

The Experiences and Education of Midwives in Three Canadian Provinces: Saskatchewan, Ontario and Nova Scotia

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To my parents, Priscilla and Dickson

and my siblings:

Daniel, Carey

Kenzie, Asefaw

Brendan, Lisa

and Elizabeth

ABSTRACT

The issue of midwifery services over the past thirty years has become a prominent question to many feminists working in the field of women's health care. As Ontario, British Columbia, Alberta, Manitoba and Québec have legalized midwifery in the last decade; the number of women accessing midwifery services has increased. With the increased need for midwives in Canada, we must ask where they are getting their training. Midwifery education has been slower to develop in the country than legislation. In Canada, there are currently only four universities offering a bachelor's degree in midwifery, with a fifth one starting this fall. Three are located in Ontario, one in Québec and one in British Columbia. With limited access to midwifery education, how are new midwives being trained? How were previous midwives trained?

This thesis explores the variety of educational routes pursued by practicing midwives in three Canadian provinces—Nova Scotia, Ontario and Saskatchewan. Based on qualitative analysis of midwives' narratives in these three provinces, it considers the educational routes that were undertaken by seven midwives and the educational routes that are recommended by them today.

To become a midwife in Canada is a long process. The perseverance that it takes to find an appropriate educational route, to follow it and begin working as a midwife in Canada has changed very little over the past thirty years. In my analysis of the midwives I interviewed for this thesis, it was apparent to me that it took all the midwives a long time to discover an educational route that was accessible to them, whether it was in the 1970s, the 1980s or 1990s. Today, all of the midwives I interviewed recommend a baccalaureate degree in midwifery, even if they prefer an apprenticeship style of learning. The status that a bachelor degree offers and the acceptance by the medical community and by the general population are reasons for this.

Despite the fact that a bachelor degree brings status, it does not make it an accessible route for educating aspiring midwives. With a decrease in accessibility, the diversity within the program suffers. Rural women, women with low or no incomes and women from diverse cultures may be restricted from applying because of financial, geographical or cultural constraints. The apprenticeship route in Canada is still the most accessible course for aspiring midwives, however, in the long term; it may be the most constraining. The necessary standard of education in the future will be a bachelor degree.

We must be cautious in implementing a minimum of a bachelor degree for midwifery education. We must address the issues of diversity within the program for midwifery education in Canada to be successful. The university programs that are currently in place are a good starting point but there is still much work to be done to make midwifery education accessible to all that desire it across Canada.

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CHAPTER ONE

Introduction

All over the world, midwives play a role in pregnancy and birth in different capacities. In Canada, it is The World Health Organization's definition of a midwife that is most commonly used.

... a person who[m] having been regularly admitted to a midwifery education program, duly recognized in a country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for patients, but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and childcare. She may practise in hospitals, clinics, health units, domiciliary conditions, or in any other service (Daniels 1997, 69).

The issues of scope of practise, education and legislation frame this internationally recognized definition of a midwife. In Canada, midwifery is regulated provincially. Canadian provinces are in various stages of implementing the services of midwives. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec, have legalized midwifery. In British Columbia, midwifery has been recognized as a self-regulating profession since 1998 (Rice 1997). Alberta previously offered an extended nursing degree with specific training in obstetrics care, which it defined as midwifery training. This training was reserved for nurses who planned to work in northern communities without a practising physician and is no longer available (MacLellan 1997; Rooks 1997). In Saskatchewan, midwifery is in the process of being legalized, the provincial government has to proclaim the Midwifery Act and regulations have been drafted (Friends of the Midwives 2001). Manitoba has legislated midwifery and their standards of care follow the North American Registry of Midwives (NARM)¹ requirements. In Ontario, midwives have practised as an autonomous profession since January 1, 1994 (Sharpe 1997). Québec completed a pilot project in 1999 to introduce midwives into the provincial health care system and is currently implementing midwifery services (Friends of the Midwives 2001).

Presently, midwifery consumers² and consumer groups in Nunavut, the Northwest Territories, the Yukon, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador are lobbying provincial governments for legalization and legislation of midwifery. For example, in Nova Scotia a coalition of midwifery consumers has consistently lobbied provincial governments for at least fifteen years to recognize

¹NARM is a certification group based in the United States (Rooks 1997).

²I am uncomfortable with the word 'consumer' when referring to midwifery services. Women do not 'consume' midwifery services; rather they seek aid from another individual who is knowledgeable in normal pregnancy and childbirth. However, the word 'consumer' is recognized and used within midwifery circles, therefore I will continue to use accepted terminology.

midwifery, through legislation, as an autonomous profession (Midwifery Now! 2000). The Newfoundland and Labrador Midwives Association promotes the legalization and legislation of midwifery services as well as the right to midwifery care (Newfoundland and Labrador Midwives Association 2000).

While there appears to be some progress in terms of lobbying and legislation, the process for established programs for midwifery education has been slower. Only two provinces, Québec³ and Ontario⁴, have established direct-entry (meaning without concurrent training in nursing) midwifery education programs. In Ontario, direct-entry midwifery education requires completion of an undergraduate degree at one of three accredited universities. The Interdisciplinary Working Group on Midwifery Education in Nova Scotia has similarly recommended that a university degree program be established in that province (1999). The Saskatchewan Midwifery Implementation Working Group (2000) has in contrast recommended that midwives receive practical, non-degree, training outside the province that would in turn be recognized by the province of Saskatchewan.

All these options may present limitations for some people interested in being midwives. For example, a midwife who is required to obtain a university degree before they can practise, or continue to practise midwifery, may face financial and time constraints. Many aspiring midwives have prior pressing commitments, such as family and paid and/or unpaid work responsibilities. Opportunity to travel to universities offering a midwifery education program may be limited.

Another potential difficulty is that practising midwives who obtain the requisite university education may be required upon completion to work in a hospital under obstetricians and gynecologists, locations where they have not traditionally practised, and they may miss out on opportunities for home births. This is because universities may put more emphasis on institutional learning rather than practical learning. On the other hand, midwives who complete their training outside of universities may face difficulties in terms of credibility because education obtained outside of formal institutions tends to be undervalued. The general perception of practical education as inferior to formalized education in a university setting can be problematic. Chester (1997) has argued that apprenticeship training is not only necessary to midwifery, but that it may be more desirable to midwifery practise than a university education. Overall, the practise of midwifery may suffer if the areas of knowledge, expertise and /or skills are discredited. However, this does not negate in any way the value of formal education.

In the absence of legislation to practise freely and competently, without acclaimed educational routes and recognition of the unique scope of practise of midwifery, there is likely to be resistance to the profession. Without legalization, midwives are in danger of being prosecuted for practising medicine without a license (Burtch 1994). The profession may also face resistance from physicians who regard midwifery as unsafe (Jezioranski 1987), or from those who regard midwives as competitors in the context of fees-for-service based medicine (LeBourdais 1988). Provincial governments and professional bodies, such as the

³Québec's program is based in Trois Rivières, at the Université de Québec. It accepted its first cohort of students in September 1999.

⁴The three institutions are: Laurentian University in Sudbury, which offers a full time program in French and English; McMaster University in Hamilton, which offers a full time program in English, and Ryerson University in Toronto, which offers a program of part-time study in English. The degree obtained is a Bachelor of Health Sciences in Midwifery.

Canadian Medical Association and the College of Physicians and Surgeons may receive conflicting, and perhaps incomplete, information about the profession.

The differing messages that the medical community receives about midwives and their training, combined with the difficulties in finding suitable educational routes for midwives creates a difficult environment for aspiring midwives. My interest in the education and practise of midwives stems from my own struggles regarding appropriate education and training in midwifery. I am situated as an “interested researcher” (MacDonald & Bourgeault 2000) (albeit a neophyte researcher) in midwifery, yet I am an “interested researcher” that is on the outside of communities of midwifery practise. This is an important distinction to make because my situation will affect midwives’ perceptions of my research and of me. I am not aware of any scholarship that considers the range of midwifery education routes pursued by midwives practising in Canada, or that considers the various educational routes that are being considered in the face of provincial legislation (Tritten & Southern 1998)⁵. This thesis examines these issues. It explores the variety of educational routes pursued by practising midwives in three Canadian provinces – Nova Scotia, Ontario and Saskatchewan. Based on qualitative analysis of midwives’ narratives in these three provinces, it considers the educational routes that were undertaken by seven midwives and the educational routes that are recommended by them today.

My thesis will contribute by serving as a possible resource for women interested in pursuing midwifery as a profession, and women who are interested in learning more about the experiences and practises of those who have pursued various educational routes. It may also guide lobbying efforts in provinces that have not yet enacted legislation and /or established midwifery education programs.

In the interviews, I explored the way in which midwives have pursued their training to learn the necessary skills and how they envision midwifery education in Canada. I have also explored the legislation in Saskatchewan, Ontario and Nova Scotia through government documents and midwifery consumer groups and associations.

There has been little research done with first hand accounts of midwives in Canada and I hope that my work allowed the voices of these seven midwives to come through. As Smith (1981) believes

Taking the standpoint of women locates the beginning of inquiry outside the conceptual framework and relevances established in sociological discourse. Women’s position in general in the form of society has been and continues still to be outside the social locations where its thinking, knowledge, and principles of judgment are made, and outside the abstracted conceptual mode of its ruling (12).

Although I recognize that I will not directly be countering critiques in the literature that midwives’ stories are being told by others, including “interested researchers” (MacDonald & Bourgeault 2000) and because I am interpreting the ‘voices’ of these seven midwives, I realize it is not their direct interpretation (Baker 1998). Nonetheless, in using their words in my analysis I believe that I have conveyed their knowledge and information with as much accuracy as possible. “Taking the standpoint of women means recognizing that as inquiries we are also located in ways in which bring us into determinate relations with those whose experience we intend to express” (Smith 1981, 7).

⁵Tritten and Southern (1999) have edited a collection *Paths To Becoming A Midwife: Getting an Education*, which specifically deals with the issue of midwifery education. While their preface claims to consider Canada, articles included do not.

CHAPTER TWO

Methodology and Research Design

This thesis explores the educational background of practising midwives⁶ in three Canadian provinces: Saskatchewan, Ontario, and Nova Scotia. I discovered that accessing an educational route has been difficult for the practising midwives in varying degrees. I found that all of the midwives recommend a university degree in midwifery based on the current trend and future educational possibilities. I interviewed two midwives in Saskatchewan and Nova Scotia and three midwives in Ontario. I chose to conduct open-ended interviews with the seven practising midwives. Given that there are differences in provincial legislation, I interviewed midwives whose education and training were received through a variety of educational routes, from local to international apprenticeship, to university accreditation, as currently exists in Ontario.

My theoretical orientation is based on Smith's belief in using women's direct experiences in research, we are using our own language, not that of our "fathertongue"⁷ (1990).

the practices of thinking and writing that are of special concern here are those that convert what people experience directly in their everyday/everynight world into forms of knowledge in which people as subjects disappear and in which their perspectives on their own experiences are transposed and subdued by the magisterial forms of objectifying discourse (...) what we make here is an object of investigation is what we ourselves are immersed in. The ideological practices explicated here are our own. Explicating such practices enables us to become more aware of how, in deploying them, we participate in the relations of ruling. Feminism, a commitment to women, does not alone protect us from being implicated in the relations of ruling, the language of which is the "fathertongue" (Smith 1990, 4-5).

Setting

I chose to study midwives in Saskatchewan, Ontario, and Nova Scotia because I have access to midwives in all three provinces. I have lived in all three provinces and I am familiar with them and involved in the midwifery community in various capacities.⁸ Second, each province is at a different stage in legislating midwifery and this affects the types of education available for midwifery training. The accessibility of the educational route is important because it is unclear to women in Saskatchewan and Nova Scotia what the government will require for midwifery training once legislation has passed. In Ontario, women are aware of the requirements that have been established; however, the accessibility to midwifery education remains limited.

The experiences of the midwives that I interviewed varied in response to their education and their locations of practise. My intention was to listen to the narratives of

⁶Practising midwives' in Canada includes midwives who are working as primary and secondary midwives and working overseas.

⁷Smith (1990) defines "fathertongue" as the mode of participation in the relations of ruling; I understand our use of language and conceptual practices of the fathertongue as entering us into those relations as agents or objects" (4).

⁸I am a past member of Friends of the Midwives in Regina, Saskatchewan; in Ontario I attended a community discussion group about midwifery in Ottawa for two years and in Nova Scotia I am a student representative with the Midwifery Coalition of Nova Scotia.

the midwives and to record, analyze and draw conclusions about the accessibility of an educational route and their vision of midwifery education in the future. To examine this data, I transcribed my interviews and manually coded them thematically over a three-month period. I identified many common themes among the participant's transcripts.

I conducted the interviews in person and over the phone. I utilized these methods for two reasons; my schedule in accordance with the midwives schedule and financial constraints. This style of research methodology allowed me access to first hand accounts of the ways in which midwives have become educated and how they would like midwifery education to proceed in Canada.

The interview schedule was open-ended. It pertained to the educational route they chose to become a midwife; their practise today and their views on midwifery education today and in the future. As the interview came to a close, I confirmed with the participants that we covered everything we both wanted discussed. I also confirmed with the midwives that they are comfortable about what they have told me (Kirby & McKenna 1989). In the process of interviewing, I was respectful of the time constraints the midwives face, and I was aware that a lengthy interview could be an intrusion on their time. I was conscious that midwives have a busy schedule and without regular work hours. I was cutting into their income for the midwives in Saskatchewan and Nova Scotia because they work on a fee for service basis. There were occasional interruptions during the interview, but none of the participants felt the need to end the interview. The interviews varied from forty to eighty minutes in duration.

Method of Attaining Participants

In selecting midwives I interviewed in each province, I contacted various midwifery organizations and associations in Saskatchewan, Ontario, and Nova Scotia. In Saskatchewan, I contacted the Friends of the Midwives in Regina and Saskatoon, the Midwives Association of Saskatchewan and the Saskatchewan Midwifery Implementation Working Group. The Friends of the Midwives is a group of women that have been lobbying the Saskatchewan government to legalize and promote midwifery services and educate the community about midwives; they also have direct access to practising midwives. The Midwives Association of Saskatchewan is an association comprised of the practising midwives in the province. The Saskatchewan Midwifery Implementation Working Group is currently writing up the guidelines and regulations for midwifery services in Saskatchewan. Through these different groups, I contacted the midwives that were willing to participate in my research.

In Ontario, I contacted the Ontario Association of Midwives (OAM) and the College of Midwives of Ontario (CMO). The OAM holds a current list of all practising midwives across the province. From the list of midwifery practises I received, I contacted each one by email and telephone. I asked for volunteers to interview for my research. I received a positive response from three different midwifery practises in Ontario.

In Nova Scotia, I contacted The Midwifery Coalition of Nova Scotia (MCNS) and The Association of Nova Scotia Midwives (ANSM). The MCNS is a community based advocacy group, which has been lobbying the Nova Scotia government to legalize midwifery, and the ANSM is a group of midwives working in Nova Scotia. These two groups work closely with one another. Through them, I found two midwives that were agreeable to participating.

Participants

The midwives I interviewed in Saskatchewan, Ontario and Nova Scotia are well educated. Each has a minimum of a Bachelor's degree and five of the seven hold a second degree, all in diverse fields. All of the participants became interested in midwifery by being exposed to it through different means. For some, it was through their pregnancies, for others it was through their friend's pregnancies and for one midwife it was being exposed to the practise of midwives in Vermont while working on her second degree. Despite the fact that all the midwives came into the profession through different avenues, they all talked about feeling pulled towards it once they learned about midwifery; although many expressed a previous interest in babies and mothers. Once they were exposed to midwifery they all had an 'aha' moment – they knew that they were going to pursue a profession in midwifery.

Meghan: *I found out at first about midwives in Ontario and I was looking for alternatives when I was pregnant and contacted a midwife and had a home birth with my first; this is prior to legislation. And then I had my two other kids with a midwife after that, with home births. After the first delivery, I realized that I strongly felt that midwifery was exactly what I had been looking for all along.*

Laura: *Midwifery somehow "chose" me, that it was somehow "choiceless" and out of my hands.*

Anne: *When I was pregnant, when I was in another country, I helped with the delivery of a couple of babies and I helped and saw what it looked like. So, that's when I got the idea that was what I would do.*

The midwives I interviewed are all middle class with university degrees. They are all currently, or previously have been, married; they all have children and supportive families. They have all experienced their own trials and tribulations in their profession and their training, despite belonging to a prevailing population.

I attempted to interview midwives with various backgrounds, however, it was difficult to go beyond the dominant groups that currently exist in Canada. Many of the groups that exist are comprised mainly of white middle class women and without a resource person in various communities; it was difficult to reach beyond the known groups. Nestel (2000) explores the issue of race and the lack of diversity in the Ontario midwifery education model. She believes the main reason for the lack of diversity can be attributed to "how racist exclusion operated to construct the Ontario midwifery movement and the bureaucratic structures which superceded it, as normatively white spaces" (Nestel 2000, iii). She goes on to argue that because of an inherently racist system through hierarchy and the construction of the midwifery profession as a 'white' space, the education of midwives in other countries, and the exclusions of women of colour is inevitable. Nestel (2000) was able to ensure the confidentiality of her interview participants in various communities because she is a known researcher and teacher within the birthing community which allowed her access to these diverse communities.⁹ Despite this, Nestel (2001, personal communication) described the reluctance of her participants because it is a small community without absolute anonymity.

Two issues that are reflected within my interviews, which contribute to the lack of diversity in midwifery in Saskatchewan, Ontario and Nova Scotia, are economic constraints and the legalization of midwifery. Without proper financial assistance, it is very difficult for

⁹ For more details please see Sheryl Nestel's PhD dissertation *Obstructed Labour: Race and Gender in the Reemergence of Midwifery* (2000), University of Toronto, about diversity within the midwifery community in Ontario.

people to get training as a midwife and without provincial remuneration many cannot live off their income from midwifery. Secondly, only five of the ten provinces and none of the three territories have legislated midwifery,¹⁰ immigrant women and women who are not willing to take a legal risk in the absence of legislation may not practise midwifery for these reasons.

There are so few practising midwives in Nova Scotia and Saskatchewan it was difficult to find midwives from various communities. Although Saskatchewan has a recognized College of Midwives, there is no enforcement to register with them to practise midwifery in the province. Nova Scotia does not have a recognized College of Midwives; however, the midwives in the province do register with the Association of Nova Scotia Midwives. With no requirements for midwives to register with a central body, the search for midwives out of a few known circles, is difficult. Within Ontario, there is a requirement for midwives to register with the College. However, there is a clause that allows First Nations midwives to choose whether or not they would like to register with the College of Midwives of Ontario. Therefore, without a resource person, it was difficult to find a midwife to talk with outside of the College of Midwives of Ontario and this limited the diversity of the midwifery participants in this research.

While I was unable to interview midwives with varying cultural and ethnic backgrounds, I attained my goal in interviewing midwives in each province with diverse educational backgrounds, geographic locations, and the length of time each midwife had been practising. I interviewed only practising midwives because my focus is the experiences that midwives are currently faced with in terms of legislation and their viewpoints about midwifery education today and in the future.

Data Analysis

All of the interview participants were provided a consent form to sign, which was given to them at the interview, mailed or faxed to them prior to the interview. The interviews were taped using an audiocassette, with one exception. For one interview, I took notes as there was a problem with the recording equipment. There were no names recorded or included on the cassette or the transcripts. I have used pseudonyms for confidentiality. I also took interview notes throughout the interview. I transcribed in full each interview in order to conduct my analysis of the interviews. Once the transcript of the interviews was complete I offered the participating midwives a copy of their interview transcript to verify, change or delete any information they did not want me to use.

In analyzing the interviews, I identified major themes in the narratives of the midwives. I paid particular attention to the education process and their vision of midwifery education today and in the future. Initially, I set out to see how midwives practises were affected by their educational route, however while doing thematic coding, I discovered that the future training of midwives in Canada was a more important issue to the midwives; therefore I decided to change the focus. I found that midwives who were educated through university and in the traditional apprenticeship route recommended a university based education program with a strong clinical component. I had expected to find more midwives

¹⁰British Columbia, Alberta, Manitoba, Ontario and Québec have legalized midwifery. Saskatchewan has legislated midwifery, but has not proclaimed the Midwifery Act. New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon, North West Territories and Nunavut have not legalized midwifery.

who would like to preserve the apprenticeship model. Although each participant valued the apprenticeship route, they believe to achieve the necessary support from the medical community and to follow the current trend, every province should offer a bachelor degree in midwifery.

I compared transcripts from each interview for commonalities among the women's stories; even though each woman has had unique training and experiences. I believe this is necessary because "Sometimes individual cases are combined in order to examine the relation between cases and particular social structures or process" (Reinharz 1992, 169).

There are large segments of the transcripts included in my thesis to allow the narration of the midwives to be 'heard' first hand. Although the portions included in this paper are my interpretation, I believe by using their own words I have minimized the potential of misrepresentation; I hope I achieved this end. There is little research about midwives that uses their voices directly in the final work. First hand accounts of midwives' experiences are important for the community, for those lobbying to have increased access to midwifery, and for future researchers.

Ethical Considerations

I obtained approval for the interview process from the Research Ethics Committee, Mount Saint Vincent University. Upon approval, I contacted the groups that I have indicated in Saskatchewan, Ontario and Nova Scotia, to set up interviews. Over the course of three months, I found seven midwives who were interested in participating in my research and I conducted the interviews.

At the beginning of my interviews, I informed the participants about the focus of my research. I outlined the reasons why I am conducting this research, how their narratives will be useful in my thesis and how I will use them in my research. I discussed with the participants how I would like the interviews to proceed; I was striving for an egalitarian setting (Kirby & McKenna 1989). This was important to me because as a researcher, I have the power to interpret and represent or misrepresent their narratives. I have included large sections of their narratives to help achieve a fair representation of their experiences and viewpoints. Furthermore, I am not a member of their profession and as MacDonald and Bourgeault (2000) argue, as an 'other', I am constructing the midwifery profession from the position of an outsider. While conducting my research I also kept in mind that feminist research begins "with the discovery of learning how to explore the social from within without allowing it to be swallowed up into the wholly subjective. That means exploring as insiders the socially organized practises that constitute objectified forms as knowledge" (Smith 1990, 12). I was very aware of being an outsider from the midwifery community, but very much an insider in that I am an aspiring midwife. While writing my thesis I hope I have achieved a fair estimation of the midwives experiences.

Confidentiality was maintained, as specified by research ethical guidelines. In Saskatchewan and Nova Scotia, this was more difficult to guarantee because of the relatively small number of practising midwives. I made a concerted attempt to guarantee anonymity to the reader through the use of pseudonyms and by changing identifying information in the narrative accounts. In all cases, the participants themselves determined whether or not I have successfully maintained confidentiality with reference to their particular cases.

In return for the participant's time, I offered all interview participants a copy of my completed thesis. This will allow them to see how their narratives have informed my analysis of the various educational routes on midwifery practise in three Canadian provinces.

CHAPTER THREE

Midwifery in Canada – Twentieth Century

Introduction

In reviewing the literature about midwifery, I will focus on the last century to demonstrate that no single factor accounted for the decline and the re-emergence of midwifery in Canada. Combined influential factors in the decline of midwifery can be found in economic, political and social issues. Biggs identifies these themes in more detail. They include:

competition between midwives and physicians (...) a decline in physicians' respect for woman's intellectual ability (which ranged from sexist to misogynist beliefs); physicians' concerns about midwives' lack of formal training (although it is clear that physicians were on weak ground until the ascendancy of the germ theory in the 1880s); the superiority of physicians' knowledge and skill particularly with the introduction of anesthesia; the failure of midwives to organize and lobby for professional status, as a result of class, linguistic and geographic barriers; the inability to recruit younger women into midwifery; and finally, women's demand for physician services which, no doubt, represented a mixture of accepting the propaganda about midwives and a desire for 'the new, modern way of birth' (2001, 23-24).

Others believe that "By the end of the nineteenth century, Canadian physicians were well on their way to controlling the process of childbirth" (Comacchio 1993, 12). Physicians were able to do this for a number of reasons. Laforce (1990) describes a situation in which midwives were legally allowed to practise but the medical community placed undue restrictions on the work midwives could do and they no longer had access to training.

Among the factors that account for its re-emergence include: active resistance by women to the medicalization of their bodies and a rise in feminist discourse about women's choices in pregnancy and childbirth (Davis-Floyd 1992; Starr 1991; Arney 1982). Many feminists believe, and continue to believe, that childbirth is a form of unpaid labour that must be recognized. "The feminist perspective also recognizes that childbearing and all forms of unpaid domestic work are central to capitalist production because the household does not simply consume, but also produces and reproduces labour power" (Comacchio 1993, 8).

There is no statistical evidence of the number of midwives working at the beginning of the twentieth century, their decline in numbers over the course of time and in their re-emergence after the 1970s. However, with the insurmountable conditions placed upon midwives, as described by Laforce (1990), the institutional barriers, the politics involved with the medical community and the gradual decline of homebirths, we can assume that the numbers of midwives across Canada did diminish. However, with the second wave of feminism in full force in the 1970s, we see women taking control over their bodies and giving power back to other women, and themselves, in their childbearing years. Midwifery services was an avenue that many women pursued in the 1970s to fulfill these desires. This is evident with the proliferation of books written for women and their health care over the past thirty years.

Much of the history of midwifery in Canada is in English and based primarily on the British settlers history. First hand accounts of midwifery from various cultural groups are

difficult to find. When they are found, it is often “only available to bilingual researchers” (Biggs 2001, 22). This renders my research difficult because I am unable to recount the history of midwifery across Canada without access to information from various cultures. Biggs notes “To date, no systematic study of midwives living in racialized, ethnic and /or religious communities in Canada has been conducted” (2001, 22). Whenever possible, I will include as many different cultural groups as possible in recounting midwifery history in Canada.

For convenience, I have divided the historical literature critique into three historical periods: the early twentieth century to the Second World War; the post second world war period to the late 1960s and the re-emergence of midwifery services since the 1970s to the present. I have chosen these specific time periods because there is a significant shift in reproductive care, whether it is people’s attitudes or medical advances for women’s reproductive care, during each of these eras.

Early Twentieth Century

In the early twentieth century, midwifery was a profession with many faces. For the First Nations people on the Pacific Coast, before contact with Anglo-Europeans, midwives were held in high regard among their people and birth was part of the natural cycle of life. The midwife was trained through a long apprenticeship and was knowledgeable about birth, as well as cultural traditions associated with birth. Midwifery was not a female profession, moreover, both men and women could become midwives (Biggs 2001).

In Northern Manitoba, once again before contact with Anglo-Europeans, the Inuit also had an incredible amount of knowledge about birthing. They were known for “the safety of birth in the pre-contact period, the competency of midwives which was linked to the possession of knowledge, and the control that birthing women exercised in labour” (Biggs 2001, 16). It is shown in other cultural specific areas across Canada, such as among the Icelandic population in Saskatchewan, that midwives in these communities had a vast amount of knowledge about birthing and were highly trained individuals. One famous Icelandic midwife, Gudron Goodman, was known to have been trained in an institution in Iceland (Biggs 2001). First Nations, Inuit peoples and Icelandic midwives as well as those affiliated with other cultural groups across Canada, all underwent their midwifery training in different forms. However, what each one of them has in common is the respect that they received from their community with regard to their skills as midwives.

Much of this changed when many of these communities came into contact with Anglo-Europeans. Numerous settlers in the prairies, for example, were young and were away from their families and support networks. When a woman was pregnant, she no longer had her mother, sisters, friends and neighbours around her. Midwifery was not sustained in settings such as these. “They did not come to Ontario...or the prairies with a “a community fund of birth knowledge”; nor did they have ready access to trained birth attendants of any kind” (Biggs 2001, 19). As Canada became more industrialized and modernized, midwives were often pushed to the margins in their communities.

In much of Canada, as British settlers arrived, midwifery within these communities was fading because there was a lack of trained midwives coming across to Canada, therefore the pool of knowledge was not being passed on. As the lack of Anglophone women with experience in midwifery grew, there were fewer opportunities to train new midwives

in English through an apprenticeship model. Around the same time, the importance of formalized education was becoming prevalent and midwives did not have access to this style of education (Biggs 2001).

“Pendant des siècles, les femmes ont été des médecins autodidactes et sans diplômes, n’ayant pas accès aux livres et aux cours, elles firent elles-mêmes leur propre enseignement, se transmettant leur expérience. Le peuple les appelait «femmes sages» alors que les autorités les traitaient de sorcières et de charlatans. Les sages-femmes, elles, ont été éliminées vers 1910” (For centuries, women were self-taught and had no diplomas, they did not have access to books or courses; they looked after their own education, by apprenticing others through their own experiences. Everyone called them “wise-women”, while the authorities treated them as witches and quacks. The wise-women, or midwives, were eliminated around 1910.) (My Translation) (Kaley 1987, 19).

It is noted time and again that the education of midwives was a central issue at the turn of the twentieth century, but the midwifery community was continuously blocked from setting up a formal program. “Women’s organizations (...) did attempt again and again to lobby for trained midwives” (Comacchio 1993, 78). Yet, “In the end, no attempt was made to train and license midwives” (Comacchio 1993, 80).

Women were not admitted to universities, especially into medicine. Almost all of the midwives practising at the time were women; therefore it was easy to denounce midwifery. In Canada, midwives did not have a formal education system like physicians and they had no formal association, such as the College of Physicians and Surgeons. Midwives had a difficult time in forming an association or support network because midwives in Canada were living in isolated communities, and quite often in different and separate cultural communities. With language, culture and distance between midwives, it was difficult to rally together to fight for the work that they did (Biggs 2001).

As the field of allopathic medical field grew, in part because of the education offered in institutions, many women became more isolated. Until the early twentieth century, women were not allowed to enter into the field of medicine, as they were deemed to be too delicate to learn about the human body (Davis-Floyd 1992). Arney (1982) argues that obstetricians who wanted to dominate the area of pregnancy and childbirth elevated, through the development of a specialized field of knowledge, the prestige given to the allopathic medical model. The allopathic medicine model has only been revered for about 150 years. Before that, many people did not value the work of physicians as little was known about asepsis techniques. In most instances, physicians caused harm to the person through the spreading of infection (Biggs 2001). In many circumstances, especially in the case of women in labour, the outcome was often detrimental to the woman, the baby, or both. The maternal and infant death rates were comparatively high in the nineteenth and early twentieth century among doctors. Nonetheless, by the beginning of the twentieth century, we can see a shift in people’s perception of the medical field (Biggs 2001). Education in a formalized setting became increasingly important in how a profession, such as medicine, was viewed by the general public.

By promoting physicians as the best, or most highly educated, persons because of their method of education, midwives who were often trained through apprenticing or by their own involvement in birthing, were constructed to be dangerous by the medical field and blocked from receiving further training. “Canadian doctors were opposed to the establishment of formally trained midwives as proposed by the National Council (...)

Canadian doctors, however, were not the only opponents to formally trained midwives; the emerging nursing profession also objected" (Biggs 2001, 30). Allopathic medical models were able to do so for a number of reasons. Specialized medical practise was more revered by the general population than existing midwifery services because men, who held most of the power at the time, controlled medical services.

It was not so much a case of women's innate difference to male professionals, although this may have been a factor, as it was a contest that women simply could not win. Their political impotence made them especially vulnerable to medical dominance, even on issues such as childbirth (Comacchio 1993, 79).

Physicians in Canada also used propaganda to promote their own stature. They promoted births that were attended by midwives as having higher rates of infant and maternal deaths, especially if the births were attended at home (Burtch 1994; Starr 1991). However, the reverse is true. Births attended by physicians in hospitals had a higher mortality outcome than did midwives (Burtch 1994; Starr 1991).

In fact, giving birth in a hospital [until the post World War Two era] was not an advantage until the use of antibiotics and blood transfusions became routine (...) these methods were used most frequently to treat hospital-caused infections and doctor-induced hemorrhages (Starr 1991, 14).

Another factor that contributed to the shift away from midwifery attended births and toward physician-attended births was that allopathic medicine began promoting the hospital as the best location for childbirth. The medical profession tried to centralize their services. "As a result of this centralization of health services and knowledge, midwives and particularly the nuns, eventually lost control over their institutions" (Biggs 2001, 25). Nevertheless, it took over a quarter of a century for the majority of women to go to the hospital for birth (Pitt 1997; Starr 1991).

There are different factors involved in why it took so long for the birthing location to change. One of the most prevalent reasons for this is because of where the hospital was situated in relation to where the people lived. At the beginning of the twentieth century, there were doctors living in small rural areas where most of the population still resided, yet hospitals were generally located in larger urban centres. Therefore, many women did not go to the hospital to give birth because it was too far from their home. However, as the demographics changed over the years, as more people moved to the urban centres, the shift to giving birth in a hospital took place (Burtch 1994).

Demographics were not the only factor involved in births becoming centralized. In 1928, Dr. Helen MacMurchy came out with a report to help improve the safety of childbearing. She "spoke in favour of the centralization of all types of medical care into hospitals, stating that it was wasteful that only 16 percent of births took place in hospitals whereas those institutions were capable of accommodating 40 per cent" (Buckley 1988, 154). By the 1930s greater numbers of women seeking doctors during pregnancy and birth were being hospitalized and over the next twenty years "Hospital births were the experience of the majority of Canadian mothers by the mid-1950s" (Comacchio 1993, 237). Hospitals were perceived to be more convenient and professional (Comacchio 1993).

While many researchers believe that physicians did their best to oust the midwife from practising, Connor (1994) argues instead that physicians were largely supportive of midwives. Connor (1994) cites newspaper editorials, written by physicians and published

case histories of midwifery services to demonstrate the support that midwives had from physicians. The main concern for many doctors was that midwives were properly trained “so long as those who claimed to be skilled, were skilled” (Connor 1994, 115).

In instances where a physician exposed a midwife as being unskilled, it was generally one doctor targeting one particular midwife. Connor (1994) also argues that a lack of university or specialized education for midwives worked to disadvantage midwifery practises relative to obstetrics. Not being able to attend higher education to learn midwifery skills, midwives were not able to use the language of the medical community, nor did they have access to advances made in medicine.

Not only were there no recognized midwifery schools, women were not permitted to enroll in the medical schools that were being established. Since there were few opportunities available to midwives to obtain new knowledge, the quality of midwifery practice gradually fell behind that of the medical men of that time (Roberts 1995, 124).

The professionalization of medicine was able to flourish in part because of the education of physicians and nurses. At the beginning of the twentieth century, institutions were established to train physicians and nurses and apprenticeship was no longer viewed as an acceptable route of learning unless it was conducted in an institution, such as a hospital. Buckley (1979) attributes the loss of midwifery services in part to the fact that midwives were blocked from receiving training that was valued in Canada. Resistance by the medical community made it difficult for all midwives to practise, even when the need for midwifery services was apparent.

As drugs and technology became increasingly available, the prestige of the obstetrical doctor grew. There are many explanations for this. At the turn of the twentieth century, many of the women who gave birth in hospitals were poor and/or single women. At the time, urban centres, where the hospitals and many of the physicians were located, often had a large population of people with no or little income, especially women. Physicians charged more for home births and visits than did hospitals so they became a centre for poor women and single women to give birth. Hospitals began as charitable centres for people who required medical services and therefore had a reputation as a place the upper classes avoided (Starr 1991). As well, hospitals were not regarded as the ideal place to give birth because they were often rife with infection, disease and death. In the early twentieth century, the understanding of how disease, infection and germs were spread was not commonly known (Starr, 1991).

The predominate causes of death remained all too familiar: 72.6 per cent of maternal deaths, or 702 of 967 [in 1940] were still attributable to puerperal sepsis,¹¹ toxemia, and haemorrhage. Puerperal sepsis was again the foremost cause of maternal death in 1940 (...) Couture [Chief of the Federal Division of Maternal and Child Hygiene in 1942] was heartened by evidence that the use of sulphonamides since 1936 was gradually reducing its incidence. But he made no mention of the fact that gains in this category seemed more readily explained by increasing therapeutic efficacy than by progress in eliminating its cause. The persistence of puerperal sepsis calls into question Couture's optimistic judgments about improved obstetrical techniques and the superiority of hospital delivery, while simultaneously suggesting many mothers continued to give birth in conditions that were not conducive to good health, and with less than adequate assistance (Comacchio 1993, 215).

¹¹Puerperal sepsis is blood poisoning occurring during childbirth.

Many physicians would go from a surgery where the person had an infection to attending a birth without washing their hands and thus spreading disease and infections to an otherwise healthy woman. It was not until the 1930s with the advent of antibiotics that hospitals became 'safe' for birth (Starr, 1991).

Doctors promoted hospitals as the safest place for birth because they believed, and many still do, that the best medical care and emergency care was only an arms length away, whereas in home births with midwives, emergency care was dangerously unavailable. Starr (1991) also argues that the push for women to give birth in a hospital was to give the new doctors a chance to train and apprentice.

At the beginning of the twentieth century the medical profession was becoming more established and the need arose for more institutions of training and apprenticeship for eager young men. In response, hospitals sought to attract a higher quantity and broader range of obstetrical patients and practicing doctors encouraged women to consider having their children in the hospital. The medical profession waged a concerted campaign to convince women that hospitals were the safest place to give birth (Starr 1991, 14).

Giving birth with a male doctor also became fashionable for women of the upper classes as antibiotics were administered more commonly. They began to use the services of male physicians, convinced by their claim that they were better trained than midwives in the field of obstetrics. Women of upper socio-economic classes generally set the stage for what became fashionable to do and working class women began to aspire to have male physicians at their own birth (Starr, 1991). Working class women also believed that a physician would provide a safer and more comfortable birthing experience for them, in part because doctors were able to offer drugs so that the women would not remember or feel the pain of labour. Although doctors reported they were better trained than midwives in pregnancy and birth, the physicians were often learning from the midwives themselves about obstetrics. The difference was that doctors had access to drugs and technology and an organized professional community to support and propagate this idea (Arms 1994; Sullivan & Weitz 1988; Arney 1982). The "social trend was to consider midwives less able to help with birth" (Alberta Advisory Council on Women's Issues 1988, 6). Midwives were still active in the early twentieth century and physicians were just beginning the transition from offering midwifery style care to a medical style of care. The monopoly over childbirth was in the hands of the physicians and was focused in urban centres by the end of after the Second World War (Starr, 1991).

It is important to distinguish between urban and rural settings in the use of physicians and in the decline of midwifery services. In rural communities, physicians and midwives generally worked in partnership because the physician knew that to gain the respect of the community they needed the support of the local midwife (Connor 1994). In most cases, until a doctor moved to a community, the midwife was the only health care provider in the area and was a well-respected community leader and neighbour (Bourgeault 2000; Terry & Wind 1994; Healthsharing 1979). However, urban centers were different. Connor (1994) briefly mentions the class distinctions between rural and urban settings. Connor (1994) believes that doctors were more frequently sought out in urban settings because the urban population was generally of a higher socio-economic class and could afford the physicians' higher fees. Burtch (1994) argues that the use of midwifery services in urban and rural settings was seasonally determined. For example, during the winter, many rural families were cut off from urban centers and the locations where many physicians practised. The use

of midwifery services existed in rural areas later in the century than urban centres because of this isolation. Midwives, who tended to be a neighbour or a friend, were more readily accessible to families when a woman gave birth (Bourgeault 2000; Terry & Wind 1994; Healthsharing 1979).

Biggs (1983) offers an explanation for the decline of midwifery that is not based on the medical practitioner, but rather on the importance of the scientific paradigm under which they practised. Biggs (1983) emphasizes that at the turn of the twentieth century, science, and not the person, became more important to medicine. Thus, through scientific specialization, the medical community was able to exclude previous health care givers, especially midwives. Because of the professionalization and specialty training offered in universities to doctors and nurses, the scientific language became inaccessible to many midwives. The use of scientific language posed a barrier to midwives to allow competition with doctors in this area. The change in language and the concomitant use of drugs and other interventions marginalized the role played by midwives in Canada.

Another factor that contributed to the rise in popularity of allopathic medicine is the use of drugs associated with childbirth. Physicians began using drugs, such as twilight sleep and chloroform, which promised a more comfortable birthing experience for women. These drugs allowed physicians to use invasive measures, such as forceps to extract the fetus from the mother's body. Midwives did not use these drugs because they were excluded from the education system and they were not permitted to prescribe drugs; whereas physicians learned how to use and administer the drugs when they deemed it appropriate. At the beginning of the twentieth century, Canada was becoming more industrialized and the use of drugs and medication was a new and important discovery for doctors in their practise. Women giving birth were no exception in the exploration of these new found drugs (Arms 1994).

The nursing profession also played a role in the professionalization of medicine. McPherson (1996) writes that as the nursing occupation grew in status through professionalization, fewer midwives practised because nurses regarded midwives as competitors in the area of pregnancy and birth care. "Nurses sought to disassociate themselves from the unscientific, uneducated, and traditionalists role represented by midwifery" (Comacchio 1993, 78). The General Superintendent for the Victorian Order of Nurses (VON), who attempted to bring midwives from England to Canada to help reduce maternal mortality rates in the early part of the twentieth century, did not receive a favourable response. "Her efforts at improving women's health services were undermined by opposition from the medical and nursing professions, which refused to sanction any scheme that promised further competition in the medical marketplace" (McPherson 1996, 60).

Buckley (1979), like McPherson (1996), concludes that nurses generally supported any form of improving health care, as long as it did not interfere with their own professional interests. Buckley argues that nurses "much applauded dedication to service ended when their own professional needs were more important" (1979, 11). Laforce (1985) and The Alberta Advisory Council on Women's Issues (1988) concur with McPherson (1996) and Buckley's (1979) view that the nursing profession did not support midwifery services.¹²

¹²It should be noted that many nurses who immigrated to Canada were themselves midwives who were forced to practice in hospital settings if they were to continue to practice in maternal/child arenas.

Although many foreign trained nurses also had training in midwifery, they generally did not support an independent midwifery practise. Many nurse-midwives were forced to practise in hospital settings because midwifery practise was often illegal in most parts of Canada. For foreign trained midwives, independent practise was too risky. As well, hospitals gave a sense of security to many nurse-midwives by ensuring professional status, regular pay and unions (McPherson 1996).

In the early part of the twentieth century, midwives were being phased out in large part because of the economic gain that physicians could obtain by taking over pregnancy and birth in their practise. The fact that physicians were able to charge more for their services is rarely explored in detail. Rooks (1997), Burtch (1994), Connor (1994), Starr (1991) and Biggs (1983) all state that physicians stood to gain financially, yet they do not explain why. It can be assumed that it is because most doctors were men and because physicians used more physical interventions, such as forceps, and drugs in their care of pregnant women, which drove up the cost of their service.

Physicians used pregnancy and birth as one route to secure the continued support of families and to secure their own financial security. In the rural areas, the population was sparse and scattered and there was not a heavy reliance on doctors. By bringing childbirth and pregnancy into a practise, a doctor was able to gain the trust of the family, keep their services and gain financially from this 'exchange' (Tyson, Nixon, Vandersloot & Hughes, 1995; The Alberta Advisory Council on Women's Issues, 1988). Midwives who were not challenged by physicians were generally located "where they pose no economic [gain], only in communities too poor or too far away to interest doctors in setting up practices" (Healthsharing, 1979, 11). As communities across Canada became urbanized, where physicians were centered, the shift from home births with midwives to physician-attended births in hospital became more prevalent.

Post World War Two Era

After the Second World War, the majority of births happened in hospitals with a physician in attendance. As the profession of medicine was heightened in status, and the majority of births took place in hospitals, the medicalization of women's bodies became more prevalent. Findlay and Miller define medicalization as "the process whereby an object or a condition becomes defined by society at large as an illness (either physical or psychological) and is thereby moved into the sphere of control of the medical profession" (1994, 276).

Physicians and patients alike have called birth 'pathological', not a normal state of being (Roberts, 1995). Midwives, on the other hand, viewed birth and pregnancy as a normal part of a women's reproductive life (Roberts, 1995). Dodd contends that doctors further contributed to the medicalization of women's bodies by "asserting the need for medical attendance at childbirth" (1994, 139). However, the increased use of medicine has helped lower infant mortality rates in Canada over the past century. In 1997, the infant mortality rate was 5.5 deaths per 1000 births (Statistics Canada 2002). In 1926 it was 102 deaths per 1000 births and in 1940 it was 58 deaths per 1000 births (Federal Divisions of Maternal and Child Hygiene, A Study on Maternal, Neonatal and Infant Mortality, 1942, as cited in Comacchio 1993).

The development of the medical profession was integral to the development of the medicalization of the body. With the advances made in obstetrics, such as the realization of

how to prevent puerperal sepsis, during the post World War Two era, more women began to give birth in hospitals allowing more interventions during labour to occur (Comacchio 1993). Medicalization took a variety of forms: explanatory frameworks, definitions of disease, outright opposition to midwives on the part of physicians and the advent of technological devices to assist in birth that were otherwise unavailable to midwives (Roberts, 1995; Burtch 1994).

One of the major obstacles that midwives faced from the medical field in the post World War Two Era was technological advancement. Obstetricians regularly advocated the use of drugs during labour to help women with the pain as well as the use of forceps to extract the fetus from the vagina. Many women viewed these advances in medical care as positive because they no longer needed to experience the pain associated with labour and birth while fulfilling their maternal duties. Women were exercising power over their bodies by using drugs during childbirth (Arnup 1994; Comacchio 1993). There is controversy over this issue as many view these women as early feminists because they were exercising agency over their own bodies. It is important to note that women do have free will and many do not want the experience of pain in childbirth to be viewed as positive.

While many women believed, then and now, that it is their choice to use drugs and other interventions during childbirth. It is also argued that obstetricians regarded the woman's body as an instrument during labour and delivery. Thus, new drugs and instruments were administered to the woman, even when their use may not have been warranted (Arms, 1994). While technology and drugs have had a positive impact on Canada's infant mortality rate, we must be cautious not to exploit their use. Some of the drugs and interventions that have been used in the past century include twilight sleep, chloroform, Demerol, fetal monitors, pitocin and epidurals (Arms 1994), many of which can be both harmful and beneficial; it is not a clear picture.

While many physicians believed that childbirth was a medical event that required drugs and other interventions, there were some doctors who tolerated the few midwives left practising. However, many of the doctors that worked with, or knew of, midwives working, believed that midwives practising autonomously were not a good idea. "Medical authorities were generally agreeable to registering midwives only if medical control was secured over registration" (Burtch 1994, 67). This also extended to the nursing profession. Some nurses agreed that midwives should be under medical control, that midwives should have nursing training prior to becoming a midwife, if midwives wanted to continue, or begin, practising (Kornelsen, et al, 2000; Burtch, 1994; Report of the Midwifery Services Review Committee, 1992; Alberta Advisory Council on Women's Issues, 1988; Ordre des Infirmières et Infirmiers du Québec, 1985). In sparsely populated areas, nurse-midwives were tolerated, "hospitals have been set up at strategic points, attached to each there are outpost nursing stations (...) Midwifery is a necessity in their work, and there is only one training school for this in Canada. It is in the Province of Alberta, but it does not turn out more than six midwives annually" (MacDermat 1967, 51). Yet, because midwives were not under medical control and there was no recognized route for them to obtain their skills, many midwives discontinued attending births. Midwives, because of the constraints of not having a recognized educational route that conferred a professional designation were not allowed to administer the drugs that were now commonplace during labour and delivery (Burtch 1994).

The use of drugs in response to the notion that women need not suffer, worry, or ask questions during their pregnancy and birth was illustrative of the medicalization of

women's bodies in the post World War Two Era. Many people, men and women, accepted doctors' opinions about their pregnancy and what was best for the baby and mother (Arnup 1994; Comacchio 1993). There was a proliferation of literature after the Second World War surrounding childbirth and rearing. This was in part due to the fact that following the Second World War there was a concerted effort to have middle class women leave their factory jobs and return to the domestic sphere (Starr 1991). Comacchio argues that "the medical profession articulated its views on the ideal doctor/mother and mother/child relationship and formulated an ideology of scientific motherhood" (1993, 92). Physicians were esteemed as "maternal mentors" and "child savers" in this model (Comacchio, 1993). Women were encouraged to let their physician worry about childbirth and care. Arnup (1994) and Oakley & Houd (1990) support Comacchio's (1993) claim that women were encouraged to strictly follow doctor's orders. Instead of women following their instincts, "women were told to rely upon the medical profession, who would teach them the rules of 'scientific' child rearing" (Arnup 1990, 203) and childbirth. If this was the case, we must ask ourselves if women in the post World War Two era were really practising feminism by electing medication during childbirth. Did these women choose to have interventions through medicine, or were they told they must have them? Comacchio (1993) argues that

it was not feasible to ensure slavish compliance, even if it was clearly what reformers [of childbearing] wanted. Judging by the view of the mothers themselves, it is likely that they incorporated into their childbearing practices those ideas that best suited them in terms of practicality, personality and economics. Some mothers followed the advice closely, while others discarded it entirely (12).

Few women in Second World War Era had the ability to ask for a different style of care from their physician. Many women would not have realized that it was possible to have a birth without drugs and medical intervention. The use of these drugs and interventions can be helpful in complicated births; however, most births are uncomplicated (Arms, 1994; Ordre des Infirmières et Infirmiers du Québec 1985). A majority of women wanted to take advantage of the medical advances, such as drugs for pain relief, because it allowed women to exercise their right to have pain free childbirth and pregnancy (Findlay & Miller 1994). Yet, Comacchio (1993) and Arnup (1994) cite that women were told by their physicians to have a pain free birth, not to even think of going through childbirth naturally, "what was required were medical supervision and education of women" (Comacchio 1993, 71). Therefore, within this notion of medical compliance, we must question how many women were following the doctor's orders and how many women were using the drugs of their own free will. "From the medical perspective, Canadian mothers were handicapped in their childbearing duties by an ignorance that could be remedied only through expert tutoring and supervision" (Comacchio 1993, 4).

Despite the fact that midwifery was almost extinct across much of Canada after the Second World War, midwifery did continue to flourish in one Canadian province. Benoit (1991) documents that midwifery was thriving in Newfoundland well into the 1960s. She attributes the success of the practise in this province to the fact that many physicians were unwilling to work in remote, sparsely populated areas, typical of Newfoundland during this time. The Canadian government paid the midwives in Newfoundland and established birthing centres after the Second World War. This situation for midwives in Newfoundland is unique in Canada. In no other province or territory did the federal government help to establish and maintain midwifery services (Benoit 1991).

While Newfoundland was the only area to receive support from the Canadian government to maintain midwifery services, Inuit and First Nations communities in Canada were permitted to continue their tradition of having Inuit and First Nations midwives attend births. However, they received little or no financial support from the government to do so (Terry & Wind 1994). There has been very little research done into how the Inuit and First Nations midwives were revered in their community, how they practised and how they were trained.

Little attention has been paid to the history of midwifery as practiced by Aboriginal women, it is as Benoit and Carroll (1995) observe, "a narrative untold." What little information exists suggest that the cultural meaning of 'midwife' in Aboriginal communities differs significantly from Anglo-European models (Biggs 2001, 16).

With the exception of Newfoundland and in specific, cultural communities,

throughout the 1950s and 1960s, midwives continued with little fanfare to provide services to traditional religious families especially among Orthodox Jews, Roman Catholics, and Jehovah's Witnesses, as well among Mennonites in Ontario and Hutterites in Saskatchewan (Biggs 2001, 20).

There were no formal education routes for midwives, nor were there any midwifery organizations. Any new midwives, it is assumed, trained in Canada were educated through an informal apprenticeship model in specific cultural communities.

The prevailing attitude of physicians that pregnancy, labour and birth were medical events and the medicalization of women's bodies all contributed to the decline of midwifery in Canada. This made it difficult for midwives to work and many that had been practising and wanted to continue practising saw too many hurdles to overcome. The midwives that continued to work did so under the threat of prosecution and aspiring midwives were trained by apprenticing. As they were few and far between, there were very low numbers of new midwives in Canada.

Many provinces either made midwifery illegal to practise or designed laws that made midwifery alegal¹³ during the Post World War Two era. Midwives could be prosecuted for practising medicine without a license, if something was to happen during the birth that harmed a baby or mother. It also meant that midwives were unable to help with deliveries outside of a woman's home.

[P]ractitioners were everywhere and at all levels making sure they were gaining ground. This included the surveillance and harassment of country midwives (1890-1980) as well as the control of midwives holding a diploma, be they midwives (1870-1920), midwife-nurses (1920-1980) or immigrant midwives (1920-1986) (Laforce 1990, 42).

This limited the scope of what a midwife was willing, and able to do. The only province where it was legalized was Newfoundland and the laws were not enforced in Northern communities.

The Reemergence of Midwifery: 1970s To The Present

The professionalization of medicine, the economic benefit that doctors received from attending birth and the medicalization of women's bodies and lack of training opportunities were factors in the near disappearance of midwives in Canada during the twentieth century.

¹³"alegal, adj. Outside the sphere of the law; not classifiable as being legal or illegal" (Garner 1999, 71).

Yet, in the 1970s, in part because of the second wave of feminism, the issues of medicalization and economic gain were questioning the central issues surrounding pregnancy and birth.

Midwives started to re-emerge across Canada during this period, in large part because women sought to 'reclaim their bodies'. Midwives began training themselves through their own births, by attending friends' births and by reading obstetrical texts (Bourgeault, 2000; MacLellan 1997; Burtch 1994; Van Wagner 1988; Wertz & Wertz 1977). There were no formal training programs in Canada during the 1970s. Some women chose to leave Canada for brief periods of time to obtain training in other countries. However, the vast majority of women educated as midwives in Canada in the 1970s learned on their own or through an apprenticeship.

In the 1980s, we see a re-emergence of women apprenticing with local midwives and in the 1990s, we begin to see the escalation of formal training programs gaining importance and prestige (Bailey 2002). The feminist movement also played a pivotal role in encouraging women to assume control of their own bodies and participated in the re-emergence of midwifery (Ferguson-Parker 1990; Ruzek 1978). With books, such as *Our Bodies, Ourselves* by the Boston Women's Collective, *Spiritual Midwifery* by Ina May Gaskin and *Birth Without Violence* by Frederick LeBoyer, among others, we see that the issue of women's health care and specifically pregnancy and childbirth are central to the feminist movement for many. "The resurgence was partly due to the feminist movement and the desire of a rising number of people to take charge of their own health. Women wanted to simplify and de-pathologize the birth process and to return to midwifery and home birth" (MacLellan 1997, 332-333).

The 1970s was also marked by a proliferation of writing about midwifery and childbirth. Even today, issues of motherhood, pregnancy and childbirth are at the forefront of writings with regard to women's rights (Biggs 2001; Wolf 2001; MacLellan 1997; Bourgeault 1996; Walker & Thompson, 1996; DeVries, 1996; Tyson, Nixon, Vandersloot & Hughes, 1995; Oakley & Houd 1990; Van Wagner 1988; Barrington 1985; Hughes, 1985; Healthsharing, 1979).

With the feminist movement gaining popularity in the 1970s, we see that women fighting for reproductive rights in choosing their health care provider were also fighting professions dominated politically by men. "In the medical context, predominantly female occupations such as nursing and midwifery are subordinated within the profession itself, closely regulated or even excluded outright" (Comacchio 1993, 8). Many women were fighting this ideology while lobbying for legal midwifery services.

Since the early 1970s, there has been a resurgence of interest in midwifery services. As well as a changing birth culture among certain groups of women, other issues began to surface, including the questioning of medicalization,¹⁴ professionalization, and the economics of pregnancy and birth (Tyson, Nixon, Vandersloot & Hughes 1995; DeVries 1985). During the past three decades, the effects of the decline in midwifery services on specific populations in Canada, such as First Nations and Inuit populations, has been studied more extensively (Frideres 1994; Terry & Wind 1994; Linehan 1992; O'Neill and Saillant 1987).¹⁵ Furthermore, there is a cautionary tone in the literature against seeing First

¹⁴Some of the problems of medicalization include an over-use of drugs and women not having full control over their bodies, including reproductive issues.

¹⁵The use of midwifery services in the North is subject to the availability and the desire of doctors, nurse practitioners and outpost nurses to attend births. Communities do not have a lot of power in deciding their health care provider.

Nations and Inuit peoples as homogenous populations similarly affected by the decline in the midwifery services. "Just as variation in the meaning and the role of the midwife exists among Anglo-Europeans communities, there are notable differences among Aboriginal communities" (Biggs 2001, 17). First Nations and Inuit peoples have a strong tradition of midwifery, but each nation has its own specific customs that must be recognized (Tyson, Nixon, Vandersloot & Hughes, 1995; Terry & Wind 1994). A call for further research about First Nations and Inuit midwifery by Biggs (2001); Benoit & Carroll (1995) and the Equity Committee of the Interim Regulatory Council on Midwifery (1993) are noted.

The economics of midwifery in the last thirty years is another area that has received scant attention and requires more extensive research. Issues include: how midwives will be paid, the cost of implementing midwifery services, and whether these services will help ease the financial burden of Medicare in Canada. The argument about economics is generally centered on whether or not midwifery services are less or more expensive than physician care. While some believe that midwifery services will save money for the consumer and the government (Bird 1994; Burtch 1994; Fooks and Garner 1986; Evans 1981), one group, The Interdisciplinary Working Group on Midwifery Regulation in Nova Scotia (1999) concluded that the cost-effectiveness of midwifery care versus physician care is inconclusive. In a personal correspondence with one of the committee members (July 2001) from The Interdisciplinary Working Group on Midwifery Regulation in Nova Scotia (1999), Catano states the results from this study are not complete because the long term effects of midwifery care were not taken into account. This was a short-term study only. A paucity of literature and research on cost-effectiveness in this area warrants further study.

Currently, the professionalization of midwifery services in Canada has been a prominent topic in midwifery literature in Canada. "The practice of midwifery in its historical and contemporary forms has become an increasingly popular subject of study among social scientists in recent years" (DeVries 1982, 77). There are differing opinions about the importance of the professionalization and legalization of midwifery. Some argue that the licensing of midwives may lead to a loss of autonomy vis-à-vis the medical profession and will make it more difficult to resist medical interference (Neilans 1992; Benoit 1989; DeVries 1985). In contrast, there are those who believe that legalization and professionalization are preferable routes. While Van Wagner (1988) and MacLellan (1997) are both in favour of the legalization of midwifery, they offer different reasons as support for their positions. MacLellan (1997) argues that it would put an end to legal risk and liability, whereas Van Wagner (1988) regards legalization as a step toward better training opportunities for prospective midwives.

What has emerged from all the struggles by women 'taking back their bodies' during the 1970s and the fight for legalization of midwifery in Canada during the 1980s is a clear indication that the provincial and territorial governments are slowly beginning to listen. In the 1990s, many provinces have legalized midwifery, while others are still considering it (Saskatchewan Midwifery Implementation Working Group 2000; The Interdisciplinary Working Group on Midwifery Regulation 1999; Fooks & Gardner 1986; DeVries 1985).

It has become apparent that there is considerable emphasis on the importance of self-regulation, and evidence that midwifery in Canada is developing as an autonomous profession. What this autonomous profession will look like and how it is defined will be of interest in the future to midwives, their clients, and other medical practitioners and researchers. To further explore the role of midwifery in Canada in the past thirty years, I

investigate issues in three Canadian provinces, Saskatchewan, Ontario and Nova Scotia. An analysis of the professional and educational evolution of midwifery in each one of these provinces is unique as each of these provinces has a different history in regard to the challenges that midwives faced in the past three decades.

CHAPTER FOUR

Midwifery Today in Saskatchewan, Ontario and Nova Scotia

Introduction

In Saskatchewan and Nova Scotia, the profession of midwifery is a legal and in Ontario midwifery has been legislated with an education program since January first, 1994. In this chapter, I will outline the different organizations that are working to legalize and legislate the midwifery profession in Saskatchewan and Nova Scotia. I will also look at the draft legislation and recommendations that have been made to the government by midwifery consumer groups and associations of practising midwives in these provinces. For Ontario, I will briefly outline the historical background prior to midwifery becoming legislated and the implementation of an education program for midwives. I will examine some of the issues brought about by a university-based program versus a college program both which arose around the time of implementing midwifery services into the province.

The evidence presented here is confined to a specific population – that of the white middle class. This presents limitations in my data analysis. Firstly, information relating to a global population, namely within the First Nations, Hutterite and Black communities, was unavailable. Secondly, the majority of the known practising midwives and community activists in each of the three provinces are white middle class females. This group is heavily urban based which reduces the experiences of women from remote communities or from reserves. Midwifery in diverse populations is an area that needs to be researched but this is beyond the scope of this thesis.

The Current Status of Midwifery Practice and Legislation in Saskatchewan

Provincial Consumer Groups and Associations

The Friends of the Midwives is a community-based organization that has been fighting for midwifery legislation in Saskatchewan for the past two decades. They are based in Saskatoon, but have members across the province. Their main objective is to have midwifery legislated and to promote midwifery services (Friends of the Midwives 2002).

The Friends of the Midwives was first formed in the 1980s as a small group of women active in the Saskatchewan birthing community. They came together to initiate “an association for safe alternatives in childbirth” (Henderson 1994, 14). Henderson, in her article “Friends of the Midwives: Gathering Strength” outlines the history of the group Friends of the Midwives. Its primary goal is to educate other families that may not be aware of midwifery services in the province as well as to change the birthing practices in Saskatchewan hospitals. They made presentations to the government, to other health professionals and attended conferences. In 1993, Friends of the Midwives “was given to understand that the government was not hearing from women that childbirth practices needed to change” (Henderson 1994, 15). As a result, the group began to circulate a petition and presented it to the former Saskatchewan Minister of Health, Patricia Atkinson. At this point in time the provincial government, in collaboration with Friends of the Midwives,

set up an Advisory Committee to look at implementing midwifery in Saskatchewan (Henderson 1994). It is the work of this advisory committee and the Friends of the Midwives that enacted the Government of Saskatchewan legislation for midwifery services in the province.

While the Friends of the Midwives were lobbying the government to legislate midwifery services in Saskatchewan, the midwives in the province also began their own association, the Midwives Association of Saskatchewan. Today, there are ten members with five active midwives that support each other's practises, offer back-up services when necessary and set out guidelines for practise (MacKenzie, 2001, personal communication). There is one midwife located rurally, three midwives in Saskatoon and one midwife in Regina. The midwife in Regina is currently working overseas, and one midwife in Saskatoon has just arrived and is still being supervised by her colleagues. Her apprenticeship was completed in Alberta, but it is common practise in midwifery apprenticeships for a period of supervision and assessment.

With so few midwives available to the provinces and the severe lack of midwives geographically, action needs to be taken in order to expand their services. To do so, midwives need legal, legislative and financial security and an education system. As learned through interviews with midwives in Saskatchewan and with the Friends of the Midwives (2001), one of the top issues facing midwives is financial remuneration. Currently, in Saskatchewan, clients must pay midwives privately. This limits the type of clients that will seek out midwifery care. While most will work with women who cannot pay the full fee, midwives do wish they could make a living by midwifery. Also, privately funded practises limit the women and families who can afford midwifery care in Saskatchewan. Legislation would thus allow midwives to have access to insurance, hospital privileges and recognition within the province, and consequently render the service available to the entire demographics of the province.

Midwives in Saskatchewan practise as independent health care professionals. Like in the rest of Canada, they never attend a birth alone. They always have a second attendant¹⁶ on call for back-up and support. For second attendants, they rely on women in the community who have knowledge in home births, nursing backgrounds or midwifery backgrounds, but do not want to be, or are unable to be primary midwives¹⁷ in the province. During the past fifteen years, it was common for a midwife to drive up to four hours to be the second attendant, if required. Midwifery practises in Saskatchewan are confined to women birthing at home because the current legislation does not permit them access to hospitals nor do birthing centres exist in the province.

Current Provincial Government Policies and Practises

Saskatchewan is in a precarious position with regard to having midwifery legislated. The New Democratic Party (NDP) currently holds power; however, it has gone through some dramatic changes with regard to the leadership of the party. Roy Romanow, the former

¹⁶ A second attendant is a woman who has experience in assisting at births, typically at home. They are there as a back-up to the midwife. They generally arrive later than the primary midwife during labour and look after the baby once it is born. The second attendant will meet the mother only a few times during her pregnancy. The second attendant may be another midwife or a lay person with the above stated qualifications (Maranta 1999).

¹⁷ A primary midwife is the health care provider for the woman throughout her pregnancy and the birth. She is responsible for the mother after the birth (Maranta 1999).

Premier, and the current Health Minister, John Nilson, passed legislation for the legalization of midwifery in Saskatchewan in 1999 and set up the College of Saskatchewan Midwives which will regulate the profession in the province. However, two years later, the legislation has yet to be proclaimed. This means that midwifery legislation exists only as words on paper, but the intention to legislate midwifery exists (Bailey 2002, personal communication). In the past year, Romanow has resigned and Lorne Calvert is the new NDP leader and Premier of Saskatchewan. The midwives that exist in Saskatchewan are frustrated because of the practising conditions created by the process and they are beginning to lack the interest to continue practising and lobbying. The midwifery community and its supporters are small and are beginning to burn-out.

In the past, the NDP government had made several promises to the midwives in regard to legislation and its benefits, such as financial remuneration and access to hospitals. As of July first, 2001, Saskatchewan midwives were to be remunerated by the government, in other words, covered by the provincial health plan, for the work that they do. A year later, midwives have yet to receive a salary. "We had promises that it was going to begin with paid midwifery on July first of 2001 and the Minister of Health just decided not to do it" (Anne).

An education program in the province does not appear to be a priority for the government at this point in time. It has been proposed by the provincial government and accepted by midwives that they will go to another province, such as British Columbia, Alberta, Manitoba or Ontario, and go through the process of registration and accreditation there. Upon completion, they will then be considered for registration and certification in the province of Saskatchewan by the Provincial Government. This is a time consuming and an expensive process. The province chosen by each midwife for accreditation will determine the cost and time spent at this task. One of my interview participants described the process she has gone through. For her, it has cost thousands of dollars and a move to another province for several months. Upon the proposal, the government had promised to contribute to the cost of accreditation for one of the midwives, but it unfortunately has gone back on this assertion. All five midwives in the province, with the exception of one, have completed the process and will not receive any financial remuneration to help with the extra cost of outside provincial training.

At this point in time, the Government of Saskatchewan has not taken action in proclaiming the midwifery legislation. They have not altered the Pharmaceutical Act to allow midwifery to be included, Saskatchewan Health Care is not covering the cost for midwifery services and access to hospitals has been so far denied. The midwifery legislation in the province of Saskatchewan is at a stand still.

Saskatchewan Draft Legislation

Legislating midwifery in Saskatchewan has been an ongoing struggle for over ten years. In 1994, the provincial government began "setting up an Advisory Committee to look at implementing midwifery in a wellness model of care" (Henderson 1994, 15). In October 1998, the College of Midwives of Saskatchewan submitted a document, "Competencies of Registered Midwives" to the provincial government. Nearly four years later it is still a draft copy; it has not been approved by the provincial government. Included in this document are the definition of a midwife and the general competencies and specific competencies of midwives in Saskatchewan. The categories within the specific competencies include: antepartum care; intrapartum care; postpartum care of the woman; care of the newborn

and young infant; breastfeeding; education and counseling; sexuality; collaboration of other caregivers and the professional, legal, and other cornerstones of the profession (College of Midwives of Saskatchewan 1998).

An Act Respecting Midwives, Chapter M-14.1, 1999 was drafted by the Saskatchewan government; the Act was assented May 6th, 1999. The Act includes: councils; bylaws; membership and registration; prohibition; discipline; general information and transitional and plans for implementation. Again, this document has not been implemented in legislating midwifery in Saskatchewan.

The last document produced by the College of Midwives of Saskatchewan for the government about midwifery in Saskatchewan is the "Integration of Midwifery Services into Saskatchewan Health Care System". The seventh draft was printed in May of 2000. It still has not been approved. This is the only document that has any mention of the education of midwives in Saskatchewan. It provides a brief description of what should be developed over time for a program in the province.

In Saskatchewan, a midwife is eligible for licensure if she has:

- a) *successfully completed a competency assessment process in place in one of the other provinces that is approved by the College of Midwifery; or*
- b) *has a baccalaureate in midwifery from a recognized university; or*
- c) *has been approved by the College of Midwifery based upon her combination of education, experience and competency outcome; or*
- d) *has been registered and licensed in good standing with a midwifery regulatory body with comparable standards (emphasis in original) (Saskatchewan Midwifery Implementation Working Group, May 2000, 2).*

In this sixty-seven page integration document, this is the only mention of midwifery education in Saskatchewan. Midwives are leaving the province for accreditation but are not coming back because of less favourable working conditions compared to other Canadian provinces.

The government has not finalized what the pay structure will be for midwives. "But while the government is legalizing midwifery, Friends of the Midwives warn that without government funding to support the profession, the legislation will in essence kill midwifery in the province" (The Canadian Press 2000). This is the most important issue facing them. There are three proposed pay structures recommended by the College of Midwives of Saskatchewan to the government in the "Saskatchewan Midwifery Implementation Working Group" (May 2000). They are: the independent practise model that means midwives would "practice within the accountability framework of the health system." (2000, 4); the contract model which states "The contract would be negotiated between the midwife and health district" (2000, 4); and the employment model, which is defined as "midwives may be directly employed by health districts (...) the district will need to establish mechanisms for hiring midwives" (2000, 5). These three suggestions for integrating midwives into the provincial health care system would ensure that midwives be financially remunerated. These are only recommendations, not an approved pay structure. There is no current guarantee from the Saskatchewan Government that they will remunerate midwives for their work.

Saskatchewan has numerous documents, committees and organizations that support midwifery and a Midwifery Act yet to be proclaimed. The government seemed to be well on its way in legislating midwives; however at the present, everything is at a standstill

with a new Premier. The urgency to legislate midwifery has slowed down over the past two years. The government and the different committees have also made it clear that the education of midwives in Saskatchewan is not a priority. If someone is sent out of province to get a midwifery education, with no financial support and then expected to return with no legislation, financial remuneration and formalized midwifery practise to support the practise, one cannot expect midwifery to flourish. This makes for a very frustrating environment for practising midwives. If Anne's prediction is correct, there will be very few midwives left in the province in the near future unless the provincial government starts making some changes.

The Current Status of Midwifery Practise and Legislation in Ontario

Introduction

Ontario was the first province in Canada to legislate and provide an education program for midwives. The Midwifery Act came into effect on December 31st, 1993 (Shroff 1997). Since then, midwives in the province of Ontario have been covered by the Ontario Health Insurance Program (OHIP); midwives have been able to work in homes, birth clinics and in the hospital. There is a Baccalaureate in Health Sciences in Midwifery and a Prior Learning and Experience Assessment (PLEA) programs offered. The bachelor's degree is one program with three different sites; Laurentian University in Sudbury, Ryerson University in Toronto and McMaster University in Hamilton. The PLEA process is offered by the College of Midwives of Ontario every two years (College of Midwives of Ontario 2001). The process of attaining legalized and legislated midwifery care in Ontario involved many factors. According to Rochon Ford (2001, personal communication), the implementation of midwifery legislation is the result of overall acceptance by the general population and the medical profession as well as the right political climate when midwifery was legalized and implemented.

Although Ontario is the first province to achieve and implement midwifery services, the midwifery communities fought a long and hard battle to attain legislated midwifery with an education program and health coverage (Maranta 1999). The re-emergence of midwifery in Ontario is the most chronicled history in all of Canada This is perhaps because Ontario is regarded as the pilot project for legislation for the rest of Canada and therefore a great deal of research has been conducted about midwifery in the province.

Provincial Consumer Groups and Associations

In 1981, the Ontario Association of Midwives (OAM) was formed. The initial groups of women who participated in OAM were lay¹⁸ midwives. Following inquests into two baby deaths in 1982 that occurred with a midwife in attendance, the Ontario Nurses-Midwives Association (ONMA) and the OAM submitted a brief called "The Midwifery Coalition" to the Ontario Government. The brief stated that they would like to see legislated midwifery in the province of Ontario. Shortly thereafter, the Midwifery Task Force of Ontario, which was largely a consumer based group, began lobbying the government for legalized midwifery as well (Sharpe 1997).

¹⁸A lay midwife is someone who has received their training through an informal process, such as an apprenticeship or through self-study (Maranta 1999).

In 1984, after the amalgamation of the ONMA and the OAM,¹⁹ which became the Association of Ontario Midwives (AOM) and in 1985 after another inquest into a baby death, the Ontario Government appointed the Task Force for the Implementation of Midwifery Care in Ontario. In 1987 the Task Force submitted its paper to the government recommending the legislation of midwifery in Ontario (Sharpe 1997).

The Task Force document was the beginning of legalized midwifery in Ontario. In 1989, The Interim Regulatory Council on Midwifery (IRC) was created. The Minister of Health, Elinor Caplan, also announced a curriculum project in 1989 for midwifery education. The report was submitted in 1990 to the Ministry of Health (The Gazette 1990). The purpose of the IRC was to “function until the Midwifery Act is proclaimed and a statutory College of Midwives is established in Ontario” (The Gazette 1990, 1). Among the IRC’s responsibilities were the education and registration of midwives in Ontario (The Gazette 1990). An Act respecting the regulation of the Profession of Midwifery, Bill 56, Chapter 31, Statutes of Ontario, 1991, received Royal Assent on November 25, 1991.

The seventy-two midwives that were already practising in the province in 1993 began a one year evaluation process through the Michener Program in Toronto. The Michener Program was the “pre-registration education and testing process for the first group of midwives who were regulated” (Shroff 1997, 35).

By “January 1994, when the Health Professions Legislative Act, which included the Midwifery Act was enacted, fifty-eight Ontario midwives began practising as publicly funded, regulated health professionals” (Sharpe 1997, 205).

The Midwifery Integration Planning Project also delineated a midwifery education program. This outline recommended a four year baccalaureate level program for midwifery training. In the fall of 1993, the Midwifery Education Program accepted its first cohort of students (Sharpe 1997).

The decision to have a baccalaureate program over a community college level curriculum was hotly debated. Rochon Ford (2001, personal communication), a former member of the IRC, stated each model has its pros and cons. While both sides of the argument agreed that the education program should be based upon a feminist model,²⁰ independent from other health professions and that midwives should be able to work in homes, birthing centres and hospitals, there was no consensus about how to achieve that (Rochon Ford, 2001, personal communication). In the end, the baccalaureate model was chosen because it would provide a “status” that was important to the public and to other health professions. It was assumed that this model would allow for more recognition of midwifery skills and valued as peers from doctors. Finally, it would teach students research skills and train them to be professors in the program one day. The IRC was committed to not importing professionals from other disciplines to teach midwifery to help preserve midwifery attitudes and values. A university degree would allow future midwives to teach within the midwifery program if they chose to do so (Shroff 1997). While Rochon Ford (2001, personal communication) said that she realizes that the university program can be regarded as elitist, she firmly believes that the baccalaureate program was the best route for the education of midwives at the time.

¹⁹The amalgamation of the ONMA and OAM grew out of the Midwives Alliance Conference of North America in 1984 (Sharpe 1997).

²⁰There are many definitions and kinds of feminism. Rochon Ford is not sure which definitions were followed by the IRC (Rochon Ford, 2002, personal communication).

The Prior Learning Assessment (PLA), now known as the Prior Learning and Experience Assessment (PLEA), was initiated in response to those who wanted to practise midwifery in Ontario and who had previous training in midwifery.

The College became committed to structuring a process that would provide fair and equitable access to registration. We are anxious to make the services of qualified midwives more accessible to the women of Ontario, and to enrich the pool of midwives with a range of language skills and cultural backgrounds. At the same time, it is equally important to make the assessment process comprehensive and credible. This is especially important given that midwifery is a newly recognized profession in Ontario, under a deal of scrutiny. We strive towards ensuring that quality midwifery services are provided by a unified profession that meets the expected standards of Ontario consumers (Allemang et al., 1994).

The PLEA program was designed to evaluate midwifery skills of women coming from other countries and provinces in Canada and allowed them to register in the province of Ontario (Shroff et al., 1997). While the PLEA program was being discussed, the College of Midwives of Ontario (CMO) decided to make the emphasis of the program for people who were already practising midwifery in the province but did not qualify through the Michener Program and had enough experience that the university program would not be beneficial. The PLEA program was integrated more slowly than the baccalaureate program because the midwifery model in Canada is independent²¹ and “it is critical that midwives are comfortable and trained to practise adequately in all settings” (Rochon Ford, 2001, personal communication).

There are five stages that need to be followed in the PLEA process. The initial step is attending orientation sessions to describe the PLEA process. The second stage is an English proficiency test (Shroff et al., 1997). Third, candidates must go through a Portfolio Assessment. This includes an assessment of:

- 1) clinical experience,
- 2) baccalaureate equivalency in the areas of social science, basic sciences, women’s studies, research, health studies,
- 3) their commitment to the Ontario model of midwifery practice (through an autobiography),
- 4) their knowledge and skills in midwifery and obstetrics through a self-assessment and a referee’s assessment of the core competencies for Midwifery Practice (Shroff et al., 1997).

At this point in time, women who pass the Portfolio Assessment are eligible for registration. However, when there is a lack of certain skills shown in the Portfolio Assessment they must also go through the Multifaceted Assessment, which includes oral, written and practical exams. Finally, women applying for registration must attend a course called “Midwifery in Ontario” to explain how midwifery is designed and how it works in the province (Shroff et al., 1997). This process takes, on average, two years to complete and costs anywhere from \$3500 to \$3900, according to the CMO. However, Nestel (2000) documents that one participant in the PLEA program spent nearly \$8000 and had yet to finish the process. The participant must pay at each stage of the process as it is offered. This

²¹Independent midwifery means that midwives are not subordinate to or dependent on other health professions and they are confined to working only in one setting, i.e. in hospitals. This is the case in many countries, such as Australia.

cost does not include travel and accommodation for the participants and “All exams are offered in Toronto only” (College of Midwives of Ontario 2001).

Many women who had expressed interest in the PLEA Program at its onset did not pursue it for many reasons. Nestel (2000) argues “while the process appeared equitable, it compelled women with many years of midwifery training and practise to undergo a long, arduous and expensive re-assessment process” (119). Amid the inception of the PLA program in 1994, nearly 1000 women expressed an interest in participating. From that 1000, less than 35% of women participated in the sessions, and by the time they got to the Multifaceted Assessment, only 172 underwent the process, which is less than 18% of the starting cohort (Nestel 2000).

In April 2001, the Council of the College of Midwives of Ontario decided to offer the PLEA Program every two years because of financial constraints, while the Midwifery Language Proficiency Test continues to be offered twice a year (College of Midwives of Ontario 2001). However, in March 2002 the College of Midwives of Ontario sent out a notice that states:

The College of Midwives of Ontario (CMO) is participating in a new initiative that will replace the current PLEA Program. The new initiative is a collaboration between the CMO, the Ontario Midwifery Education Programme and the Continuing Education Divisions of Ryerson University. When implemented, this program will build on the current PLEA Program by including language, culture and clinical skills courses, as well as orientation to practise and clinical placements in Ontario midwifery practises.

The goal of the program is to increase the number of internationally trained midwives who are eligible for registration in the province by providing not only an assessment but upgrading as well. The new program is intended to launch in September of 2002 and to run every year in place of the CMO's existing PLEA Program (College of Midwives of Ontario 2002).

The PLEA process is now in a state of uncertainty because the CMO does not have any more details about the changes of the PLEA Program at this point in time. It is apparent that the PLEA program is rife with problems, financial and social, but hopefully with the new changes, some of these problems may be remedied.

Current Provincial Legislation

The PLEA process and the Baccalaureate Midwifery Program have now been in effect for over seven years. A formal midwifery program in Ontario offers two options, the baccalaureate degree and the revamped PLEA process. In implementing midwifery into the Ontario Health Care system, midwives are now covered by the Ontario Health Insurance Plan (OHIP), which means that families that choose a midwife as their health care provider do not have to pay; midwives receive a salary from the provincial government (Sharpe 1997). Following legislation in Ontario, midwives were able to be a primary health care provider in hospitals; be a prenatal and postnatal care provider; document care in hospitals; order tests as required and prescribe certain drugs; attend pertinent meetings at the hospital to maintain admitting privileges; participate in workshops and education presentations; act as preceptors for students in the midwifery program and attend to office and administrative duties (Sharpe 1997). In addition to their new duties, especially within a hospital, midwives continue to provide care to women in a home setting (Shroff 1997; Sharpe 1997). Midwives maintain the same quality of care to their clients, but are now able to do so without fear of prosecution, more respect from other health care providers, and a steady income.

The Current Status of Midwifery Practise and Legislation in Nova Scotia

Provincial Consumer Groups and Associations

A consumer group, The Midwifery Coalition of Nova Scotia (MCNS) has been lobbying the Nova Scotia government for over twenty years to incorporate midwifery into the health care profession. "We are working to have midwifery accepted as part of Nova Scotia's health care system and to have midwifery care covered by MSI [Medical Services Insurance]" (Midwifery Coalition of Nova Scotia 2002). Similar to Saskatchewan, the largest obstacle the MCNS is facing is a change in the provincial government. Catano (2001, personal communication) stated that one factor delaying the legislation of midwives is because the Ministers of Health change so often and that it takes a long time to explain midwifery care, as a result action is never taken.

The Midwifery Coalition of Nova Scotia was formed in 1984. It grew out of support for midwives who were facing criminal trials in Nova Scotia in 1983. Three midwives in Nova Scotia attended a home birth where the baby required resuscitation, was transferred to the hospital and died six months later. All three were charged with criminal negligence causing death. A doctor at the hospital where the baby was taken brought charges, against the family's wishes. The charge was dropped nine months later (MacLellan 1997). Midwifery supporters realized how vulnerable midwives were in the province without legislation.

Until 1987, practising midwives and midwifery consumers were part of the MCNS. The midwives, in 1987, decided to form their own professional organization, the Association of Nova Scotia Midwives (ANSM). Although both groups work toward the legalization and the legitimization of midwives, the ANSM also set the standards of practise that midwives must follow in Nova Scotia (MacLellan 1997). Although they work together formally and informally, it is important for both groups to be recognized as separate organizations. It is important for the government to realize there are consumers of midwifery services, as well as midwives, interested in legislating midwifery (Catano, 2001, personal communication).

Over the years, the MCNS and the ANSM have worked diligently to bring the issue of legalizing midwifery service in Nova Scotia to the forefront. In 1995, the Medical Society of Nova Scotia attempted to change the Medical Act to include pregnancy and parturition. Previously, the Act had included birth in the care of obstetrics. The MCNS and the ANSM were able to prevent this change.

In 1996, the ANSM and the MCNS organized a large conference with midwives across the country in Halifax. At this time, the provincial government decided to have the Reproductive Care Program (RCP)²² look at the issue of midwifery. This was a disappointment for the ANSM and the MCNS. The government, in response, redesigned the group to include five doctors and nurses from the RCP, a Department of Health representative, a project assistant, and one member each from the ANSM and the MCNS. Over the next year, much work was done in researching the public's opinion about midwifery and developing recommendations. However, "the representing consumer and midwife were relieved of their involvement before the third and final draft of the Group's [Midwifery Review Group] report was written" (MacLellan 1997, 340). In the fall of 1996, the report "The Potential for Midwifery in

²²"The RCP is described as a multi-disciplinary group of professionals including representatives from the Medical Society of Nova Scotia, Dalhousie University, the Registered Nurses Association of Nova Scotia and hospital staff" (MacLellan 1997, 339).

Nova Scotia” was released. It recommended that midwifery be implemented into the Nova Scotia healthcare system and be an autonomous profession. Another recommendation was the creation of The Interdisciplinary Working Group on Midwifery Regulation.

Currently, there are four practising midwives in Nova Scotia. There is one in Halifax, two in the Annapolis Valley and one in Wolfville. They will help each other as second attendants as needed, but more often than not, they are assisted by someone in the community with a midwifery or nursing background in births. With no legislation in place, midwives in Nova Scotia are paid privately and attend only births in private homes.

In the past five years, the Midwifery Coalition of Nova Scotia has made quite a bit of progress in lobbying the government to legalize midwifery. In May 1998, the Interdisciplinary Working Group on Midwifery Regulation was formed and comprised of individuals that were selected by the government. The Interdisciplinary Working Group on Midwifery Regulation “was given a mandate to develop legislative options for regulating the practise of midwifery in Nova Scotia” (Midwifery Coalition of Nova Scotia 2002). This group was comprised of individuals from many health care fields. In June 1999, the Working Group completed its report called “Recommendations for the Regulation and Implementation of Midwifery in Nova Scotia” (Midwifery Coalition of Nova Scotia 2002). Among the report recommendations were:

Recognition of Midwifery as a Profession

1. That Nova Scotia recognizes midwifery as an autonomous self-regulated primary health care profession with midwifery included as an insured service.
2. That a Midwives Act be enacted to regulate the practise of midwifery in Nova Scotia

Educational Requirements for Midwives

1. That the education requirement for midwives be a direct entry Baccalaureate Degree in Midwifery
2. That the Nova Scotia Government financially supports the education of midwives in a manner similar to the education of other health professionals.

Professional Self-Regulation

1. That a College of Midwives of Nova Scotia be established to regulate and administer the Midwives Act.

Implementation of Midwifery in Nova Scotia

1. That an Implementation Council be appointed to establish the College of Midwives of Nova Scotia.
2. That the Implementation Council be composed of midwives, consumers, a physician from the College of Physicians and surgeons of Nova Scotia, and one representative each from the Nova Scotia Department of Health, Registered Nurses Association of Nova Scotia, and the Nova Scotia Reproductive Program.
3. That the Nova Scotia Government fund the initial assessment and review process and subsidize the upgrading processes of those individuals who qualify for initial registration as a midwife (Midwifery Coalition of Nova Scotia 2002).

The Nova Scotia Government also stipulates that if midwifery services were to be covered under MSI, “it would also require that an effective self-disciplinary process be put in place. According to the Minister of Health, there are only four midwives in all of Nova Scotia, an insufficient number for self-disciplinary action” (Moulton 2000, 1). The Health

Minister, Jamie Muir believes this would be very difficult because “If there was a single disciplinary matter, it would mean there would only be three people left to deal with it” (as cited in Moulton 2000, 1). This creates a double bind because without remuneration for midwives in the province, not many people will want to pursue midwifery. Without people pursuing midwifery, the government does not seem willing to provide financial remuneration for midwives in the province.

Unlike Saskatchewan, there have not been as many published documents developed for the Nova Scotia Government because the MCNS and the ANSM are still fighting for the legalization of midwifery in the province. Berry (2002, personal communication) from the MCNS has told me that the group has put together many briefs for the government over the years, but few official government documents have been created. Once it is determined that midwifery will be legislated, governmental committees, as in Saskatchewan, are expected to be formed.

Current Provincial Government Policies and Practises

In 1999, when the “Recommendations for the Regulation and Implementation of Midwifery in Nova Scotia” was submitted to the Nova Scotia Liberal Government, the Department of Health sent out a press release stating that they will begin “drafting legislation over the summer [of 1999] to legislate midwifery and to form an implementation committee to establish a midwifery regulatory body” (Midwifery Coalition of Nova Scotia 2002). However, soon afterward, there was a change of government. The Progressive Conservatives came into power and there was a new Health Minister, Jamie Muir. The MCNS had to yet again explain midwifery care to Mr. Muir, who had no health or political background. He has been willing to meet with the MSNS to discuss midwifery “especially in relation to Primary Health Care reforms and midwifery’s role in primary health care delivery” (Catano, 2001, personal communication). Despite this, the legislation of midwifery continues to be a slow process in Nova Scotia.

There have been other promising moves by the government to legislate midwifery. A midwife in Nova Scotia is currently participating in the Primary Health Care Delivery Task Force in Nova Scotia. Also the MSNS and the ANSM were consulted about the need for midwifery practise in Nova Scotia by the Health Care Human Resource Sector Council review of health care in Nova Scotia. Although the Department of Health does not see legalization of midwifery as a priority, the momentum is there (Catano, 2001, personal communication).

While the past government seemed willing to legalize midwifery in Nova Scotia, the education process for midwives remains a point of contention. The government has stated that it does not have the money to set up an educational program at this point in time (Catano, 2001, personal communication). The ANSM and the MCNS have discussed the different options available to future midwives in the province. The two preferences are to ‘buy seats’ in Ontario’s current educational program and bring the students back to Nova Scotia for clinical experience, or to set up an Atlantic School of Midwifery (Catano, 2001, personal communication). Both of these options are possible, yet fraught with problems, as will be addressed in the next chapter.

In the interviews I conducted, and in my time as a MCNS member, I spoke to other members about how they envisioned midwifery education in Nova Scotia. They would like to see an educational program established and they realize it will not be an easy process.

They believe that if midwifery practise was legislated in the near future, there would have to be a granny-ing-in²³ process for currently working midwives. Catano, (2001, personal communication) believes that the midwives currently practising, and with the upgrading of midwifery skills for other women in Nova Scotia, there could be as many as fifteen qualified midwives in the province with a granny-ing-in process. For people that would like to begin midwifery training, midwives and consumers would consider approaching the Nova Scotia Government to ask them to buy seats from the College of Midwives of Ontario. They realize that the CMO and educational programs in that province may not be open to the idea. However, they contend that the Nova Scotia students would be in Ontario only during the first half of the program when the students are involved in course work. For the required clinical placement, the MSNS and ANSM suggest that the students could return to the province of Nova Scotia to work with local midwives. Again, this would require the midwives in Nova Scotia to be willing to act as educators and to take on student midwives or apprentice (Catano, 2001, personal communication).

Another option is the establishment of an Atlantic School of Midwifery, with the suggested location in Halifax. With collaboration among the Atlantic Provinces, the creation of an Atlantic School of Midwifery may be a possibility. Finances could be shared among these provinces and they would have enough students to sustain an interest in the course (Catano, 2001, personal communication). However, this is problematic as Prince Edward Island and New Brunswick are not currently contemplating the legalization of midwives; therefore their participation cannot be guaranteed. Catano (2001, personal communication), believes that at this point, Newfoundland would prefer to have a nurse-midwifery program.²⁴ Despite Nova's Scotia's eventual move to the legislation of midwives (Catano, 2001, personal communication), an education program is not yet regarded as a priority.

A foreseeable problem of such a system is the need of the students to relocate to a central location for the education, therefore limiting the number of students that the program would be accessible to. For example, if a single mother in St. John's, Newfoundland is interested and accepted into the program, she may not have the finances or the support required to relocate to Halifax.

Despite the progress made over the years, many problems over the years have become apparent. In the following chapter, I will look at midwives education in Saskatchewan, Ontario and Nova Scotia. I will also discuss what the midwives currently practising in these three provinces envision for a midwifery education program and what changes they believe would be beneficial to the existing programs in Ontario.

²³This is a term used to describe the process of midwives exhibiting their skills as a midwife to attain certification within provinces that are enacting legislation (Maranta 1999).

²⁴Nurse-midwifery programs do exist in other countries and are popular in the United States. This program requires nurse training to begin with and then eighteen months to a two year follow-up for midwifery work (Tritten & Southern 1998).

CHAPTER FIVE

Introducing the Midwives

Introduction

Over a course of three months, I interviewed a total of seven midwives; two in Saskatchewan, two in Nova Scotia and three in Ontario. I asked these seven midwives about how they were educated and about their own view on the education of midwives and the current legislation. In this chapter I outline the diverse routes that these midwives pursued to obtain their training in midwifery, their reasons for following these routes and the difficulties and barriers they encountered. Their stories demonstrate the importance of having various educational routes accessible to aspiring midwives. All of the midwives I talked with had to work industriously and over many years to receive an education in midwifery. Whether the midwife began her training in the 1970s, the 1980s or the 1990s, it was a long and arduous process.

Participant's Midwifery Education

International Apprenticeship Training

Of the seven midwives I interviewed, two of them left Canada to receive their apprenticeship training. Anne was living outside of Canada when she decided she wanted to be a midwife. Her interest arose during her first pregnancy, while she was working in another country, volunteering at a local clinic. As part of her clinical duties, she was trained to work as a midwife with the doctor and the nurse in the area. Anne stressed that although her work placed her as midwife, she was trained to do much more than pregnancy and birthing care. She also inserted and removed intra uterine devices (IUDs) and helped with other minor ailments such as providing immunizations and prescribing drugs for ear infections. She said she provided well woman care.

Anne: [I] did the prenatal, the postnatal, the birth control, the pelvic exams, put in IUDs, [took] them out, sort of thing. It's actually part of a midwives portfolio in a country like that. We also vaccinated and it's kinda whatever was needed. You have to do [that] even though you are the midwife and that's your specialty, for other kinds of things you help out.

Her initial training as a midwife was brief. She began attending and learning about births in 1976 and by early 1977 she was going out on calls to attend a woman in labour solo. The local doctor and nurse attended births with her for a few months until they felt she was qualified to attend births on her own.

Anne: So how long it was before I was attending and without direct supervision? Probably fewer than a dozen births. But I had read many texts, many articles, many magazines and I went to the first conference of practicing midwives in El Paso, which was in [19]77. So, it isn't just that I went to a couple of births and started [practising midwifery] 'cause I wasn't working at anything else. I had my baby a few months after I started this process of studying and going to births. So, all I [did was] basically took care of a baby and read about birth, [did] prenatal visits in the clinic with a doctor and nurse and then [went] to the birth, and I did six births a month and they were usually in the home and I was usually by myself. At first the nurse often went with me or the doctor, I'd say approximately the first three months.

Despite having a doctor and nurse nearby in case of emergencies and complications, she notes that there was no local hospital, no running water and no electricity.

Anne: *But it wasn't hard to get help either. Even though you didn't have a phone, they would send a runner, and then the doctor would run. The runner would go get the doctor and then the doctor would either run or come by vehicle, if there was a road where we were. This is quite a long time ago I am talking about and I think the village might have modernized. [...] We were six hours from a public hospital. People didn't have vehicles, there was no ambulance. So, we attended all the births that were, [that] the mother wasn't at risk from dying basically, so I attended all that stuff.*

Anne stayed there for two and half years where she became an experienced midwife. Today, Anne describes this time as 'phase one' in her education.

Anne: *During that period, I think I attended about 250 births. So, when I think back and when I review my career and my life, I refer to that as phase one. And I think it took 250 births and two and half years before I felt [comfortable]. When I look back at that point, I was quite competent. I could do normal births, I could do complicated births, I did breeches, twins, preterm, post term, like we had to handle it all. We had no choice unless they were going to die. Then if they needed a caesarean obviously we wouldn't do [one unless] somebody who was hemorrhaging and was going to die; like you'd send them in [to a hospital]. But people didn't want to go in 'cause it wasn't an easy thing to go in.*

In the 1980s, Anne went on to get her nursing degree because at the time she believed Canada was leaning towards having nurse-midwifery programs. Once she completed her nursing degree she continued on with her Masters which she completed in 1994.

Sarah first developed an interest in midwifery while she was beginning her second degree. She was exposed to midwifery care in Vermont and she realized that this is what she wanted to pursue and began apprenticing with a midwife. Upon her return to Nova Scotia, Sarah attended a conference where Ina May Gaskin²⁵ spoke. Gaskin suggested to Sarah that she pursue apprenticeship training in El Paso, Texas as the Farm was not taking on any apprentices at the time. She spent ten months learning about births and attending classes at the clinic in El Paso. After returning to Nova Scotia, she continued to work under the supervision of a midwife. Sarah began her practise as a primary midwife in 1992, approximately three years after beginning her training.

Sarah: *I was living in Vermont in a little town and it just so happened that a good percentage of the kids born in that town were delivered with the help of midwives. I had already finished university and was starting on a second degree and I just realized at that point that that was exactly what I wanted to do. I started apprenticing and I came back to Nova Scotia and it just so happened that Ina May Gaskin was here for a midwifery conference and I asked her how I could go about training or if I get training at the Farm in Tennessee and they weren't taking on any apprentices. So, she referred me to go to Maternidad La Luz in El Paso. She said that would probably be the best place. So I flew out about two months later, I moved down there and stayed there for about ten months and I came back up to Nova Scotia. I worked under the supervision of the midwives here for a little bit longer and then I started practising, a supervised practise.*

Today Sarah is working as a secondary midwife in Nova Scotia. She is politically active and is playing an instrumental role in lobbying the Nova Scotia government to legalize midwifery services.

²⁵Ina May Gaskin is a self trained midwife and began a commune called The Farm in Tennessee in the 1970s with her husband. They have trained aspiring midwives and provided midwifery care for thirty years.

Canadian Apprenticeship Training

Despite the barriers that existed for the midwives I interviewed in pursuing their education in Canada, many of them succeeded. Two midwives I interviewed completed an apprenticeship training in Canada, and a third midwife spent some time in an apprenticeship before moving to the midwifery program offered at McMaster University. Both of the midwives who completed the apprenticeship route in Canada did so in the early 1980s.

Amy found the apprenticeship model fairly accessible to her. Amy knew for a number of years that she was interested in pursuing midwifery, but she was never sure if her interest was related to her desire to have children. After the birth of her first child with a midwife in Calgary in the early 1980s, she began apprenticing with the same midwife in 1982. By 1984 she was practising on her own in Calgary.

Amy: At first I thought oh, maybe I really only wanted to have [a] baby and I thought I wanted to be a midwife so I had my baby, but a little bit later, I [realized I] really do want to be one and then many years later after I became a midwife. I was able to apprentice then with my midwife that I had in Calgary.

Amy also went through the Michener Program in Toronto.²⁶ She moved to Ontario during the 1980s and was required to go through the examination process in Ontario as legislation was being passed. She initially failed the Michener Program but was later approved through an extended examination to practise midwifery in the province. Amy has mixed feelings about the process, but she is unsure of what could be done differently to include more midwives, or to make it more equitable.

Amy: So, I went to Toronto and having that month long thing that was, great in that I got to hang out with other midwives that I wouldn't have been able to otherwise. So, that was a very good thing about that process, and then I was sad that the process overall meant that there's three legal midwives in Eastern Ontario now, whereas it used to be ten. So, I thought that part was unfortunate, I think it would have been better to have a process that included everybody and that provided training as needed in any discreet information areas that people need rather than saying that, ok the bar is this high, you have to have attended sixty births and oh, sorry fifty-eight is not good enough. Yeah, that's a waste of talent and education and all kinds of stuff. I'm hoping that other provinces are seeing what I consider to be a mistake that we made here in Ontario and figuring creative, other creative ways to do that. Yeah, and then for me personally, I was failed by the assessor that assessed me at my births and prenatal care, so instead of getting my registration right on January first of [19]94, I had to do some remedial work and then I got my registration on November first. I needed to be observed in some prenatal care, a certain number of births, and postpartum care and stuff and then do some oskies, do you know what an oskie is? It's a situation when, play acting, more than anything else. So, I had to do that, and the really challenging thing was, ok, here folks set up the pre-registration program and then there were some of us that didn't make it through it for whatever reason, the decisions, the evaluators. But there wasn't anything in place, of course, to remediate us, so there was a coordinator assigned and she was flying by the seat of her pants thinking well, ok, what should we do here? So it just, because it was that way, it felt a bit arbitrary, ok, is this enough? Oh well maybe not quite enough, maybe you need to remediate for another couple of months, and, so that part was unfortunate 'cause then it felt like a personal vendetta thing. Nobody did it on purpose, it just kinda the way things unfolded and then, I was happy to see that the four or five of us who didn't make it originally, eventually we all did get our registration, by the fall of [19]94. So, I was happy about that part.

²⁶Please see page twenty-nine for more details about the Michener Program.

Amy spent approximately four years between the time she decided she would like to pursue midwifery to the time she began to work independently as a midwife in Calgary. She also spent about a year going through the Michener Program to practise midwifery in Ontario, with the inception of legislation.

Laura spent much more time than Amy in obtaining her midwifery training. Laura began researching midwifery and how to obtain an education in midwifery after the birth of her first child in the late 1960s. She began pursuing midwifery because it was a 'calling' and because of her disillusionment with the high intervention rates in the hospitals during labour and birth.

Laura's first solution to becoming a force of change in how pregnancy and birth was handled was to pursue nursing and medical schools. When she discovered through her own research that it was really midwifery that she wanted to practise in the 1970s, there were many constraints to her pursuing it. Laura had two options: an apprenticeship model of training that was developing in the 1970s and 1980s in Canada, or an apprenticeship overseas. Laura chose the Canadian apprenticeship model and moved to Montréal, where there was a higher concentration of midwifery births. She studied with a senior midwife for four years. She stayed in Montreal until 1998 when she moved back to Nova Scotia where she continues to practise midwifery.

Laura also spent a lot of time participating in education workshops related to midwifery and later pursued a Masters degree with a focus on midwifery education. For a number of years she was also a childbirth teacher and she was involved in the movement for family centered maternity care, which was considered at the time to be the 'alternative approach'. Laura spent approximately fifteen years learning about and pursuing midwifery.

Kenzie's interest in midwifery began in the early 1980s when she was pregnant with her first child in Saskatchewan. She researched her options about available birthing and pregnancy care in Regina and was happy to learn about midwifery services. After the birth of her first child she decided to pursue midwifery as a profession. In Regina, she began providing labour support for her friends and then to other women in the city.

Kenzie: So I actually had a number of friends who were having babies at that time and I started to do some labour support. First on a volunteer basis and then I had a company here, an agency [in Regina].

Kenzie was active politically in the birthing community as well. She helped lobby the government for the legislation of midwifery and was a member of "Friends of the Midwives", Saskatchewan.

Kenzie: I began to read more [about] midwifery and to be involved with the consumer organization that was called Saskatchewan Association for the Safe Alternatives, for Safe Alternatives in Childbirth, SASAC was the name and it was part of a larger umbrella group- NAPSAC from the United States looking at, I guess, alternatives in childbirth. At that time there were a number of different provincial organizations, but we were consumer driven and specifically, trying to get changes in childbirth but more specifically involving midwifery so I got involved with that in 1984. [I] had another child in 1986 with midwives and then in 1988, and then by that time I knew that I was really interested in actually following this career path. So, I continued to do my labour support, made the connection with the midwives who were practising in the community read more, but all quite informal at that point.

In the early 1990s, when Kenzie's children were older, she began apprenticing with the local midwife. At the same time she felt she needed some knowledge through a formal system. She participated in a distance midwifery course called "Ancient Art" through Oklahoma but did not complete the course as it did not meet all of the requirements that she felt she needed. At that point in time, in the mid 1990s, she began researching other options available to her.

Kenzie: *There was a midwife in Saskatchewan and [I] began to talk to her about working with her, apprenticing with her, which I did in a formal way beginning in, I think, 1995. Just prior to that, I think it was 1994, that I began looking around at what the different possibilities were for getting a more structured training. I looked at all of the different options in the United States looked at New Zealand and didn't really think about there so much probably because we had no intent or interest in moving. [...] I also got involved with the Ancient Art Midwifery course, Fairmount I think it is, Oklahoma. I never completed it. I got about a third of the way through it, I got started in the modules. Just prior to that I began to work with the midwife in a more concentrated way as an apprentice and, at that time, I continued to do labour support and those sorts of things. And then from there I guess I was still taking the course and finding it a bit of a struggle because I was working and I had three kids. I had a busy life and that kind of thing and at that time, I was involved in what was trying to get midwifery legalized in Saskatchewan, so I had Advisory Committee that looked at, was it feasible, should we do it, how should we do it. It was in 1993 that it began. I knew that eventually, we would get midwifery legalized in the province. It was gonna be a period of time so I said, "Well what is going to be my best option for being able to practise?", you know, when this comes to be, is it going to be through the apprentice model or it is going to be through [the] midwifery education program, and I knew that the Ancient Art Midwifery course was good but it wasn't entirely what I needed. I felt I really needed more of depth in understanding about physiology, pharmacology, just more concentrated education. So [I] began to look more seriously at where I could get that training. I knew about the Seattle course, knew that were also problems in terms of being able to get clinical placements, looked at New Zealand and decided it was too costly.*

Kenzie also applied to McMaster University in Hamilton, Ontario and was accepted in 1997.

University Based Midwifery Programs

Of the seven midwives I interviewed, two followed a university based midwifery program and Kenzie, as previously mentioned, followed a combination of apprenticeship and university training in midwifery. In 1997 Kenzie began her formal training as a midwife and graduated from McMaster University in 2001.

Kenzie: *[I] decided I would just, not quite on a lark, but put in an application to the midwifery education at McMaster to see. I knew it was very difficult to get in, that they don't accept a lot of people from out of province, preferential treatment and it was in Ontario and so on, got an interview and thought well, still we'll go to the university and see where it leads to and then I was accepted.*

Kenzie offers a unique perspective on midwifery education in Canada because she participated in an apprenticeship training program as well as a university accredited program. She also has the distinctive point of view of having experienced and worked in the midwifery community in Saskatchewan and in Ontario. From the time that Kenzie decided she wanted to work as midwife until the time she began practising was seventeen years.

Meghan took one of the most direct routes to becoming a midwife. Although she realized with the birth of her first child that she wanted to pursue midwifery, she decided to wait until the inception of midwifery in Ontario before following her desire to practise

midwifery. Meghan preferred to stay at home with her children when they were young and she would begin working as a midwife when they started school. By the time her children were older, the midwifery education program in Ontario universities had begun. She was accepted the first time she applied. She began the midwifery program in 1994 and completed it three years later.

Meghan: *I considered the apprenticeship model which was what was available at the time [where she lived in the late 1980s], but my midwife lived quite far away and my children, my first was still quite young and I had my second one within two years and I was just waiting for them to get older. At the same time we were getting closer to legislation and the legalization of midwifery [...] and when I was having my third I realized I would be waiting for the formal education program which was being developed then because the apprenticeship model wasn't around anymore. So the timing for me was just fine, and my youngest went into Junior Kindergarten, I applied to the program. [...] From the time I decided to apply, I got in that first year, that spring, and in the fall I started and finished three years later. It was at that time the program was done in three years, right through the summer. So, for me it was quite short. Although, I had known since my first that was, I wanted to do [this] from my first baby. That was in, she was in [19]86, [19]87. But I was happy being at home, that's what I wanted to do, to stay with my kids. But in the meantime, I took courses, correspondence courses, and childbirth education, I did a lot of reading, was involved in the midwifery movement. I was aware of the consumer movement to advance midwifery [as a consumer and an advocate] and was very aware with that.*

Meghan spent twelve years researching and training to become a midwife.

Elizabeth began her career as a nurse. Over time, as she became more experienced in labour and delivery in the hospital, she began asking herself why there were such discrepancies between women's perceptions and experiences of pregnancy and birthing care in hospitals and doctors care and intervention rates. She asked herself why some doctors had low intervention rates and others' much higher and why some women would take an active role in their pregnancy and birth while others left it all up to the doctor. She discusses these discrepancies in the following passage.

Elizabeth: *Well I was a maternity nurse for a couple of years and it was sort of, well, what I would call a paradigm shift in my thinking. It was just attending conferences that were on, more on interventionist approaches, childbirth education conferences and seeing a whole new way of looking at birth from the obstetrical and sort of the medical view and that's kinda of when, when my shift began. It was quite a process. It was a longer process than just sort of an overnight thing or anything like that, frustration on the unit. Probably looking at all the different ways that all the different physicians looked at things and the intervention rates of some physicians, [the] high intervention rates of some physicians. The other physicians who could get away with much lower interventions, waiting process and things like that. And just realizing that there was such a dichotomy between how people practised and their views on it and so if one doctor could get away with not having those kinds of rates, for example, episiotomy, then why was it so high with other physicians. Also in looking at consent, looking at them looking at the way some women approached it compared to other women and realizing that some of them were quite prepared and others sit there, doctor, here I am kinda thing, so it was those kinds of things that started to make me sort of take a second look at it and say like why is this happening? There was one other thing actually that stimulated that change. Partly it was getting some independence from, in particular one obstetrician who was quite supportive of us [nurses] taking more of an active role in assisting women and doing the actual births and the other thing was listening to a presentation from a midwife that was at one of our obstetrical conferences and realizing like hey, I think I could do that.*

Elizabeth always wanted to do a Masters in Nursing and decided she would do it with a focus on midwifery care. She applied to a Masters in Nursing at the University of Edmonton and was accepted. She received her training there over a course of four years and spent two months in New Zealand learning and participating, by apprenticeship, in births outside of hospitals. When she came back to Saskatchewan she contacted the midwives in the province and began practising.

Elizabeth: When I finished my course work, I did one final clinical rotation in New Zealand for two months and I was very much on my own there, but in a birthing centre. So, I hadn't been involved with homebirths. And that, it was the home birth part that I actually apprenticed; you could call it apprenticed with, in Saskatchewan. And I came back as a second attendant, probably not a whole lot of births before I started taking over primary care once I actually had the routine, the equipment, the preparation, around the homebirth experience for the woman, like preparing her as well and being involved with probably less than ten for sure and then, I did feel a comfort level. Now, having said that I also had a backup that had experience with homebirth I think that increased my comfort level.

Elizabeth also went through the Manitoba registration program because it was required to become registered in Saskatchewan.²⁷ Elizabeth was the only Saskatchewan midwife accepted into the registration process that year.

Elizabeth: [19]98 I think it was, Manitoba began, with assessment upgrading and I was able to get in on that first class, because I live close enough to the Manitoba border that [...] I am registrable²⁸ in Manitoba. So I did assessment and upgrading. It gave me an opportunity to get assessed and upgraded where everybody else was having to make decisions about going to BC and a lot further away. Again it came down to 'this is workable for me', and so I applied, the other midwives in Saskatchewan applied as well but I was fortunate enough to be chosen because they thought I could work rurally in Eastern Manitoba. So they allowed me in the on the first course which was really very fortunate for me because the other midwives were refused and had to go elsewhere like to BC, which was a lot more difficult. It was basically, we had to submit our portfolio and had to do a certain number of births in that last two years and also looking at our midwifery education and that kind of thing. [...] It took, I think it took four months of driving back and forth to Winnipeg sometimes twice a week dealing with and going through many workshops like courses, like one or two day courses writing an exam after each one, after each module and then doing one big final, that we, we wrote the North American Association of Midwives, NARM,²⁹ the NARM exam and did the NARM's skills assessment and they were very, very sticky about everything being done very methodically and I think it was partly because it was, it being the first group and it was health centered.

From the time that Elizabeth decided she wanted to practise midwifery to the time she actually finished her training and began practising was fifteen years.

Barriers and Difficulties Faced in Pursuing Midwifery

Many of the women I interviewed expressed the difficulties they faced in receiving training to become an independent midwife. In each case, the midwives articulated the accessibility of midwifery education as a barrier. The lack of training opportunities was

²⁷Please see chapter four for more details on Saskatchewan's registration requirements.

²⁸To be registrable means that the midwives have the credentials to register in a province that has legalized midwifery but they are not required to do so.

²⁹The NARM assessment is discussed in chapter one.

limited abroad, in Canada, and locally. This made it difficult for many people to pursue because the timing and personal circumstances had to be right. In the case of the midwives I interviewed, some found it difficult to find training; for others it was family constraints that did not allow them to relocate to pursue midwifery training.

Sarah and Laura had to leave Nova Scotia to pursue midwifery training. Upon Sarah's return to Nova Scotia from Vermont, she was not aware of any midwifery education programs. She discovered the lack of opportunities available to her in Canada and returned to the United States to pursue further training in midwifery.

Sarah: At that time there were no midwifery programs in Canada; midwifery wasn't even regulated in Ontario. So you had to look at going out, there were no midwives here that would accept to apprentice someone. So I had to look at going out of the country. That was in [19]89.

Laura found it necessary to relocate to Montreal in order to have a sufficient volume of births in her apprenticeship. In both cases, the lack of midwifery training available in their home province was a barrier.

Elizabeth had to leave Saskatchewan for midwifery training. She found herself commuting for an extended period of time between Edmonton, Alberta and her home, about an eight hour drive, to pursue her midwifery training. She was unable to leave the country because of her family.

Elizabeth: I started out in nursing. I did a diploma and then went on to do a post-RN degree and where I focused a lot on maternity nursing. Like, that was kinda my specialty. Then, from there I always wanted to do a Masters. And I said if I was ever going to do a Masters, it was going to be with a midwifery focus. And the only midwifery focus was through Edmonton at the University of Alberta where they have the MN with a certificate in Nurse Midwifery. And that's what I chose. Like, that's what I had my eye on. It was the only conceivable program that was close enough to me that would be achievable. So, I chose that route.

Meghan also had family constraints that did not permit her to leave Canada. There was no local midwife and therefore she would have been required to travel to apprentice. This was not a feasible option for her and she decided to wait for the formal education program at the university level in Ontario before she pursued her dream of becoming a midwife.

Anne and Amy were both in a position to take apprenticeship training either locally or outside of Canada, but they faced barriers later in their midwifery careers. Anne was working internationally in the 1970s when she began apprenticing

Anne: Well, I was working, was volunteering at a rural clinic in another country, with a doctor and a nurse they were, there were lots of deliveries there. That seemed like the natural way to do it. It isn't like I knew of any midwifery course that I could actually take.

Anne has had problems in getting her midwifery skills accredited because she followed the apprenticeship route. She has tried to be accepted into other international midwifery programs but has been denied because the skills she possess are not recognized by the Saskatchewan Government, where midwifery is not legalized, and therefore not by the international community.

Anne: I applied to take my Masters in Midwifery at Thames University in England two or three years ago and I was rejected even though I have a Masters of Community Health and Epidemiology, which is from the College of Medicine. I was rejected because I am not a registered midwife. Well, they have to reject me though. Like you have to be a midwife to take a Masters in Midwifery. It wasn't anything personal.

Amy's problems also occurred when the Ontario government legalized midwifery in 1994. She began apprenticing in Alberta in the early 1980s with the midwife that was present at the birth of her first child.

Amy: I started kinda 1984. Yeah, I considered myself full fledged by that time. Yeah and what I mean is that's after my apprenticeship.

Jessica: So you started apprenticing about 82?

Amy: Yeah

She was required to undergo additional training as legislation was being passed to work as midwife. Amy describes the process of granny-ing-in as an arbitrary process in Ontario. She hopes that other provinces implementing legalized midwifery will learn from Ontario's oversights.³⁰

All of the interview participants spent a great deal of time waiting and researching midwifery education before actively pursuing a training program. Laura spent over fifteen years trying to figure out how to become a midwife in Canada. Kenzie said "Yeah it began probably eighteen years ago". From the moment the women decided they wanted to pursue midwifery until the time it took before they were working as an independent midwife varied from two to eighteen years. For the women I interviewed, midwifery is a 'calling' that they felt they were compelled to pursue and they persevered despite the length of time it had taken them.

In the majority of cases there is a direct correlation between the prolonged time line between choosing midwifery as a career and having the necessary training to be able to practise as a midwife in Canada. This is because there are limited, and often inaccessible, midwifery education programs available in the country. The need to relocate not only out of province, but out of the country played a major role in determining when and how feasible it would be for the interviewees to obtain their education. The hardships they faced serve to stress the need for a more geographically dispersed and flexible midwifery programs in Canada.

The Accessibility of Midwifery Education in Canada

The midwives that I interviewed all have different stories to tell about their training as a midwife. All were happy with the education that finally allowed them to work as an independent midwife; however, it was not a straightforward process for anyone, whether it was in the 1970s, the 1980s or the 1990s. Today, there are still limited routes available to individuals in Canada that want to pursue midwifery. There are inadequate numbers of university courses because there are only three provinces out of thirteen provinces and territories that offer degrees in midwifery. Therefore, for most Canadians, the apprenticeship route is still the most readily available. Even though midwifery apprenticeship training may be the most accessible route in Canada, it is also the most problematic. In September 2001, representatives from midwifery communities in every province and territory, including one interviewee, signed a reciprocity document about many issues facing midwives.³¹ One issue that was addressed was the education of midwives. It was agreed that every

³⁰Amy's descriptions of the mistakes made in the Ontario granny-ing-in process are highlighted earlier in this chapter.

³¹Sarah was unable to provide the title of the document and I have contacted the College of Midwives of Ontario several times over many months to obtain a copy of the reciprocity agreement. To date, they have yet to send me one.

province would follow the same standards in educating their aspiring midwives. They all agreed upon a Bachelor of Midwifery. One of the arguments used for this decision was the reciprocity this would allow between provinces as midwives moved.

Sarah: So we had to, in effect, make midwifery coincide with the free trade mandate whereby we couldn't impose undue restrictions for midwifery practise throughout Canada. So in doing that we had to really research and investigate what standard would be acceptable for midwifery in province 'A' to accept a midwife who was regulated from province 'B' without needing to impose further examination, no restrictions on them. So, through that there were, there are minimum requirements and those requirements were agreed upon.

The midwives who pursue apprenticeship training in Canada may find this problematic in the future as this may limit their ability to practise in provinces and territories that have existing midwifery legislation; their skills may not be recognized if they do not possess a university degree in midwifery. If this is the case, the provinces and territories should provide a granny-ing-in process that is shorter and less expensive than the PLEA³² process that is in effect in Ontario. Although there is a document stating a minimum requirement of a Bachelor of Midwifery for education programs in Canada, not every province or territory offers a university degree for aspiring midwives. In acknowledgment that a formal education program is still elusive in Canada, I asked my interview participants how they envision midwifery education in their home province. In the next chapter, the suggestions that are made by the midwives are examined.

Conclusion

Each midwife interviewed obtained her education via the means most viable for her, taking into account constraints imposed by geography and family. Limited accessibility to formal training programs due to geography was the most pressing issue for the midwives interviewed. This was further emphasized by their inability to relocate due to family concerns. For each, it was many years before they were in a position to pursue any formal training, and to receive the full spectrum of training they felt necessary for the career in midwifery. Many of them felt their training was lacking in some areas, such as the volume of births as in Laura's case, to a deficiency in a structured overview of the scientific side of midwifery, as in Kenzie's case. It is important to recognize the educational routes that each midwife followed because it highlights the need for a varied approach to midwifery education in Canada. Until university midwifery programs are offered in universities with extensions for distance learning sites across Canada, the accessibility of midwifery education remains limited. Indeed, I believe that we should not confine ourselves to university programs, but offer midwifery programs in community colleges and through distance learning sites to accommodate those that wish to pursue midwifery but are unable to relocate and will then be most likely to remain in these more remote locations to practise. In chapter six I will discuss that variety of options that should be available in Canada.

³²Please see chapter four for more details about the PLEA process.

Proposed Education Systems and Possible Changes to the Ontario Program

Introduction

In Canada there are four universities that offer a university baccalaureate degree in midwifery, with a fifth one beginning this fall. In previous chapters, I have outlined the schools in Ontario and Québec, and in September 2002, the University of British Columbia will begin a program. The university programs available to those interested in pursuing midwifery are relatively few and far between. Ontario was the first province to offer a university midwifery education program and British Columbia views the Ontario program as a template for its own curriculum.

During the interviews I conducted with the seven midwives, I asked them what they envisioned as the most appropriate route for midwifery education in their own province. All of the midwives I interviewed believe that a university based midwifery program in combination with a strong clinical component is the most appropriate route for midwifery education in Canada, even though not all of them have gone through this model, nor do they wish to. The interview participants were well aware of some of the difficulties associated with this, such as accessibility and family constraints, and they propose different options that should be made available to aspiring midwives to facilitate the process. In Saskatchewan, Anne proposes with the inception of an education program that community colleges be used as distance sites to train midwives for the first two years to reach out to diverse populations and then begin a university midwifery program.

The midwives that I interviewed in Ontario shared their thoughts about midwifery education outside of legislation and legalization. I also explore midwifery education in various communities; suggestions for an education program in Saskatchewan and Nova Scotia and proposed changes for the Ontario model.

Midwifery Outside of Legislation and Legalization

Saskatchewan

For midwifery in Canada to exist as an independent health care profession, midwives realize that the profession must become legalized and offer a university degree in midwifery to gain credibility and acceptance in the existing health care model and by the general population. As previously mentioned, the Saskatchewan government has not proclaimed midwifery in the province, nor does the government see a midwifery education program in the province as a priority. "Well, right now, it's not so much a priority because we don't even have it [legalized midwifery] [...] Like there's no way they're going to put up a big educational system here when it's not legal yet" (Anne). The Saskatchewan College of Midwives and the Saskatchewan Government have documented very little about midwifery education. Currently, the only education available to aspiring midwives in Saskatchewan is to leave the province to obtain education and then return to practice, or apprentice with a local midwife and then become 'registrable' in another province. The aspiring midwives do not need to register in another province, but they need to be registrable.

Elizabeth: *[If] you are registrable in [another province] then you can become registered in Saskatchewan.*

Jessica: *Ok, so you don't actually have to register in another province?*

Elizabeth: *No [...] 'cause it doesn't make sense if you're living in Saskatchewan to pay probably \$8000 between insurance and the College and Associations fees in another province not to practise just so you become registered in Saskatchewan and pay all their dues. [...] I think what we looked at was registrable when we were working on, looking at the Implementation Working Group [to avoid paying dues in two provinces].*

This is problematic because Saskatchewan is not offering aspiring midwives a salary, access to hospitals, or insurance upon their return to the province.

Anne: *To have midwives go and train in another place, I don't think they'll come back. There's no reason why some couldn't train in another place and come back, but if they really want to have it, you have to have education available where people live. Because most midwives are women, most women who want to become midwives have families. Not all, but many do and if they're already living here it's because somebody in the family is working. And so, to get up and uproot and just go is very difficult for somebody of the age who is usually starting a career.*

Jessica: *Ok, so you see that as problematic, that midwives may go [to another province] and register and not come back?*

Elizabeth: *In this situation in Saskatchewan, yeah, but if it were legislated and publicly funded, I can see that we, it may actually be attractive to midwives who are working in other provinces. Even provinces that are already publicly funded, I think we could see some mobility from those provinces to Saskatchewan. It's my sense from talking from other midwives in those provinces.*

Anne is unsure why the Association of Saskatchewan Midwives agreed to this form of registration, to have midwives and aspiring midwives leave the province to become 'registrable' in another province and then return to Saskatchewan to work. She believes it may be because they never realized what going to another province to become registrable entailed.

Anne: *So, I don't know how we ever agreed to that thinking. Like so many years ago when we were putting together, 'cause midwives have participated in all the processes of Saskatchewan, but we haven't necessarily had the power to do things the way we wanted, but we participated. And basically, they probably said well, they're not enough midwives here to have a process to get a license here. So, midwives will have to do it through one, go the other provinces and then have their license here and then come back with their license. But then, I don't think anybody at the time ever realized that you would actually have to go to BC to up to a year. 'Cause if we would've known that nobody would have agreed to it. Like we didn't even know what it entailed. If it entailed just going somewhere for exams, that doesn't seem like a big deal. Even though it costs money you're expected to spend money. Like, I think Saskatchewan people will almost always have to go for the practical exams, like the oral exams because they're very expensive and that's reasonable. You fly somewhere on a seat sale, like six months ahead when it's going to be. You practise, you study or whatever, you fly here, you're there for two days of exams and you come home, no big deal. But to go time and time again to another province, like keep going there for every little thing, and then go and do work under supervision, it just doesn't make sense.*

For people that are interested in pursuing midwifery in Saskatchewan, the burden of becoming 'registrable', as recommended by the Saskatchewan Implementation Working Group and the Provincial Government, and relocating to another province to undergo

the exams is a double bind. They must find the financial resources to move and have the flexibility to relocate for a number of months. Elizabeth and Anne do not view this option as ideal.

Elizabeth and Anne both have very concrete ideas about what they would like to see in an education system in Saskatchewan. They both view the education of midwives in Saskatchewan as a priority, but not until the Midwifery Act is proclaimed.

Anne: Until it's proclaimed it's not legalized. But, if they want to have midwifery here, then they have to produce midwives. I mean that's just clear and to have midwives go and train in another place, I don't think they'll come back. There's no reason why some couldn't train in another place and come back, but if they really want to have it, you have to have education available where people live.

Elizabeth: I think it needs to be a priority. I think whether we have the funds or the manpower to, the capability to provide it here in our own province. If that isn't the case I think the government should have the foresight enough to buy seats elsewhere and really provide support as much as possible to women who [go to] another program. You know, but it definitely needs to be a priority 'cause I must say, we need to generate more midwives.

The education of midwives in Saskatchewan is important, but first the government must legalize midwifery.

Ontario

The midwives I interviewed in Ontario also believe that a midwifery education in a province that is legalizing midwifery needs to prioritize midwifery education for many reasons. They vary from financial reasons, to the volume births that the aspiring midwives could attend.

Meghan: I definitely think it should be prioritized, I don't see how, if you legalize it, but don't have an education program, you're going to have very few midwives when you don't have an education route for them. And it's much more expensive for them to have to leave, less successful, if they have to leave their province to get educated in another province and then move back. If they come back, once you make contacts, and then, spend that many years in another province, it creates a real sense of community amongst the midwives in that province. When they're educated together and they make contacts and establish networks in terms of setting up new practises and having a sense of knowing how they're practising in a group. It's a different, at least what the diversity is, what the kind of arrangement of the practises are, where they kinda fit in, where they feel comfortable, that all gets increased when you have an educational program. More accessible, more affordable when one is developed in your province.

Amy believes:

Amy: I think it's kinda goofy to have a legislated profession and not have education available for them.

Kenzie also believes that midwifery education needs to be a priority as legislation is passed. She recognizes the barriers that exist in pursuing midwifery when someone is forced to relocate to another province.

Kenzie: [Education] should be [a priority]. Yeah, I mean simply because I've been very privileged in being able to move and to have the finances and family support to be able to move out here and that's not the case for everybody. People might be single parents or whatever, and families are the main support so to pull that single mother with her child out of her support system and hold her down to some place she's never lived before that's more expensive to live and so on,

it's just not an option. It just will not happen. Or not until those people are older, you don't have as many working years by virtue of the fact that they have to delay training until they're not as in need [of] that support system that they need to have at home. I think it should be a priority for Saskatchewan for sure.

Ontario midwives realize the importance of having an education system in place in every province. They realize that the midwifery education program that exists in Ontario is not perfect; but overall they are content with the current model.

Nova Scotia

Unlike Ontario, Nova Scotia does not have a midwifery education program in place, nor do they have plans for one. For the Association of Nova Scotia Midwives and for the Midwifery Coalition of Nova Scotia, their first priority is getting midwifery legalized in the province. However, once this first step has been attained, they would like to see the development of an education program for midwives in the province take priority.

Sarah and Laura believe that an education program for midwives in Nova Scotia needs to be a priority after it is legalized. Laura deems the education of midwives as fundamental, that we cannot ask midwives to be part of the health care system but not educate them. However, it is hard for Laura to imagine a midwifery education program in the immediate future because there are not enough midwives to work with incoming midwifery students. She believes that “we may have to “import” them” (Laura), meaning midwifery educators, until the numbers in Nova Scotia increase. However, we must ask how practical and realistic this may be. This could take, according to Laura, about five years to attain legalization and an education system. Sarah believes:

Sarah: Oh, I mean, ideally it should be [a priority], it all should be part of the package. It's just whether, I mean if they're inherent upon legislation, [...] otherwise it's a different situation. And we have lots of midwives who would love to practise in Nova Scotia once it's regulated who are practising elsewhere in regulated provinces so even that would generate an increase in the number of midwives practising here. And some of them are just waiting here [for legalization].

While the midwives in Nova Scotia propose an Atlantic School of Midwifery, they realize it may not happen for various reasons. First, midwifery needs to be legalized and second; there would not be enough teachers or preceptor placements. In Nova Scotia there are four practising midwives. For a university program to function, it would require more teachers and preceptor placements because the midwives who are working cannot teach, be a preceptor and be a full time midwife at one time. There are so few practising midwives in Atlantic Canada it will be difficult to find teachers and preceptorship placements for the students.

Midwifery Education in Various Communities

The diversity of midwifery students is an area that the midwives I interviewed all expressed needs to be worked on. For many aspiring midwives, the university education route is not accessible to them. Two areas that were identified as barriers to diversity through my interviews were financial and family constraints and living in an area where a university was not available and relocating is not an option. Some of the midwives I interviewed had some suggestions to aid in increasing the diversity once an education system has been established in Saskatchewan and Nova Scotia and what may assist in increasing diversity within Ontario.

Distant Learning Sites

For Anne, the diversity of a program in Saskatchewan must reach out to people of First Nations descent. This would allow the different Nations to practise midwifery according to their tradition while possessing the necessary knowledge that may have been lost by colonization. To attain this goal, Anne believes we need distant learning sites to reach reserves in the far north.

Anne: Like in Northern Saskatchewan, for example, if we had a birth centre, there's no reason that we couldn't formally train local midwives over a period of years. With a book, with lectures, videos, whatever, with exams, working as an apprenticeship, in that sort of model. But I think the person would have to write the challenge exams at the end. Like you have to prove competence. So, theory wise and by having someone watching you do deliveries, whether real or simulated. Probably both, to make sure that you were doing it well. Well, especially if I think about the nature of the communities in Canada. Like, why shouldn't they be able to train some of their people, particularly Aboriginal people without having to leave their whole environment. Like why should they have to leave at all? With so many things available through Internet, through distance education. Like you can beam programs up to community colleges in communities quite easily now. And I think it will be now, more and more the wave of the future. How can't you have that kind of system, 'cause really, the core of midwifery training is through mentorship. Like, you have to know the book stuff too. But you have to be able to interact with the people and do the hands on stuff. And you usually, you learn that by modeling somebody else's behaviour. [...] I think that you have to go to lots of prenatal visits, lots of births, lots of postnatal, lots of clinic work, all that stuff. I think it's really important. And I think that's why it has to be four years.

In creating distance learning sites, using the internet, telecommunication systems and community colleges, we would be creating and allowing more accessibility to midwifery education in isolated communities. The education offered through these different means would be based on the university model, but it would allow aspiring midwives to stay in their home community with their support systems and fewer financial demands.

Buying Seats from Established Education Programs

In Nova Scotia, Laura and Sarah propose an alternative in educating individuals that would like to pursue midwifery after legalization while there is no recognized education system in place. Laura and Sarah, along with some members from the Midwifery Coalition of Nova Scotia suggest that the government of Nova Scotia could buy seats in Ontario for the course work required and bring the students back to the province for the clinical component of the training. However, this may be problematic. I asked the Ontario midwives how they felt about this and I did not get a positive response.

Meghan: The few numbers of spots we have for students is limited by the number of clinical placements that we have. And we need more midwives. Ontario has a huge birth rate, we need midwives. For every spot that goes to someone who's waiting, every practise, well, every practise has a waiting list, we don't need to do anymore PR [public relations] because we'll just turn away more people, we need more midwives. So it will impact the growth, and the growth of midwifery in Ontario.

Buying seats from another province is not only problematic in that it will limit the number of midwives who will potentially work in Ontario, but the course work is closely tied to the clinical work. It is not easy to bring students in from another province and then have the students leave for the clinical placement. The sense of community that is created

among students, as noted earlier by Meghan, is also disrupted; it is not just a case of creating more spots within the existing midwifery education program in Ontario. Students, midwives and midwifery consumers are often a small community and a strong component of midwifery care is continuity of care.³³ As students come and go for clinical placement, the sense of community and continuity of care may be disrupted. As well, the limited number of students accepted in Ontario each year is in correspondence with the number of available midwives who can teach and act as preceptors. The number of midwives that are available to teach, the community that is created among students and midwifery practises, the finances available to the program and the numbers of possible Ontario midwives will be affected. To buy seats from Ontario for students in Nova Scotia or Saskatchewan is a very complex issue and could adversely affect the midwifery community in Ontario.

As expressed by the midwives in Saskatchewan, Ontario and Nova Scotia, it is not an ideal situation for student midwives be forced to leave their communities for their education. It disrupts the sense of community that is created among students and midwifery practises, it may disrupt their family life and the financial constraints placed upon them are not ideal. The midwives I interviewed all believe that midwifery education must be made accessible in various communities to improve upon these barriers and to increase diversity within the midwifery profession.

Proposed Education Programs

Education Model

In Saskatchewan, Anne and Elizabeth visualize midwifery education as a four year university Bachelor degree with a strong clinical component. Essentially, they would like to see it modeled after the Ontario midwifery program; however, they realize that some differences would have to exist. A few distinctions they propose are to have a distance learning component in which community colleges would be used and they would like to see more diversity within the program, especially among the First Nations community.

Incorporating distance learning sites would be imperative to allow for a range of people within the program. Anne and Elizabeth do not mind if the University of Regina or the University of Saskatchewan (Saskatoon) is the main site, as long as an extension to community colleges would make it accessible to rural aspiring midwives.

Elizabeth: Well, I would propose [a] Bachelor of Midwifery, a direct entry, I would support a direct entry Bachelor for Midwifery, Health Sciences and Midwifery. I would like to see a distance aspect to it so that rural women can [...] get on board. So that they can do some of that at home. And I would agree a proportion of it concentrated on attending births with physicians in hospitals. As well as, you know, because you're not going to get the same amount of volume and in just observing birth is helpful. And so a concentration of clinical as well. [...] I think they need to be introduced to the clinical setting, like soon after they start and [...] I think it can be one [university] site. Like use the other university site as an extension of the original, program or the initial program.

Anne: Well it needs to be a four-year degree so it's the same qualifications in every province because there has to be reciprocity [between provinces]. But I think if they were really serious about midwives eventually do the majority of normal births in the province, which they should

³³Continuity of care is a core principal of midwifery care across Canada. This means that a midwifery consumer will consistently see the same midwife, and student, throughout her pregnancy, labour, birth and post-partum.

be very serious about very soon because physicians aren't interested in doing it, except obstetricians and that's a damn waste of money to have them do it, plus, they don't give the same kind of service that midwives do. [...] If they really were serious, like if they were, future thinkers they would have a degree of midwifery available by distance education through several universities and the first two years available through several community colleges. Particularly in areas where there's a lot of Aboriginal people, trying to get them involved in becoming midwives. Because the majority of births in Saskatchewan, increasingly among people of Aboriginal descent. So, it's quite a hands on profession, nevertheless, if people, are starting their training in midwifery when they have some younger children, maybe they could start with the classes at a community college, little by little and take this four year degree, over six or eight years [...] but you could start it little by little. You still need to have a strong hands on component where they do; like they do the numbers of births they get to at McMaster is very good. I think they need to have that same thing here.

In creating distance learning sites in Saskatchewan, midwifery education will become more accessible, and affordable, for many people. Without the cost of relocating to a city with a university, midwifery education becomes feasible for many more individuals.

Ontario has had a university midwifery education program since September 1993 with the inception of legalized midwifery. With the university education system being the only recognized system in the province;³⁴ the midwifery apprenticeship model became obsolete for those wishing to pursue midwifery through this path.

The system that is currently in place is a four-year Bachelor of Health Sciences in Midwifery degree offered at three different sites. Ryerson University in Toronto offers a part time English program, McMaster University in Hamilton offers a full time English program and Laurentian University in Sudbury offers a full time English and French program.

I interviewed three midwives in Ontario and two of them have gone through the university program and one was certified through the Michener Program in Toronto. Rather than ask them what they envision as an appropriate education program for midwives, I asked them about their thoughts about the university program that already exists. Overall, they all believe that the system in place is a very comprehensive and challenging degree. Kenzie and Meghan are content they went through the program.

Kenzie: The university program, there were a lot of things that were valuable. Not, the least which was its focus. So I knew that I would get what I needed and be able to practise midwifery in four years. The courses were very full. The range of courses I felt was really quite valuable, normal anatomy and physiology and reproductive physiology, pharmacology, a bit of chemistry, biological sciences, studies, research methods, health promotion, health education, all those kinds of classes. It was quite valuable for the most part. There were some of the courses that I found slightly less valuable but one of the things with the program in Ontario, there really is quite a strong component of what I call apprenticeship, which is two and a half years of clinical placement. So you have an opportunity to work with usually at least two or three different

³⁴Ontario also has the Prior Learning and Experience Assessment (PLEA) evaluation. This route, as mentioned in chapter three, is for individuals who have prior midwifery training. I have chosen not to examine this form of learning here because for aspiring midwives, this route is not an option. Also, my intent in this thesis was to examine midwives in three provinces and to talk about their training and how they view the education of midwives. I was unable to interview a midwife that had participated in the PLEA evaluation and therefore I feel unable to examine it as thoroughly as the University Program. For more details about PLEA, please see chapter three and Sheryl Nestel's PhD thesis "Obstructed Labour: Race and Gender in the Reemergence of Midwifery" (2000), or contact the College of Midwives of Ontario. Appendix A

practises and getting that range of experiences that I felt we needed. And also working with other care providers you don't have that whole, how do you work collegially and collaboratively with your other health care providers. In Saskatchewan [where it is not legalized], it wasn't an option. They didn't see us as legitimate and so the connection wasn't there in the same way, it was in a legislated environment where they can point to your curriculum and say, I know how you've been trained and who trained you and that kind of thing and there's a legitimacy with it that, apprentice training doesn't.

Meghan: *Initially, I thought, like most people thought that you had to move for four years or three years, to campus, Laurentian, McMaster or Ryerson, but it's not like that at all. I lived about two hours from the university that I applied to and I stayed at home my first year. I did the courses, things like that, I did at a distance. It's all geared to allow you to send in, do your exams at a distance. I had an invigilator in my hometown, so I didn't have to do that. I drove once every two weeks or once a week to the campus for a three-hour course with the other midwifery students and with a midwife for the first term. That was very manageable and I had my clients that I followed two hours from home in that community, near the university, which I had to meet with so I had a schedule around the days that I was driving there. It was all very manageable with my young family to stay home for that whole first year, which made it accessible for me. And then the next two years during my clinical placements, two were not in that community, so I had to move, I moved for four months at a time, twice. Each time and I lived; I found a place to live. Midwives helped with that or friends there, rather inexpensively, they were very understanding, I was able to take my weekend off call per month and I would go home and they [children and husband] came on weekends in between to stay with me for a long weekend. So, we managed. With lots of support at home from my mother and my husband was very available and did a lot with the kids. Then I had a placement much closer to home, which, I lived at home. I was on call from home, which was great, and I had my final placement [far from home], that was my hardest one. But they were three years older and I was away for three months. And they came down, again I went home for the one weekend and they came down once. My husband would take them out of school for a week as well and they would come down and stay for a week when I was on call.*

While Amy did not go through the University program, she has some thoughts about it from working as a supervisor for student midwives and appreciates the differences between a university system and an apprenticeship route.

Amy: *Roughly half of the program is, runs on clinical work, having a placement in practises in, around Ontario, so I have gotten to hear the groaning about different stuff, why do we have to know what hormone? You know, the molecular stuff that they have to cover and so on. I'm much more of a hands on, it's got to be big enough for me to see, kind of gal. I appreciate that people have the more cellular knowledge kind of stuff, I'm happy to have them tell me about it, rather than reading about it myself.*

Aspiring midwives in Ontario are privileged to have a university degree in midwifery. While the accessibility of the program still eludes many individuals, people interested in pursuing midwifery in Ontario are not required to leave the province for midwifery education.

In Nova Scotia, both interview participants recommend a four-year Bachelor degree as a standard for midwifery education. "Midwifery should be a bachelor's degree" (Laura). Sarah notes that "ideally it would be an Atlantic School of Midwifery". Laura believes that it is the obvious choice, but she is not sure where "the midwifery teachers for an educational program will be found in Atlantic Canada". None of the Atlantic Provinces have legalized

midwifery, hence, there are few practising midwives and even fewer that would be available to teach and act as preceptors. Laura noted that they need legalized midwifery first and experienced midwives on top of that before they can develop a school. Nevertheless, an Atlantic School of Midwifery is an option if there were the necessary number of midwives who could act as preceptors and teachers.

Education Curricula and Admission Considerations

In the education system that Elizabeth and Anne propose in Saskatchewan, they believe the admission requirements should be a combination of academic achievement and the person's background so the program is as inclusive as possible. A person's background would include their desire to become a midwife, their involvement in their community and any previous experience they may have with birthing.

Anne: It has to be competitive through both application and interview and partly based on a person's prior life experience. Not necessarily people out of grade twelve 'cause they don't have a clue what they're getting into. It should be an interview process, both application and verbal interview, try and get a variety of people from different cultural backgrounds and who have enough academic know how to get through a four year degree because it's not just touchy feely. Like they have to be able to pass the sciences. So they would probably have to have at least a B average in high school. So, but I'm not sure all the best midwives are, want particularly one way or another. There's so many good ones, people are different right? Like they're not all scientific. It's not just a science, it's an art with science, so we don't want to lose the art part to it.

Elizabeth: Well, I think we can learn from what is happening in other provinces, and their admission requirements and I think we would have to take a serious look at what they are, how successful they've been, why they put those admission criteria in place. I think that's where we would have to start for sure and then do the research into and then see what successes and changes could be made. I don't have anything sort of in my head that would say definitely this, this or this 'cause I don't think we can exclude people. We have to make it as inclusive as possible [for] all cultures, for different age's rural and urban women, that kind of thing. Like we have to look at an inclusive model for education as well, and so, that would be the best out of every province and what they've put in.

In the curriculum Anne believes that "A good theoretical and good clinical component. Working with preceptors the same as there [Ontario]" is necessary. Neither Anne nor Elizabeth addresses the issue about how to make the clinical component available from a distance. I would surmise that the College of Saskatchewan Midwives would concentrate on training midwives in urban centres and following the establishment of a base number of midwives, they could establish midwives in other communities to offer the clinical component.

Anne also proposes an alternate system for women who live in the far north of Saskatchewan and may not have access to a university or a community college.

Anne: I think working with a preceptor in a university setting is probably the way that I think would be the best even though I didn't do that. [...] But just because of the fact that some places are more isolated. Like, some of the programs that had, I think are quite interesting in Canada have to do with Northern communities. Like, I think that some programs would be creative and thinking of ways to integrate an apprenticeship model that would, could take place in a community with a distance education component that we might not have at a university.

Meghan, from Ontario, has some suggestions for the curriculum in the Ontario model. Today, she would like to see more education about lactation and breastfeeding; in the past,

she addressed her concern about more education in alternative medicine. Overall she is very satisfied with the program.

Meghan: *I think they've made some changes and are offering more, education of the alternative modalities and therapies, I think that they've increased the science background or the science slant a little bit. Which I think is a recommendation that we made. There were a few areas that we would have found to have more helpful, to have a bit more education background in those areas. [...] I enjoy the good balance of the clinical with the academic. I think the McMaster style of learning with the distance education with the small groups was excellent, the onus on the student to go off and do the research, the self-directed learning is really, really excellent. I think that the clinical placements are in many ways like an apprenticeship. They're not exactly, but, I think it's a pretty good balance, where you are learning from one midwife or a couple of midwives and learning from their particular strengths and skills, things that aren't in the program. [...] [As a preceptor today] I'm getting the impression that we're seeing more younger students that don't [have] the experience of having had children and breastfeeding. So I think maybe some more educating, formal education in the system about breastfeeding. Breastfeeding matters need to be in there, they get a lot of it clinically but I think they need more academic background, some more breastfeed, something with lactation, working with lactation consultants, more intensives to prepare them. With problems and how to work on them. [...] I just think we need to adjust the program as the age changes and the background of the student's changes. When I applied most, when I got in, most students had a degree in something else, so that meant that we were a little older, so there were just so many people applying they could pick and choose. Most students had had children, had exposure to midwifery in one form or another and that's changing.*

The basic admission requirements that Sarah and Laura envision in Nova Scotia are very similar to the Ontario admission requirements. Laura also stresses that an individual's academic record is important, but that the person's background should also be considered. Sarah believes that:

Sarah: *I think realistically what you're going to see, like in Ontario the basic requirements may be high school but because they've got so many people applying it's going to raise the bar up. I think that's going to happen everywhere.*

Sarah would like to see the program curriculum modeled after Ontario and would like a qualifying process similar to the Michener Program applied in Nova Scotia with legalization.

Sarah: *Ideally it would be very similar to what you have in Ontario. Having a one year education and exam for currently practising midwifery to in effect granny them in, to train them in things that they haven't had the exposure to, through no fault of their own but because it's not regulated because certain hospital procedures and other things. So do a one year one time only in a program and after that, it would be a four-year baccalaureate program.*

The Nova Scotia midwives I interviewed believe that the midwifery program should have a good grounding in basic biology and chemistry, yet not be an exclusive science basis. The different aspects of midwifery care need to be included; the biology and "the biophysical" (Laura).

The situation in Nova Scotia with regard to legalization and a midwifery education system are very similar to Saskatchewan. Both provinces believe that a Bachelor degree should be required. The midwives that I interviewed in Saskatchewan, Ontario and Nova Scotia view the education of midwives as essential.

Proposed changes to the Ontario Model

Even though Kenzie, Meghan and Amy are happy with the university education system in Ontario, they recognize that it is also a demanding program.

Meghan: *It's a very, very, demanding program, it's easier [being a midwife than a student], it's hard being a midwife, midwives that haven't gone through the program there's pre-registration, I think, don't think fully appreciate it. It's a hard job being a midwife, it's very demanding, but it's easier than being a student. I found it, but I had a full-time family, I was a full time, trying, to be a full time mother, well, I was a full time parent anyway, I was a full time student, and a full time midwife. I was expected to be a full time midwife. It was very hard.*

Kenzie: *It's not an easy course because it's, your on call, there's no opportunity to work during the four years if you are in the program full-time. You're on call all the time right now, the clinical placement is a lottery process. So you have an opportunity to be able to tell the program where, sort of three spots that you would most like to work at, maybe because of midwives you heard of or maybe because of location or whatever. But it's a lottery process so you may put down Hamilton, Oakville, Mississauga, because they are ones that are close to you. You could be placed in Mississauga for a year but I've got three kids who are in high school, I'm not going to be dragging them out of high school to bring them to Mississauga with me. So for myself, and I would say for most students in the program, there were times when you were away from the family for extended periods of time. I went to Ottawa for three months on my own and found other accommodation which you know comes at a cost. And [I] worked in a practise in Guelph which I commuted, I went to British Columbia to work with a naturopath there for a month, and I worked in Oakville for a year but commuted from Hamilton so, and then worked in Hamilton for a year or so. [...] You know we've gotta have a car that works well, like you gotta have money to put gas in the car, you've got to have extraordinary childcare or kids that are older so that they can take care of themselves because you are coming and going at all hours of the day and night, that takes it's toll I think. It's not something everybody can accommodate and it was something that I seriously, I thought really seriously about before getting into to it. Which is why I am forty, which is why I delayed getting my training, my education. I just felt like it was too high a price to pay to do it when the kids were young. I have no regrets about that.*

With all of these demands placed upon them I asked if they had any changes they would like to see made to the program. Oddly enough, only Amy, who did not follow the university program, mentioned the volume as a possible change.

Amy: *Sure, not to run the students ragged. Yeah, that's a hard one, once again this isn't anybody's fault, it's just that, it's hard when students have to move and, and what not, to have their placements, especially when they have families. It's very difficult. So my bottom line with that is well, so don't do it while you have young families.*

Kenzie believes that the program needs to recognize adult learners in a better way and to work on the diversity of the students within the program.

Kenzie: *Overall I am happy with the education program. I think that it is a program that is evolving. I think it is quite an adequate education in midwifery. Having said that are there things that I would like to see change in the program? [...] I would like to see a bit more of the recognition of adult learning. McMaster has quite a reputation for problem-based learning and that is a component of the program, and I really enjoyed that component of the program because it more learner directed, learner focused a lot of the courses are like that and some are very challenging just simply because an adult learner didn't take into consideration my life experience, my ability to be an independent learner. [...] I think that the clinical placement*

that is an asset to that model and to that approach which are very challenging for students. Sometimes they are, you're working with a preceptor, like one person who is kinda responsible for you [...] and if there's a personality conflict, with a dynamic that's not working very well it can be very difficult. First of all, you can fail, it can be a very difficult learning environment. And the preceptor, I mean the midwives are really quite fabulous at willing to take students on and teach them and share their knowledge. I'm mostly grateful for that, but a lot of these are people who have never taught before who have never had responsibility to be a guide to a student and I think that that's made it sometimes really [difficult], having to work at that dynamic and that interaction and giving it more energy and perhaps one would think that one wouldn't have to. Which maybe took away from your ability to actually learn what you are supposed to learn. And my other comment about the program is that I think generally there is a real focus on, I'm not sure how to say this, on a middle of the road type of client. By middle of the road, I mean middle class, white, from privileged and so on. And while there are attempts within the program to recognize diversity and the population of childbearing women I really think it's got a ways to go to actually, helping to aid learners to understand the depth of that diversity and the ways in which we as health care workers can be aware and strong in our abilities to be able to support women who may have English as their second language, or just learning English who may have significant cultural differences that makes, providing care to them very challenging within, within sort of the, the mainstream maternity care. So anyway I think there's a way to go in improving that. And they're aware of it, it's just one of those things that's hard to change. And one of the other issues is that most people being accepted in the program are middle class white women because they're the ones that have the financial backing who can do it. So not to say that people that are non-white and non-rich, but you know I mean, there are certainly more of a, they are in higher numbers well anyway, more privileged.

Meghan recommends changes to the curriculum to adapt to the type of students that are currently in the program. She believes that the students today are less likely to have children than when she was a student; hence the program needs to offer more extensive courses in breastfeeding and lactation. The changes that each of the interview participants mention are all difficulties that arise in a new program. As Kenzie described it, it is a program that is evolving.

Conclusion

From the point of view of an aspiring midwife, and as an applicant to the Ontario midwifery education program, the issues addressed by the interview participants are important to me and other aspiring midwives. I do have some reservations about midwifery training being available only through university. The midwifery profession exists to guide women through pregnancy and childbirth physically, mentally and emotionally. Through a university setting, the danger exists that the art of midwifery may be lost. Many advocates of the university program disagree, but there is a fine line dividing the art and the science of midwifery. They are both equally important, but the art of midwifery cannot be taught in a classroom. The extensive clinical component in the Ontario model exists in part to make sure that this does not happen. However, with nearly two years of course work before a midwifery student begins working primarily with a midwifery practise during her clinical rotation, a sense of institutionalization may have already begun.

With the reciprocity document that was signed in September 2001 stating that the minimum requirement for midwifery training across Canada must be a Bachelor of Midwifery, the creation of university based programs will become the norm across the country. On the positive side, this will allow for easier acceptance among peers in the

country as midwifery is legalized. This also allows people to see exactly what type and how much training individuals have undergone. However, we must approach this cautiously as the opportunity to relocate to where programs exist may be limited for many individuals and the financial cost may be too much for some.

We must keep in mind the restrictions of relocating and the financial cost that may be imposed on some individuals wanting to pursue midwifery. For some aspiring midwives, the restriction of moving may be the main factor. As suggested by Anne and Elizabeth, we need to create distance learning sites to help those who cannot relocate. In turn, this may create and maintain diversity within the program. The midwifery program will be reaching out to communities of people that may otherwise be unable to access midwifery education, for example First Nations people in remote Northern Saskatchewan. We must make midwifery as accessible as possible through different sites. With a distance education component the chances of preserving cultures and communities increases.

Another fundamental issue with a university based program is the financial cost. A university education is expensive, and the midwifery program is even more so.

Kenzie: It's not an easy program at many different levels; it's not an easy program in part because it's very costly. It's one of my issues with midwifery education in Canada right now. Only those who are privileged enough to have money can get into midwifery, so there's a real barrier there. I was very fortunate.

By providing training in a person's home community, it may help ease the financial burden because they will not need to pay for relocating. As well, by allowing people to stay in their home communities with their support networks will help aspiring midwives attain their goals.

In Ontario, legalized midwifery is a new profession and therefore the access to bursaries and scholarships remains limited. Amy believes that anyone in Canada who truly would like to pursue university studies can do so; I disagree. Financially, many individuals will rely solely on student loans or family support to pay for midwifery training. For some, incurring debt through student loans may not be possible, or desirable. For others, they may not qualify for a student loan and they may not have family financial support. The midwifery program in Ontario is expensive. The cost of tuition for one year amounts to \$4106.00 at Laurentian University. The accessory fees are approximately \$319 and the cost of books and equipment can range from \$500 to \$1000. Owning a car is also a requirement of the program (Baril 2002). These are only the costs for the first year and do not include living expenses. Once the clinical rotation begins in the following years, the student is also responsible of the cost of moving to another community during the placements while maintaining a base residence in the city where their university is located on top of tuition, books and accessory fees. In my letter of acceptance from Laurentian University I am strongly advised "that you consider the financial implications of this four year program" (Baril 2002, 1). It is clear that this program is not accessible to everyone.

The apprenticeship style of training midwives has been the historical method in Canada to learn midwifery skills. The growing importance of a university based education and the stature that this portrays for the midwifery profession in Canada has marginalized apprenticeship. There are still apprentice midwives in Canada and we must ask ourselves how they will be assessed in their own province as legislation passes. Will we learn from Ontario's implementation mistakes as described by Amy? Will their

skills and their knowledge be accepted? We must keep these questions in mind while implementing midwifery services in Canada. Apprenticeship training is becoming a thing of the past. Ideally, I would like the apprenticeship route to remain, but realistically with the trend within Canada and the viewpoints of midwives today, learning to be a midwife by apprenticing will become documented history. By either creating community based programs, distance sites based on the university program, or offering an apprenticeship education, or a combination thereof, would aid in making midwifery education more accessible.

CHAPTER SEVEN:

Conclusion

When I began my research within midwifery communities I expected to find that accessing midwifery education may have been difficult for some of my interview participants and that they may experience, or have experienced, difficulties in their practise with the inception of legislation. I discovered that all the midwives I interviewed had some barriers and difficulties in accessing education. However, only one midwife experienced difficulties in becoming registered in Ontario when midwifery was legalized. Another midwife feels she has been held back because the province has not legalized midwifery and therefore has not officially recognized her skills; this has prevented her from attaining desired educational routes. Because of these findings I have highlighted the various educational routes that the midwives followed and the different barriers and difficulties they faced. I also focused on the current and proposed education program in Saskatchewan, Ontario and Nova Scotia. Although none of the midwives I interviewed are in a position to directly influence the policy makers and the governments, it is important to recognize their expertise in the area because they have lived through the various stages of midwifery legislation and the different models of education available. Their experiences have much to offer other aspiring midwives and the Saskatchewan and Nova Scotia Governments as midwifery is legalized and as education systems are developed.

To help understand midwifery today, I believe it is important to understand how midwifery was phased out of Canada. I provide a brief history of midwifery in Canada. The current trends in this country are based on the past, in particular the resistance to implement midwifery into the health care system and the limited accessibility of education for midwives. As legislation is being examined in nearly every province and territory by the local governments, midwifery consumers, advocates and midwives often ask how it was possible that midwives nearly disappeared in the first place. It is for this reason that I include a historical background.

In Canada the current trend is to legalize midwifery. Every province and territory is doing this on their own time. I have outlined the stage that Saskatchewan, Ontario and Nova Scotia are at in implementing legislated midwifery. Each province has its own history of midwifery and they are at different stages in executing midwifery services into the health care system. It is important to understand the history of midwifery because we can help reduce, or eliminate past problems. The legislation is important to understand in order to appreciate why certain midwives have gone to the lengths that they have to pursue midwifery. In some cases, it involved a move to another country, and for others it meant apprenticing with a local midwife.

In Canada, midwifery education still eludes many aspiring midwives. Despite the many obstacles that my interview participants faced, they all persisted to attain their goal. Until the 1990s, apprenticeship training was the only option available to aspiring midwives who did not have a nursing background in Canada. With the legalization of midwifery in Ontario in 1994, this changed. Ontario offered the first university midwifery education program in Canada and it has now become the model on which British Columbia is basing its program on. It has become accepted, and expected, across Saskatchewan, Ontario and Nova Scotia that a Bachelor of Midwifery will eventually be the only accepted route

of midwifery education. The reciprocity document signed states that this must be the minimum standard across Canada. This could potentially cause problems for midwives who are currently pursuing midwifery training through an apprenticeship, or for midwives that do not have a university degree in midwifery as legislation is enacted into their province or territory. Nearly all the midwives I talked with considered midwifery apprenticeship as their preferred method to learn the necessary skills. Despite this, and contrary to my expectations, none of them would recommend this today because of the changes that are taking place across Canada with regards to legalization. They all suggest to aspiring midwives to apply to the universities in British Columbia, Ontario or Québec.

I had expected to find that the midwives I talked with would have preferred an apprentice style of midwifery training; I discovered that they preferred the university route with a heavy emphasis on a clinical rotation. There are several reasons for this. The midwives I interviewed all mentioned the “status” that a university education offers aspiring midwives. It also provides a more detailed background in the sciences. These seemed to be the top two reasons for developing a university based education program. However, each midwife also mentioned the necessity to have a clinical, or preceptorship, component to the program because midwifery is not just science, nor is it just art, it is a combination thereof. The midwives I talked with believe that a university midwifery education program is the best way to provide these together.

I realized while conducting my research that the education of midwives in Canada is a priority, but it is still secondary to the legalization of midwifery and financial remuneration by the government in each respective province and territory. I believe that without an education system in place with the inception of legislation in any given province or territory, the number of practising midwives will not increase. It may in fact drop because people may no longer meet the criteria for practising midwifery. Without a program to upgrade their skills many people may discontinue to practise. My interview participants echoed this same sentiment. It must be made clear to the provincial and territorial governments that as legislation is enacted, a salary and an education program are priorities to the midwifery communities or we may in fact see an end to practising midwives.

The inception of a midwifery education program is a priority for the midwives I interviewed and it is essential to the survival of the profession. It is important for the governments and policy makers to keep this in mind while they legalize midwifery in the provinces and territories in Canada. The issue of accessibility to midwifery education and the financial cost are two areas that need to be addressed in the Ontario program and they need to be improved upon in other provinces as education programs are developed. If these two issues are addressed, it may be easier to have a more diverse population in the midwifery programs.

Recommendations for Future Research Directions

Midwives in Saskatchewan, Ontario and Nova Scotia have all gone through different routes to become practising midwives in Canada. Their education has spanned over three decades with available options for training expanding every decade. However, as the legalization of midwifery happens all over the country we may see a narrowing of available educational routes. The requirement enacted in every province may not allow for a diversity of training, as identified by the interviews I conducted. The legalization is the first step in implementing midwifery services and after this first step has been achieved, the education

of midwives becomes a priority. However, it became apparent to me that setting up a midwifery education program is complicated. I have chosen to focus solely on the education that midwives undertook and the proposals they make about midwifery education because there were so many other issues that come into play, such as financial remuneration by the government and the importance of diversity within the midwifery education systems and communities.

The diversity within the Ontario program; the financial remuneration for midwives in Saskatchewan and Nova Scotia; the accessibility of midwifery education across Canada; the role of aspiring midwives families, the issue of “buying seats” in existing education programs; and in the case of Saskatchewan and Nova Scotia, aspiring midwives following apprenticeship training and the complications that may arise in the future as university training becomes inevitable, are all issues the need to be investigated. There is a paucity of research done in these areas. The interview participants identified each of these themes. I believe these topics are necessary to mention but are beyond the scope of this research.

A final note

I am interested in midwifery education in Canada because I am myself an aspiring midwife. I have spent many years trying to decide what the best options are for me in today’s changing system. I pondered whether or not I should pursue a Bachelor of Sciences, or apply to midwifery programs internationally. I wondered whether I should try apprenticeship training or apply to existing university midwifery education programs. I discovered while I was doing my own personal research that there is limited information available to aspiring midwives in Canada. It became apparent to me that while continuing my research I could potentially help other aspiring midwives. To do so, I first needed to learn more about the experiences of midwives across Canada to learn and confirm some of my own feelings, thoughts and discoveries. I believe with this research, I have outlined the range of possibilities for aspiring midwives in Canada, and the current trends and thoughts about midwifery education in this country. I hope this research offers aspiring midwives the opportunity to hear about the experiences of practising midwives in three different areas of Canada and through persistence, it is possible to become a midwife. I have outlined the expectations and difficulties that midwifery students may face in the future. I hope this will serve other aspiring midwives to choose the educational route that will enable them to work in Canada.

In writing this paper I faced many challenges along the way. Being on the fringe of midwifery communities, because I am an aspiring midwife and I have a vested interest in midwifery for my own future, but still an outsider from these communities, has allowed me to glimpse at the inner world of midwifery in Canada. I learned that in the future all midwives will be required to obtain a university degree to work as a midwife. This allowed me to make an informed choice about the midwifery education I will be pursuing at Laurentian University. The unique opportunity to talk with midwives about their education and has left me in awe of their persistence in pursuing midwifery and their belief in the necessity of midwifery care in Canada. As I conclude, I am about to embark upon my own midwifery education. Further research about this process will no doubt be forthcoming after my degree is completed.

APPENDIX A

Current Laurentian University Curriculum Outline

Year One

- *Introduction to Midwifery Intensive*
- *Introduction to Midwifery*
- *Topics in Biological Sciences*
- *Social and Cultural Dimensions of Health Care*
- *Pharmacotherapy*
- *Life Sciences for Midwifery*
- *Women's Studies*
- *Elective*

Year Two

- *Critical Appraisal of Research Literature*
- *Reproductive Physiology*
- *Two of: Health, Science & Society; Principles & Methods of Research; Health Education & Promotion*
- *Midwifery Care I Intensive*
- *Midwifery Care I*

Year Three

- *Midwifery Care II Intensive*
- *Midwifery Care II*
- *Midwifery Care III*
- *Midwifery Care III Intensive*
- *Community Placement*
- *Midwifery Synthesis Paper*

Year Four

- *Midwifery Care IV*
- *Professional Issues Intensive*
- *Midwifery Care Clerkship*

(Laurentian University 2002)

APPENDIX C

Interview Schedule

1. *Tell me about your decision to become a midwife.*
2. *How did you decide on your educational route?*
3. *How long did it take you to complete your education?*
4. *Can you describe your education process for me? What courses were required? How many births did you attend as an apprentice? Were there any prerequisites?*
5. *How did you enjoy your educational process?*
6. *When did you begin practising as a midwife?*
7. *Describe a typical day or week in your professional life.*
8. *How has your practise changed since you began?*
9. *Have there been external factors that have changed your practise, such as legislation, family life, or other factors?*
10. a) *How do you anticipate your practise would change if the Saskatchewan/Nova Scotia government legalized midwifery?*
b) *How has your practise changed since the Ontario Government legalized midwifery?*
11. *How has the route you chose to become a midwife affected your practise?*
12. a) *What recommendations would you propose if an education system were to be set up in Saskatchewan/ Nova Scotia?*
b) *What recommendations, if any, would you make as possible changes to the Ontario Education Program?*
13. *Why do you think that an educational route for midwives should/should not be a priority as legislation passes?*
14. *What do you think should be the admission process to an education system for midwives?*

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