Building Blocks To Sustainable Rural Maternity Care:
Supporting 1A Services

Jude Kornelsen, PhD

Co-Director, Centre for Rural Health Research, DFP, UBC.

Kira Barwick, MSc

Research Coordinator, Centre for Rural Health Research, DFP, UBC

Objectives

Reflect on the state of rural maternity care in BC

Describe the community-based process in the Kwakwaka'wakw territory, North Vancouver Island, to determine local priorities for maternity care

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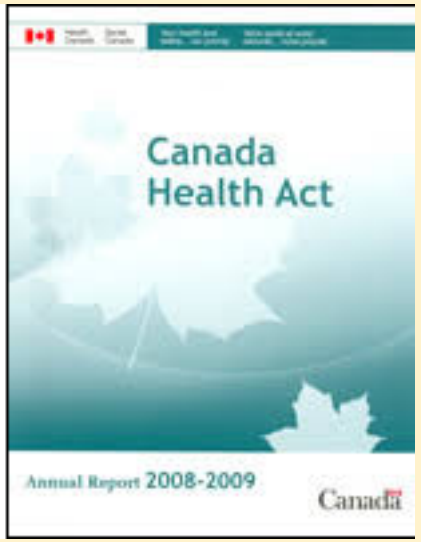
Discuss the development and implementation of 'Building Blocks to Sustainable Maternity Care"

Consider the applicability to other rural communities in BC

Canada Health Act

"To protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

[Canada Health Act, 1984, c-6, s-3]



‘Closer to Home’

‘The Royal Commission on Health Care and Costs’ (The Seaton Report 1991):

> “[M]edically necessary services must be provided in, or as near to, the patient’s place of residence as is consistent with quality and cost-effective health care”
>
> (B.C. Royal Commission on Health Care and Costs 1991: A-6).

‘Standards of Accessibility’ (BC Ministry of Health Services and Health Planning 2002):

- Recognized that maternity care services in rural BC could be negatively impacted by regionalization;
- suggested expanding the function of general practitioners to make more services including perinatal surgery, available.

Prioritizing Primary Maternity Care

Setting Priorities for Health
Policy Papers

CROSS SECTOR POLICY DISCUSSION PAPER 2015

PRIMARY AND COMMUNITY CARE IN BC: A STRATEGIC POLICY FRAMEWORK

- 'All British Columbians requiring maternity care will have timely, local access to a primary maternity provider or network.' (p20)

- 'Women who live in rural and remote areas want high-quality maternity care as close to home as possible.' (p23)

Returning Birth to Aboriginal, Rural and Remote Communities Policy Statement (SOGC)

"The SOGC strongly supports and promotes the return of birth to rural and remote communities for women at low risk of complications. Training and protocols need to be established to ensure proper identification of women with low-risk pregnancies."

SOGC POLICY STATEMENT

No. 251, December 2010

Returning Birth to Aboriginal, Rural, and Remote Communities

This policy statement has been reviewed by the Aboriginal Health Initiatives Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada. This policy statement has been endorsed by the Indigenous Physicians Association of Canada, the Canadian Association of Midwives, and the Aboriginal Council of Midwives.

J Obstet Gynaecol Can 2010;32(12):1186–1188

INTRODUCTION

Giving birth close to home has been a significant maternity care issue for many years in rural and remote communities in Canada. Twenty-one percent of the Canadian

without the presence and support of family and community members. Childbirth has therefore become a stressful event that disrupts rather than strengthens families and communities. Transfer out of the community for birth is costly for the family and the community, as well as for the federal health care budget. The large economic and social costs to families include support for women living away from the community and childcare for the children left behind. Teenage girls may be in particularly vulnerable situations when left without their mothers for weeks at a critical time in their development.

Traditionally, Aboriginal women gave birth in their communities. Cultural practices established strong community

JOGC
Journal of Obstetrics and Gynaecology Canada
Journal d'obstétrique et gynécologie du Canada

December 2017 Volume 39, Issue 12, Pages e558–e565

Recommendations

1. Women who reside in rural and remote communities in Canada should receive high-quality maternity care as close to home as possible.
2. The provision of rural maternity care must be collaborative, woman- and family-centred, culturally sensitive, and respectful.
3. Rural maternity care services should be supported through active policies aligned with these recommendations.
4. While local access to surgical and anaesthetic services is desirable, there is evidence that good outcomes can be sustained within an integrated perinatal care system without local access to operative delivery. There is evidence that the outcomes are better when women do not have to travel far from their communities. Access to an integrated perinatal care system should be provided for all women.

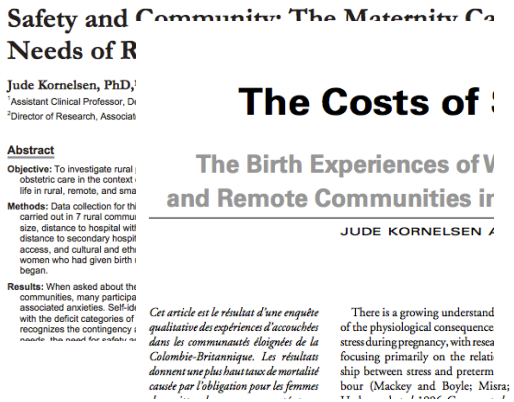

Masset
Burns Lake
Bella Coola
Bella Bella
Port Hardy
Alert Bay
100 Mile House
Clearwater
Ashcroft
Lytton
Merritt
Summerland
Arrow Lakes
Kimberly
Sparwood
Mission
Hope
Oliver
Tofino
Grand Forks
Castlegar
Saanichton

Building the evidence

Patient Satisfaction

Maternal-Newborn Outcomes

Provider Outcomes



Safety and Community: The Maternity Ca
Needs of R

Jude Kornelsen, PhD,[1]
[1]Assistant Clinical Professor, D
[2]Director of Research, Associat

Abstract

Objective: To investigate rural
obstetric care in the context
life in rural, remote, and sma

Methods: Data collection for th
carried out in 7 rural commu
size, distance to hospital wit
distance to secondary hospit
access, and cultural and eth
women who had given birth
began.

Results: When asked about th
communities, many participa
associated anxieties. Self-id
with the deficit categories of
recognizes the contingency
needs, the need for safety a

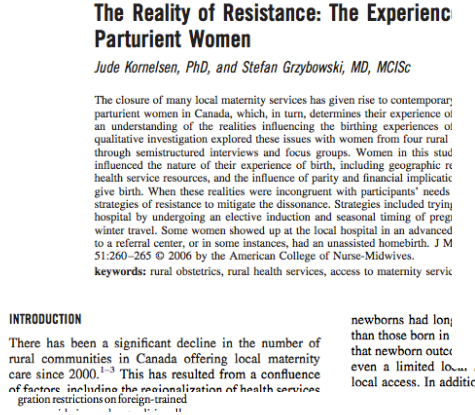
The Costs of

The Birth Experiences of V
and Remote Communities ir

JUDE KORNELSEN

Cet article est le résultat d'une enquête qualitative des expériences d'accouchées dans les communautés éloignées de la Colombie-Britannique. Les résultats donnent une plus haut taux de mortalité causée par l'obligation pour les femmes

There is a growing understand
of the physiological consequence
stress during pregnancy, with resea
focusing primarily on the relati
ship between stress and preterm
bour (Mackey and Boyle; Misra;



The Reality of Resistance: The Experienc
Parturient Women

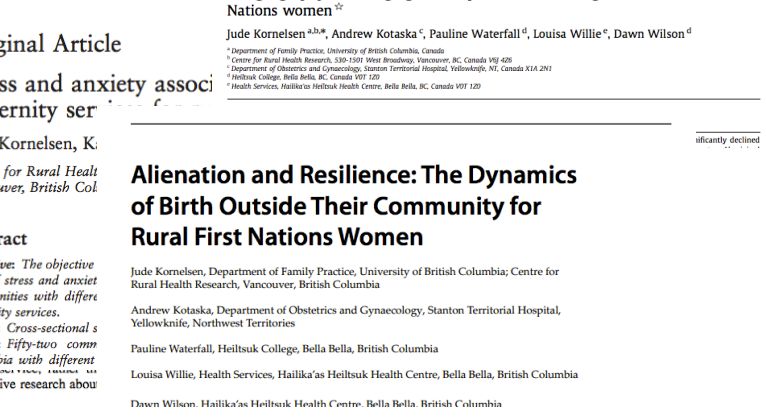
Jude Kornelsen, PhD, and Stefan Grzybowski, MD, MCISc

The closure of many local maternity services has given rise to contemporary
parturient women in Canada, which, in turn, determines their experience o
an understanding of the realities influencing the birthing experiences o
qualitative investigation explored these issues with women from four rural
through semistructured interviews and focus groups. Women in this stud
influenced the nature of their experience of birth, including geographic re
health service resources, and the influence of parity and financial implicatic
give birth. When these realities were incongruent with participants' needs
strategies of resistance to mitigate the dissonance. Strategies included tryin
hospital by undergoing an elective induction and seasonal timing of pregn
winter travel. Some women showed up at the local hospital in an advanced
to a referral center, or in some instances, had an unassisted homebirth. J M
51:260–265 © 2006 by the American College of Nurse-Midwives.
keywords: rural obstetrics, rural health services, access to maternity servic

INTRODUCTION

There has been a significant decline in the number of rural communities in Canada offering local maternity care since 2000.[1–3] This has resulted from a confluence of factors, including the regionalization of health services
gration restrictions on foreign-trained

newborns had lon
than those born in
that newborn outc
even a limited lo
local access. In addition, qualitative research abou



Original Article

Stress and anxiety associ
maternity ser

Jude Kornelsen, K
Centre for Rural Healt
Vancouver, British Col

Abstract

Objective: The objective
level of stress and anxiet
communities with differe
maternity services.
Design: Cross-sectional s
Setting: Fifty-two comm
Columbia with different

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

The geography of belonging: The experience of birthing at home for First Nations women ☆

Jude Kornelsen [a,b,*], Andrew Kotaska [c], Pauline Waterfall [d], Louisa Willie [e], Dawn Wilson [d]

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[b] Centre for Rural Health Research, 530-1501 West Broadway, Vancouver, BC, Canada V6J 4Z6
[c] Department of Obstetrics and Gynaecology, Stanton Territorial Hospital, Yellowknife, NT, Canada X1A 2N1
[d] Heiltsuk College, Bella Bella, BC, Canada V0T 1Z0
[e] Health Services, Hailika'as Heiltsuk Health Centre, Bella Bella, BC, Canada V0T 1Z0

ificantly declined

Alienation and Resilience: The Dynamics of Birth Outside Their Community for Rural First Nations Women

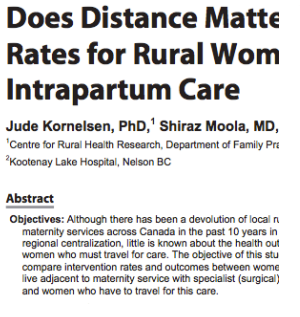
Jude Kornelsen, Department of Family Practice, University of British Columbia; Centre for Rural Health Research, Vancouver, British Columbia

Andrew Kotaska, Department of Obstetrics and Gynaecology, Stanton Territorial Hospital, Yellowknife, Northwest Territories

Pauline Waterfall, Heiltsuk College, Bella Bella, British Columbia

Louisa Willie, Health Services, Hailika'as Heiltsuk Health Centre, Bella Bella, British Columbia

Dawn Wilson, Hailika'as Heiltsuk Health Centre, Bella Bella, British Columbia



Does Distance Matte
Rates for Rural Wom
Intrapartum Care

Jude Kornelsen, PhD,[1] Shiraz Moola, MD,
[1]Centre for Rural Health Research, Department of Family Pra
[2]Kootenay Lake Hospital, Nelson BC

Abstract

Objectives: Although there has been a devolution of local n
maternity services across Canada in the past 10 years in
regional centralization, little is known about the health out
women who must travel for care. The objective of this stu
compare intervention rates and outcomes between wome
live adjacent to maternity service with specialist (surgical)
and women who have to travel for this care.

RESEARCH ARTICLE

Distance matters: a population based stu
examining access to maternity services f
women

Stefan Grzybowski*, Kathrin Stoll and Jude Kornelsen

Abstract

Background: In the past fifteen years there has been a wave of closures of small maternity services in Canada and other developed nations which results in the need for rural parturient women to travel to access care. The purpose of our study is to systematically document newborn and maternal outcomes as they relate to distance to trav

RESEARCH ARTICLE | OPEN ACCESS

The safety of Canadian rural maternity services: a multi-jurisdictional cohort analysis

Stefan Grzybowski, John Fahey, Barbara Lai, Sharon Zhang, Nancy Aelicks, Brenda M. Leung, Kathrin Stoll and Rebecca Attenborough

BMC Health Services Research 2015 15:410 | DOI: 10.1186/s12913-015-1034-6 | © Grzybowski et al. 2015

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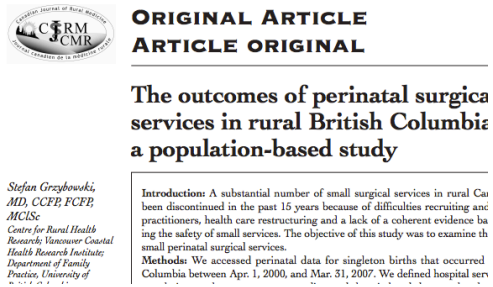
Open Peer Review reports

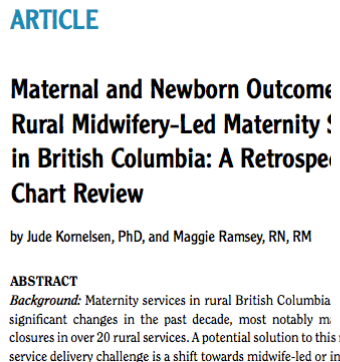


ORIGINAL ARTICLE
ARTICLE ORIGINAL

The outcomes of perinatal surgica
services in rural British Columbia
a population-based study

Stefan Grzybowski, MD, CCFP, FCFP, MCISc
Centre for Rural Health Research; Vancouver Coastal Health Research Institute; Department of Family Practice, University of

Introduction: A substantial number of small surgical services in rural Ca
been discontinued in the past 15 years because of difficulties recruiting anc
practitioners, health care restructuring and a lack of a coherent evidence ba
ing the safety of small services. The objective of this study was to examine th
small perinatal surgical services.
Methods: We accessed perinatal data for singleton births that occurred
Columbia between Apr. 1, 2000, and Mar. 31, 2007. We defined hospital ser



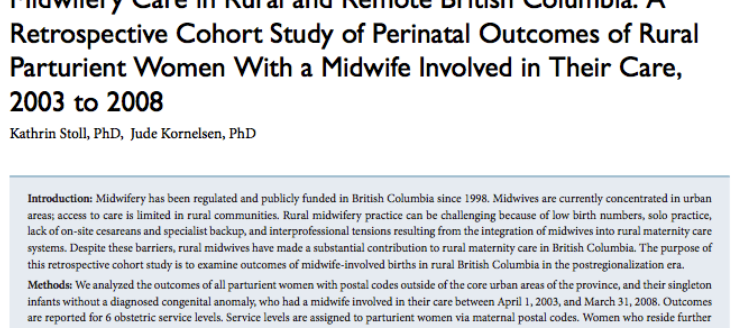
ARTICLE

Maternal and Newborn Outcome
Rural Midwifery-Led Maternity S
in British Columbia: A Retrospe
Chart Review

by Jude Kornelsen, PhD, and Maggie Ramsey, RN, RM

ABSTRACT

Background: Maternity services in rural British Columbia
significant changes in the past decade, most notably m
closures in over 20 rural services. A potential solution to this rural maternity
service delivery challenge is a shift towards midwife-led or interprofessional

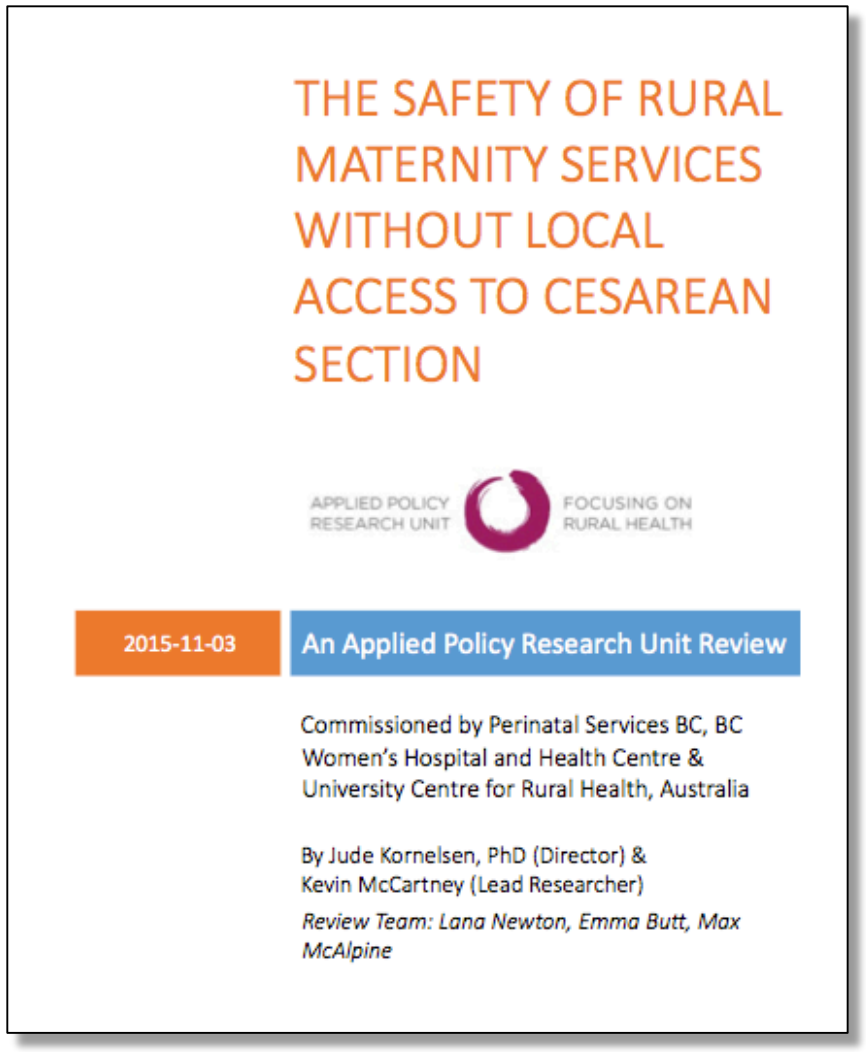


Midwifery Care in Rural and Remote British Columbia: A Retrospective Cohort Study of Perinatal Outcomes of Rural Parturient Women With a Midwife Involved in Their Care, 2003 to 2008

Kathrin Stoll, PhD, Jude Kornelsen, PhD

Introduction: Midwifery has been regulated and publicly funded in British Columbia since 1998. Midwives are currently concentrated in urban areas; access to care is limited in rural communities. Rural midwifery practice can be challenging because of low birth numbers, solo practice, lack of on-site cesareans and specialist backup, and interprofessional tensions resulting from the integration of midwives into rural maternity care systems. Despite these barriers, rural midwives have made a substantial contribution to rural maternity care in British Columbia. The purpose of this retrospective cohort study is to examine outcomes of midwife-involved births in rural British Columbia in the postregionalization era.

Methods: We analyzed the outcomes of all parturient women with postal codes outside of the core urban areas of the province, and their singleton infants without a diagnosed congenital anomaly, who had a midwife involved in their care between April 1, 2003, and March 31, 2008. Outcomes are reported for 6 obstetric service levels. Service levels are assigned to parturient women via maternal postal codes. Women who reside further

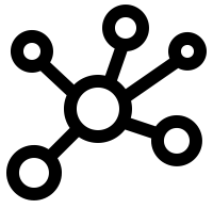


Review Questions:

1. What is the relative safety of rural maternity health services without local access to caesarean section?
2. **Is it safer for a rural population to have no local intrapartum services, or primary maternity services?**

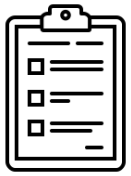
- Realist Review methodology (Pawson)
- 158 articles included from Canada, Australia, United States, Norway, Sweden, Scotland, New Zealand, France, Germany, England, Netherlands, Iceland, Italy.

First key message from the data:



Networks of Provider support

+



Comprehensive Risk Screening

+

Effective Emergency Transport

=

Safe rural maternity care

Second key message from the data:

We haven't paid enough attention to communities without local cesarean section services.

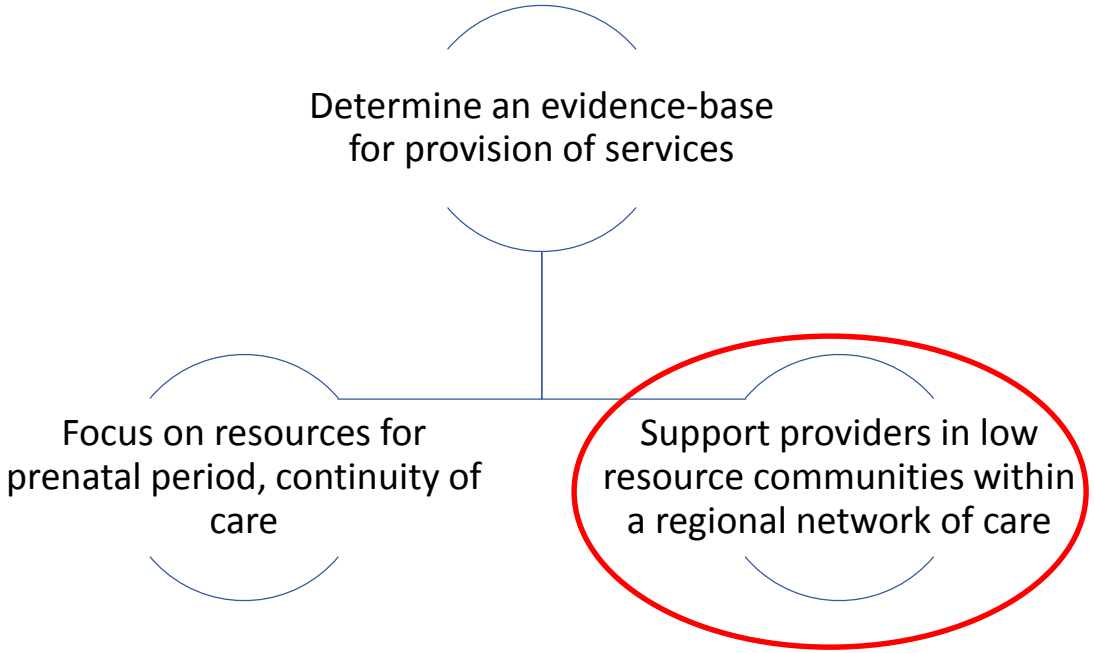
Determine an evidence-base for provision of services

Focus on resources for prenatal period, continuity of care

Support providers in low resource communities within a regional network of care

Second key message from the data:

We haven't paid enough attention to communities without local cesarean section services.



RESEARCH ARTICLE Open Access

Distance matters: a population based study examining access to maternity services for rural women

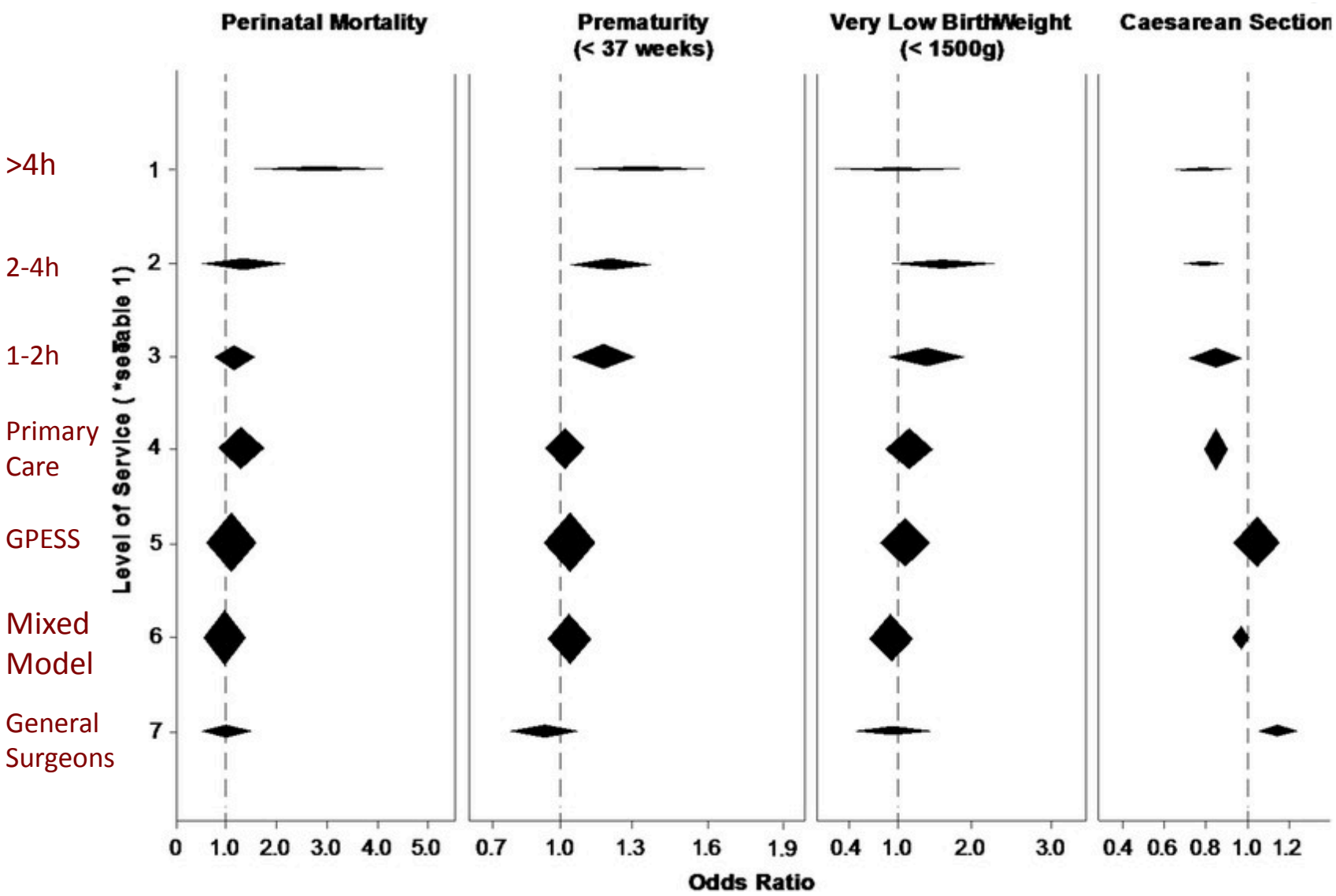
Stefan Grzybowski*, Kathrin Stoll and Jude Kornelsen

Research article Open Access

The safety of Canadian rural maternity services: a multi-jurisdictional cohort analysis

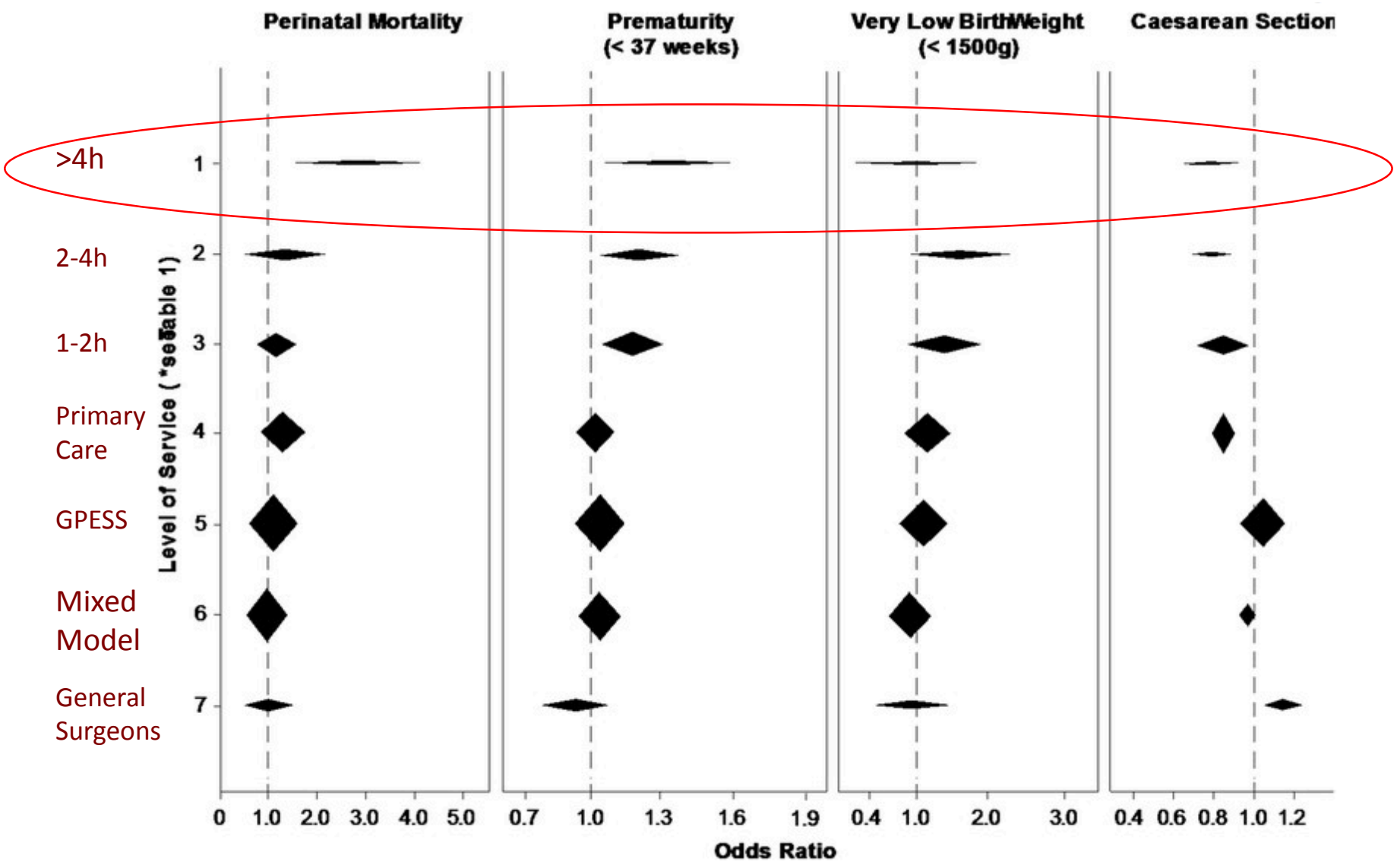
Stefan Grzybowski[1]*, John Fahey[2], Barbara Lai[1], Sharon Zhang[3], Nancy Aelicks[3], Brenda M. Leung[3], Kathrin Stoll[4] and Rebecca Attenborough[2]

BMC Health Services Research 2015, 15:410



Composite forest plots demonstrating outcomes related to level of service

Grzybowski *et al. BMC Health Services Research* 2015 **15**:410 doi:10.1186/s12913-015-1034-6



Composite forest plots demonstrating outcomes related to level of service

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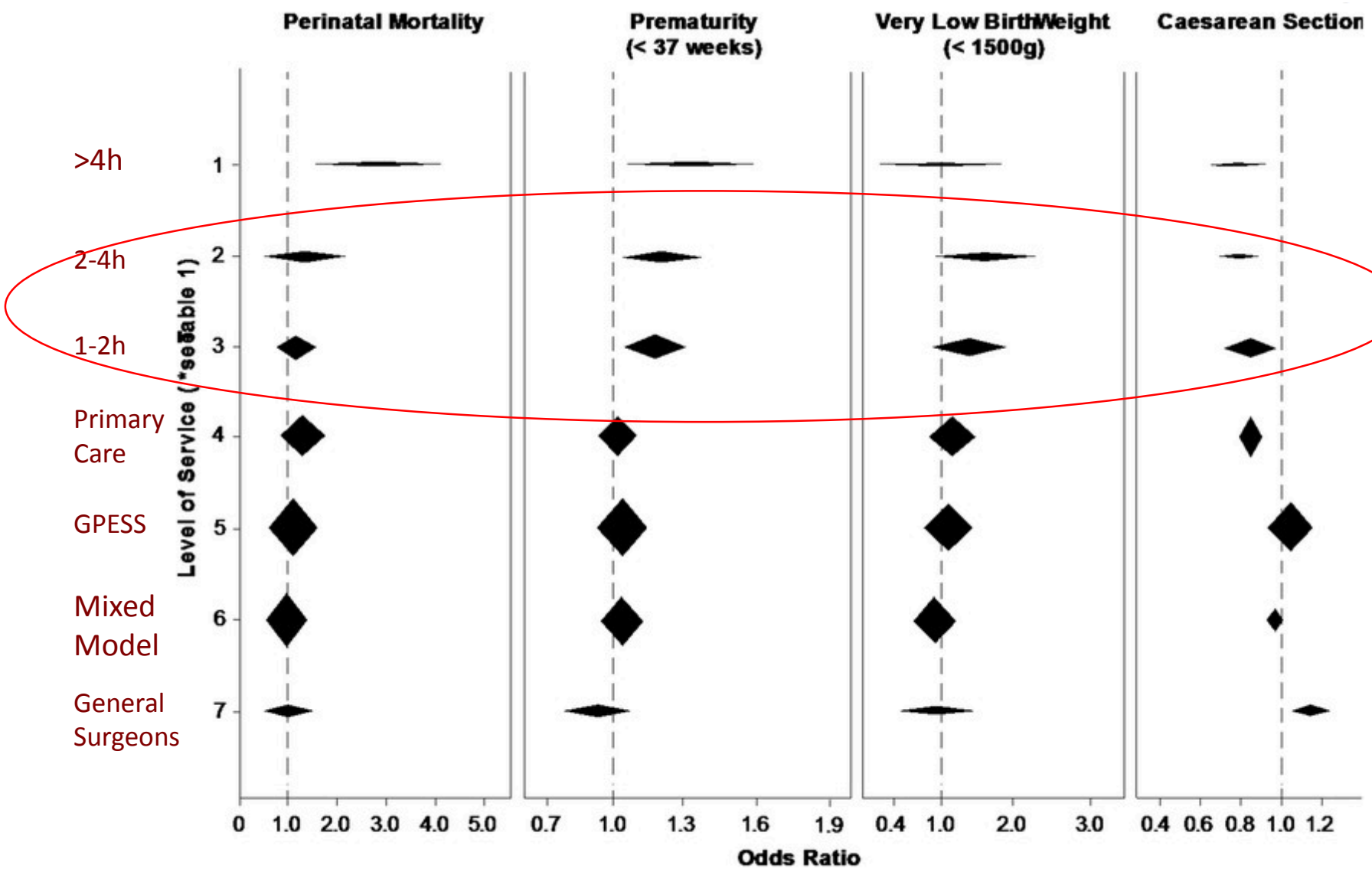

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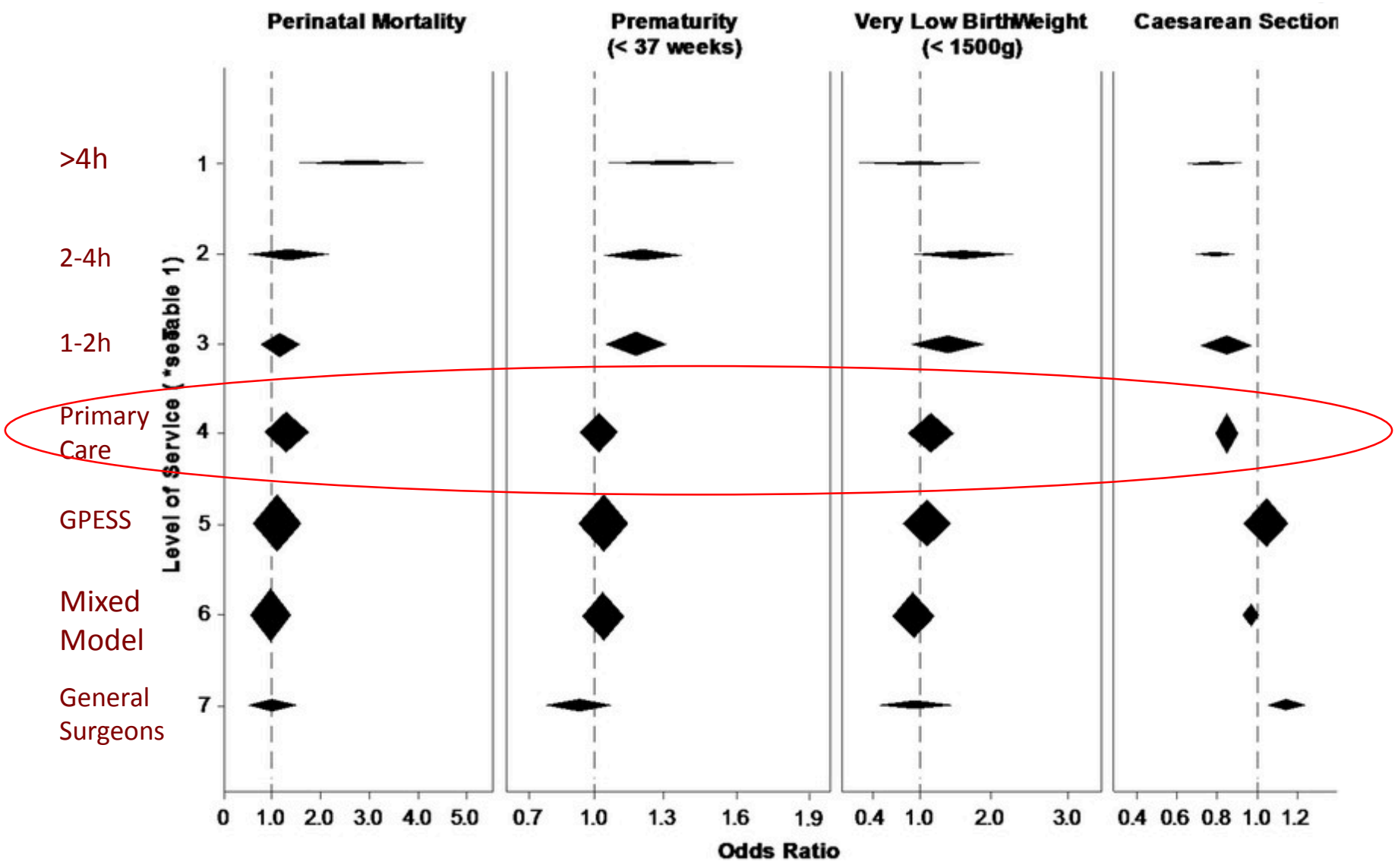

Composite forest plots demonstrating outcomes related to level of service

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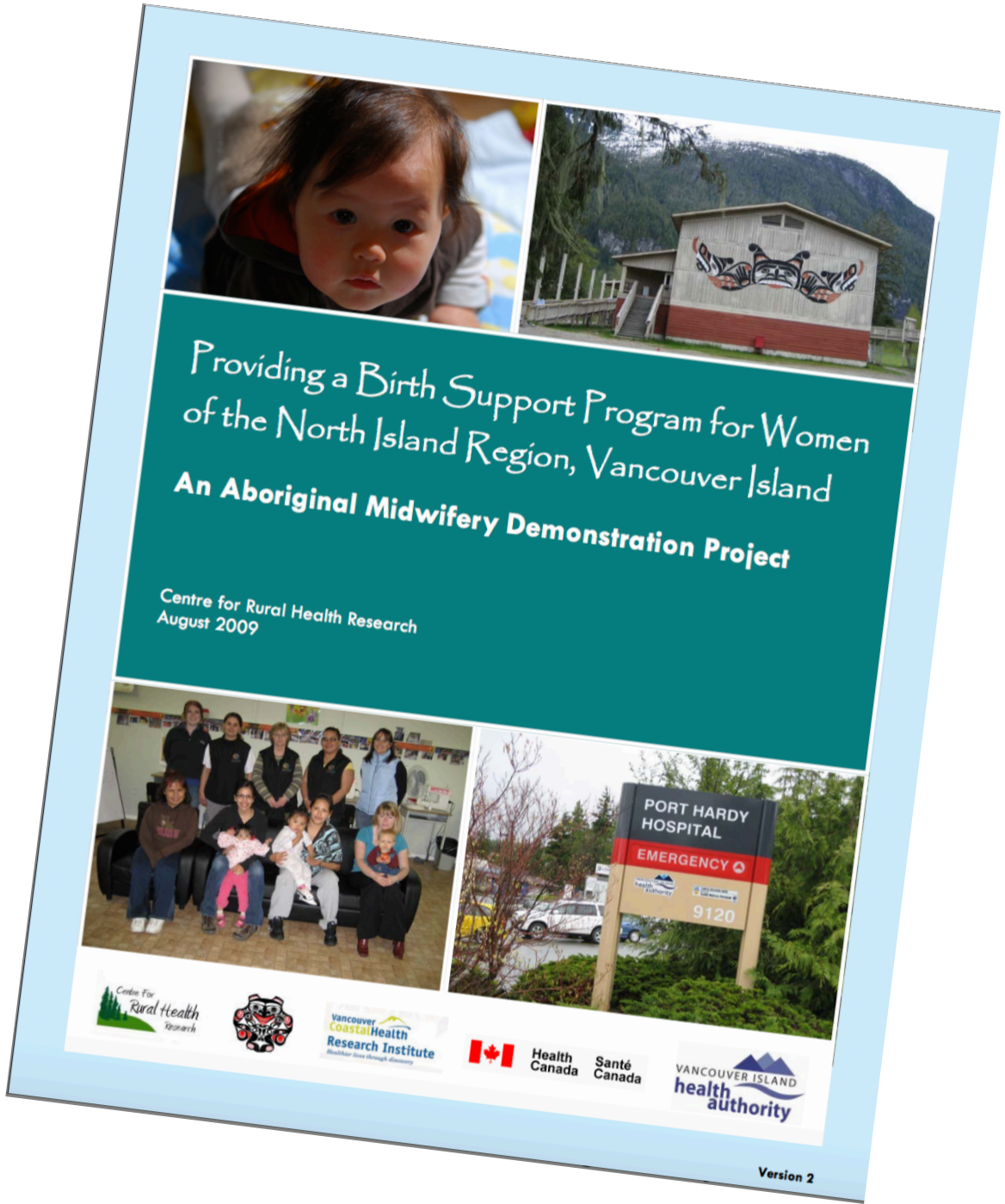


RECCOMENDATIONS:

Phase 1: Introduce two community midwives into the NI and build local capacity for maternity care;

Phase 2: Foster an active midwifery-led birthing service for the NI; and

Phase 3: Introduce local cesarean section services to the NI, subject to feasibility.

Kwakwaka'wakw Territory (North Vancouver Island)

- Kwakwaka'wakw region covers 21,157 square kilometers of northern Vancouver Island and adjacent mainland; comprised of a number of isolated communities
- The current population is 11,506, and over 26% of the population identify themselves as members of the Kwakwaka'wakw Family.
- One designated maternity site (Port McNeill)

Kwakwaka'wakw Territory (North Vancouver Island)

- The population has a **high degree of social vulnerability** represented in the high rate of teen pregnancies, single parent families, alcohol consumption and death from illicit drug use.
- Despite these known health disparities**, these communities have *less* access to health services** than populations of like size in other parts of BC.
- Many women currently **travel from the their communities** to Campbell River (2.5 hours) or Courtenay/Comox (3.5 hours) to receive primary or specialist maternity care

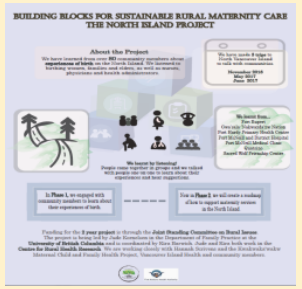
Kwakwaka’wakw Territory (North Vancouver Island)

Port McNeill Hospital

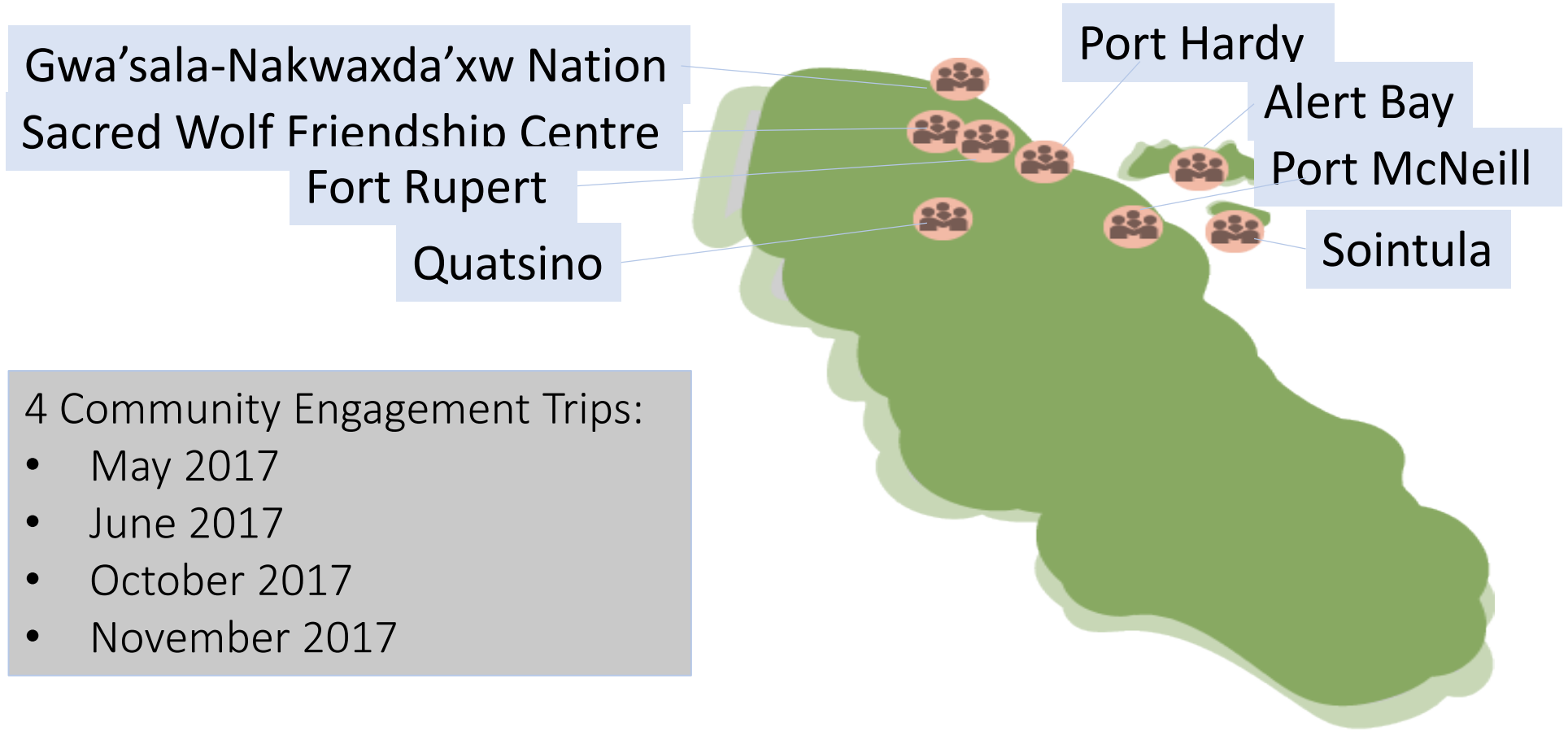
Port Hardy Hospital

Community-Driven Process

- Interviews and focus groups (n=80)
- Strong advisory committee
- Regular community updates
- Commitment to OCAP



Community-Driven Process



4 Community Engagement Trips:

- May 2017
- June 2017
- October 2017
- November 2017

Current Situation

Out of **103** pregnancies a year in North Vancouver Island, there are an average of **3** deliveries at Port Hardy hospital and **4** at Port McNeill hospital.

Where NI Moms Deliver:

Vancouver General Hospital	Nanaimo Regional General Hospital	St. Joseph's General Hospital	Campbell River Hospital	Port Hardy Hospital	Port McNeill Hospital
5.8	14.6	37.4	35.8	3	4.4

Women's Experiences: Travelling for Birth

Birthing moms suggested the following reasons for leaving the community to give birth:

- low confidence in local maternity care
- a desire for midwifery care
- being considered high risk
- a lack of awareness that they can give birth in the North Island

Women's Experiences: Travelling for Birth

Moms spoke of the **challenges** travelling for care.

- Arranging accommodation and transport
- Cost
- Experiences of loneliness, anxiety and a lack of support

Not all respondents had negative experiences, **positive experiences** in referral communities include:

- A sense of safety (OR, confident providers)

Often, these positive experiences led to a **referral pattern.**

Women’s Experiences: Transport

- Uncomfortable
- Inconvenient
- Expensive
- Inclement weather conditions

Women's Experiences: Transport

To go down, it was alright but it was really bumpy and stuff and my stomach was hurting. On the way back, because I was having a C-section, I tried to stay in the front of the bus so it wasn't so bouncy, and yeah it hurt a lot. It was bouncy, and [the driver] was stopping places, he was braking… And plus it was hard to carry, you know, all your luggage and stuff that you're needing, and supplies for the baby, supplies for yourself, and then your partner too.

– North Island Mom

Local Birth

- Desire for local birth
- Family and community supports
- Narrative of local birth
- Concerns with local birth

Desire for Local Birth

It would be really nice to stay home and not have to go down and… just being away from home and not in your environment and you're nesting, but you don't have your nest. – North Island Mom

Family and Community Supports

But in a perfect world, if we had births here, we'd have family around. There may be a doula there. There may be some of the, the family, the very support people need… Who are there, and who are visiting in the hospital before, during labour, afterwards. And the hospital staff will know who some of the support people are. The Ministry will know who some of the support people are. - North Island Mom

Narrative of Local Birth

- Strong historical birth narrative
- Common current birth narratives include:
    - Fear of birth
    - Lack of safety

I actually believe that if we had just in our community alone three or four good births, where people had folks around and then they shared those stories… Everybody would come running.

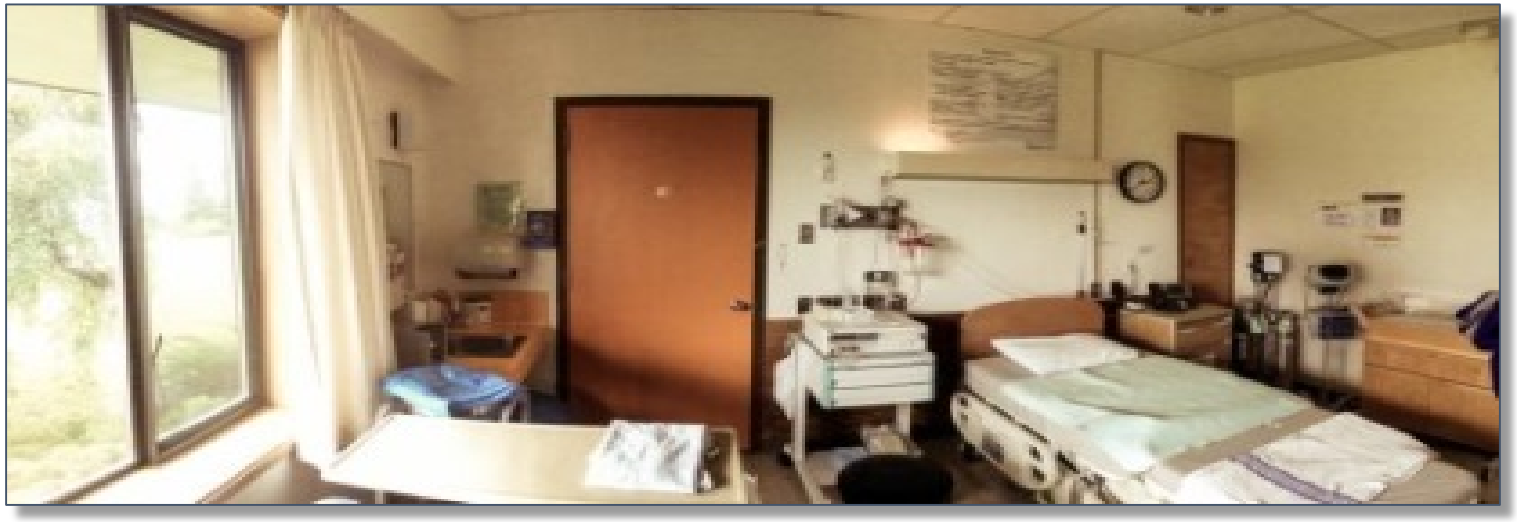
- North Island Mom

Concerns with Local Birth

- Low confidence of care providers
- Low-resource setting
    - High turnover of nurses
    - No OR
    - No access to epidural

What Moms Want

- Well supported local care
  - Culturally appropriate safe care
  - Midwifery
  - Confidence in local care providers



Directive #1: Community-Driven, Nation-Based

Directive #2: Increase First Nations Decision-Making and Control

Directive #3: Improve Services

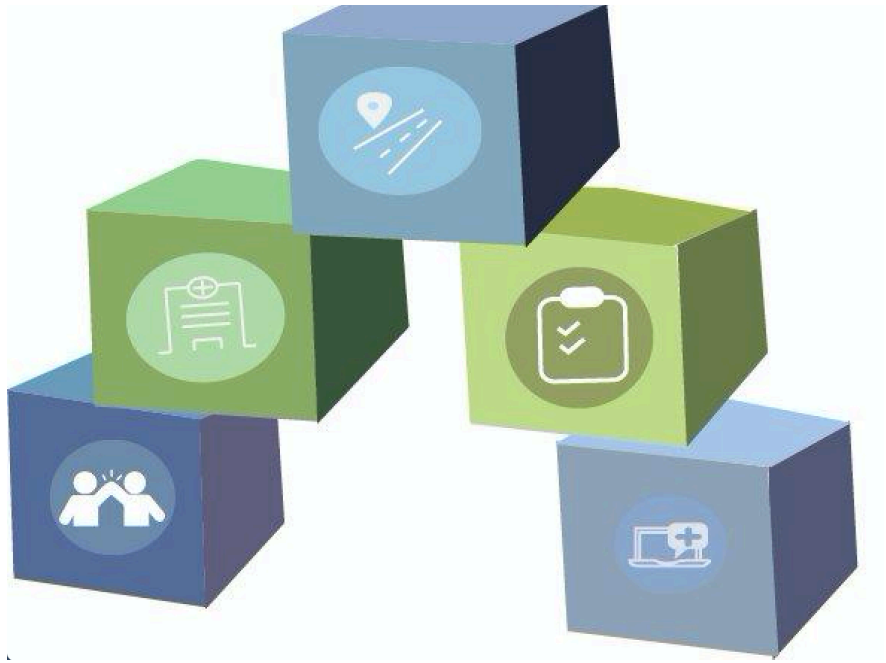
Directive #4: Foster Meaningful Collaboration and Partnership

Directive #5: Develop Human and Economic Capacity

Directive #6: Be Without Prejudice to First Nations Interests

Directive #7: Function at a High Operational Standard

- ‘Ground up’ articulation of provider needs for sustainability
- North Island physician reference group
- Regular extended meetings (Support from Kwakwaka’wakw Maternal Child Family Health project, Divisions of Family Practice and Facilities Engagement funding)



Building Blocks to Sustainable Rural Maternity Care

Timely & Reliable Patient Transport

Develop mechanisms for ground and air transports

Increased Provider Confidence

Through provider exchange to high-volume centers; local rural obstetrical CME

Expanded Inclusion Criteria for Low-Risk Deliveries

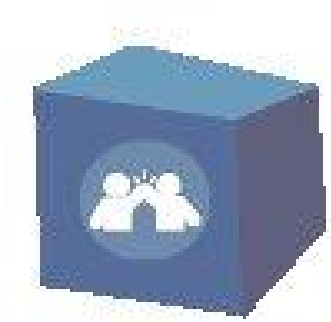
Include uncomplicated primiparous deliveries as per PSBC guidelines; include agreed-on criteria for risk screening and mechanism for collaborative decision making

Inter-profession Care Teams

Engage in a feasibility analysis of the mechanisms of inter-professional care teams with the potential of establishing a pilot project in the North Island

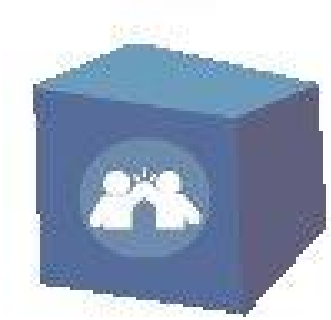
Virtual Technologies to Link with Referral Center

Mobile Maternity care (MOM2) to connect local care providers with specialists in real time



Interprofessional Care Teams

- Findings from community field work indicated a strong desire for midwifery care on the North Island (many women were leaving to seek out such care);
- Previous experiences of midwives starting practice
- Challenge of low volume in a course of care billing model
- Some physicians wish to remain involved
- Developed local model & draft job description



Interprofessional Care Teams

- Have secured funding through FNHA Joint Project Board funding to hire 2 midwives (Spring 2018)
- Will work in a collaborative shared care model with local physicians

Increased Provider Confidence

Lead by Hannah Chester, UNBC Medical Student

Focus groups revealed concern of local nurses regarding on-site deliveries due to:

- Low volume (lack of maintenance of skills)
- Lack of previous experience with deliveries
- Concerns regarding transport to referral centre should it be necessary and
- Vulnerability of the population

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- Vulnerability of the population

Expanded Inclusion Criteria for Local Deliveries

- Led by Krista Loewen, UBCO Medical Student
- Literature review looking for existing guidelines on appropriate criteria for local delivery/outcomes studies
- Consolidated local community experience

Krista Loewen in Alert Bay BC

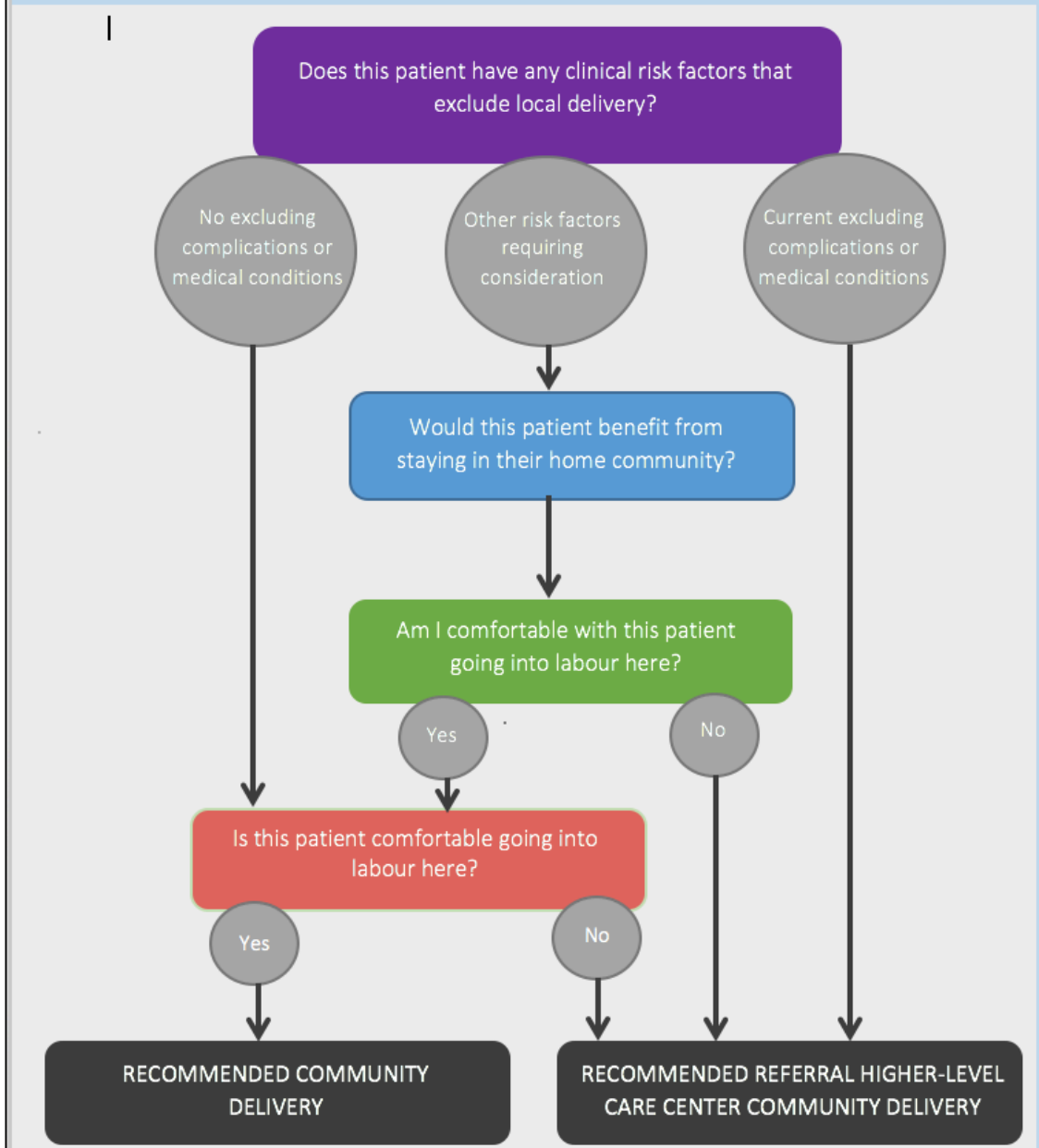
Expanded Inclusion Criteria for Local Deliveries

No published clinical guidelines were found that specifically apply to risk screening for planned delivery in rural communities without local Caesarean section

Screening process is highly localized and developed within the community context

- local resources, patient population, provider skills, remoteness
- use of multidisciplinary decision-making panels or committees

North Island Risk Screening for Planned Delivery



Exclusion factors:

- Preterm gestation <37 weeks
- Multiple gestation
- Non-vertex presentation
- Previous Caesarean
- Previous obstetric complications
- Previous stillbirth or perinatal death
- Current pregnancy complications (ie. IUGR, oligo/poly hydramnios)
- Current medical complications (ie. hypertension, diabetes)
- Known fetal anomaly
- Need for induction/augmentation
- Post-dates pregnancy

Clinical benefits of staying:

- Increased likelihood of spontaneous vaginal birth and breastfeeding
- Decreased likelihood of intervention
- Protective for emotional wellbeing

Social benefits of staying:

- Reduced financial burden
- Reduced family burden (partner, other children, other family members)
- Honouring cultural values

Consider:

- Personal risk tolerance and comfort level
- Confidence of care team
- Transport and weather

Informed choice:

- Are they aware of what services are and are not available?
- Are they comfortable with the possibility of transport?

Expanded Inclusion Criteria for Local Deliveries

- Building Block discussion led by Dr. Andrew Kotaska (OBGYN Yellowknife) regarding locally appropriate criteria (March 5th)

Timely and Reliable Patient Transport

Concerns regarding timely intrapartum transport

- ‘4 cm cutoff’
- Communication between rural sites and PTN
- Weather/geography
- Referral site refusal
- Transport escort & staff shortage
- Shift change
- Time concerns

Timely and Reliable Patient Transport

PLANNED ACTIVITIES:

- Meeting between North Island providers/paramedics to discuss transport challenges
- Meeting with Campbell River specialists (pediatricians/Obs) to discuss optimal integration
- Policy brief to Access and Flow Rural Transport sub-committee regarding addressing the NI transport challenges

- *We anticipate the NI MW will alleviate some of the transport challenges

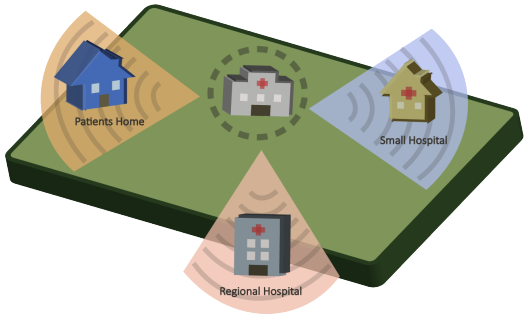
Virtual Technology Link with Referral Centre

- Less that 4% of OBGYN's practice in communities with populations less than 25,000
- Creates +++ vulnerability for rural providers
- MOM project
  - pilot initiative to increase primary health care capacity and improve patient and population outcomes by providing a specialist obstetrics telehealth service
  - Allows the patient to "meet" with her out-of-town specialist using a computer monitor, video camera and microphone;
  - Facilitates 3-way conversation between specialist, GP and patient/family
  - 'MOMI Rounds' (distributed and synchronous CME)

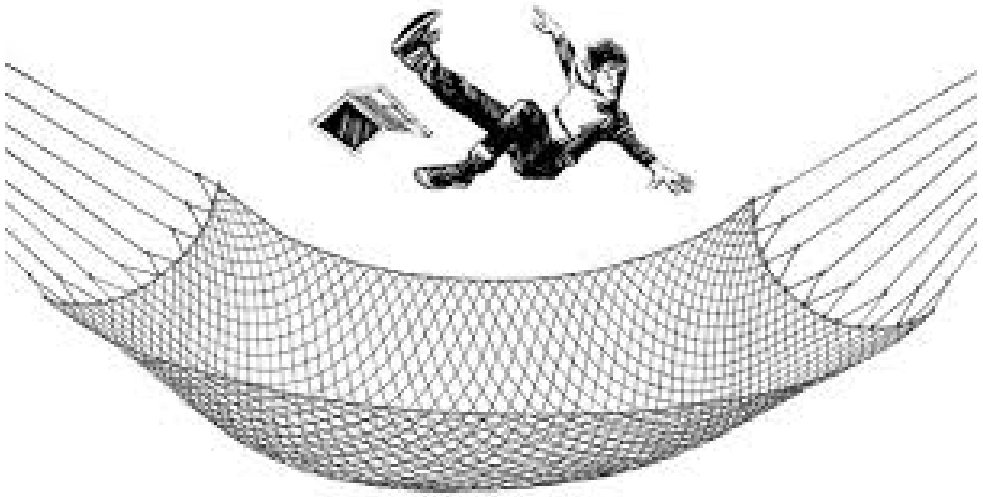
mom
MOBILE MATERNITY

The MObile Maternity Project (MOM)

- Consultations range from booked, elective tele-video appointments to urgent bed-side assessments in hospital, clinic or at home.
- Improved shared care of high-risk pregnancies to reduce patient travel to see a specialist, and, in less common situations, support for precipitous deliveries in communities without a local maternity care program.



Care Provider Support



Overarching Principles

Importance of simultaneous development of all building blocks

Importance of community-driven processes

Need for system support

Next Steps


Building Blocks For Rural Maternity Care:
Working With Communities
Cultural Safety
Generating Community Awareness
Appropriate Case Selection
Accommodation in Referral Community
Ongoing Dialogue and Listening

Building Blocks For Rural Maternity Care: Working With Communities

Cultural Safety

Prioritizing the provision of health services within a context of respectful engagement leading to a health services environment where people feel safe when receiving health care.

Generating Community Awareness

Comprehensive engagement with the community to let the women and families know about the availability of primary maternity services on the North Island, including the criteria for local delivery.

Appropriate Case Selection

Discussion with community members regarding local resources available and consequently, appropriate criteria for local delivery (i.e. no local caesarean-section, epidural capacity, neonatal intensive care).

Accommodation in Referral Community

Work with key stakeholder groups to define appropriate lodging and accommodation for mothers who must leave the community before they go into labor. Establish appropriate transportation to the referral center and back home following birth.

Ongoing Dialogue and Listening

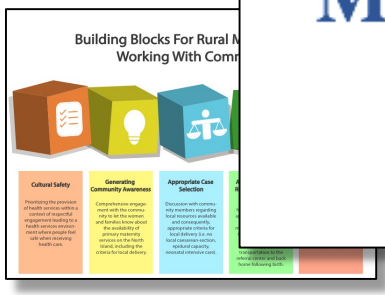
Implement an iterative quality improvement mechanism of continuous feedback with the community regarding the appropriateness of birthing services either local or away.

Next Steps


Building Blocks For Rural Maternity Care:
Working With Communities
Cultural Safety
Generating Community Awareness
Appropriate Case Selection
Accommodation in Referral Community
Ongoing Dialogue and Listening


An Invitation Symposium to support
Sustainable Rural Maternity Care in BC
June 15. 2018

Next Steps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