivers midwives act on their own responsibility, and are able to be the first point of entry to health services for women seeking pregnancy-related health care. The midwife provides a continuum of midwifery services throughout pregnancy, labour and the postpartum. Continuity of Care Women must have 24-hour access to one of the known midwives on their care team during all trimesters of pregnancy, labour, birth and the postpartum period. Each woman is cared for by a team of no more than four midwives and has the opportunity to meet and get to know each of the care providers prenatally who may attend her during her labour and birth. This group of midwives meets regularly to co-ordinate care ensuring a consistent approach to practice through a practice protocol describing their system for coordinating each woman and newborn's care. When a woman gives birth at home, a second midwife comes to assist near the time of delivery. In hospital the principal midwife is assisted by nursing staff. Where physician transfer of care is required during labour, the midwife provides supportive care after transfer and may resume primary care when appropriate. Midwives also provide education, counselling and advocacy and support in labour, and assistance with infant feeding and postpartum adjustment. Informed Choice Midwifery promotes decision-making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. Midwives recognise women as primary decision makers and respect their right to make informed choices, facilitating this process by providing complete, relevant, objective information in	Midwifery care in Alberta follows the Alberta Midwifery Standards of Practice and Competency. The practice of midwifery is based on the understanding that pregnancy, labour and birth are profound experiences which carry significant meaning for a woman, her family and her community. Midwifery is grounded in the principles of health and wellbeing, recognizing that conception, pregnancy, birth and breastfeeding are natural life processes. Midwifery care enhances these life experiences and provides continuity of care through relationship building between midwives and women and their families. Midwifery is traditionally holistic, combining an understanding of the social, emotional, cultural, spiritual, psychological and physical aspects of a woman's reproductive experience. Midwives promote wellness in women, babies and families both autonomously and in collaboration with other health care professionals. Model of Midwifery Care: Midwives provide care from pre-conceptual counselling pregnancy through to at least six-weeks postpartum to women and their infants. Informed Choice: Midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner. Primary Care Providers: Midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care. When midwives identify conditions requiring care that is outside of their scope of practice, they may request consultation, make referrals and/or transfer care as appropriate. Continuity of Care: Midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualized care. Individual or small groups of not more than four midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A known midwife from the client's practice group is available on-call throughout her care. Choice of Birth Setting: Midwives respect the right of each woman to make an informed choice about the setting and location for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals. Evidence-based Practice: Midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care on a regular basis. http://www.college-midwives-ab.ca/legislation/model-of-care/	The principles outlined below are fundamentals of midwifery practice which, when taken together, ensure that midwifery meets the needs of the women who choose this service. These principles are applicable to midwifery practice across all settings and are to be used as a basis for the planning and integration of midwifery services in Saskatchewan. Midwives are Autonomous Health Care Providers: Midwives are primary health care providers. As primary health care providers, midwives make autonomous decisions in collaboration with their clients and are fully responsible for the provision of health services within their scope of practice. They coordinate services to ensure continuity of care, identify conditions requiring management outside their scope of practice and refer such cases to other health care providers. Community Input: Community input is fundamental to the development and evaluation of midwifery practice across all settings. Community participation must be structured into the midwifery system during the development and ongoing planning of midwifery services and education. This would be achieved by: 1. Facilitating ongoing community inputs into midwifery practices in all sites. (e.g. community forums, community boards, formal liaison with consumer organizations, consumer representation on governing body) 2. Each and every client being able to give input at some level. (e.g. client evaluation of care) 3. Each midwife being responsible for soliciting client and community input (e.g. client evaluation of care) 4. Education about the role of community input at all levels incorporated into the education of midwives. (e.g. public representatives on advisory committee(s); consumer participation in the teaching of midwives) Informed Choice Responsiveness to women's needs is a guiding principle of midwifery practice. Midwives respect the right of their clients to make informed choices and actively encourage informed client decision-making. Midwives facilitate decision-making by making relevant, objective information available to their clients. Midwives support the principle of informed choice by: 1. Encouraging clients to participate actively in their care and to make choices about the services they will receive and the manner in which they are provided. 2. Recognizing and supporting the pregnant woman as the primary decision maker and promoting shared responsibility between the woman, her family and her caregivers. 3. Discussing the scope and limitations of midwifery care with their clients. 4. Allowing adequate time for discussion in the prenatal period. Continuity of Care Continuity of care is fundamental to the midwifery model of practice. It is both a philosophy and a process that enables the midwife to provide holistic care with the client in order to build understanding, support and trust. There must be 24-hour on-call availability of the primary care midwives known to the woman. In group practices, a small team of midwives could achieve continuity of care, provided the client has the opportunity to establish relationships with all the members of the team. Midwives involved in group practice must share a common philosophy in order to support continuity of care. Women must have input into the

	a non-authoritarian, supportive manner. Adequate time for discussion in the prenatal period is necessary to facilitate informed choice. – CMBC Philosophy of Care Choice of Birth Setting All midwives must offer women choice of birth setting to ensure they have equitable access to care in their chosen place of birth. This is particularly important in rural and remote communities where women may not have access to a choice of midwives. Midwives provide women with the information needed to make a safe and informed choice about where to give birth. Midwives must be competent and willing to provide care in a variety of settings, including homes, hospitals and birth centres. Midwives must have hospital privileges and be able to function within their full scope of practice in the home and hospital setting with confidence and competence. Second Midwife or Qualified Birth Attendant Two attendants attend every birth, each skilled in neonatal resuscitation and in managing maternal emergencies. Each birth in an out-of-hospital setting is planned for two midwives to be in attendance. When a second midwife cannot attend a home birth, the principal midwife must secure the assistance of a CMBC approved second attendant skilled in neonatal resuscitation and maternal emergencies prior to the birth. Collaborative Care Midwives must collaborate with other professionals to ensure their clients receive the best possible care. Consultation with physicians and other health care providers is guided by the College's Indications for Discussion, Consultation and Transfer of Care and the woman's informed choice. Midwives may apply for approval to work in shared care arrangements with physicians that are consistent with the Midwifery Model of Practice and Philosophy of Care. Accountability and Evidence-Informed Practice Midwives' first accountability is to the women in their care. They are also accountable to their peers, their regulatory body, and the health agencies where they practice and to the public, for safe, competent, ethical practice informed by the current research evidence in maternity care. Midwives must give each client the opportunity to evaluate the care she received in way that does not identify the client. Midwives must also participate in peer case review for ongoing learning at least 4X a year. Under CMBC Bylaws the Quality Assurance Committee may assess the individual practice and performance of a registrant. Midwives are expected to continue to develop and share midwifery knowledge, and promote and participate in research re: midwifery outcomes.		manner in which continuity of care is provided. Choice of Birth Setting Midwives respect the right of women to make informed choices about the setting for birth. Midwives provide care in a variety of settings, including hospitals, homes and birth centres, where available. Midwives provide their clients with the information and support required to make an informed choice about the appropriate settings in which to give birth in accordance with the Standards of Practice of the Saskatchewan College of Midwives. Two Attendants at Each Birth The Canadian standard of care is to have two attendants, skilled in neonatal and maternal emergencies, at each birth. The second birth attendant must support the midwifery model of care. Collaborative Care Midwives collaborate with other professionals to ensure their clients receive the best possible care when the needs of the client exceed the scope of practice of the midwife. In situations where transfer of care to a physician is required, the midwife is expected to continue providing supportive care after transfer and will resume primary care if appropriate. Collaboration with other health care providers occurs with informed client choice. Accountability and Evaluation of Practice Midwives are accountable to their clients, their peers and the wider community for safe, competent, ethical practice. They are also accountable to their own regulatory body, their employers, and the health care institutions in which they practice and to the public. Midwives continuously evaluate their practice to improve the quality of care they provide and to ensure their clients' needs are met. The results of this evaluation are incorporated into midwifery practice. Accessibility of Midwifery Care Midwifery care must be accessible to all women. Mechanisms should be in place to ensure equitable access to midwifery care for all women regardless of place of residence or circumstances. A midwifery practice must consider the demographics of the practice area so that services are offered to the variety of women therein. The midwives, and the community which supports their practice, are responsible for remaining knowledgeable about the women within their practice area, and for developing and implementing outreach programs. Adapted from: College of Midwives of Manitoba: Model of Practice; College of Midwives of BC: Model of Midwifery Practice http://www.saskmidwives.ca/aboutmidwifery/model_of_practice

Funding	Midwives are funded through BC's Medical Services Plan for care provided during pregnancy, labour, birth and the postpartum up to 6 weeks pp, based on funding courses of care with a cap of 60 courses of care per midwife per year. Some areas of practice within midwives regulated role and scope are not currently publicly funded such as: contraceptive services beyond six-weeks postpartum.	Midwifery services are publicly funded health services since April 2009. http://www.health.alberta.ca/services/midwifery.html Alberta Registered Midwives are able to care for up to 40 clients per midwife per year. Midwives are independent contractors and paid by Alberta Health Services based on the Course of Care for each client. The full amount for a Course of Care that an Alberta Registered midwife can bill for includes a provision for overhead, registration and insurance fees. http://www.alberta-midwives.com/aam/communications/alberta-midwifery-facts-and-figures/ Midwifery services in Alberta became publicly funded beginning April 1, 2009. The payment structure for midwives has been developed by the Alberta Health Services Board in conjunction with the Alberta Association of Midwives and was ready for implementation April 1, 2009. Midwives pay all operating expenses themselves and are responsible for setting up their own health and disability benefits http://cmrc-ccosf.ca/node/60	Currently, all midwives in Saskatchewan are employees of regional health authorities and receive an annual salary ranging from $69,080 to $ 88,904. Overhead expenses for their office, equipment, supplies, and professional liability insurance are paid for by their employer. Midwives are entitled to participate in life insurance, disability insurance, employee assistance plan, and extended health, dental and pension plans. Midwives' salary is based on a 37.5 hour work week. Midwives work flexible and variable hours and are not generally entitled to overtime pay. Midwives are entitled to 4 to 6 weeks of paid vacation per year depending on years of service. It is also possible to set up private practice in Saskatchewan. Midwives who choose private practice are paid directly by the women to whom they provide service. Midwives in private practice are responsible for paying all of their own expenses (including office, equipment, supplies and professional liability insurance). They would also be required to obtain privileges with the regional health authority in which they practice. http://cmrc-ccosf.ca/node/60
Insurance	In The Matter Of The Health Professions Act, S.B.C. 1990, C. 50 And The Midwives Regulation, B.C. Reg. 103/95 Bylaws For College Of Midwives Of British Columbia Liability insurance 58. A general registrant, a conditional registrant and a temporary registrant shall be insured against liability for professional negligence in an amount that is at least the minimum level of coverage required by the board.	Midwifery Regulation, Alta Reg 328/1994 Section 12 - Liability insurance 12 A Midwife shall carry professional liability insurance with an insurer acceptable to the Board and in an amount that is at least the minimum level of coverage required by the board.	Sect. 46(1) Liability protection The college may enter into a contract of insurance under which members or any category of members are insured with respect to professional liability claims. (2) The college is deemed to be an agent for the members or any category of members for the purpose of entering into a contract of insurance pursuant to this section. 1999, c.M-14.1, s.46.
Outcome	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 10.5 % Urban Residents: 9.8% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information* Delivery Care Provider (rate per 100 deliveries) 2002/03 Midwife: 3.6 2011/12 Midwife: 10.9 *BC Perinatal Surveillance 2002/03 to 2011/12, Perinatal Services BC, Perinatal Indicators by Place of Delivery*	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 0.6 % Urban Residents: 1.4% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information* The number of babies delivered by midwives in the province has increased by 30% from 2010 to 2011. On average, 50% of midwife- attended births in Alberta occur in hospitals. http://www.alberta-midwives.com/aam/communications/alberta-midwifery-facts-and-figures/	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 0.3 % Urban Residents: 0.6% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health* Midwifery is now available in one First Nations Hospital and thirteen health regions in Saskatchewan. The average home birth rate is around 40-60%. http://www.canadianmidwives.org/province/Saskatchewan.html?prov=12

Province	Manitoba	Ontario	Quebec
Summary	Midwifery is regulated in Manitoba under the *Midwifery Act C.C.S.M. c. M125* and the *Midwifery Regulation, Man. Reg. 68/2000* and the *CMM By-Law No. 1* Since the implementation of regulation in 2000, all midwives must be registered with the College of Midwives of Manitoba to be permitted to practice. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is regulated in Ontario under the *Regulated Health Professions Act, 1991* and the *Midwifery Act, 1991, S.O.1991, c.31, O. Reg. 240/94* ; *Registration, O. Reg. 867/93* ; *Designated Drugs, O. Reg. 884/93* ; and *Professional Misconduct, O. Reg. 858/93*; as well as by the College *Bylaws*. Since the implementation of regulation in January 1994, all midwives must be registered with the College of Midwives of Ontario to be permitted to practice. Note: There are exceptions for aboriginal midwives and healers in the *Midwifery Act, 1991*and the *Regulated Health Professions Act, 1991*, respectively. These exceptions allow aboriginal midwives to provide traditional midwifery services to aboriginal persons or members of an aboriginal community and to use the title aboriginal midwife. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is regulated in Quebec under the *Midwives Act , L.R.Q., chapter S-0.1*, and a number of regulations. Since the implementation of regulation in 1999, all midwives must be registered with the Ordre des sages-femmes du Québec (OSFQ) to be permitted to practise. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*
Scope	**Practice of midwifery** 2(1) The practice of midwifery means the assessment and monitoring of women during pregnancy, labour and the post-partum period, and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous vaginal deliveries. **Included practices** 2(2) In the course of engaging in the practice of midwifery, a midwife may (a) order and receive reports of screening and diagnostic tests designated in the regulations; (b) prescribe and administer drugs designated in the regulations; and (c) perform minor surgical and invasive procedures designated in the regulations. **Midwife as primary health care provider** 2(3) A midwife may, in accordance with this Act and the regulations, engage in the practice of midwifery as a primary health care provider who (a) is directly accessible to clients without referral from a member of another health profession; (b) is authorized to provide health services within the practice of midwifery without being supervised by a member of another health profession; and (c) Consults with other health professionals, including physicians, if medical conditions exist or arise during pregnancy that may require management outside the scope of the practice of midwifery. http://web2.gov.mb.ca/laws/statutes/ccsm/m125e.php	Ontario Midwifery Act, 1991 Scope of practice The practice of midwifery is the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries. 1991, c.31, s.3. Authorized acts 1) In the course of engaging in the practice of midwifery, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following: 2) Communicating a diagnosis identifying, as the cause of a woman's or newborn's symptoms, a disease or disorder that may be identified from the results of a laboratory or other test or investigation that a member is authorized to order or perform on a woman or a newborn during normal pregnancy, labour and delivery and for up to six weeks post-partum. 3) Managing labour and conducting spontaneous normal vaginal deliveries. 4) Inserting urinary catheters into women. 5) Performing episiotomies and amniotomies and repairing episiotomies and lacerations, not involving the anus, anal sphincter, rectum, urethra and periurethral area. 6) Administering, by injection or inhalation, a substance designated in the regulations. 7) Prescribing drugs designated in the regulations. 8) Putting an instrument, hand or finger beyond the labia majora or anal verge during pregnancy, labour and the post-partum period. 9) Administering suppository drugs designated in the regulations beyond the anal verge during pregnancy, labour and the post-partum period.	PRACTICE OF MIDWIFERY Any act the purpose of which is to provide the professional care and services required by a woman during normal pregnancy, labour and delivery and to provide a woman and her child with the professional care and services required during the first six weeks of a normal postnatal period constitutes the practice of midwifery, including: (1) monitoring and assessing a woman and her child during pregnancy, labour, delivery and the first six weeks of the postnatal period, and include the provision of preventive care and the detection of any abnormal conditions in the woman or child; (2) conducting spontaneous deliveries; (3) performing an amniotomy, performing and repairing an episiotomy and repairing a first or second degree perineal tear or laceration. In addition, in an emergency, while awaiting the required medical intervention or in the absence of medical intervention, applying suction, conducting a breech delivery, performing manual placental extraction followed by digital exploration of the uterus or performing resuscitation procedures on the woman or newborn also constitutes the practice of midwifery. The practice of midwifery by a midwife also includes the provision of (1) counselling and information on parenting, family planning, contraception, preparation for delivery and breastfeeding, the usual care to be provided to a child up to the age of one year, and on the resources available in the community, (2) counselling and information to the public on perinatal health care. For the purpose of providing the professional care and services referred to in section 6, a midwife may prescribe or administer a drug designated on the list established by a regulation made under the first paragraph of section 9, according to such conditions as may be fixed in the regulation. For the same purpose, a midwife may prescribe, conduct or interpret any examination or analysis designated on the list established by a regulation made under the second paragraph of section 9.

		10) Taking blood samples from newborns by skin pricking or from persons from veins or by skin pricking. 11) Intubation beyond the larynx of a newborn. 12) Administering a substance by injection or inhalation as provided for in subsection 4.1 (2). 2009, c.26, s.16 (1).	
Model of Practice	College of Midwives of Manitoba (CMM) Model of Practice Revised April, 2000 newmodel00.doc 1 The principles outlined below are fundamentals of midwifery practice which, when taken together, ensure that midwifery meets the needs of the women who choose this service. MIDWIVES ARE AUTONOMOUS HEALTH CARE PROVIDERS: Midwives are primary health care providers who clients may choose as their first point of entry to the maternity care system. As primary health care providers, midwives make autonomous decisions in collaboration with their clients and are fully responsible for the provision of primary health services within their scope of practice. They coordinate services to ensure continuity of care, identify conditions requiring management outside their scope of practice and refer such cases to other providers. COMMUNITY INPUT: Community input is fundamental to the development and evaluation of midwifery practice across all settings. Community participation must be structured into the midwifery system during the development and ongoing planning of midwifery services and education. This would be achieved by: a) Facilitating ongoing community input into midwifery practices in all sites. (e.g. community forums, community boards, formal liaison with consumer organizations, consumer representation on governing body) b) Each and every client being able to give input at some level. (e.g. client evaluation care) c) Each midwife being responsible for soliciting client and community input. (e.g. client evaluation of care) d) Education about the role of community input at all levels incorporated into the education of midwives. (e.g. public representatives on advisory committee(s); consumer participation in the teaching of midwives) INFORMED CHOICE: Responsiveness to women's needs is a guiding principle of midwifery practice. Midwives respect the right of their clients to make informed choices and actively encourage informed client decision-making. Midwives facilitate decision-making by making relevant, objective information available to their clients. Midwives support the principle of informed choice by: a) Encouraging clients to actively participate in their care and to make choices about the services they will receive and the manner in which care is provided. b) Recognizing and supporting the pregnant woman as the primary decision maker and promoting shared responsibility between the woman, her family and her caregivers. c) Discussing the scope and limitations of midwifery care with their clients. CONTINUITY OF CARE: Midwives provide preconceptual,	Midwives begin care in the first trimester of a woman's pregnancy and provide complete care to their client as the primary caregiver. Midwifery care includes visits with the client at the midwifery clinic, attendance at the labour and birth and post partum home visits. Throughout the client's care, a midwife or her practice back-up is available on a 24 hour basis. Midwives consult with physicians if necessary and may transfer care if required. A midwife may provide supportive care to her client if care is transferred. Midwives are trained professionals who have the skills to attend births in hospital or a home setting. Midwives carry the required equipment to attend women during the delivery of their babies in a home setting. Midwives maintain current knowledge of • Emergency skills, including neonatal and cardiopulmonary resuscitation • Laboratory testing and diagnostics • Breastfeeding counselling • Homebirth In Ontario, the practice of midwifery is based on the principles of: • Continuity of care with a small group of midwives • Informed choice for decision-making • Choice of birthplace (including home, hospital). Midwives provide their clients with information in order to help them make appropriate choices for their care. All clients are provided with an informed choice agreement at the beginning of care and kept informed throughout their care in order to make choices when necessary. http://www.cmo.on.ca/midwife_care.php	Quebec Regroupement les sages-femmes du Quebec - Report submitted October 2012 Overview of Midwifery in QC: Most of Québec's midwifery practices are located in birthing centres. All prenatal and postnatal consultations and the vast majority of midwifery led births take place in a birthing center. The facility also serves as a community space for the sharing of experiences and knowledge amongst professionals and amongst parents. Approximately 75 to 80% of midwife-assisted births occur in a birthing centre, while 20 to 25% occur at home and 1 to 2% in hospitals. **Association:** Le Regroupement les Sages-Femmes du Québec (RSFQ) has 131 midwife members and 26 midwife student members. http://www.canadianmidwives.org/province/Quebec.html?prov=6#contact

	prenatal, labour, birth, postpartum care, which includes certain areas of gynaecology to their clients. As well, they provide counselling, education and emotional support related to the client's physical, psychological and social needs. There must be a 24-hour on-call availability of the primary care midwives known to the woman. Every midwife must make the time commitment necessary to develop a relationship of trust with the woman during pregnancy, to provide safe individualized care and support the woman during the childbearing year. In group practices, continuity of care could be achieved by a small team of midwives (not greater than four) provided the client has the opportunity to establish relationships with all the members of the team. CHOICE OF BIRTH SETTING: Midwives respect the right of women to make informed choices about the setting for birth. Midwives provide care in a variety of settings, including hospitals, birth centres and homes. Midwives provide their clients with the information and support required to make an informed choice about the appropriate settings in which to give birth. TWO ATTENDANTS AT EACH BIRTH: The Canadian standard of care is to have two attendants, skilled in neonatal and maternal emergencies, at each birth The second birth attendant must understand and support the midwifery model of care. COLLABORATIVE CARE: Midwives collaborate with other professionals to ensure their clients receive the best possible care when the needs of the women exceed the scope of practice of the midwife. In situations where transfer of care to a physician is required, the midwife is expected to continue providing supportive care after transfer and will resume primary care if appropriate. ACCOUNTABILITY AND EVALUATION OF PRACTICE: Midwives are accountable to their clients, their peers and the wider community for safe, competent, ethical practice. Midwives' fundamental accountability is to their clients. They are also accountable to their own regulatory body, their employers, and the health care institution in which they practice and to the public. ACCESSIBILTY OF MIDWIFERY CARE Midwifery care must be accessible to all women. Mechanisms should be in place to ensure equitable access to midwifery care for all women regardless of place of residence or circumstance. A midwifery practice must consider the demographics of the practice area so that services are offered to the variety of women therein. This ensures that women who would most benefit from midwifery care, but who might not seek such care, have an opportunity to use midwifery services. College of Midwives of Manitoba (CMM) Model of Practice, Revised April, 2000 http://www.midwives.mb.ca/policies_and_standards/mb-midwifery-model-of-practice.pdf		

Funding	Most midwives salary is based on a 40 hour work week. Midwives work flexible and variable hours. Midwives are entitled to 3 to 6 weeks of paid holidays per year depending on years of service. All midwives are members of a union. Unions differ by regional health authority. **Manitoba,** *last revised April 2011,* Pay & Employment Status It is also possible to set up private practice in Manitoba. Midwives in private practice are paid directly by the women to whom they provide service. Midwives in private practice are responsible for paying all of their own expenses (including office, equipment, supplies and professional liability insurance). Canadian Midwifery Regulators consortium "Working Conditions" April 2011 http://cmrc-ccosf.ca/node/60	Ontario midwives are funded by the Ontario Ministry of Health and Long-Term Care. through approved community Transfer Payment agencies, for care provided during pregnancy, labour, birth and the postpartum up to 6 weeks pp, based on funding courses of care http://www.ontariomidwives.ca/ Ontario: ***last revised 2006*** **Pay & Employment Status** Midwives in Ontario are independent practitioners. They are paid through transfer payment agencies funded by the Ontario Ministry of Health and Long-Term Care. Each midwife is paid a fee for each course of care she provides to a client based on her level of experience as a midwife. An additional 18% of the experience-based fee goes towards the midwife's benefits plan. A payment for a full course of care ranges from $2,540 to $3,075. In addition, for each course of care the midwife is paid an amount for the second midwife at the birth and for operating expenses. These amounts do not vary with experience. Midwives also receive an allowance for their midwifery and office equipment, second attendant equipment, and their professional liability insurance is fully covered. Expenses that they pay themselves include registration and professional fees, recertification courses, etc. After paying for those practice expenses that they must cover out of their fee, full-time midwives are left with compensation that ranges from approximately $69,000 to $92,000 plus 18% for benefits. http://cmrc-ccosf.ca/node/60	**Government Relations & Funding:** Québec midwives are hired on contract by the *Centres de santé et de services sociaux* (CSSS – equivalent to community health clinics). They are independent workers who receive a salary and additional benefits (i.e. offices, administrative services, equipment, holidays, retirement plans, etc.).The contract agreement for midwives was last signed by the RSFQ with the *Ministère de la Santé et des Services Sociaux* in December 2004. Negotiations will continue in the Fall of 2012. **Accomplishments:** The highlight for the RSFQ in 2011-2012 is without a doubt the adjustment of pay equity (representing a salary increase of 9.31%) and the beginning of negotiations to renew the contract agreement. IN the coming year, the RSFQ will be entering a new phase of contract negotiations and looking into additional insurance coverage for midwives currently under investigation by their College. http://www.canadianmidwives.org/province/Quebec.html?prov=6#contact Quebec ***last revised April 2011*** **Pay & Employment Status** All midwives in Quebec work as autonomous professionals under a contract with a local community health centre. Midwives are paid by salary with a range from $42,500 to $72,000. An additional $3600 is paid to full-time midwives for "unsociable" hours, with a proportionate amount to part-time midwives. Equipment and supplies are provided by their employer. The cost of professional liability insurance is share by the community health centre and the midwife, who has $750 deducted from her pay annually. Benefits include a pension plan, maternity leave, sick days, and mandatory minimal health insurance (which includes options for dental, life insurance, and other "extras"). Full-time midwives get 4 weeks paid holidays, as well as statutory holidays off. http://cmrc-ccosf.ca/node/60
Insurance	Reg. 16(1)&(2) THE MIDWIFERY ACT (C.C.S.M. c. M125) Midwifery Regulation 68/2000 Registered June 13, 2000 16(1) Subject to subsection (2), a midwife shall carry professional liability insurance of not less than $7,000,000. per occurrence or $14,000,000. per year, issued by a company licensed to carry on business in the province. 16(2) A midwife is not required to carry professional liability insurance if he or she is exclusively employed by a regional health authority and does not practice midwifery outside the scope of the employment.	Midwifery Act, 1991 ONTARIO REGULATION 168/11 Registration Consolidation Period: From October 19, 2012 to the aug 14 2013 Last amendment: O. Reg. 320/12. Condition re insurance 11. It is a condition of every general, supervised practice and transitional certificate of practice that the member shall have and continue to have personal protection against professional liability in accordance with the by-laws of the College. O. Reg. 168/11, s.11.	In the coming year, the RSFQ will be entering a new phase of contract negotiations and looking into additional insurance coverage for midwives currently under investigation by their College. http://www.canadianmidwives.org/province/Quebec.html?prov=6#contact
Outcome	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 3.8 % Urban Residents: 4.2% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information*	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 7.6 % Urban Residents: 6.8% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information*	

Province	New Brunswick	Nova Scotia	PEI	Newfoundland
Summary	The *Midwifery Act* was proclaimed in New Brunswick on August 12, 2010. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is regulated in Nova Scotia under the *Midwifery Act* and the *Midwifery Regulations, N.S. Reg. 58/2009.* Since the implementation of regulation in March 2009, all midwives must be registered with the Midwifery Regulatory Council of Nova Scotia to be permitted to practise. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is not regulated in Prince Edward Island. However, in May 2010 the government announced that it will create a task force to study the issue. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	On June 24, 2010, the Health Professions Act was assented to. Midwifery will be governed under this act in Newfoundland and Labrador. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*
Scope	Sect. 2 (1) & (2) Midwifery Act, New Brunswick 2(1) In this Act, "practice of midwifery" means the care, assessment and monitoring of women during normal pregnancy, labour and the postpartum period and of their healthy newborns, and the management of low-risk, spontaneous vaginal deliveries. 2(2) In engaging in the practice of midwifery, a midwife may (a) consult with, make a referral to or transfer care to a medical practitioner as set out in the standards of practice established by the regulations, (b) prescribe and administer drugs in accordance with the regulations, (c) order and interpret screening and diagnostic tests in accordance with the regulations, and (d) provide other health care services within the practice of midwifery as set out in the standards of practice established by the regulations.	The midwife's scope of practice includes assessment and identification of risks or abnormal conditions, recommending or initiating treatment, and consulting with or referring care to medical specialists and other care providers in a timely and appropriate manner. In Nova Scotia, the registration process and requirements are consistent with those in other Canadian provinces. Sect. 2(i) Midwifery Act, Nova Scotia 2 (i) "practice of midwifery" means (i) the assessment and monitoring of the health of a mother and her baby during pregnancy, labour and the post-partum period, (ii) the provision of care in the normal course of pregnancy, labour and the post-partum period, (iii) the management of vaginal deliveries, (iv) the ordering and interpreting of screening and diagnostic tests and the recommending, prescribing or re-ordering of drugs restricted to actual delivery and care, blood products and related paraphernalia respecting the provision of care in the normal course of pregnancy, labour and the post-partum period, and (v) invasive procedures restricted to actual delivery and care, as prescribed by regulation, either within or outside of a hospital setting and research, education, consultation, management, administration, regulation, policy or system development relating to subclauses (i) to (v) http://novascotia.ca/health/primaryhealthcare/midwifery.asp		
Model of Practice	No details	The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or		

		other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education for her clients and within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare. A midwife may practise in any setting including the home, community, hospitals, clinics or health units. Fundamental to midwifery care is respect for the normal, healthy process of pregnancy and childbirth, and for women's power and ability to give birth. Midwifery care promotes, protects and facilitates normal physiologic birth. Code of Ethics: The purpose of a Code of Ethics is to set forth the ethical principles and standards which professionals are expected to meet and by which their actions can be judged. The MRC Code of Ethics identifies the moral and ethical obligations inherent in the midwife's professional role. Midwives have a responsibility to maintain the integrity of their profession and uphold ethical principles in the provision of care for childbearing women and their infants within their families and communities. This Code is grounded in values that are fundamental to midwifery practice and professional relationships with clients, families, colleagues and communities. These values include: (a) Promotion of safe, compassionate and ethical care (b) Promotion of health and well-being (c) Support for informed decision-making (d) Respect for human dignity and integrity (e) Protection of privacy and confidentiality (f) Promotion of justice and equity (g) Accountability The general and specific competencies defined by the CMRC in the following areas are approved by Council as core competencies for midwives in Nova Scotia: Education and Counselling Antepartum Care Care During Labour, Birth and the Immediate Postpartum Period Care of the Woman During the Postpartum Period, including Breastfeeding Care of the Newborn and the Young Infant Well Woman Care, Sexuality and Gynecology Professional, Inter-professional, Legal and Other Aspects of the Profession In Nova Scotia, the clinical practice of midwifery means the provision of antepartum, intrapartum,		

		postpartum and newborn care as a primary care provider. Midwives provide the full continuum of "low risk" prenatal, post-partum and newborn care as well as managing labour and birth, and are responsible for making clinical decisions within their scope of practice http://mrcns.ca/index.php/about-midwives/		
Funding	The Midwifery Association of New Brunswick is currently focusing its activities on mobilizing consumer groups to attain provincial funding for midwifery practice. The Midwifery Act received Royal assent in June 2009 and was proclaimed in June 2010. The Midwifery Council of New Brunswick has been working on developing policies, standards and registration processes for midwives to practice in the province. Government Relations The province continues to fund the work of the regulatory body the Midwifery Council of New Brunswick http://www.canadianmidwives.org/province/New-Brunswick.html?prov=4	Midwifery services are completely covered by the provincial health plan (MSI) in Nova Scotia and clients do not pay for care. http://mrcns.ca/ Midwifery Regulatory Council of Nova Scotia **Nova Scotia,** *last revised May 2011,* Pay and Employment Status http://cmrc-ccosf.ca/node/60 Midwives in Nova Scotia are employed by District Health Authorities or the IWK Health Centre. Their annual salary range is approximately $72,876-$83,980 depending on their years of service. Overhead expenses for their office, equipment, supplies, and professional liability insurance are paid for by their employer. Midwives are entitled to participate in life insurance, disability insurance, employee assistance plan, and extended health, dental and pension plans. Midwives salary is based on a 40 hour work week. Midwives work flexible and variable hours and are entitled to 3 to 6 weeks of paid holidays per year depending on years of service plus statutory holidays. Midwives in Nova Scotia are not presently members of a union. It would also be possible to set up private practice in Nova Scotia. Midwives in private practice would be paid directly by the women to whom they provide service. http://cmrc-ccosf.ca/node/60		
Insurance	Sect. 31(1) Liability insurance 31(1) No midwife shall engage in the practice of midwifery without first providing the Registrar with proof of valid professional liability insurance as may be required by the regulations upon renewal of the midwife's registration. 31(2) The Registrar may suspend the registration of a midwife who fails to provide proof of valid professional liability insurance in accordance with subsection (1).	Midwifery Regulatory Council of Nova Scotia Policy on Liability Insurance Midwives with an active-practising (clinical) or provisional (clinical) licence are required under section 29 of the Regulations to carry professional liability insurance in an amount determined by Council. The liability insurance plan for midwives in Nova Scotia will be administered by the Association of Nova Scotia Midwives (ANSM), with administrative support from the Liability Insurance and Risk Management Committee of the Association of Ontario Midwives (AOM). The insurance provider is the Health Insurance Reciprocal of Canada (HIROC). All registered midwives engaged in clinical practice in the province must carry liability insurance through the same insurance provider under the plan administered by the ANSM. The amount of liability insurance coverage for private midwifery practice must be at least equivalent to the coverage provided to midwives employed by		

		District Health Authorities and the IWK Health Centre. Midwives in private midwifery practice are responsible for their own liability insurance premiums.Adopted by the MRC on March 27, 2009 http://mrcns.ca/images/uploads/Liability_insurance__final_.pdf		
Outcome	New Brunswick, Report submitted October 2012 to CAM: Overview of midwifery practice Currently there are no registered midwives in NB. There is one midwife living in NB who is registered and working in other Canadian jurisdictions where support and funding is already in place. She hopes to start private practice in New Brunswick when another registered midwife in the province will join her. Although midwives can register in NB and practice privately, currently a registered midwife would not be able to work her full scope. It is anticipated that credentialing for midwives will proceed when the *Regional Health Authorities Act* is re-opened at the next sitting of the legislature. Credentialing will allow for implementation of many key aspects of care delivery such as clinical admitting, treatment (ordering and prescribing), consultation and referral processes as the profession of midwifery still needs to be included in the by-laws. http://www.canadianmidwives.org/province/New-Brunswick.html?prov=4	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 1.2 % Urban Residents: 0.5% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information*		Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 4.2 % (Labrador-Grenfell) Urban Residents: 0% *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information*

Province	Nunavut	NWT	Yukon
Summary	Midwifery is regulated in Nunavut under the *Midwifery Profession Act* and regulations. Since the implementation of the regulation in 2011, all midwives must be registered by the Nunavut Registration Committee to be permitted to practice. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is regulated in the Northwest Territories under the *Midwifery Profession Act, S.N.W.T. 2006, c.24*, and *Midwifery Profession General Regulations, N.W.T. Reg. 002-2005*. Since the implementation of regulation in 2005, all midwives must be registered with Northwest Territories' Health Professional Licensing Department to be permitted to practise "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*	Midwifery is not regulated in the Yukon. However, in the Fall of 2007, the government began an investigation into whether to regulate midwifery. In March and April 2010, the government carried out a public consultation. "Legal Status of Midwifery in Canada," Canadian Midwifery Regulators Consortium, *last revised January 2012*
Scope	Sect. 2&3 2 S.Nu. 2008,c.18 Chapter 18 MIDWIFERY PROFESSION ACT (Assented to September 18, 2008) Nunavut Practice of midwifery: The practice of midwifery means the application of midwifery knowledge, skills and judgment to assess, monitor and provide care to: (a) women of reproductive age in respect of health promotion, pregnancy, labour, delivery and the postpartum period; and (b) Newborn babies and infants. Scope of practice: 3. A registered midwife is entitled to, in the course of practising midwifery, (a) counsel, support, advise, examine, monitor and care for women during pregnancy, labour, delivery and the postpartum period; (b) carry out assessments necessary to confirm and monitor pregnancies; (c) advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk; (d) identify the conditions in the woman, fetus or newborn that necessitate consultation with or referral to a medical practitioner or other health care professional; (e) monitor the condition of the fetus during labour; (f) manage labour and conduct vaginal deliveries; (g) examine and care for the infant in the eight week period following birth; (h) perform, order, collect samples for and interpret the results of screening and diagnostic tests authorized in the regulations; (i) perform minor surgical and invasive procedures and physical examinations authorized in the regulations; (j) take emergency measures when necessary; (k) prescribe and administer drugs and substances authorized in the regulations; (l) order, prescribe and fit medical equipment and devices authorized in the regulations; (m) on the order of a medical practitioner relating to the midwifery care of a specific client, administer drugs and substances by the route and in the dosage specified by the medical practitioner; (n) Provide counselling and education in respect of health promotion, childbearing, newborn and infant.	Sect. 2 (1) MIDWIFERY PROFESSION ACT S.N.W.T. 2003,c.21 In force January 29, 2005; SI-001-2005 AMENDED BY S.N.W.T. 2006,c.24 In force April 2, 2007; SI-001-2007 S.N.W.T. 2010,c.16 Registered Midwives 2. (1) A registered midwife is entitled to apply midwifery knowledge, skills and judgment (a) to provide counselling and education related to childbearing; (b) to carry out assessments necessary to confirm and monitor pregnancies; (c) to advise on and secure the further assessments necessary for the earliest possible identification of pregnancies at risk; (d) to identify the conditions in the woman, fetus or newborn that necessitate consultation with or referral to a medical practitioner or other health care professional; (e) to care for the woman and monitor the condition of the fetus during labour; (f) to conduct spontaneous vaginal births; (g) to examine and care for the newborn in the immediate postpartum period; (h) to care for the woman in the postpartum period and advise her and her family on newborn and infant care and family planning; (i) to take emergency measures when necessary; (j) to perform, order or interpret prescribed screening and diagnostic tests; (k) to perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum and urethra; (l) to prescribe and administer drugs authorized in the Midwifery Practice Framework; and (m) On the order of a medical practitioner relating to a particular client, to administer any drugs by the route and in the dosage specified by the medical practitioner.	

Model of Practice	Sect. 4, 5, 6(1) Primary health care provider 4. A registered midwife may practise midwifery as a primary health care provider who (a) is directly accessible to clients without referral from another health care professional; (b) is authorized to provide health care services within the practice of midwifery without being supervised by another health care professional; and (c) Shall consult with medical practitioners or other health care professionals where medical conditions exist or arise that may require management outside the scope of midwifery practice. Duties performed and powers exercised 5. The duties performed and the powers exercised by a registered midwife under sections 3 and 4 are subject to this Act, the regulations, the standards of practice and standards of competence approved by the Minister and the terms and conditions imposed on the registered midwife's certificate of registration. Traditional Inuit Midwifery 6.1. The Minister shall develop instructional content based on traditional Inuit midwifery knowledge, skills and judgment for: (a) midwifery training and refresher programs; and (b) Midwifery professional development programs. Instruction (2) Every person who delivers a midwifery training or refresher program or a midwifery professional development program shall ensure that (a) the curriculum includes the instructional content developed under subsection (1); And (b) Persons who have experience in the practice of traditional Inuit midwifery are invited to instruct students and share their knowledge. A registered midwife is a person who has acquired the requisite qualifications to be registered to practise midwifery. She is recognized as an accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on her own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. She has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work involves antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A registered midwife is directly accessible to clients without referral or supervision from another health care professional and may practise in any setting including the home, community, hospital, and clinic or health unit. Nunavut Maternal & Newborn Health Care Strategy 2009 – 2014. Government of Nunavut; Department of Health and Social Services http://hss.gov.nu.ca/PDF/Maternal%20strategy_ENG.pdf	Philosophy of Midwifery care in the NWT Midwifery care is based on a respect for pregnancy as a state of health, and childbirth as a normal physiological process. Given that there is a great range of "normal" in pregnancy and childbirth, any decision to intervene in the natural process is made only after thoughtful and careful assessment. When pregnancy and birth deviate from normal or become complicated, supportive and appropriate care assists women to maintain a healthy perspective on the childbearing experience. The practice of midwifery is founded on the understanding that pregnancy, labour and birth are profound experiences that carry significant meaning for a woman, her family and her community. Midwives acknowledge the social, emotional, cultural, spiritual, and psychological and well as physical aspects of these lifecycle events and strive to help women and their families to move through these transforming experiences safely and with power and dignity. Midwifery care is woman-centred and family-centred and responds to the unique strengths and needs of each woman and her family. Midwives respect and support women as primary decision-makers who are capable of making thoughtful and appropriate choices for themselves and their babies based on current information available to them, in accordance with their own values and belief systems. Midwives promote health in women, babies and families through the provision of a continuum of services from the preconception period right through to the period of infancy and early parenting. Midwives work with women and their family members to encourage awareness, self-care and growth in a manner that is flexible, creative, empowering and supportive, in accordance with s 2. (1) of the [midwifery] Act [of NWT]. Midwives honour traditional and cultural birth practices. Midwives embrace the diversity of cultural lifestyles and strive to understand the wisdom of elders' teachings and the contributions of traditional midwifery. Midwives as Autonomous healthcare providers Midwives are autonomous primary health care providers whom clients may choose as their first point of entry to the maternity care system, in accordance with s. 4 (a) of the Act. As primary health care providers, midwives make autonomous decisions in collaboration with their clients and are fully responsible for the provision of primary health services within their scope of practice. They coordinate services to ensure continuity of care, identify conditions requiring management outside their scope of practice and refer such cases to other providers. Accessibility of Midwifery Care: Midwives work with the families, communities and agencies that support their practice to ensure equitable access to midwifery care for all women regardless of their place of residence or circumstances. Midwives offer their services to all women within their practice area and engage in outreach efforts approved by their Health Authority to facilitate the access of all women to midwifery care. Where the availability of midwifery services is limited, midwives make every reasonable effort to serve women in their own community and from out-lying communities. Midwives work with communities desiring midwifery services to	

		develop appropriate and practical approaches to the provisions of midwifery care. Wherever possible, midwifery services are provided as close to women's home communities as prudent. Northwest territories Minister of Health and Social Services, Midwifery Practice Framework 30 Mar 2007	
Funding	Registered Midwives are part of the Nunavut Employee's Union and has a salary range of $73,398 to $83,285.00 per annum plus a Northern Allowance. http://www.aom.on.ca/files/The_AOM/Career_Opportunities/Registered_Midwives/Casual_RM_posting.pdf	Northwest Territories, ***last revised 2006,*** **Pay and Employment Status** Typically midwives in the Northwest Territories are employed by the Health and Social Services Authorities. The salary range is $76,713 to $90,850 depending on practice location and on the midwives' years of service with the Government of the Northwest Territories. The pay range is currently under review (July 06). In addition, midwives receive an annual Northern Allowance based upon the remoteness of the community in which they are employed. The overhead expenses for office, equipment, supplies, and professional liability insurance (up to $10 Million) are paid for by the employer. Midwives in the Northwest Territories are members of the Union of Northern Workers. Their salary is based on a 37.5 hour work week. In accordance with the Collective Agreement midwives work flexible hours to meet practice and client need. http://cmrc-ccosf.ca/node/60	
Insurance	Sect. 16 - Professional liability insurance 16. A registered midwife who holds a general certificate of registration or a temporary certificate of registration shall be insured by professional liability insurance with an insurer acceptable to the Minister and in an amount that is at least the minimum level of coverage required by the Minister.	Sect. 13 - Professional Liability Insurance 13. A registered midwife shall carry professional liability insurance with an insurer acceptable to the Minister and in an amount that is at least the minimum level of coverage required by the Minister.	
Outcome	Midwife % of deliveries 2007/08 to 2011/12 Rural Residents: 0.3 % Urban Residents: n/a *Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information*	**Midwife % of deliveries 2007/08 to 2011/12** **Rural Residents: 5.8 %** **Urban Residents: 3.6%** ***Attending Providers: Rural and Urban Residents Five Years of Pooled Data (2007-2008 to 2011-2012), Discharge Abstract Database, Canadian Institute of Health Information***	

2013/14

CMBC: International Jurisdictional Comparison

Sarah Hilbert-West

June 2014

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
NORWAY Number of Midwives in Practice: 3489 Number of births per year: 60 000 Number of births per midwife per year: 17.2 Prescription training: after qualifying as a midwife, contraceptives *Survey of European Midwifery regulators, 2010.*	Midwives in Norway are authorized to prescribe contraceptives on their own authority. *Survey of European Midwifery regulators, 2010.*	2 Years of specialty training is required to become a midwife after the completion of a nursing degree. There is no direct-entry midwifery training program in Norway at this time. *Survey of European Midwifery regulators, 2010.*	"The Norwegian Association of Midwives (DNJ) works to ensure that midwives should have wage developments that reflect the professional group competence and responsibility." http://www.jordmorforeningen.no/jm/Hjem/Loenn-og-tariff/Jordmor-og-loenn The healthcare system in Norway is one of the best in the world. There are both public and private facilities – public services are subsidised by the government and are either free or cost only a small fee, while private healthcare is funded by patient fees and is much more costly. Anyone who is living and working in Norway for more than one year is required to contribute toward the National Insurance Scheme (NIS or *Folketrydgen*), which helps to fund public healthcare, and is entitled to use the public services. http://www.expatarrivals.com/norway/healthcare-in-norway	Midwives in Norway are not obligated to carry personal professional liability insurance. *Survey of European Midwifery regulators, 2010.*	1.79 fetal deaths per 1000 live births. 3.36 fetal deaths per 1000 births. In 2012, 0 maternal deaths per 100,000 live births. 51.34 Midwives per 1000 and 2.28 midwives graduated per 100,000. *European Health for all Database. WHO Regional Office for Europe, April 2014* 17% Cesarean section rate (2011) *WHO Athena Database, accessed June 2014.* In recent decades Norway has been among the countries with the best indicators for maternal and child survival. Currently in Norway there are about 60,000 deliveries annually. About 40,000 take place in obstetric units in hospitals with round-the-clock services from all main specialists (midwifery, obstetrics, neonatology, etc.). Approximately 18,000 deliveries take place in smaller units run by midwives that have access to emergency cesarean section if required. *Prepared by: Sverre O Lie, Norwegian Directorate of Health, The State of the World's Midwifery 2011, UNFPA, the United Nations Population Fund*

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
DENMARK The Danish Association of Midwives has approximately 2.500 members, out of which 1700 are active licensed midwives. Danish midwifery education: Midwifery education lasts 3,5 years. It is a direct entry midwifery program, ending in the title: Professional Bachelor of Midwifery. The yearly turnout of midwives is at present 140. *The Danish Association of Midwives http://www.jordemoderforeningen.dk/english/*	The scope of practice of midwifery in Denmark Midwives work with: • Family planning • Antenatal classes, family preparation classes • Health promotion and profylactic consultations on demand with pregnant women and their families and including: • Diagnostic ultrasound scanning • Smoking cessation intervention courses • Care for special groups, twin pregnancies, overweight/obese families, pregnant women with immigrant backgrounds, team work with pregnant women with substance abuse • Observation, care and treatment of women with complicated pregnancies in hospital or in the home • Various neonatal screening procedures *The Danish Association of Midwives http://www.jordemoderforeningen.dk/english/*	The midwife conducts births on her own responsibility and provides care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife may practise in any setting including the home, ommunity, hospitals, clinics or health units. The midwife supports the woman in the best choice of feeding her child. The immediate postpartum care as well as extended care in hospital or visits in the family home as well as the woman seeking the midwife's advice in the midwifery centre forms an essential part of the midwife's duties. *The Danish Association of Midwives http://www.jordemoderforeningen.dk/english/*	Midwives are either paid a salary if employed or paid by the client if independent. But there are very few private practices. The salaries of the public sector are regulated according to the developments in salaries of professional groups in the private sector. So, when the salaries of, for example, policemen rise, the salaries of midwives will also rise. The average income annually for a midwife is about € 32,000 to 35,000. This is exclusive of extra payments for overtime, late nights etc. *Midwifery In Europe: an inventory of 15 EU member states, Emons and Luiton, of Deloitte and Touche, Sept 2001*	Health care in Denmark is generally considered to be a public responsibility. Virtually all health care services are financed, planned and operated by public authorities. *Deloitte and Touche*: *Midwifery in Europe* http://www.deloitte.nl/downloads/documents/website_deloitte/GZpublVerloskundeinEuropaRapport.pdf	3.78 fetal deaths per 1000 births. 1.72 maternal deaths per 100,000. 27.99 Midwives per 1000 and 2.39 graduated midwives per 100,000. *European Health for all Database. WHO Regional Office for Europe, April 2014* 21.2% Cesarean section rate (2012) *WHO Athena Database, accessed June 2014.*

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
GERMANY According to the latest available figures from the German Federal Statistical Office, close to 10,000 midwives aid in the births of 644,274 babies at hospitals each year. *"Midwife Crisis: Reforms Needed to Stem Shortage of Birth Caregivers," By Lisa Erdmann, June 3, 2011. Der Speigel*	Since 1985, the Law has been protecting the profession of German midwives. According to this law, a midwife is trained and qualified to provide care and counseling to women during normal pregnancy, birth and post-partum. A midwife is the only skilled person, other than a physician, in the health care profession who is legally entitled to deliver medical care independently (without a nurse or physician). The law also requires that for every birth, both at home and in hospital, a midwife must be present. Physicians are required to call in a midwife for every delivery. However, a physician must be called in for any complications. When it comes to decision-making in cases of complicated labour, the physician assumes the final decision (Scheuermann 1995). Areas in which midwives are entitled to provide professional services include the following: 1. Antenatal examination and monitoring; 2. Antenatal classes and counselling; 3. Treatment of disorders during pregnancy, such as diabetes mellitus, hypertension and anaemia (this may only be done after the midwife has informed the woman of the disorder and treatment options by a physician); 4. Normal deliveries, including episiotomies; 5. Complete postnatal care for at least ten days, including nutritional counseling and a follow-up. *Deloitte and Touche*: *Midwifery in Europe* http://www.deloitte.nl/downloads/documents/website_deloitte/GZpublVerloskundeinEuropaRapport.pdf	- Assumption of responsibility for a family-oriented and process-oriented Obstetrics unit taking into account the Midwives Act and the midwives job order, according to the reserved activities - Loyal cooperation with the obstetric team - Proper, professionally and cost-effective use of medicines, equipment and medical devices - Compliance with relevant statutory provisions eg Hygiene, Working Time Act, fire safety, accident prevention, etc. - Careful execution of the obstetric and administrative documentation Quality assurance - Responsibility for the professional assistance to persons under supervision into account the individual needs and different cultures - The midwife is responsible for the qualified, professional practical Guidance of student midwives, apprentices according to the appropriate Laws - Cooperation with other professional groups for a high level of quality in family-oriented obstetrics - Active participation of social and professional policy processes - The involvement and implementation of quality assurance measures - Observation of the Quality Manual - Participate in the compilation of observations and statistics - Responsibility for the implementation of the current hygiene regulations file:///C:/Users/OWNER/Downloads/MusterStellenbeschreibungHebammen%20(1).pdf Accessed June 2014, translated using Google Translate, 2014.	Today, the average taxable income of a self-employed midwife is about €14,000 per year. However, insurance premiums can cost more than one-quarter of that. Over the past five years, the financial situation of Germany's midwives has become increasingly dire: While liability insurance premiums for attending midwives have increased, the fees midwives charge for their services have increased only incrementally. *"Midwife Crisis: Reforms Needed to Stem Shortage of Birth Caregivers," By Lisa Erdmann, June 3, 2011. Der Speigel*	Four years ago, liability insurance fees for a midwife cost €1,218 ($1,755) per year. Now, a self-employed midwife who attends births can expect to pay €3,689 in liability insurance fees annually. Those who don't attend births, and provide only pre- and postnatal care, pay a fraction of this cost. *"Midwife Crisis: Reforms Needed to Stem Shortage of Birth Caregivers," By Lisa Erdmann, June 3, 2011. Der Speigel*	2.19 Neonatal deaths per 1000 live births. 3.554 fetal deaths per 1000 births. 4.6 maternal deaths per 100,000 live births. 23.21 Midwives per 1000 and 0.7 midwives graduated per 100,000. *European Health for all Database. WHO Regional Office for Europe, April 2014* 32.1% Cesarean section rate (2011) *WHO Athena Database, accessed June 2014.*

Facts

Inhabitants	16,780,566 (November ´12, CBS)
Active midwives	2612, 27% work in a hospital (´11, Nivel)
Total Fertility Rate	1.80 (´10, CBS)
Maternal age at birth of 1st child	29.4 years average (´10, CBS)
Births	180,060 (´11, CBS) primips 45.1% (´08, PRN)
Home birth	23.4% (´08-´10, CBS) 29.4% (´05-´07, CBS)
Birth in primary care	32.8% (´08, PRN)
Referral during birth (1st → 2nd level)	32% (´07, PRN)
Induction of birth	15.5% (´08, PRN)
Caesarean section	15.4%, 74% in case of breech (´08, PRN)
Vaginal birth after caesarean (VBAC)	54% (´02-´03, NVOG)
Epidural pain relief (1st stage of birth)	11.3% (´08, PRN) 6.2% (´04, PRN)
Maternal mortality	8.1/100,000 live births (´08, PRN)
Perinatal mortality (22 wks – 1st wk)	9.1/1000 live births (´08, PRN)
Perinatal mortality (28 wks – 1st wk)	4.8/1000 live births (´08, PRN)
Women who start with breast feeding	75% (´10, TNO)
Women who breast feed 6 months pp	18% (exclusive BF ´10, TNO)

(Midwifery in the Netherlands, 2012, THE ROYAL DUTCH ORGANISATION OF MIDWIVES)

http://www.knov.nl/uploads/knov.nl/knov_downloads/526/file/KNOV_Midwifery_in_the_Netherlands_20121112.pdf

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
THE NETHERLANDS *(Midwifery in the Netherlands, 2012, THE ROYAL DUTCH ORGANISATION OF MIDWIVES*	The midwife is an independent, autonomous, medical professional who: • acts as case manager and advocate during pregnancy, childbirth and the post-partum period; • coordinates the midwifery care; • has a professional profile and is academically trained; • can support her actions with scientific evidence. The midwife is responsible for continuous supervision and care. From the start of labour, she stays with the pregnant woman. If an increased risk of complications arises, the midwife continues to offer care where medically appropriate. She then works in close collaboration with the midwife employed by the hospital, the ObsGyn on call and any other disciplines. Following guidelines, protocols and other agreements, midwives and ObsGyns work closely together, which encourages mutual consultation. The midwife is responsible for conducting the risk analysis. In high-risk situations, she refers the pregnant woman to an ObsGyn. Midwifery care is easily and freely available for all pregnant women at home or elsewhere. Safe midwifery care also demands an enabling environment with easily accessible hospital facilities within an agreed timeframe. Agreed national emergency response times apply to ambulances to guarantee emergency accessibility of midwifery care in hospital (the WTZi-norm). Professionals involved in perinatal care meet periodically to discuss matters in the Perinatal Care Partnership (VSV). The Netherlands Perinatal Audit (PAN) and a well functioning VSV contribute to bringing challenging areas up for discussion and look at the quality of the hands-on work and cooperation. Midwives form part of a network of public health facilities with other professionals who provide care in the community, like maternity assistants, primary care physicians, dieticians and physiotherapists. Communication between them is supported by PWD (perinatal web based medical records). These professionals are jointly responsible for properly coherent processes of care. *THE ROYAL DUTCH ORGANISATION OF MIDWIVES, June 2012, A New Balance in Midwifery Care* *http://www.knov.nl/uploads/knov.nl/knov_downloads/718/file/KNOV_A_new_balance_in_midwifery_care_june_2012.pdf*	In the Netherlands, maternity care is organised in a so called primary, secondary and tertiary care model. The primary care, for low-risk women, is formed by midwives and GPs. GPs are responsible for only about 0.5% of all births, mainly in rural areas with a low population density ('11, Nivel). Secondary care consists of obstetricians and specialized 'clinical' midwives in general hospitals and the tertiary care comprises obstetricians in academic hospitals. Risk selection, a clear distribution of tasks and a close mutual co-operation between these different strata forms the strength of the Dutch system. The principle idea is that a healthy woman with a healthy pregnancy (low-risk) is best taken care of by a midwife. This minimises her chances of receiving an unnecessary intervention of any kind, gives her a high standard of care and is furthermore very cost-effective. The midwife guiding a woman through her pregnancy, birth and puerperium is autonomous in her actions and decisions. Emphasis is placed on natural processes, with intervention only occurring when a problem arises. In this case, the midwife will consult or refer to an obstetrician. *Midwifery in the Netherlands 2012, Royal Dutch Organization of Midwives http://www.knov.nl/voor-verloskundigen/internationaal/midwifery-in-the-netherlands/* For the midwife, the woman and her partner are the focus of her work. While planning for parenthood, during pregnancy, childbirth and the post-partum period the woman and her partner need an accessible and approachable care provider. Midwives provide personalised care, information, advice and support in all phases of this process. A midwife offers care in the community, either at home or close to where the pregnant woman and her partner live. She accompanies the pregnant woman during childbirth at home, in a birthing centre or in the hospital. Her care contributes to the well-being of both mother and child and an optimal start for young parents. Quality and continuity of care provision for pregnant women and their partners are key aspects of this. They are realised by broadening and deepening tasks and competencies on the one hand, and close collaboration between midwives, obstetricians/gynaecologists (ObsGyn) and other care providers on the other. In this integrated care model, the care providers themselves make agreements based on equality and retain their own competencies and responsibilities. This creates a new balance in the organisation and collaboration with direct partners in midwifery care. Pregnant women consider freedom of choice to be essential. The midwife provides objective and clear information about	Government funding for maternity care exists in the Netherlands. Midwives are compensated as hospital employees or independent practitioners. file:///C:/Users/OWNER/Downloads/200910_WomensHealth_7.pdf	The Netherlands has a low litigious culture and the role of independent midwives affects the commerciality of product Insurance co-payments are paid, where both the woman and the midwife pay for insurance. file:///C:/Users/OWNER/Downloads/Professional-indemnity-insurance-for-privately-practising-midwives---Research-report.PDF	3.41 Maternal deaths per 100,000 births. 15.46 Midwives per 1000 and 0.88 midwives graduated per 100,000. *European Health for all Database. WHO Regional Office for Europe, April 2014* 17% Cesarean section rate (2010) *WHO Athena Database, accessed June 2014.* Dutch researchers looked at a nationwide cohort of 529, 688 low-risk women in primary midwifery care who gave birth between 1 January 2000 and 31 December 2006. Previous studies into home births have been limited by their small sample sizes and this is the largest study of its kind to date. The findings show 321, 307 (60.7%) women had planned to give birth at home. 163, 261 (30.8%) intended to give birth in hospital. There was no data on place of birth for 45, 120 (8.5%) women. Researchers examined the perinatal mortality rate during the first 24 hours of delivery and during the first week after delivery and found no significant differences between women who gave birth at home with those who had a planned hospital birth. Babies of women who had planned a home birth were equally as likely to be admitted into a neonatal intensive care unit (NICU) when compared to women who had a hospital birth. The risk of poor outcomes was found to be higher in women who were primiparous (women having

		the benefits and disadvantages of different choices in each phase of care. Based on this information and her own expectations, the pregnant woman can make a well-informed decision. This also applies to the decision of where to give birth: at home, in a birthing centre or in an outpatient clinic in a hospital. Healthy women can choose to give birth at home. The choice for home birth is a responsible one; it is safe and has a favourable effect on the course of childbirth. The reproductive process is primarily physiological. The midwife employs her knowledge and skills to promote the physiological aspects of each woman's pregnancy, childbirth and post-partum period. She acts in an evidence-based manner to provide personalised medical and psychosocial care. She is the expert and authority in the field of the normal course of pregnancy, childbirth and the post-partum period. THE ROYAL DUTCH ORGANISATION OF MIDWIVES, June 2012, A New Balance in Midwifery Care http://www.knov.nl/uploads/knov.nl/knov_downloads/718/file/KNOV_A_new_balance_in_midwifery_care_june_2012.pdf			their first child), gave birth at 37 or 41 (compared with 38-40) weeks of gestation, were 35 years or older, were younger than 25 years old, and of non-Dutch origin. These factors were taken into account in the comparison between planned home and planned hospital birth. *New figures from the Netherlands on the safety of home births* *Published on 15/04/09 by de Jonge A, van der Goes B, Ravelli A, Amelink-Verburg M, Mol B, Nijhuis J, Gravenhorst J, Buitendijk S. Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. BJOG 2009 10.1111/j.1471-0528.2009.0217*

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
SWEDEN Sweden has long had trained professional midwives. Research shows this has resulted in a sharp reduction in mortality among women in childbirth. In the 18th century, the maternal mortality rate was about one in a hundred. By the beginning of the 20th century, mortalities had dropped to 250 women per 100,000 live births. The Swedish Association of Midwives recently celebrated its 125th anniversary as a professional organisation and 300 years of midwife training. The first regulations governing midwifery in Sweden were established in 1711, and stipulated that midwives in Stockholm should be trained, assessed and must take an oath. *http://sweden.se/society/healthcare-in-sweden/*	The midwife's field of work includes the woman's sexual and reproductive health with a lifecycle perspective. • Care and supervision of the uncomplicated /normal pregnancy, labour, delivery and the postnatal period • Identification of abnormal conditions during pregnancy, labour, delivery and the postnatal period including midwifery care for these conditions • Care of the healthy newborn baby and care in connection with breast feeding • Support of parenthood including the dignity and autonomy of the individual • Counselling and care concerning fertility control and sexuality • Health care information concerning reproductive health including menopausal counselling • Care in connection with gynaecological health problems The Swedish Association of Midwives *http://www.barnmorskeforbundet.se/english/*	In Sweden, midwives have an exclusive right to practise their profession, and the professional title is protected. This means that only a person who holds a licence to practise is allowed to use the title or exercise the profession. However, there is no basic training to become a midwife in Sweden. All midwives have undergone nurse training, and received licence to practise as a nurse, before they go through midwife training. Accordingly, you need to obtain a Swedish licence to practise as a nurse and a Swedish midwife diploma before you can apply for a licence to practise as a midwife. If you were trained in a country outside the EU/EEA your training has to be assessed by Socialstyrelsen before you can submit a formal application for a Swedish licence to practise as a nurse. *http://www.socialstyrelsen.se/applicationforswedishlicencetopractiseothercountries/midwife*	Nowadays, the average income for the normal working midwife is approximately €2,183 per month (i.e. €26,196 annually). In big cities, the midwives earn more money than midwives do in smaller towns. *Deloitte and Touche*: *Midwifery in Europe* http://www.deloitte.nl/downloads/documents/website_deloitte/GZpublVerloskundeinEuropaRapport.pdf	The major part of the costs of health care is financed by income tax levied by each of the 26 counties on their population (75%), like a universal public health insurance of providers (ibid.). The social insurance system is centralised at a national level. Insurance is compulsory. The main part of social insurance is financed by employers (80%), and the rest by government through transfer payments. *Deloitte and Touche*: *Midwifery in Europe* http://www.deloitte.nl/downloads/documents/website_deloitte/GZpublVerloskundeinEuropaRapport.pdf	4.42 Maternal deaths per 100,000 births. 76.94 Midwives per 1000 and 2.94 midwives graduated per 100,000. *European Health for all Database. WHO Regional Office for Europe, April 2014* 17% Cesarean section rate (2011) *WHO Athena Database, accessed June 2014.* Today, maternal mortality in Sweden is among the lowest in the world; fewer than six out of 1,000 babies and fewer than one woman out of 100,000 die in birth. *http://sweden.se/society/healthcare-in-sweden/* *Perinatal Deaths per 1000 births: 4.9. Neonatal Deaths per 1000: 1.6 births* *The Health and Welfare Statistical Database, Sweden.*

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
NEW ZEALAND Midwifery in New Zealand regained its status as an autonomous profession in 1990. The Nurses Amendment Act of that year restored the professional and legal separation of midwifery from nursing and established midwifery and nursing in New Zealand as separate and distinct professions. The legal changes in 1990 also made it possible to offer pre-registration midwifery education to people with no previous nursing registration (i.e direct entry midwifery). *Midwifery: An Autonomous Profession, New Zealand College of Midwives*	The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn. The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals. Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being. The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides. *http://www.midwife.org.nz/in-new-zealand/definition-and-scope-of-practice*	Midwifery is a profession with a distinct body of knowledge and its own Scope of Practice, Code of Ethics and Standards of Practice. The midwifery profession has knowledge, skills and abilities to provide a primary complete maternity service to childbearing women on its own responsibility. Midwives work in many ways to provide maternity services to women and their whanau. All midwives are expected to work in partnership with women, providing or supporting continuity of midwifery care throughout the woman's childbirth experience. Midwives work collaboratively with other health professionals when necessary to meet any additional medical, health or social needs of mothers and their babies. Midwives may be self-employed providing continuity-of-care to individual women and their families as Lead Maternity Carers (LMCs); employed by District Health Boards (DHBs) to provide a continuity-of-care service; or employed by DHBs to provide 24 hour, rostered shift cover in a maternity facility. Approximately half of New Zealand's midwives are self employed while the other half are employed. A small percentage of employed midwives are employed as caseloading midwives to provide LMC services. Midwives work in partnerships with other midwives, as practices of midwives, as part of continuity-of-care teams or as core rostered-shift staff in hospitals. *Midwifery: An Autonomous Profession, New Zealand College of Midwives* *http://www.midwife.org.nz/in-new-zealand/autonomy* Contexts for practice: The maternity service in New Zealand is an integrated system of primary, secondary and tertiary maternity care. All maternity care is free except if a woman chooses a private obstetrician, who may charge the woman on top of the set fee the obstetrician receives from the government. Primary maternity care is provided by Lead Maternity Carers (LMCs) who work under Section 88 of the New Zealand Public Health and Disability Act 2000. LMCs are selected by women to provide their lead maternity care, LMCs can be either midwives, general practitioners with a diploma in obstetrics or obstetricians. LMCs take responsibility for the care provided to women throughout pregnancy and the postpartum period including the management of labour and birth. One LMC is expected to take responsibility for all modules of care (registration, second trimester, third trimester, labour and birth, services following birth) so that each woman receives continuity of care. Women in New Zealand can give birth at home, in primary maternity facilities or birthing centres, or in secondary maternity hospitals. Primary facilities are often in rural	Midwifery care is fully funded in New Zealand and free for all eligible, pregnant women. Midwives cannot charge the woman for care. Their fees are set and paid for by the government. 70% of women register with a midwife in the first three months of pregnancy. This midwife (Lead Maternity Carer) will provide them with care until six weeks after the baby is born. Midwives can work providing community based care as self employed Lead Maternity Carers or in hospital based maternity services as core midwives. *New Zealand College of Midwives, Fact Sheet 3*	Professional Indemnity Insurance covers the costs and expenses of defending allegations of professional malpractice in client care. The policy also pays any costs if damages are awarded against you in such cases. The current Accident Compensation Scheme means that registered health professionals can only be sued for compensation on narrow grounds. There are many other forums where a midwife may need legal assistance to defend her practice so indemnity insurance is vital for all members. Currently the Ministry of Health requires authorised practitioners holding an Access Agreement to maintain Professional Indemnity protection. Indemnity Insurance covers	0 Neonatal Deaths per 1000 live births in 2012. *WHO Athena Database, accessed June 2014.* 20.4% Cesearean section rate (2008) *WHO 2010* The majority of women in New Zealand give birth in a maternity facility with a midwife in attendance that is known to them. Midwives support women to birth in all settings. Approximately 4-6 % of women choose to give birth at home. New Zealand women have had a midwife present at their birth for over 100 years. This care is free for women who are New Zealand residents. All current maternity data indicators demonstrate maternal and perinatal mortality rates similar to Australia and the United Kingdom – and lower than many other countries. *New Zealand College of Midwives, Fact Sheet*

		settings although there is a move to establish more primary facilities in urban centres so that women have more options for normal birth. Secondary facilities have cesarean section capabilities. There are five tertiary maternity facilities in New Zealand that also provide tertiary neonatal intensive care units. Some primary maternity facilities and all secondary and tertiary facilities employ midwifery staff. These employed midwives may be employed as LMCs to provide continuity of care for their own caseload of women, in which case they must meet the DHB Funded Primary Maternity Service specification. Midwives may also be employed on shifts to provide core midwifery services. This care includes 24-hour care to women and babies in the facilities and working in collaboration with LMCs. These midwives are often referred to as 'core' midwives because they provide the core essential care to women in hospital. In the secondary and tertiary facilities core midwifery may also provide essential midwifery care to women who require secondary obstetric care and who's LMCs have handed care over to the secondary service. Secondary maternity care is free to women; obstetricians employed in the facilities provide this service with the core midwives. Maternity facilities are funded by the Government for all women who use them. There is an additional budget for the secondary and tertiary level services they provide for some women. The services that they are required to provide are described in the Secondary and Tertiary Maternity Services Specification. *http://www.midwife.org.nz/in-new-zealand/contexts-for-practice* *http://www.midwife.org.nz/in-new-zealand/new-zealand-model-of-partnership* The following standards provide the benchmark for the midwife's practice and appropriate usage of midwifery's body of knowledge. They identify a series of actions that are essential to the development and maintenance of the midwifery partnership with women. Turanga Kaupapa, developed by Nga Maia are included as the cultural framework which guides midwives practice. Turanga Kaupapa are a reference and source of support for midwives, wahine and whanau. These standards with accompanying criteria provide the framework for Midwifery Practice in New Zealand. These are listed below (excluding the accompanying criteria). The full version is published in the Midwives Handbook for Practice which can be purchased through the NZCOM shop. Standard one: The midwife works in partnership with the woman Standard two: The midwife upholds each woman's right to free and informed choice Standard three: The midwife collates and documents		midwives for incidents that may result in: Human Rights Review Tribunal proceedings, Coroner's Court inquiries and hearings. The policy provides for up to $1,000,000 for each year in the aggregate, including legal costs. However, for criminal defence costs and Midwifery Council proceedings there are limitations and special conditions. **Midwives** are covered by the policy 24 hours a day, seven days a week, while working anywhere in New Zealand. http://www.midwife.org.nz/join/professional-indemnity-insurance	

		comprehensive assessments of the woman and/or baby's health and wellbeing Standard four: The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons Standard five: Midwifery care is planned with the woman Standard six: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk Standard seven: The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice Standard eight: The midwife evaluates her practice Standard nine: The midwife negotiates the completion of the midwifery partnership with the woman Standard ten: The midwife develops and shares midwifery knowledge and initiates and promotes research 2013 New Zealand College of Midwives *http://www.midwife.org.nz/quality-practice/standards-of-practice*.			

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
THE UNITED KINGDOM Number of Midwives in Practice: 35889 Number of births per year: 787 057 Number of births per midwife per year: 21.9 *Survey of European Midwifery regulators, 2010.* *Ordre des Sage Femmes*	Midwives must be capable of meeting the competencies and essential skills clusters set out in standard 17 of Standards for pre-registration midwifery education (NMC, 2009) that are within their scope of practice. They must make sure the needs of the woman and her baby are the primary focus of practice and should work in partnership with the woman and her family, providing safe, responsive, compassionate care in an appropriate environment to facilitate her physical and emotional care throughout childbirth. Except in an emergency, midwives must not provide any care, or undertake any treatment, that they have not been trained to give. In an emergency, or where a deviation from the norm, which is outside a midwives' current scope of practice, becomes apparent in a woman or baby during childbirth, midwives' must call such health or social care professionals as may reasonably be expected to have the necessary skills and experience to assist in the provision of care. Midwives must only supply and administer those medicines for which they have received training as to use, dosage and methods of administration and for which they are exempt. Both the title 'midwife' and the function of a midwife are protected in law. A midwife must not, or permit anyone else to, arrange for anyone to act as a substitute for her, other than another practising midwife or a registered medical practitioner. *Midwives rules and standards 2012 Page 15, Nursing and Midwifery Council, UK* Competencies required to achieve the NMC standards: These are divided into four domains: • effective midwifery practice • professional and ethical practice • developing the individual midwife and others • Achieving quality care through evaluation and research. Domain: Effective midwifery practice Communicate effectively with women and their families throughout the pre-conception, antenatal, intrapartum and postnatal periods. Communication will include: a) listening to women and helping them to identify their feelings and anxieties about their pregnancies, the birth and	The Royal College of Midwives defines normal childbirth as one where a woman commences, continues and completes labour physiologically at term. The College believes that a policy of maximising normal birth in the context of maternal choice is safe. Further, that it offers short and long-term health and social benefits to mothers, children, families, and communities. Such a policy is more likely to succeed if childbirth is placed within a social and family context. The majority of women with uncomplicated pregnancies are fit and healthy and have the potential to give birth normally with healthy newborns as the expected outcome. This is best met within a social model of care. Midwives are expert professionals skilled in supporting and maximising normal birth and their skills need to be promoted and valued. The role of the midwife is integral to models of care, which promote normality. Maternity Services can enhance midwifery skills and autonomous practice by providing the appropriate practice settings. The RCM recommends that maternity service providers review their policies, guidelines, practices and models of care to ensure that they are based on a philosophy committed to maximising normal birth and to ensure that a range of options are available to women. The RCM recommends that midwives value, support and develop their own skills and knowledge and those of their colleagues, in the area of normal childbirth. May 2004 RCM *Royal College of Midwives normal childbirth: position statement No 4. RCM*	As Independent Midwives are all self-employed they are all able to choose what they charge. Independent Midwives have to cover all their own costs such as training, equipment and travel. Rates may vary in different areas of the UK; currently a complete package of care will cost you between £2000 and £4500 (approx). Many Independent Midwives will want to receive payment in full by the time you are 36 weeks pregnant but if you have genuine difficulties in paying please discuss it with your Independent Midwife as most can offer flexible payment plans. The Department of Health has made it clear that women who choose to have their midwifery care provided by an Independent Midwife are not opting out of the NHS. You are fully entitled to all the blood tests and scans that a woman under full NHS care can have. Should you require any specialist input or emergency care the NHS will provide it. Independent Midwives have the same referral rights as NHS midwives and are able to arrange a consultant appointment or hospital admission if required. http://www.independe	Midwives are obligated to have their own professional liability insurance. *Survey of European Midwifery regulators, 2010. Ordre des Sage Femmes*	4.82 fetal deaths per 1000 births. *European Health for all Database. WHO Regional Office for Europe, April 2014* 22% Cesarean section rate (2008) *WHO, 2010* 87 per cent of women gave birth in obstetric units in hospital in 2012 12 per cent increase in the number of midwives since 2007 2,300 shortfall in midwives in 2012, calculated using a widely recognised benchmark of 29.5 births per midwife per year 152 midwifery-led units in June 2013, an increase from 87 in April 2007 79 per cent of women are within a 30-minute drive of both an obstetric unit and a midwifery-led unit, compared with 59 per cent in 2007 28 per cent of maternity units reported that they closed to admissions for half a day or more between April and September 2012 *National Audit Office, Report by the Comptroller and Auditor general, Department of Health, Maternity Services in England. (HC 794, Session 2013-14, 8 November 2013)*

	the related changes to themselves and their lives b) enabling women to think through their feelings c) enabling women to make informed choices about their health and health care d) actively encouraging women to think about their own health and the health of their babies and families, and how this can be improved e) communicating with women throughout their pregnancy, labour and the period following birth. Refer women who would benefit from the skills and knowledge of other individual to an individual who is likely to have the requisite skills and experience to assist at the earliest possible time supported by accurate, legible and complete information which contains the reasoning behind making the referral and describes the woman's needs and preferences. Referrals might relate to: • women's choices • health issues • social issues • financial issues • psychological issues • child protection matters • The law. Care for, monitor and support women during labour and monitor the condition of the fetus, supporting spontaneous births. This will include: a) communicating with women throughout and supporting them through the experience b) ensuring that the care is sensitive to individual women's culture and preferences c) using appropriate clinical and technical means to monitor the condition of mother and fetus d) providing appropriate pain management. e) providing appropriate care to women once they have given birth. Undertake appropriate emergency procedures to meet the health needs of women and babies. Emergency procedures will include: a) manual removal of the placenta b) manual examination of the uterus c) managing post-partum haemorrhage d) resuscitation of mother and/or baby e) undiagnosed breech. Examine and care for babies immediately following birth. This will include:		ntmidwives.org.uk/?node=750		

	a) confirming their vital signs and taking appropriate action b) carrying out a full assessment and physical examination. c) Complete, store and retain records of practice which: d) are accurate, legible and continuous e) detail the reasoning behind any actions taken f) contain the information necessary for the record's purpose. Practise in accordance with The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC 2008), within the limitations of the individual's own competence, knowledge and sphere of professional practice, consistent with the legislation relating to midwifery practice. This will include: a) using professional standards of practice to self-assess performance b) consulting with the most appropriate professional colleagues when care requires expertise beyond the midwife's current competence c) consulting other health care professionals when the woman's and baby's needs fall outside the scope of midwifery practice d) identifying unsafe practice and responding appropriately *Standards for pre-registration midwifery education, Nursing And Midwifery Council,* *http://www.nmc-uk.org/Documents/NMC-Publications/nmcStandardsforPre_RegistrationMidwiferyEducation.pdf*				

COUNTRY	SCOPE	MODEL OF PRACTICE	FUNDING	INSURANCE	OUTCOME
AUSTRALIA	The midwife is recognised as a responsible and accountable professional who works in partnership with each woman to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to each woman's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units. Adopted by the International Confederation of Midwives Council meeting, 19 July 2005, Brisbane, Australia; supersedes the ICM Definition of the Midwife 1972 and its amendments of 1990. *Nursing and Midwifery Board of Australia, Code of professional conduct for midwives in Australia*	The graduate midwife practises within a woman centred, primary health care framework and is committed to seeing midwifery as a public heath strategy that encompasses a broad social context. The graduate midwife understands that health is a dynamic state, influenced by particular sociocultural, spiritual and politico-economic environments. The graduate midwife has an important advocacy role in protecting the rights of women, families and communities whilst respecting and supporting their right to self-determination. A graduate midwife has a commitment to cultural safety within all aspects of her practice and acts in ways that enhance the dignity and integrity of others. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being. The graduate midwife has a role in public health that includes wellness promotion for the woman, her family and the community. Whilst the graduate midwife has the skills "to do" they also have an ability to develop relationships with the women for whom they care as well as others with whom they interact in their professional lives. The graduate midwife works collaboratively with health care providers and other professionals referring women to appropriate community agencies and support networks. The competency standards have an overarching framework – woman centred care. Woman-centred care is a concept that implies that midwifery care: • is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or professions, • recognises the woman's right to self determination in terms of choice, control, and continuity of care, • encompasses the needs of the baby, the woman's family, significant others and community, as identified and negotiated by the woman herself, • follows the woman between institutions and the community, through all phases of pregnancy, birth and the post natal period, and • is 'holistic' – in that it addresses a woman's social, physical, cultural and spiritual elements. *Nursing and Midwifery Board of Australia* *T 1300 419 495 /+61 3 8708 9001* *GPO Box 9958* *Melbourne VIC 3000* *AUSTRALIA* *www.nursingmidwiferyboard.gov.au*	On 1 November 2010, new laws came into effect that give eligible nurse practitioners and midwives access to specific items in the Medicare Benefits Schedule (MBS) and access to a limited list of items under the Pharmaceutical Benefits Scheme (PBS). To be eligible to access these services you must apply for a Medicare provider number and PBS prescriber number. *Austrailian Government Department of Human Services, Medicare* *http://www.medicareaustralia.gov.au/provider/other-healthcare/nurse-midwives.jsp*	Under section 129 (1) of the Health Practitioner Regulation National Law, a health practitioner must not practise the health profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force. There are currently 2 sources of insurance for private midwives; 1. The Commonwealth supported insurance on offer from MIGA, covering pregnancy and postnatal care in any setting, and labour and birth care in a 'clinical setting', 2. A policy on offer from Vero (via an insurance broker, Medisure), for pregnancy and postnatal care in any setting,	Neonatal death in 1000 live births in 2012. *WHO Athena Database, accessed June 2014.* 31.5% Cesarean section rate (2009) *WHO Athena Database, accessed June 2014.* Planned home births accounted for 0.38% of 300,011 births in South Australia. They had a perinatal mortality rate similar to that for planned hospital births, but a sevenfold higher risk of intrapartum death and a 27-fold higher risk of death from intrapartum asphyxia. Review of perinatal deaths in the planned home births group identified inappropriate inclusion of women with risk factors for home birth and inadequate fetal surveillance during labour. Low Apgar scores were more frequent among planned home births and use of specialised neonatal care as well as rates of postpartum hemorrhage and severe perineal tears were lower among planned home births, but these differences were not statistically significant. Planned home births had lower cesarean section and instrumental delivery rates, and a seven times lower episiotomy rate than planned hospital births. Perinatal safety of home births may be improved substantially by better adherence to risk assessment, timely transfer to hospital when needed, and closer fetal surveillance.

				excluding labour and birth care. *Australian College of Midwives: Professional Indemnity Insurance for Midwives http://www.midwives.org.au*	*Med J Aust. 2010 Jan 18;192(2):76-80.* *Planned home and hospital births in South Australia, 1991-2006: differences in outcomes.* *Kennare RM, Keirse MJ, Tucker GR, Chan AC.* *Source: Pregnancy Outcome Unit, Epidemiology Branch, SA Health, Adelaide, SA, Australia*