The Maternal and Child Healthcare Services (MACHS) Task Force

Advice to the Minister of Health

September 5, 2008
Honourable Theresa Oswald  
Minister of Health  
Room 302 Legislative Building  
450 Broadway  
Winnipeg MB R3C 0V8  

Dear Minister Oswald:  

In March 2007 we were invited to co-chair the Maternal and Child Healthcare Services (MACHS) Task Force and make recommendations for the future that would ensure the long-term sustainability of a maternal and child health-care system, enhance access to care services, promote collaboration across RHAs in the development and adoption of best practices, and enhance prevention and health promotion throughout the province.

You have shown a commitment to Manitoba’s maternal and child health-care services and recognition that they are an important component of the overall health-care system. It has been apparent throughout this process that you have been personally committed to this objective. Healthy Child Manitoba has worked to develop coordinated and supportive services for children and youth across Manitoba. We hope that the recommendations from the work of this task force will build on those successes. The next step is to now continue to work with the regional health authorities and other stakeholders to further enhance coordination of service across the province for all women and children but particularly those living in rural and northern Manitoba.

We have been privileged to undertake this endeavor and will continue our work to move towards these goals to meet your objectives. We are pleased to submit this advice on behalf of the task force members with initiatives for your consideration for the short, intermediate and longer term. We hope that it will act as documentation of our progress to date.

Respectfully submitted,  

Brian Postl, MD  

Marie O’Neill  

cc: Arlene Wilgosh  
Deputy Minister of Health & Healthy Living
EXECUTIVE SUMMARY

As Manitoba’s Minister of Health, you established the Maternal and Child Healthcare Services (MACHS) task force as a means of action to improve maternal and child healthcare services in Manitoba. Leaders within the healthcare community were personally invited to participate and have shown enthusiasm and contributed vast amounts of their professional time to this endeavor. You personally attended the inaugural meeting of the task force to emphasize the importance of this work.

The task force focused on identifying pragmatic initiatives where a measurable impact can be seen and with good prospect for early success in relation to improving care, access and outcomes with due consideration given to the broader determinants of care (i.e. poverty, education, etc). This includes short, intermediate and long term strategies for improving care and access although the focus to date has been primarily on “short term.” We have identified three areas for recommendations that will:

- **Support** access to services closer to home;
- **Address** service gaps and support and
- **Promote** promising practices across Manitoba.

The initiatives within each area have the potential to be implemented in 2009/10 and beyond. The expectation is that the “longer term” initiatives will continue to be developed during the implementation of the “short term” initiatives.

I. **Supporting Access To Service Closer To Home**

The MACHS task force has identified four (4) initiatives that support access to service closer to home beginning immediately with 24/7 cell phone coverage to increase access and support to specialist consultation for rural and northern healthcare providers. These recommendations suggest continuing to expand the 24/7 telehealth links between maternity units and children’s hospital neonatal intensive care units (NICU) and exploring the potential to expand to include other healthcare professionals and build on Health Links–Info Santé. In some instances it will decrease the need to transport rural and northern Manitobans away from their communities for care.

1. Establish a designated phone “HOTLINE” for immediate access to the neonatal specialist on call, to a designated pediatrician “of the day” and to the obstetrician “on call.”

2. Continue to expand the dedicated 24/7 telehealth links between maternity units and neonatal intensive care units (NICU) to include all Manitoba facilities providing planned birth services and establish a similar dedicated 24/7 telehealth link for obstetrics between one rural or northern maternity unit and a tertiary care obstetrical unit.

3. Explore the potential to expand the capability of Health Links–Info Santé.

4. Explore opportunities to promote “shared care” models using physician champions.
II. **Addressing Service Gaps**

There are twelve (12) initiatives (5 are subcomponents) that address service gaps and include establishing structures to define, monitor and improve perinatal care; addressing health human resources for maternal and child services; and providing direct services to women and children who travel outside their communities to access birthing services.

**Establish Structures**

5. Explore the potential to undertake an “engagement” model similar to the one used in the “Need to Know Project.”

6. Building on what already exists, further develop a central repository of maternal and child health data, indicators and publications that can be used to support comprehensive planning, delivery and evaluation of birthing service and maternal and child health programs in Manitoba.

7. Hold an annual “round table” that disseminates and features current analyses of data and information, within the context of past and emerging issues and regional and provincial priorities.

**Health Human Resources**

8. Support each Region to:
   a) complete the Multidisciplinary Collaborative Primary Maternity Care Project (MCP²) analysis with a view to assess and coordinate existing maternal newborn services for all communities within the region (including First Nations, Inuit and Métis).
   
   b) utilize the MCP² toolkit to develop a regional maternal newborn service strategy.

9. Explore the potential to increase education spaces, maximize scopes of practice and support collaborative practice as appropriate for maternal and child healthcare providers (i.e. midwives, physicians, nurses and nurse practitioners).

10. Explore the potential to provide support for the development and maintenance of maternal/newborn skills and knowledge for providers of prenatal, perinatal and postpartum services.

**Direct Services to Women and Children**

11. Ensure that expectant women who relocate from First Nations, Inuit and Métis communities and rural/remote communities for extended periods of time to give birth have access to a coordinated system of prenatal and social support as follows:

   a) Create a coordinated referral process between Federal and Provincial (RHAs) jurisdictions that includes consultation with First Nations, Inuit and Métis, a two-way communication between RHAs at all critical points of service provision from when women leave the community and return home to ensure a quality, seamless delivery of healthcare services and supports.
b) Establish a program-level working group (government departments, service delivery staff and key stakeholders) to engage the community-owned boarding homes to create and formalize policies, provide a supportive environment, identify resources that will address the well-being of prenatal women including safety, nutrition, breastfeeding, physical and emotional needs of women.

c) Provide training for peer support workers to provide pre and post-natal social support as well as labour support for delivery in a culturally appropriate manner including services in First Nations, Inuit and Métis languages.

12. Develop human resource capacity within regions that provide support to women who have temporarily relocated to access birth services outside their home communities, including Public Health Nurse positions (and support) in Winnipeg to act as contacts and service coordinators.

13. Develop resources to inform women of the services available to them (i.e. Healthy Baby Program, transportation costs to attend programming, room rental for gatherings, payment for other services such as Elder support, speaker honorarium, healthy food provision, etc) and support them to access these services (i.e. card with contact numbers).

III. SUPPORTING AND PROMOTING “PROMISING” (BEST) PRACTICE

There are nine (9) initiatives (3 are subcomponents) identified that have the potential to make a measurable difference in the health and well-being of mothers and children. The first is to provide a one-time dose of 100,000 International Units of Vitamin D at the appropriate time to address a specific need with regard to Manitoba’s high incidence of Vitamin D deficiency and/or rickets in the women and their offspring living in the north who have limited exposure to sunlight. The second is to explore two promising primary health care models that have demonstrated success in other jurisdictions and have potential to provide care to mothers and children closer to home. In addition a number of areas have been suggested for further exploration including educational tools and models that have demonstrated success in other jurisdictions and the potential to expand HPV and other immunization programs.

**Vitamin D**

14. Administer a one-time dose of 100,000 international units of vitamin D orally in midtrimester to approximately 100 pregnant mothers (followed at HSC) and:

- measure the cord hydroxy levels in the babies at birth.
- encourage daily vitamin D supplements to the infants post discharge after delivery
- begin a source of supplementary vitamin D (i.e. Sprinkles Global Initiative) once complementary foods are introduced to infants.

15. At one year of age, complete dental examinations for evidence of dental caries, complete physical examinations and measure 25 hydroxy vitamin D levels.

**Education Tools**

16. Explore the potential for using similar tools (passports) to those discussed to promote Healthy Pregnancy and Child Health developed in collaboration with public healthcare providers and Regional Health Authorities, including a coordinated campaign with those activities already in place or under development.
17. Explore the potential for purchase and distribution of “Toddler’s First Steps” and assess its suitability for use in First Nations, Inuit and Métis communities.

**Sexual Health and Human Papillomavirus (HPV)**

18. Direct Manitoba Health and Healthy Living to:
   a) explore the potential to expand the HPV program to include “at risk” females who do not attend public school;
   b) provide a need assessment; and
   c) build public health nursing capacity (adequate number and mix of the public health nursing workforce, education and training and IT support) to address a comprehensive sexual health strategy that includes HPV vaccination.

**Immunization**

19. Direct Manitoba Health and Healthy Living to work with RHAs to identify strategies to increase immunization rates.

**Models of Interest**

20. Explore the potential to implement one or both of the primary health care models discussed within appropriate regions to address service gaps and provide services closer to home.

The initiatives identified within this document are straightforward and would be well supported by many practitioners. They also address a number of the recommendations of the Ministerial Working Group on Maternal Newborn Services (2005)\(^1\), Closing the Gap and The Final Report of the Federal Advisor on Wait Times (2006) relating to access. Early results can be achieved by building on those elements that are already established.

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BACKGROUND

There has been an enormous amount of time and effort invested in identifying the needs, challenges and opportunities facing Manitoba in regard to maternal and child healthcare services. This is evident from the variety and number of reports that have been produced over the years which include (but are not limited to):

1. **The Health of Manitoba’s Children (March 1995)** – Dr. Brian Postl on behalf of the Child Health Strategy Committee

2. **Assessing the Health of Children in Manitoba (February 2001)** – Manitoba Centre for Health Policy (MCHP)

3. **Healthy Kids, Healthy Futures Task Force Report (June 2005)** – All-Party Task Force


It was apparent at the onset of this task that although many advances have been made in improving the care and services and implementing the suggestions within this “body of work,” a catalyst is necessary to further escalate the activities necessary to complete this work and coordinate those endeavors that have already taken place or are underway. As the Minister of Health, you established the Maternal and Child Healthcare Services (MACHS) Task Force with the hope of addressing this need in a coordinated and comprehensive manner.

The MACHS Task Force Terms of Reference include (but are not limited to):

- Providing advice and making recommendations regarding maternal/newborn and youth healthcare and service delivery provincially;
- Establishing priorities and recommending strategic direction regarding provincial planning and coordination of human resource needs for maternal and child health;
- Working toward “closing the gap” in services for First Nations, Inuit and Métis child health and maternity care and addressing cross-jurisdictional barriers to care;
- Identifying and promoting “best practices” across regions;
- Encouraging health promotion and disease prevention.

The task force has been expertly advised by its membership, which includes representation from all Regional Health Authorities, Manitoba Health and Healthy Living (MHHL), Manitoba Family Services and Housing, Healthy Child Manitoba and numerous external stakeholder groups including doctors, nurses, midwives and Aboriginal groups.

OVERVIEW OF PROCESS/ACTIVITIES OF MACHS

The Maternal and Child Healthcare Services Task Force was announced on March 30, 2007. Research, planning and recruitment began immediately and involved numerous activities to prepare for the inaugural meeting. These included (but were not limited to) formal recruitment of experts, establishing a structure to support the co-chairs and direct the work of the task force, developing draft “terms of reference” to be presented to members for discussion, developing an agenda and work plan and making the necessary arrangements for your opening address to members.
The first meeting of the Maternal and Child Healthcare Services Task Force was held in Winnipeg on September 14, 2007. A workshop to establish priorities and develop a work plan to provide direction for the work was held on October 30, 2007.

The task force has initially concentrated on identifying pragmatic initiatives where a measurable impact can be seen and with good prospect for early success in relation to improving care, access and outcomes with due consideration given to the broader determinants of care (i.e. poverty, education, etc). This includes short, intermediate and long term strategies for improving care and access although the focus to date has been primarily on “short term.” We have identified three areas for recommendations that will: support access to services closer to home; address service gaps and support and promote promising practices across Manitoba. The initiatives within each area have the potential to be implemented in 2009/10 and beyond. The expectation is that the “longer term” initiatives will continue to be developed during the implementation of the “short term” initiatives.

Eight meetings of the Maternal and Child Healthcare Services (MACHS) Task Force have taken place since September 2007. In addition we (co-chairs) have met with you and the Deputy Minister of Health and Healthy Living on five occasions to provide updates on the progress of the work and seek direction.

The task force began by reviewing the body of work prepared to date including the various reports noted above. Members subsequently targeted a number of priority areas. To facilitate the work involved with the preparation of this document, smaller working groups met individually on several occasions to address the following:

1. Supporting Access To Service Closer to Home
2. Addressing Service Gaps
3. Supporting Promising (Best) Practice
4. Cross Jurisdictional Issues

As well, we initiated contact with Manitoba’s experts in the areas of data, telehealth and electronic health records and asked them to identify initiatives that will enhance existing services within the province and be demographically appropriate. MACHS has hosted presentations by the Manitoba Immunization Monitoring System (MIMS Program) and Health Links–Info Santé to inform this work. Preliminary data from a research project “Factors Associated with Inadequate Prenatal Care Among Inner City Women in Winnipeg” was presented to help inform the work. Promising practice models from across the country and province have also been explored that could have potential to improve access to service and outcomes.

In recognition of the fact that many of the initiatives identified in this document must be supported by funding (either one time and/or ongoing) we are exploring an opportunity to provide support and partnership through Manitoba Health and Healthy Living and health researchers in the development of an application for two recently announced CIHR grants related to Maternal and Child Health. These grants have the potential to provide funding up to $250,000 beginning in 2009. The relevant priority areas cover a wide range including: fetal growth and preterm births; childhood injury and maltreatment; Aboriginal issues; chronic disease; and mental health and addiction. If successful, the data from the research will inform decisions on the longer term initiatives identified by the task force to build on primary health care services and improve outcomes for mothers, youth and children.
TERMINOLOGY

It was clear early in this process that an understanding of the terminology as it will apply to the initiatives identified was needed. Many of the terms used in maternal and child health vary slightly from one document to another. In the interest of clarity, assumptions for the purpose of this document are:

**Maternal** from beginning of pregnancy to approximately 8 weeks after birth

**Perinatal** time period immediately before and after birth: the period when women without access to birth services must travel to access these services (approximately 37 weeks gestation to approximately 1 week postpartum)

**Newborn** birth to approximately 8 weeks

**Infant** 2 months to approximately 2 years

**Child** 2 years to approximately 12 years (puberty)

**Youth** approximately 13 to 18 years (puberty to age of majority)

**Short Term** approximately 6 months to 1 year

**Intermediate** approximately 1- 2 years

**Longer Term** approximately 2- 3 years and beyond

**Aboriginal** refers to those persons who identify with at least one Aboriginal group that is, North American Indian, Métis or Inuit, and/or those who reported being a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada, and/or those who reported they were members of an Indian band or First Nation.
THE INITIATIVES

I. SUPPORTING ACCESS TO SERVICE CLOSER TO HOME

Hotlines

- 24/7 coverage by cell phone; tele-health and Health Links–Info Santé

There are two tertiary healthcare centres for obstetrics and neonatology in Winnipeg and one tertiary centre for pediatrics at Winnipeg Children’s Hospital. Healthcare providers requiring urgent consultation do not currently have in place well organized and dependable systems of contacting “the right people.” Currently, all obstetrical/gynecological calls from healthcare providers go to the 24-hour “in-house” obstetrician at Women’s Hospital or St. Boniface General Hospital (SBGH). Unfortunately the process of reaching this individual is unpredictable and often frustrating. Although similar mechanisms are in place to reach the ambulatory pediatrician on call for the ambulatory group at Children’s Hospital, this does not cover the entire province and similar frustrations and uncertainty of “who to call” (other than the Children’s Emergency) can exist.

A systematic method of reaching the right person, right away, all the time is necessary. We suggest beginning immediately with 24/7 cell phone coverage to provide the much needed increase in access and support to specialist consultation for rural and northern healthcare providers. In some instances it will decrease the need to transport rural and northern Manitobans away from their communities for care. This concept can be further supported by a practitioner “e-community” providing 24/7 access to communication links, best practice information, practice guidelines, continuing education and the use of “shared care” models. In addition this concept has the potential to be expanded in the longer term to include:

- 24/7 telehealth links between maternity units and neonatal intensive care units (NICU) in all Manitoba facilities providing planned birth services and establishing a similar dedicated 24/7 telehealth link for obstetrics between one rural or northern maternity unit and a tertiary care obstetrical unit;
- other healthcare professionals; and
- building on Health Links–Info Santé to include prenatal and maternal care.

The above suggestions are straightforward and would be well-supported by many practitioners. They also address a number of the recommendations of the Ministerial Working Group on Maternal Newborn Services (2005)\(^2\), Closing the Gap and The Final Report of the Federal Advisor on Wait Times (2006) relating to access. Early results can be achieved by building on those elements that are already established (i.e. neonatal telehealth and Health Links–Info Santé).

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2 Report of Manitoba Health’s Ministerial Working Group on Maternal Newborn Services – May, 2005; Recommendation # 6; page 64.
Recommendation(s):

1. Establish a designated phone “HOTLINE” for immediate access to the neonatal specialist on call, to a designated pediatrician “of the day” and to the obstetrician “on call.” (Short Term)

2. Continue to expand the dedicated 24/7 telehealth links between maternity units and neonatal intensive care units (NICU) to include all Manitoba facilities providing planned birth services and establish a similar dedicated 24/7 telehealth link for obstetrics between one rural or northern maternity unit and a tertiary care obstetrical unit. (Intermediate Term)

3. Explore the potential to expand the capability of Health Links–Info Santé. (Intermediate Term)

4. Explore opportunities to promote “shared care” models using physician champions. (Longer Term)

II. ADDRESSING SERVICE GAPS

Establish structures to define, monitor and improve perinatal care

*Maternal and Child “Need–to-Know Project” Model*

The “Need to Know” research project is a collaboration consisting of the Manitoba Centre for Health Policy, Rural and Northern Regional Health Authorities, and Manitoba Health and Healthy Living. It is funded in part by the Canadian Institutes for Health Research (CIHR) through the Community Alliances for Health Research.  

Goals are:

- to create new knowledge directly relevant to rural and northern Regional Health Authorities, both in Manitoba and as a model for the wider community;

- to develop useful models for health information infrastructure, as well as for training and interaction, that will increase and improve capacity for collaborative research interaction;

- to disseminate and apply health-related research to increase the effectiveness of health services and ultimately the health of RHA populations;

- to foster high-quality research of relevance to community groups and agencies;

- to enhance mutual learning and collaboration among community organizations and researchers about healthcare issues of concern to the community; and

- to provide opportunities for training of health researchers in all disciplines in an environment characterized by community interaction.
It would be beneficial to develop a similar process or build upon the existing process with a mandate specific to maternal and child healthcare services. This process has the potential to address the needs for research and knowledge gaps and promote knowledge transfer with regard to maternal and child health and services. It could include consultation with Aboriginal groups (i.e. First Nations, Inuit and Métis) and women from rural and remote communities to identify appropriate supports and services for women and families who must travel to access and await birthing services away from home.

Annual Round Table

“The Report of the Manitoba Health Working Group on Maternal and Child Health Care” (2005) suggested that planning and provision of maternal and newborn care be based on current and evolving knowledge of best practices. It is important also to acknowledge those areas where there is insufficient research for conclusions to be drawn. There is a need to establish a forum to review data. To address this need we are suggesting an Annual Round Table of experts to review recent research, select a research agenda for the following year and facilitate ongoing discussion. The workshop should include university faculties, regulatory bodies, providers (i.e. midwives, MDs, nurses, allied health workers), RHAs and government departments. The first meeting of the Annual Round Table should include presentation of the current data available and introduce the Multidisciplinary Collaborative Primary Maternity Care Project (MCP) (discussed in greater detail below) to the stakeholders and obtain input to other provincial structures that may be needed for maternal and child healthcare services. Annual activities could include determining a Manitoba Centre for Health Policy deliverable based on the needs identified from the data presented.

Central Information Repository

Data and information are key components of an accountability framework that enable the development of appropriate program and service goals and access targets for measuring our progress. The collection of data, its timely dissemination and analysis are elements that provide Regional Health Authorities with the tools to monitor trends and make informed decisions. The recommendations for a central repository of maternal and child health information and an annual "round table" address the dissemination and analysis of the data. As well, a deliverable through a partnership between Manitoba Center for Health Policy and the Manitoba Métis Federation (MMF) could be considered to create data that would be analyzed by academics and interpreted by MMF Knowledge Networks (includes RHA and MHHL partners).

Recommendation(s):

5. Explore the potential to undertake an “engagement” model similar to the one used in the “Need to Know Project.” *(Intermediate Term)*

6. Building on what already exists, further develop a central repository of maternal and child health data, indicators and publications that can be used to support comprehensive planning, delivery and evaluation of birthing service and maternal and child health programs in Manitoba. *(Intermediate Term)*

7. Hold an annual "round table" that disseminates and features current analyses of data and information, within the context of past and emerging issues and regional and provincial priorities. *(Short Term)*

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Health Human Resources for Maternal Child Services

Various challenges currently exist that often necessitate the need for women to go outside their home community to obtain healthcare services to give birth to healthy infants. The critical needs in this area have been identified in prior reports including the Report of Manitoba Health’s Ministerial Working Group on Maternal Newborn Services (2005)^4_. A number of options exist that can be implemented (both short term and longer term) to enhance community capacity and improve access. These include (but are not limited to):

- establishing appropriate Public Health Nurse positions (and support) to serve as contact points and service coordinators to ensure seamless referrals to public health and other services for women who live outside Winnipeg and must come to Winnipeg to deliver
- increasing the number of education spaces
- maximizing “scopes of practice”
- supporting collaborative practice for maternal and child healthcare providers (i.e. midwives, physicians) to allow specialists (i.e. obstetricians and pediatricians) to focus on specialist skills in collaboration with all other care providers
- access to midwifery services
- developing and maintaining maternal/newborn skills and knowledge for providers through services such as:
  - telehealth and website supports (to enable access to prenatal and postpartum education resources)
  - provision of multidisciplinary training programs for all regions that are appropriate for the setting, in emergency maternal and newborn skills (i.e. NRP, AcORN, ALARM, ESW, MOREob, A.L.S.O.).
- increased access to simulation labs
- increased access to educators
- support for ongoing access to information regarding current best practice in maternal/newborn services

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^4 Report of Manitoba Health’s Ministerial Working Group on Maternal Newborn Services – May, 2005: Chapter 4: Section 4.2 Care Providers; pages 31-39; Recommendations #4,5,6 & 7; page 63-64.
support for travel where skills training or experience with specialists in urban settings is required to maintain or develop local providers’ maternal/newborn skills

One of the tools available to initiate this endeavor is the **Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)**.

**Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)**

In 2004, Health Canada funded a national project called the **Multidisciplinary Collaborative Primary Maternity Care Project (MCP²)**. Organizations that participated in this initiative include:

- Association of Women’s Health, Obstetric and Neonatal Nurses (Canada),
- Canadian Association of Midwives,
- Canadian Nurses Association,
- College of Family Physicians of Canada,
- Society of Obstetricians and Gynaecologists of Canada, and
- Society of Rural Physicians of Canada.

The overarching goal of this project was to reduce barriers and facilitate the implementation of national multidisciplinary collaborative primary maternity care strategies as a means of increasing the availability and quality of maternity services for all Canadian women. Manitoba Health and Healthy Living participated on this initiative.

The project had several main objectives including:

- Guidelines for Model Development
- Harmonization of standards
- Continuing advocacy at a pan-Canadian level for the resources to support the appropriate delivery of multidisciplinary collaborative maternal/newborn care services in each jurisdiction
- Change Practice Patterns
- Facilitate Information Sharing
- Promote Benefits of Multidisciplinary Collaborative Maternity Care
- Evaluation

The following recommendations have the ability to make advances in both the short term and over the longer term. It remains imperative that RHAs continue to provide and meet known standards of care for pre-and post-natal services for clients close to home irrespective of whether birthing facilities are available within the region. All of the strategies below should help to ensure that effective prenatal and post partum care are available close to home, even in regions where deliveries do not occur. As well the following recommendations will address a number of concerns identified by Manitoba Health’s Ministerial Working Group (2006) and have the potential to be incorporated into the community health assessments for the health planning process.
Recommendation(s)

8. Support each RHA to:
   a. complete MCP² analysis with a view to assess and coordinate existing maternal newborn services for all communities within the region (including First Nations, Inuit and Métis). (Short Term)
   b. utilize the MCP² toolkit to develop a regional maternal newborn service strategy. (Short Term)

9. Explore the potential to increase education spaces, maximize scopes of practice and support collaborative practice as appropriate for maternal and child healthcare providers (i.e. midwives, physicians, nurses and nurse practitioners). (Intermediate Term)

10. Explore the potential to provide support for the development and maintenance of maternal/newborn skills and knowledge for providers of prenatal, perinatal and postpartum services. (Intermediate Term)

Direct services to women and children requiring service outside their community/region (i.e. traveling for birth)⁵

A “gap in service” exists for women who relocate temporarily to larger centers to give birth to their babies or to obtain specialized obstetrical care. In the Winnipeg Regional Health Authority, Public Health Nurses (PHNs) contact clients who are staying in the Winnipeg region for postpartum/infant assessment. However the PHNs are not currently aware of when these women arrive in the prenatal period and where they are staying. The concern is that these women are not accessing the support and services they need. The assumption is that similar situations exist in other Regional Health Authorities.

Expectant women from First Nations, Inuit and Métis and rural and remote communities may stay in these larger centers for as long as two to eight (2-8) weeks depending on their “assessed risk status.” Women from Aboriginal communities will primarily stay in boarding homes. Others may stay with family or friends. There is good indication that these women are not receiving adequate services and support related to a healthy pregnancy once they reach these urban locations. Peer workers have expressed concern that boarding homes are not set up to consider the health of the women. As well, women staying in these homes often experience loneliness, boredom and isolation from family, friends and support. They have also expressed feeling overwhelmed and fear for their health and safety (Eni)⁶ This information is consistent with evidence that many of these women are young, of low income status, have high perceived stress, low self-esteem and often, many risk factors. (Heaman⁷, Chamberlain⁸, Eni)

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⁵ Report of Manitoba Health’s Ministerial Working Group on Maternal Newborn Services – May, 2005; Chapter 4: Section 4.3 Leaving One’s RHA to Give Birth; pages 39 - 43; Recommendations 4, 5, 6 & 7; pages 63-64.


Support for women who must travel to give birth may be provided through the public health system and through “peer” support models. Peer support models have the potential to provide pre and post-natal social support as well as labour support for delivery in a culturally appropriate manner including service in First Nations, Inuit and Métis languages. Efforts to increase referrals to public health over the past three years have anecdotally resulted in positive changes for family and clients.

Supports for clients and families should link to existing resources and provide services where none exist. The approach should encompass social, educational and cultural components where appropriate. The focus of the educational component should be based on best/promising practice literature and positively impact the health of the woman, fetus and family. This may include nutrition, breastfeeding, family assessment, tobacco/substance use reduction, referrals, etc. To arrive at an approach that will address the needs of Aboriginal women it is important to consider their individual and specific needs. The absence of adequate consultation from the “grass roots” has often resulted in failure. Engagement and consultation with First Nations, Inuit and Métis on this issue will not only reveal the right approach – it will also empower the women involved, encourage “buy-in” to the plan by First Nations, Inuit and Métis and be consistent with the Aboriginal direction toward self-determination (AMC).

Geography, demography and other natural barriers will always exist and make it impossible for every woman to give birth within her home community. In some instances these barriers are difficult, if not impossible to overcome and as a result some women must go elsewhere in order to obtain essential healthcare services to give birth to healthy infants. The following initiatives focus on those areas where it is possible to make a measurable difference for many women and allow them to remain closer to home for longer periods of time.

It is essential that regions address the following recommendations in coordination with their particular regional maternal newborn strategy. As well it must be understood that the following recommendations will not fix these problems in the longer term but are short term in nature. The longer term objective must be that we work harder on processes and structures that will enable birthing to move closer to home. Having access to midwifery service within home communities has the potential to meet this objective. In the meantime, the appropriate funding for Public Health Nurse positions (including support staff) in Winnipeg would ensure the necessary capacity to provide timely assistance to women who must relocate to Winnipeg to access birthing services currently unavailable to them in their home communities. These essential services could include referral to public health and other services as well as communication back to the home regions.
Recommendation(s):

11. Ensure that expectant women who relocate from First Nations, Inuit and Métis communities and rural/remote communities for extended periods of times to give birth have access to a coordinated system of prenatal and social support as follows:

   a) Create a coordinated referral process between Federal and Provincial (RHAs) jurisdictions that includes consultation with First Nations, Inuit and Métis, a two-way communication between RHAs at all critical points of service provision from when women leave the community and return home to ensure a quality, seamless delivery of healthcare services and supports. *(Intermediate Term)*

   b) Establish a program-level working group (government departments, service delivery staff and key stakeholders) to engage the community-owned boarding homes to create and formalize policies, provide a supportive environment, identify resources that will address the well-being of prenatal women including safety, nutrition, breastfeeding, physical and emotional needs. *(Intermediate Term)*

   c) Provide training for peer support workers to provide pre and post-natal social support as well as labour support for delivery in a culturally appropriate manner including services in First Nations, Inuit and Métis languages. *(Short Term)*

12. Develop human resource capacity within regions that provide support to women who have temporarily relocated to access birth services outside their home communities, including Public Health Nurse positions (and support) in Winnipeg to act as contacts and service coordinators. *(Short Term)*

13. Develop resources to inform women of the services available to them (i.e. Healthy Baby Program, transportation costs to attend programming, room rental for gatherings, payment for other services such as Elder support, speaker honorarium, healthy food provision, etc) and support them to access these services (i.e. card with contact numbers). *(Short Term)*

III. **Supporting and Promoting “Promising” (Best) Practice**

**Vitamin D**

Vitamin D deficiency and congenital rickets are over represented in Aboriginal communities in Manitoba and Nunavut. The only source of vitamin D available to the fetus is derived by the mother and vitamin D freely crosses the placenta. There is now accumulated published evidence that 25 hydroxy vitamin D levels in most pregnant women and their infants are in the deficient or insufficient range. In addition, there is anecdotal evidence that 100,000 International Units of Vitamin D when administered orally (one time) to pregnant women in midtrimester produces
sustained increases in vitamin D levels in the pregnant woman and her newborn. However, formal documentation or publications are lacking regarding the efficacy of such supplementation leading to sustained increases in vitamin D levels in newborns, decrease in the incidence in vitamin D deficiency or rickets or improvement in dental health. There are ongoing investigations trying to link 25 hydroxy vitamin D levels in infants and their dental health in the first few years of life.

Previous strategies including “Healthy Start” of daily prenatal supplementation with vitamin D or provision of each mother leaving hospital with her newborn with a bottle of Di-Vi-Sol have not met expectations in reducing vitamin D deficiency because of lack of sustained compliance outside of the clinic/hospital setting.

The dosage of vitamin D supplementation is under discussion with recommendations varying between different professional organizations, scientific bodies and government agencies. The following recommendations relating to vitamin D are to provide an appropriate dose of vitamin D at the appropriate time (appropriate dosage of vitamin D and timing of administration) to address a specific need with regard to Manitoba’s high incidence of Vitamin D deficiency and rickets in infants and their dental health in the first few years of life.

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**Recommendation(s):**

14. Administer a one-time dose of 100,000 international units of vitamin D orally in midtrimester to approximately 100 pregnant mothers (followed at HSC), and:
   - measure the cord hydroxyl levels in the babies at birth
   - encourage daily Vitamin D supplements to the infants post discharge after delivery
   - begin a source of supplementary Vitamin D (i.e. Sprinkles Global Initiative) once complementary foods are introduced to infants. *(Intermediate Term)*

15. At one year of age, complete dental examinations for evidence of dental caries, complete physical examinations and measure 25 hydroxy vitamin D levels. *(Intermediate Term)*

**Educational Tools**

Immunization is a key part of a public health plan to promote healthy child developmental outcomes from the prenatal stages to age 16. There is concern that children are becoming less protected against preventable diseases due to declining immunization rates. In 2002, 84% of children in Manitoba were vaccinated. In 2006 this figure declined to 77%. Several jurisdictions provide a child health passport to parents or caregivers shortly after the birth of the child. Child health passports are intended to assist parents and healthcare providers to track and have access to all of the child’s important health information and act as a communication tool to create a link between practitioners and healthcare providers who are assisting in the ongoing care of the child. Two particular models that are of interest are those in use in British Columbia and France where child health passports have been in use for a number of years.

In addition to the Child Health Passport, British Columbia also provides a follow-up book to the Baby’s Best Chance book called “Toddler’s First Steps.” This publication provides child health

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9 Stephens WP et al Lancet 1982: 1199-1201 – Annual high dose vitamin D prophylaxis in Asian Immigrants (stosstherapy)

10 Vieth R: Vitamin D toxicity: policy and science J Bone and Mineral Research Dec 2007 22(suppl2): pgs v 64-68
information including immunization information for children ages six months to three years of age in an effort to ensure optimal growth and development for children. It provides parents and caregivers with practical information on child development, nutrition, health and wellness, parenting and safety. Manitoba has already purchased the publication “Baby’s Best Chance” from British Columbia and distributes it to parents and caregivers throughout Manitoba. The “Child Health Passport” and the “Toddler’s First Steps” publication are in alignment for integration and could further enhance this initiative.

Other initiatives are being investigated to enhance immunization rates but require further exploration and discussion.

The development and implementation of these tools (i.e. healthy pregnancy and child health document, Babies First Steps) have demonstrated success. Application of similar models in Manitoba have the potential to reduce the rates of preventable diseases and promote continuity and integration of maternal and child healthcare.

Recommendation(s)

16. Explore the potential for using similar tools (passports) to those discussed above to promote Healthy Pregnancy and Child Health developed in collaboration with public healthcare providers and Regional Health Authorities including a coordinated campaign with those activities already in place or under development. (Intermediate Term)

17. Explore the potential for purchase and distribution of “Toddler’s First Steps” and assess its suitability for use in Aboriginal communities. (Intermediate Term)

Sexual Health and Human Papillomavirus (HPV)

The implementation of the Human Papillomavirus (HPV) vaccination program is planned for fall 2008. The rollout of the provincial plan will provide protection for those accessing the vaccine through the school program, initially resulting in a reduction in the number abnormal cytology smears and subsequent colposcopic examinations. This would be followed by a decrease in the incidence rates of cervical cancer. These represent long term goals where we will see a direct benefit in the health of Manitoban women in approximately 10 years.

There is an opportunity to see that benefit sooner and in a more comprehensive way by ensuring that clinics providing care for high risk adolescents and those who are already or soon to be sexually active, who will not be captured in the school-based immunization program, are provided with access to the vaccination. Many of the high-risk teens can only be immunized through this route. A similar model already exists with hepatitis B immunization where there is a province-wide immunization program for hepatitis B vaccination in the clinic setting for those teens who failed to access it through the school immunization program. This may initially result in an increase in cost and volumes; however these would be offset by bringing the vaccine effectively to those who will not be included in the rollout of the school-based program.

One option to enhance capacity to the necessary levels is to explore opportunities to expand the “scope of practice” for Public Health Nurses (PHNs) in areas where access to primary care
service is limited. This would require ensuring that appropriate policies, practice guidelines and delegation of functions are in place to allow PHNs to offer services such as pregnancy testing, provision of the morning-after pill (emergency contraception) and DepoProvera, urine testing for gonorrhea and chlamydia, venipuncture for syphilis, hepatitis B, hepatitis C and HIV and treatment of uncomplicated STIs – gonorrhea and Chlamydia.

**Recommendation(s):**

18. Direct Manitoba Health and Healthy Living to:

   a) explore the potential to expand the HPV program to include “at risk” females who do not attend public school; *(Short Term)*

   b) provide needs assessment; *(Short Term)*

   c) build public health nursing capacity (adequate number and mix of the public health nursing workforce, education and training and IT support) to address a comprehensive sexual health strategy that includes HPV vaccination. *(Intermediate Term)*

**Immunization**

A trend of declining immunization rates is of concern in Manitoba. To counter this trend will require investment by public health program staff to identify and address immunization myths and to provide evidence-based information regarding immunization.

**Recommendation:**

19. Direct Manitoba Health and Healthy Living to work with RHAs and physicians to develop a strategy to improve immunization rates. *(Short Term)*

**Models of Interest**

A number of models developed and in use elsewhere in Canada have demonstrated success in bringing patient-centered, culturally appropriate healthcare services to women and children in rural and remote areas. These programs rely on peer workers, nurse practitioners and Doulas\(^{11}\) to deliver patient-centered care, with respect for individuality, ethnicity, dignity and privacy. Two models of interest are the *Toronto Access Alliance Community Health Clinic Peer Outreach Workers and Gesundheit Fur Kinder: Woolwich Community Health Care St. Jacobs Ontario.*

**Toronto Access Alliance CHC (AA CHC) Peer Outreach Workers (POWs)**

- works with immigrant and refugee communities to hire Peer Outreach Workers (POWs).
- provides three months of training
- three-year contracts

\(^{11}\) Wikipedia [http://en.wikipedia.org](http://en.wikipedia.org) definition: “a non-medical assistant who provides various forms of non-medical support (physical, emotional and informed choice) in the childbirth process. Based on a particular training and background, may offer support during prenatal care, during childbirth and/or during the postpartum period.”
• POWs run parenting workshops and facilitate well children and well women care run by AA professionals
• have brought maternal and child services to 10,000 refugee women and their children
• 85% of POWs get jobs in health or social services after their contracts have expired.

Gesundheit Fur Kinder: Woolwich Community Health Center, St. Jacobs, Ontario

• prenatal care, well woman and well child clinics run by nurse practitioners
• nutrition education
• peer nutrition workers
• breastfeeding support
• children's program
• material support
• transportation
• building social networks

Recommendation:

20. Explore the potential to implement one or both of the above primary health care models discussed within appropriate regions on a trial basis to address service gaps and provide services closer to home. **(Short Term)**
IV. OTHER ISSUES/CONSIDERATIONS

Cross Jurisdictional Issues

The Maternal and Child Healthcare Services (MACHS) Task Force did not specifically address “cross jurisdictional issues” but focused on the broader context of healthcare services for women and children while working towards “closing the gap” in Aboriginal health and maternity care. Nevertheless “cross jurisdictional issues” are, in themselves barriers to care and are therefore worth mentioning.

Jurisdictional ambiguity prevails in our province in regard to First Nations\footnote{12 First Nations is an English term that acknowledged and described the indigenous "tribes of Indians in Canada", and "Indian Nations", who spoke dozens of distinct languages with widely different customs, traditions and economies. It is a term with both political and historical significance that first appeared in the Royal Proclamation of 1763 and appeared again in Treaties, and in other major legal decisions in Canada and the United States. It has gained popular usage today, generally referring to these "Nations" and citizens of these nations, who are considered "Indians" under the Indian Act. Adapted from: Government of Canada and the Special Committee on Indian Self-Government, Indian Self-Government in Canada, Report of the Special Committee. 1983. Queens Printer.} health service delivery. This is a direct result of two parallel and distinct healthcare systems - one federal and one provincial - that are both providing health services to on-reserve and off-reserve registered First Nations people. As a result, disputes have arisen over payment of services and over roles and responsibilities. This has resulted in many gaps, limitations or inconsistencies in services to First Nations or has resulted in services that have been eroded, non-coordinated, highly complicated or non-existent.

Currently, some administrative and healthcare data bases lack the capacity to identify First Nations individuals, making data linkages and information sharing across jurisdictions difficult. This also poses challenges for research, particularly in the area of incidence and prevalence rates for specific health states for this group of people. In some instances, it is not possible to accurately track individuals of First Nations descent; utilization of programs, differential use of Manitoba Health and Healthy Living programs and differences in treatment protocols. In addition, there are limitations to specialized programs, and understanding where and how these residents access healthcare services may be difficult as some individuals move between their communities and larger centers to access care. (Lavoie)

Finding solutions to these jurisdictional challenges is daunting and longer term in nature. Regardless of this, they must be addressed and resolved. The recommendations within this document, in particular exploring the potential creation of information systems with capacity to link both federal and provincial jurisdictions, will provide the foundation on which other linkages are created or expanded in the future.

Children’s Wait Times

The mandate of MACHS included addressing concerns around pediatric wait times. Upon further review, it became apparent that there is significant work underway to identify and address issues in pediatric wait times. As illustrated below, there is significant attention on addressing issues of pediatric wait times occurring on several fronts. While the focus is predominantly on surgical
waiting time for children at this point, lessons learned from these initiatives will be instrumental in responding to pediatric access issues in other areas such as medical consultation. MACHS will continue to engage partners leading these initiatives to coordinate efforts and to investigate opportunities to expand activities to other areas of pediatric care.

**Children's Hospital's participation in the National Pediatric Surgical Wait Times Project**

- This project includes the collection of wait time information for children awaiting surgical services in cancer, cardiac, dental treatment, neurosurgery, scoliosis, strabismus, urology, gynecological surgery, plastic surgery and otolaryngology.

**Children's Hospital's participation in the provincial Patient Access Registry Tool**

- This provincial IT system collects information on children waiting for all surgical services in Manitoba, and will, in phase two of the project, capture information on wait times for consultations with pediatric medical specialists as well.

**A Re-Design of Children's Hospital Surgical Patient Flow**

- This project, led by Dr. Gerarda Cronin and funded by the Manitoba Patient Access Network, is analyzing and redesigning the current surgical patient flow at Children's Hospital. Business process reengineers are working collaboratively with clinical teams and management to redesign the flow of surgery patients by mapping out current processes, comparing to other jurisdictions, developing and implementing process improvements at Children's Hospital to improve access for children's surgical services.

**Provincial Pediatric Dentistry Access Strategy**

- This initiative, funded by the Manitoba Patient Access Network, has resulted in a provincial audit of pediatric dental surgery to ascertain any issues in access and quality of surgical dental service provision to children throughout Manitoba. Additionally, Children's Hospital received Manitoba Patient Access Network funding to establish a centrally managed wait list and patient navigation for children awaiting pediatric dental surgery at Children's Hospital surgical sites (Misericordia, Maples Surgical Centre and HSC). The experience gained in delivering a centrally managed wait list and patient navigation in pediatric dental surgery will be examined for possible expansion and application in other areas of Children's Hospital.

**Public and Stakeholder Education**

A common characteristic of public and stakeholder expectation is that it is focused on the short term. This document suggests a number of initiatives that have the potential to be implemented in the shorter term, with minimal cost and demonstrated success in terms of improving access and outcomes and assisting expectant mothers to remain in their communities longer. Sustained improvements take time and require patience from both the public and stakeholders and expectations for what can be achieved in the short term must be contained. This can be achieved through collaborative communication efforts beginning with a plan to share information about the work of the Maternal and Child Healthcare Services Task Force (MACHS) with various stakeholder groups.

**Implementation of the Initiatives**
This document contains a total of 20 recommendations (25 initiatives). It has been estimated that the implementation of the recommendations identified fall within the following timelines:

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Term (6 months to 1 year)</td>
<td>11</td>
</tr>
<tr>
<td>Intermediate Term (1-2 years)</td>
<td>13</td>
</tr>
<tr>
<td>Longer Term</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

It is understood that the task force does not have responsibility for the implementation of recommendations. However, those initiatives identified above for implementation in the Intermediate or Longer Term are complex, require further development and would benefit from the collaborative efforts of the RHAs and a body of individuals with expertise.
V. SUMMARY OF INITIATIVES

Supporting Services Closer To Home

Hotlines

1. Establish a designated phone “HOTLINE” for immediate access to the neonatal specialist on call, to a designated pediatrician “of the day” and to the obstetrician “on call.” (Short Term)

2. Continue to expand the dedicated 24/7 telehealth links between maternity units and neonatal intensive care units (NICU) to include all Manitoba facilities providing planned birth services and establish a similar dedicated 24/7 telehealth link for obstetrics between one rural or northern maternity unit and a tertiary care obstetrical unit. (Intermediate Term)

3. Explore the potential to expand the capability of Health Links–Info Santé (Intermediate Term)

4. Explore opportunities to promote “shared care” models using physician champions. (Longer Term)

Addressing Service Gaps

Establish Structures

5. Explore the potential to undertake an “engagement” model similar to the one used in the “Need to Know Project.” (Intermediate Term)

6. Building on what already exists, further develop a central repository of maternal and child health data, indicators and publications that can be used to support comprehensive planning, delivery and evaluation of birthing service and maternal and child health programs in Manitoba. (Intermediate Term)

7. Hold an annual “round table” that disseminates and features current analyses of data and information, within the context of past and emerging issues and regional and provincial priorities. (Short Term)

Health Human Resources

8. Support each Region to:
   a) complete MCP² analysis with a view to assess and coordinate existing maternal newborn services for all communities within the region (including First Nations, Inuit and Métis). (Short Term)
   b) utilize the MCP² toolkit to develop a regional maternal newborn service strategy. (Short Term)
9. Explore the potential to increase education spaces, maximize scopes of practice and support collaborative practice as appropriate for maternal and child healthcare providers (i.e. midwives, physicians, nurses and nurse practitioners). *(Intermediate Term)*

10. Explore the potential to provide support for the development and maintenance of maternal/newborn skills and knowledge for providers of prenatal, perinatal and postpartum services. *(Intermediate Term)*

**Direct Services to Women and Children**

11. Ensure that expectant women who relocate from First Nations, Inuit and Métis communities and rural/remote communities for extended periods of times to give birth have access to a coordinated system of prenatal and social support as follows:

   a) Create a coordinated referral process between Federal and Provincial (RHAs) jurisdictions that includes consultation with First Nations, Inuit and Métis, a two-way communication between RHAs at all critical points of service provision from when women leave the community and return home to ensure a quality, seamless delivery of healthcare services and supports. *(Intermediate Term)*

   b) Establish a program-level working group (government departments, service delivery staff and key stakeholders) to engage the community-owned boarding homes to create and formalize policies, provide a supportive environment, identify resources that will address the well-being of prenatal women including safety, nutrition, breastfeeding, physical and emotional needs. *(Intermediate Term)*

   c) Provide training for peer support workers to provide pre and post-natal social support as well as labour support for delivery in a culturally appropriate manner including services in First Nations, Inuit and Métis languages. *(Short Term)*

12. Develop human resource capacity within regions that provide support to women who have temporarily relocated to access birth services outside their home communities, including Public Health Nurse positions (and support) in Winnipeg to act as contacts and service coordinators. *(Short Term)*

13. Develop resources to inform women of the services available to them (i.e. Healthy Baby Program, transportation costs to attend programming, room rental for gatherings, payment for other services such as Elder support, speaker honorarium, healthy food provision, etc) and support them to access these services (i.e. card with contact numbers). *(Short Term)*

**Supporting and Promoting Promising (Best) Practice**

*Vitamin D*

14. Administer a one-time dose of 100,000 international units of vitamin D orally in midtrimester to approximately 100 pregnant mothers (followed at HSC) and:
   - measure the cord hydroxy levels in the babies at birth
   - encourage daily vitamin D supplements to the infants post discharge after delivery
   - begin a source of supplementary vitamin D (i.e. *Sprinkles Global Initiative*) once complementary foods are introduced to infants. *(Intermediate Term)*
15. At one year of age, complete dental examinations for evidence of dental caries, complete physical examinations and measure 25 hydroxy vitamin D levels. *(Intermediate Term)*

**Education Tools**

16. Explore the potential for using similar tools (passports) to those discussed to promote Healthy Pregnancy and Child Health developed in collaboration with public healthcare providers and Regional Health Authorities including a coordinated campaign with those activities already in place or under development. *(Intermediate Term)*

17. Explore the potential for purchase and distribution of “Toddler’s First Steps” and assess its suitability for use in First Nations, Inuit and Métis communities. *(Intermediate Term)*

**Sexual Health and Human Papillomavirus (HPV)**

18. Direct Manitoba Health and Healthy Living to:
   a) explore the potential to expand the HPV program to include “at risk” females who do not attend public school; *(Short Term)*
   b) provide a need assessment; and *(Short Term)*
   c) build public health nursing capacity (adequate number and mix of the public health nursing workforce, education and training and IT support) to address a comprehensive sexual health strategy that includes HPV vaccination. *(Intermediate Term)*

**Immunization**

19. Direct Manitoba Health and Healthy Living to work with RHAs to identify strategies to increase immunization rates. *(Short Term)*

**Models of Interest**

20. Explore the potential to implement one or both of the primary health care models discussed within appropriate regions to address service gaps and provide services closer to home. *(Short Term)*