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INTRODUCTION

The Inuulitsivik Health Centre in Puvirnituq, Quebec, created in 1986 by the efforts of a local women's association and a supportive physician, is but one example involving Inuit and non-Aboriginal midwives collaborating with other health professionals to deliver their children in their communities. Traditional midwifery passed from one generation to another is regarded as an important conveyor of cultural knowledge and identity, and as a source of esteem among Aboriginal women (Paulette, 1995). Current debate about appropriate legislation, educational requirements, models of training, registration, licensing and questions concerning safety issues and financial costs must include Inuit, Métis and First Nations women who have a vested interest in any outcome or decision. In addition to honouring the wisdom of Elders who have passed on their knowledge and skills to the next generation, readers will be sensitized to past and present midwifery and Aboriginal midwifery in Canada, with a focus on the future; therefore the paper:

- Discusses midwifery and examines the history of the profession in relation to Aboriginal and non-Aboriginal communities, in addition to describing the current status of midwifery in all jurisdictions of Canada.
- Outlines the paths to becoming a midwife and related issues in terms of recognition and/or accreditation are identified. The gaps in current maternity care policy and practice in Aboriginal communities are highlighted, as well as the critical need for maternity care services.
- Presents emerging models of community-based care, based on Aboriginal midwifery.

The paper concludes by identifying issues that must be addressed for midwifery to be revitalized and expanded within Inuit, Métis and First Nations communities.

SECTION 1 – WHAT IS A MIDWIFE?

Definition of a Midwife

The international definition of a midwife is:

A person who, having been regularly admitted to a midwifery educational program, duly recognized in the 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 practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour, and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. (WHO, 1992)

Care given by midwives 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. Midwives also play a role in maternal, family, and

community education. They may practice in hospitals, clinics, birth centres, or in private homes, depending on the jurisdiction in which they practice.

It is emphasized by the World Health Organization (WHO), and by health authorities in developing traditional cultures, that traditional beliefs and practices are not always safe, and that safe birthing requires midwives who have relevant modern knowledge and training (WHO, 1998). In fact, midwives/midwifery advocates have fought for access to appropriate medical training since the advent of modern medicine in the 1600s. The best midwives are those who have formal training as well as the relevant cultural knowledge of social and ritual practices. Worldwide, health authorities make a distinction between trained midwives and traditional birth assistants.

Traditional Aboriginal birthing practices are as diverse as the number of Aboriginal nations. (An overview of different nations' practices is included in Appendix 2.) However, all nations generally believe that being born is a sacred event - it is the entrance of a new spirit into the world. In the past, midwives assisted with both the ceremonial and the physical aspects of birth. A Stony Creek Elder quoted by Carroll and Benoit in 2001 explained that: "In the 1930s, midwives used medicines for dealing with rituals; they helped with the 'in-between'. The traditional art of midwifery was learned from mother and grandmother. Today modern medicine and doctors have taken over."

History of Midwifery in Western and Aboriginal cultures

In all cultures, women experienced in childbirth have traditionally attended births, and such caregivers generally gained their knowledge through apprenticeships with older, more experienced midwives. Formal training and regulation was evident in some early Western cultures. Hippocrates, the Greek forefather of Western scientific medicine, began a midwifery training program in the 5th century BC (Wagner, 1998). In ancient Greece, midwives were also required by law to have had children themselves (Griers, 2003). In 1452, Germany passed the first, and still existing, European law mandating midwifery and guaranteeing a midwife to every woman giving birth (Wagner, 1998). Soranus, a Roman physician in the second century, outlined the characteristics of a good midwife, including the need for literacy so she would have access to medical obstetrical knowledge (French, 1986). Soranus also wrote an obstetrics textbook that was used until the 1500s, but there is little evidence of physician-related obstetrics practice until the 1600s.

The practice of midwifery began to change somewhat in the 1600s-1700s, with the development of a scientific medical profession and the introduction of forceps. Obstructed labour and the shrunken pelvis were major causes of infant and maternal death. The proper use of forceps greatly reduced the number of these deaths. However, the use of forceps was restricted by and to physicians, midwives were not provided with the technology or the training (Carr, n.d.). Usually, wealthy women, for whom professional medical care was a symbol of status and affordable, turned to doctors. There occurred, in fact, the development of male midwives for such women. Generally only men were able to get formal medical education. However, midwives were the caregivers for the majority of births, and despite initial resistance from

doctors, education and training programs were made available to midwives in Europe. The oldest existing formal midwifery association/training program – now known as the Royal College of Midwives – was established in Britain in the mid-1800s as a response to maternal deaths and complications:

Childbirth in the late 19th Century was both difficult and dangerous. Maternal mortality stood at around 500 per 100,000 births compared with approximately 12 per 100,000 today. Few women had access to trained attendants in childbirth and many of the poor had to depend on local untrained midwives (Royal College of Midwives).

The availability of effective anesthetics in the 1800s, very much desired by women but administered only by physicians, led to an increased in physician-attended births by those who could afford it. The discovery of bacteria as sources of infection and new requirements in physician/hospital hygiene also led to fewer cases of puerperal fever and other birth-related infections in hospitals. However, despite the developments in medical/obstetrical practice, midwives continue to be the primary maternal care providers in most Western countries even today (Wagner, 1998). Some countries had combined nursing and midwifery education/regulation, but midwifery is now regarded as a profession separate from and complementary to medicine.

In New Zealand, for example, midwives had been actively involved in maternal care, but as part of the nursing profession. They regained the legal right to practice independently in 1990 (New Zealand College of Midwives). Germany has long had a law stipulating that a midwife must be present at every birth even though a doctor is present. And as a recognized and trained profession, midwives do not need medical supervision except in North America. Dr. M. Wagner, former Regional Officer for Women's and Children's Health with the World Health Organization, advocates for midwifery as a crucial component of Canadian maternity care. He reports on midwifery in other industrialized countries:

In Scandinavia, the Netherlands, New Zealand and other countries, all prenatal, intrapartum and postpartum care for at least 70 percent of women is provided solely by midwives. These countries have much lower obstetrical intervention rates than Canada and have maternal and perinatal mortality rates equal to and, in some cases, better than Canada. (Wagner, 1998:7)

European midwives were brought to North America in the 1600s by both French and British governments, to provide maternity care to the female colonists. As late as the 1880s, midwives taught medical students at McGill University (Wagner, 1998). During the great waves of immigration in the late 19th /early 20th centuries, immigrants also brought their own culturally knowledgeable midwives with them.

Native Americans had midwives within their various tribes. [Colonial] midwifery...began as an extension of European practices...Midwives filled a clear important role in the colonies...Midwifery was seen as a respectable position, even warranting priority on ferry boats to the Colony of Massachusetts. Women actively sought well skilled practitioners,

however, the apprentice model of training still predominated. A few private tutoring courses such as those offered by Dr. William Shipman, Jr. of Philadelphia existed, but were rare (Parkland Memorial Hospital School of Nurse Midwifery, n.d.: 1).

The use of and respect for midwives in North America, however, declined dramatically in the first half of the 20th century. The virtual disappearance of North American midwifery began with the rise of new knowledge and practices in the medical profession from the mid-1800s and on. North American doctors, usually male, resisted education and training for primarily female midwives. Not only did the medical profession wish to preserve its exclusive access to the income from patients, it also subscribed to the general belief that most women were not intellectually capable of a scientific education. Thus, the knowledge explosion in pharmacology, hygiene, physiology, etc., was not provided to midwives, whose practice generally remained informal and based on generations-old remedies and procedures. Although such opposition has also initially occurred in Europe, the European decision to provide formal training to midwives was successfully resisted by the North American medical profession. Comparisons of the difference in practices and outcomes between doctors and untrained midwives increasingly discredited the safety of midwifery. The decline was further accelerated by the development of anesthetics. Female suffragettes and doctors successfully fought for the right of all women to have access to anesthetics, but they could only be provided by doctors/hospitals.

The practice of midwifery became almost exclusively a practice of immigrants and the non-white. U.S. statistics show that in 1915, 40 percent of all births were still attended by midwives; by 1935, only 10.7 percent were, and 54 percent of these midwife-assisted births were non-white (Parkland Memorial Hospital School of Nurse Midwifery). From World War I on, hospital births came to be much more accessible to the general public, and by the 1950s, almost all births in North America occurred in hospitals. The public grew to believe that midwife-attended births were unsafe. As the medical profession reinforced this perception midwifery was outlawed in many jurisdictions “for the sake of the health of the country” (Parkland Memorial Hospital School of Nurse Midwifery: 2). In Australia, midwifery had lost its professional voice by an Act of Parliament in the 1920s, and the profession has been playing catch-up ever since. Aboriginal women have been the biggest losers in this, with a similar situation existing in Canada. Elsewhere, midwives operated on the margins, in a kind of legislative limbo. Those formal midwifery services that were available were incorporated in limited nurse-midwife programs generally set up for rural and urban poor populations.

This change in attitude inevitably affected Aboriginal health care. Whereas midwifery had been the customary, respected practice even among the colonists, the emphasis on supposedly necessary modern medical intervention was spread by doctors to Aboriginal health services. The result is that many ancient birthing and midwifery practices have been lost and few Aboriginal midwives are left to pass along Indigenous knowledge in this and other areas. The removal of births from many Aboriginal communities has had profound spiritual and cultural consequences, which are difficult to quantify. The loss of traditional birthing practices has been linked to the loss of cultural identity. This has happened because of ongoing colonialism, which includes:

- the residential school system

- the imposition of Western medicine
- government legislation
- epidemics leading to large numbers of Aboriginal deaths
- a range of other processes and events that undermined Aboriginal cultures and societies

On July 1, 1920, a day set aside to celebrate Canada's nationhood, royal assent was given and the newly revised *Indian Act* became law. Duncan Campbell Scott, deputy superintendent general of Indian Affairs and the main architect of the law whose "only goal was the piecemeal but complete destruction of distinct social and political entities within the broader Canadian community" (RCAP, Ch. 13: 598-600).

RCAP also states that "Federal policies and actions were aided by 19 false assumptions based on ignorance [and/or prejudice] (Aboriginal Peoples were inferior, incapable, undeveloped...) and sustained by the excessive, unimpeded abuse of power (intrusive policies and laws of enforcement used by the state to invade Aboriginal Peoples' lands, [laws], traditions, lives, families and homes, with a cradle-to-grave pervasiveness. The Report of the Royal Commission on Aboriginal Peoples looked at four areas of federal policy and action; the *Indian Act*, residential school policy; relocation policy of entire Aboriginal communities; and the policy of neglectful treatment of Aboriginal veterans (Ch.8: 248-253). Profound damage includes loss of life, denigration of culture, destruction of self-respect and self-esteem, rupture of families, impact of these traumas on succeeding generations (Ch. 13:601-602). Incredibly, the *Indian Act* continues to interfere in the lives of Indigenous Peoples today." (RCAP, Vol.1, 1996)

Michael Klein et al. (2002) have written that when non-Aboriginal communities in Canada lose the capacity to manage births, this "precipitates a negative cascade of events that undermines the economic and social viability of a community." It is reasonable to assume that this impact is magnified in Aboriginal communities due to cultural considerations (See Appendix 2).

Canada and the United States are the only industrialized countries in which midwifery was quite thoroughly discredited. The process of recognition and autonomy for midwives has thus been slow despite an increasing body of literature that demonstrates midwives provide safe, cost-effective care to women's satisfaction throughout pregnancy and the postpartum period, as long as there are appropriate screening methods for including women in midwifery care (Khan-Neelofur et al., 1998; Mac Dorman and Singh, 1998). There must also be an appropriate referral and transportation system for the women who will require surgery. The United Nations International Children's Emergency Fund (UNICEF, 1995, 2002), the WHO (1998), the global Maternal and Neonatal Health Program (2002), the MotherCare Project (2000) and other international health agencies report that complications during pregnancy and birth are the leading cause of death and disability for women of reproductive age in countries that have limited access to medical care. They unanimously agree that skilled trained birth attendants (doctor, nurse, or formally trained midwife) are critical for safer motherhood. However, they advocate best-practices models that utilize trained midwives who are familiar with the community as primary care providers, supplemented by traditional birth attendants (TBAs, generally self-taught or informally trained in the community) who can provide culturally appropriate practical help, emotional support and socially accepted rituals.

Current Status of Midwifery in Canada

Canada is currently facing a shortage of maternity care providers that grows more acute every year (Milne, 2001). The shortage is felt most acutely in rural and remote communities and has fostered an increased acceptance of midwives as appropriate care providers for low risk pregnancies. For Aboriginal communities, this development provides opportunities for the restoration of midwifery and community births.

The present situation of midwives in Canada is a patchwork quilt, with a number of arrangements including:

- Midwifery as a regulated, publicly funded profession
- Midwifery as regulated but not publicly funded
- Midwifery as funded but unregulated
- Midwifery as unregulated and non-funded

Specific midwifery legislation exists in only three provinces: Quebec, Ontario, and Manitoba and the Northwest Territories. The profession is regulated under other legislation in Newfoundland and Labrador, Saskatchewan, Alberta, and British Columbia. In the Northwest Territories, Nunavut, Yukon, Prince Edward Island, New Brunswick, and Nova Scotia, midwives work without any applicable legislation (an overview of this legislation in regard to midwifery can be found in Appendix 3).

In some parts of Canada, Aboriginal midwives are exempt from midwifery regulations. This is true for example, of Ontario, where Aboriginal midwives practice at the Six Nations Birthing Centre.

SECTION 2 – BECOMING A MIDWIFE

Skills and Education

Aboriginal midwifery has the goal of providing safe and culturally appropriate birthing that emphasizes respect for life and the empowerment of women. In both Ontario and Quebec, community-based training programs exist where Aboriginal midwives learn from practicing midwives at local birthing centers. These centres aim to deliver culturally relevant maternal care. This process reflects ancient Aboriginal practices, as well as the place of older women as repositories of medical and spiritual knowledge. Moreover, in areas of Canada such as Nunavut, traditional midwives continue to pass their Indigenous knowledge and skills on to the next generation of midwives, as they have always done.

In the rest of Canada, midwifery is generally an accredited four-year program at post secondary institutions (See Appendix 4 for a description of midwifery education programs in Canada and the USA). Recently, the province of Manitoba has been invited to submit a full proposal to the Primary Health Care Transition Fund of Health Canada to develop an apprenticeship-training

program for Aboriginal midwives.

Recognition/Accreditation

The issue of who determines that someone is qualified to be a midwife warrants exploration. In Canada, some Aboriginal midwives want to be exempt from midwifery regulations for reasons of culture and self-determination – for individuals, families, and communities. These midwives believe that Aboriginal culture, with its effective healing and life cycle traditions and knowledge, can be practiced and protected through Aboriginal midwifery. The sacredness and safety of the birth experience is of paramount concern.

In some nations, birthing practices were shared and midwifery was not viewed as a profession with specialized education and training. For these reasons, some Aboriginal midwives and pregnant women see the medicalization of childbirth as yet another manifestation of colonialism.

Other Aboriginal midwives prefer to work within the College of Midwifery of their respective province, as is the case in Manitoba and British Columbia. These midwives believe that by integrating contemporary midwifery and traditional best practices, they are able to provide the best quality care possible to Aboriginal women. They also enjoy the flexibility, portability and financial rewards of an accredited health profession.

SECTION 3 – WHAT CHANGES ARE HAPPENING TO BIRTHING IN ABORIGINAL COMMUNITIES?

Current Situation

An overview of the current status of maternal and child health care in Aboriginal communities was carried out in August 2002 by Dawn Smith, in an unpublished document. Smith identified that the cornerstone of maternal child health care for Aboriginal communities has been the medical evacuation of women from remote, isolated, and semi-isolated communities to secondary or tertiary care centers at 36 weeks. The women give birth in major urban areas, separated from their families and communities.

Smith demonstrated that the following evidence does not support this practice:

- When women are separated from the support of families and friends, there is an increase in small, premature infants, as well as maternal and newborn complications, even though the majority of women have come to maternity centers with a good standard of care (Klein et al, 2002)
- Postpartum depression is more likely in women experiencing high stress and low support during the perinatal period (Armstrong et al, 2000)
- The ability to successfully establish breastfeeding may be compromised

- Family relations are strained and paternal attachment during the critical first week is negatively impacted (Armstrong et al, 2000)
- Communities and extended families are denied the opportunity to celebrate birth

In 1993 Martha Greig, vice-president of Pauktuutit stated: “To us, healthy children are born into their family and their community; they are not born thousands of miles from home to an unhappy, frightened mother” (RCAP, (3) 3:136) Carol Couchie and Herb Nabigon are quoted in a book by Lesley Ann Page called *Midwifery in Canada: A New Midwifery for the New World*, in which they connect the healing and strengthening of contemporary Aboriginal communities with Aboriginal midwifery. Both national and international support exists for these positions.

The Safe Motherhood Inter-Agency Group (SMIAG), which includes groups such as the United Nations Children’s Fund, and the World Health Organization, has identified that good quality maternal health services “should be accessible and available as close to where women live as possible, and at the lowest level facility that can provide the services safely and effectively.” The SMIAG also advocates a partnership between the health system and communities because:

- Communities can be a powerful force for improving the quality of care by demanding, facilitating, and evaluating changes in services and facilities so that they respond to local needs
- Communities are key to increasing utilization by addressing the barriers that can limit women’s access to care

Smith found that even in communities where women are not evacuated long distances to give birth, continuity of care is compromised by staff shortages and turnover, and health promotion and prevention are inadequately addressed.

The Need for Comprehensive Maternal Health Programs

While services are inadequate, the need for services remains high. The First Nations and Inuit Regional Health Surveys Report (AFN, 1999) provides data that highlights this need for a program emphasis on maternal health.

The Aboriginal population is young and growing rapidly. The 3% growth rate is double that of the general population. Moreover, prevalent risk factors exist among Aboriginal women who give birth. Some of these risk factors follow:

- Stillbirth and perinatal death rates among Indians are about double the Canadian average; among Inuit living in the Northwest Territories, they are about two and a half times the Canadian average (RCAP, 3(3): 127)
- Although dramatic improvements have been made in Aboriginal neonatal health, in 1979-

81 and 1991-93, the Aboriginal post-neonatal mortality rate was roughly 3.5 times that of the national population (CICH, 2000,(6): 173)

- Breastfeeding rates in the Aboriginal population are 54% compared to 75% for the Canadian population (RHS, 1999)
- Aboriginal parents are much more likely to rate their child's health as poor/fair (16% compared to 2% for the Canadian population) (RHS, 1999)
- Many Aboriginal women are isolated, impoverished,... suffering from low self-esteem; [they] experience inadequate nutrition during pregnancy,...general self-neglect; and lack of appropriate and affordable housing (RCAP, 3(3): 103-31)
- Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE) is believed to be "alarmingly high" among Aboriginal Peoples (RCAP, 3(3): 132)

The Emergence of Aboriginal Birthing Centres

In response to the problems identified, four community-based birthing centers have been established in Aboriginal communities. These are described below.

Inuulitsivik Health Centre, Puvirnituk, Quebec

In 1986, Inuit women created and began this maternity program for those women who wanted to give birth in their own community, rather than Moose Factory or Montreal. A registered midwife works at "the Maternity", as it is popularly known, along with local women who are trained as community midwives. An interesting feature of this program is that a multidisciplinary committee decides whether a pregnant woman can deliver locally or should leave for delivery. The registered midwife, or a physician and a community midwife assist local births. Community midwives also provide women with useful advice on infant nutrition and postnatal care. In the beginning years, staff managed 84% of 350 births in eight communities and achieved perinatal mortality rates comparable to or lower than the rates for Quebec as a whole (RCAP, 3 (3):136).

Rankin Inlet, Nunavut

The birthing centre in the central Arctic community of Rankin Inlet was a pilot project from 1993 to 1995. It was initially staffed with nurse-midwives by the NWT Department of Health. Later it accepted registered direct entry midwives from other jurisdictions due to difficulties in recruiting experienced nurse-midwives in Canada. It is now an established program under the Nunavut Department of Health, with positions for three midwives, two Inuit maternity workers and a clerk-interpreter. Although it is a permanent facility, it operates without a legislative framework due to absence of midwifery legislation in Nunavut. It continues to be plagued with recruitment and retention problems and from time to time is forced to withdraw community birthing services because of staff shortages. The expressed desire of the community to have Inuit primary care providers has never been fulfilled as no comprehensive midwifery training program has ever been provided to local women. Discussions are under way about the development of such a training program.

Iewirokwas Midwifery Program, Akwesasne, Quebec/Ontario/USA

Iewirokwas means, “pulling the baby out of the earth”. The Mohawk Nation at Akwesasne operates this program, which focuses on education, empowerment, and Aboriginal healing practices. Because of the program, more Mohawk women have begun using the birthing stool, smudging, and other Mohawk birthing practices. The program trains Mohawk midwives here and in other Mohawk communities (Cook, n.d.)(See Appendix 3).

Tsi Non:we Ionnakeratstha Ona:grahsta: Six Nations Maternal and Child Centre, Oshweken, Ontario

This centre is located on the Six Nations of the Grand River Reserve. Full time Aboriginal midwives who provide a balance of traditional and contemporary midwifery services and programs staff it. The community, family and the expectant woman are offered a choice of services that compliment and support personal beliefs and customs. These services include complete prenatal, labour, birth, and postpartum care. Between opening in 1996, to December 2002, the “the birthing centre” served 252 clients. It also provides a training program for Aboriginal midwives (See Appendix 3, 10).

SECTION 4 – WHERE DO WE GO FROM HERE?

Review of Main Points

- The current policy and practice in regard to maternity care services are:
 - not supportable in terms of a growing body of evidence,
 - inconsistent with internationally accepted best practices and no longer sustainable in terms of financial and human resource costs.
- The growing acceptance of midwifery in Canada and abroad presents an opportunity to address long-standing grievances of Aboriginal Peoples concerning the evacuation of all women from their communities to give birth.
- The re-establishment of maternity care services in communities, and the recruitment of Aboriginal women into the profession of midwifery, has the potential to:
 - improve birthing outcomes for Aboriginal women,
 - contribute to the self-determination aspirations of Aboriginal communities, and allow for the emergence of new models of community-based maternity care in Aboriginal communities.

Identification of Main Issues

Sandra Kanck, an Australian MP said in 2001 that, “the lack of government funding and policy commitment has eroded birth choices for women in rural and regional areas. If maternity services have been undermined for white women, then they are almost non-existent for indigenous women” (Kanck, 2001).

A description of the issues that must be addressed if Aboriginal midwifery is to be restored and expanded follows.

Need for An Enabling Environment

The Safe Motherhood Inter-Agency is a unique partnership of international and national agencies, working together to reduce the burden of maternal death and ill-health in developing countries by raising international awareness about safe motherhood, setting goals and programmatic priorities for global initiatives, stimulating research, mobilizing resources, providing technical assistance and sharing information to make pregnancy and childbirth safer (SafeMotherhood.org). Although improvements have been made in reducing infant mortality, Aboriginal Peoples in Canada still lag behind national rates. The policy brief of the Inter-Agency Group identifies the following components of an enabling environment:

- A clear policy commitment linked to mechanisms that include women and community members in the design and implementation of health programs.
- Availability of necessary supplies and equipment.
- Functioning systems in place to refer and transport women with complications to health centers or hospitals.
- Effective programs of education, supportive supervision, and ongoing monitoring and evaluation.
- Legislation that both protects and allows maternity care workers to carry out all life-saving procedures in which they are competent.
- Development of national standards and guidelines for maternity care that are updated regularly based on clinical evidence, and developed in collaboration with key stakeholders including policy-makers, representatives of professional groups, and the community.

The Need for More Aboriginal Maternity Care Workers and Training Programs

In order to address the current human resource crisis for maternity care workers in Aboriginal communities, a human resource strategy, including new training initiatives, is needed to dramatically increase the numbers of Aboriginal midwives and related maternity care providers. In addition, other health workers in nursing stations and health centers should have the skills necessary to save the lives of women who suffer serious complications. The Society of Obstetricians and Gynaecologists of Canada offers an emergency skills program called ALARM (Advances in Labour and Risk Management) that has been recognized both nationally and internationally. It is recommended that health care workers take this course every 4 to 5 years.

Organizational Support

Currently, there is no association for Aboriginal midwives in Canada. However, NAHO is playing a supportive role in the development of such an organization. The first national gathering of Aboriginal midwives in Canada took place in December 2002 at the Six Nations Birthing Centre. At this meeting, the midwives identified the need for an Aboriginal Midwives

Association that could:

- validate the long tradition of Aboriginal midwifery
- articulate the diverse concerns of Aboriginal midwives
- advocate for recognition of Aboriginal midwifery
- educate others about the importance of Aboriginal midwifery
- support Aboriginal women who want Aboriginal midwifery services

The Safe Motherhood Inter-Agency Group strongly supports the establishment of professional associations to “shape policies and protocols, establish standards of practice and core competencies, and facilitate communication and information exchange.”

A list of national and international midwifery associations is attached in Appendix 6.

Research

There is a lack of research on Aboriginal midwifery. Until there is both qualitative and quantitative research on a substantial scale, a wider audience will not understand the nature, value, and importance of Inuit, Métis and First Nations midwifery. The right of First Nations (and relevant to Inuit, Métis and other Indigenous Peoples internationally) communities to *Own, Control, Access and Possess* (OCAP) information about their peoples is fundamentally tied to self-determination and to the preservation and development of their culture. OCAP’s principles apply to research, monitoring and surveillance, surveys, statistics, cultural knowledge,...including its creation, and management (Schnarch, FNC NAHO).

Two examples of relevant research were published in *Birth Issues*: “Aboriginal Birth: Psychological or Physiological Safety” (Chamberlain et al, 2001), and “Traditional Aboriginal Birth Practices in Australia: Past and Present” (Callaghan, 2001). The first article argues for the necessity of offering culturally sensitive maternity care in remote Aboriginal communities in Canada and Australia. The second article illustrates how childbirth in Australian Aboriginal communities strives to keep women and their babies safe. It also emphasizes the role of grandmothers as holders of Aboriginal knowledge.

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www.anac.on.ca

Canadian Association of Midwives

www.members.rogers.com/canadianmidwives

Capers Bookstore (books on family health, pregnancy, birth, fertility, midwifery, breastfeeding, etc.)

www.capersbookstore.com.au

College of Midwives of British Columbia

www.cmbc.bc.ca

College of Midwives of Ontario

www.zfc-consulting.com/webprojects/midwives/mss/home/about.asp

International Confederation of Midwives, Netherlands

www.internationalmidwives.org

Midwives Alliance of North America

www.mana.org

Midwives Coalition of Nova Scotia

www.mcna.chebucto.org

Midwifery Education Accreditation Council, US

www.meacschools.org

Midwifery program, University of British Columbia

www.midwifery.ubc.ca

Midwifery Today (Publications about midwifery)

www.MidwiferyToday.com

Ontario Midwife Education Program, Laurentian University

www.midwifery.laurentian.ca

Ontario Midwife Education Program, McMaster University

www.fhs.mcmaster.ca/midwifery

Ontario Midwife Education Program, Ryerson Polytechnic University

www.ryerson.ca/midwifery

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APPENDICES

Appendix 1: Glossary and Acronyms

- AMNL:** Association of Midwives of Newfoundland and Labrador
- AOM:** Association of Ontario Midwives; professional organization in the province.
- ANSM:** Association of Nova Scotia Midwives; a provincial association of midwives.
- Caesarean section:**
Surgical birth procedure, which must be performed by a licensed physician.
- CAM:** Canadian Association of Midwives: the national professional association for Canadian midwives.
- College of Midwives (of BC, Manitoba, Ontario):**
Licensing bodies for midwives in various provinces.
- DONA:** Doulas of North America, an international organization that trains and certifies doulas.
- Doula:** a Greek word, meaning “woman who serves”. Today it refers to a woman experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during, and just after childbirth. Doulas do not provide medical services, unlike midwives.
- Epidural anaesthesia:**
practice of freezing a woman’s lower body for pain relief during childbirth.
- Episiotomy:** practice of enlarging vaginal opening through cutting during childbirth.
- FAS/FAE:** Fetal Alcohol Syndrome/Fetal Alcohol Effects, both caused by maternal alcohol drinking during pregnancy, leading to permanent physical, psychological, and cognitive damage in the fetus.
- HIV/AIDS:** HIV is the virus that causes AIDS, acquired immune deficiency syndrome.
- ICM:** International Confederation of Midwives, headquartered in the Netherlands.
- IDM:** International Day of the Midwife; a day of focus on international midwifery in early May of each year, promoted by the ICM.
- Ikajuqti:** Inuktitut word for women who assist other women to give birth.

MCNS: Midwifery Association of Nova Scotia; a provincial consumer advocacy group.

MEAC: Midwifery Education Accreditation Council; the accreditation body for midwifery education programs in the United States.

Midwife: an Anglo-Saxon word meaning “with woman”.

MMCN: Manitoba Midwifery Consumer Network.

Native Midwife:
An Aboriginal woman who offers her services as a midwife in the province of Ontario.

Ona:grahsta: Cayuga word for “a birthing place”.

OMCN: Ontario Midwifery Consumer Network; a provincial association of consumers.

OSFQ: Ordre des Sages-Femmes du Québec; Licensing body for midwives in Québec.

Pauktuutit Inuit Women’s Association:
National organization representing all Inuit women in Canada.

Sage-femme: French term for midwife; literal translation is “wise woman”.

TBAs: Traditional Birthing Assistants

Tsi Non:we Ionnakeratstha:
Mohawk word meaning “the place they will be born”.

Appendix 2: Overview of Traditional Birthing Practices

During pregnancy, Inuit women increased their intake of caribou, char, muktuk, and seal. They limited their consumption of berries and did not eat aged food at all. In some Arctic societies, Inuit men helped their wives give birth. When no one else was available, children were involved. Birth occurred in a snow house or an animal skin tent and women who assisted were called *Sanaji* (in most Inuktitut dialects). The *sanaji* is the helper who first touches the baby, and becomes the one who is entitled to “create” the child by bestowing certain skills and characteristics on the newborn.

In the Mittimatalik (Pond Inlet) area, Inuit women gave birth all alone, guided by instructions given from outside her dwelling. Labour was carefully monitored through the use of questions, with the aim of encouraging a short delivery. Inuit had many positions for giving birth. One position involved the woman on her knees with her body upright. Inuit believe that the spirits of deceased Elders re-enter the world through the birth of infants thus, babies and children were treated with great respect.

It seems that there is less information available on First Nations and still less on Métis birthing practices than those of Inuit.

In many First Nations societies, birthing was a woman-centred process while in others, family and community members of both genders played important roles. Prior to European contact, and for many years afterwards, Newfoundland Mi'kmaq women gave birth in tents that were removed from the community and specially constructed for the purpose of giving birth. In good weather, women gave birth in the open air in the woods. Further west, Anishnawbe babies were born into a moss bag and the mother was given a broth of salmon or whitefish to stimulate lactation.

In a study of 60 women from an unidentified First Nation in Canada (Wilson, 2003), two birthing scenarios emerged:

- Women in labour are attended by female family members, including one with birthing experience
- A practicing midwife (not a family member) attended women in labour.

Women in labour supported themselves with specifically selected birthing sticks and a birthing pillow, which was square and filled with local dry leaves or hay. Bindings were used to encourage adequate lactation and to restore muscles to pre-delivery firmness.

In British Columbia, Aboriginal midwives were charged with passing moral and ethical values from one generation to the next in addition to guiding the birth process. The Nuu-chah-nulth called the midwife “she who can do everything”. The Coast Salish translate the term midwife as “to watch, to care”. For the Chilcotin, midwives were “women’s helpers”. All these terms testify to women’s power in this central area of life.

A number of historical studies (e.g. Yarrow, 1881; Simpson, 1892; Jones, 1893; Gilmore, 1930)

provide evidence on Indigenous birthing practices in New Mexico, Alaska, Honduras, and along the Missouri River. Some of these reflect the biases of the time. They tell us, however, about the wide-ranging methods Indigenous peoples developed to ensure safe births. One common practice is the use of plants; chokecherry juice was used among the Arikara to alleviate post-partum hemorrhage. The Zuni used hot stones to expedite labour. Alaskan Indian women gave birth in a hole, dug two feet deep and lined with moss. In Honduras, birth was a community event; “sitting or standing about the room are from five to twenty women, interested spectators, smoking and talking, and occasionally squeezing the patient’s abdomen...” (Jones, 1893: 97).

The ceremony also had a place in Aboriginal birthing. An ethnologist described Hopi birth ceremonies in 1892 (Owens). After birth, the mother washed her head in suds made of amole root. An attendant washed the baby in the same water and rubbed it all over with ashes, except its head. An ear of corn, symbolic of our origins in the earth, was placed beside the newborn’s crib to watch over it. The mother was not allowed to see the sun or put on her moccasins until the fifth day. Then on the 10th and 15th days respectively, she repeats the washing ritual that took place after birth. On the 20th day, a more elaborate three-part ceremony was held, involving: the purification of the mother; the naming of the baby; and the presentation of the baby to the sun. Community feasts were part of this ceremony, as was the godmother of the child, usually his or her paternal grandmother or paternal aunt.

Although there appears to be no corresponding data available for Canada, it is known that throughout the 1980s, Native American women in the United States (U.S.) were the most likely of all studied cultural groups to use the services of a midwife (Parker, 1994: 1140). In addition, their use of midwives “increased rapidly during that time” (*ibid*).

Appendix 3: Status of Midwifery in Canadian Jurisdictions

Midwifery as a regulated publicly funded profession

(See: Canadian Association of Midwives website)

British Columbia

Midwives in BC are fully integrated into the province's health system. The profession became autonomous and self-regulated in 1998 through the *Health Professions Act*, which gave authority to the College of Midwives of BC (CMBC). There is no stand-alone (or separate) Midwifery legislation. The existing legislation does not apply to Aboriginal midwives who practiced on-reserve before the Act came into force.

BC midwives must maintain hospital privileges. There are 67 midwives in BC, each providing care to 40 women annually. Because this represents only 1% of the babies born in BC each year, there is a shortage of midwives in the province. Further, most midwives practice on Vancouver Island and the urban, lower mainland, which raises access issues for many Aboriginal women. The (international) Association for the Improvement of Maternity Services (AIMS) is a consumer group with a chapter in BC. The enabling legislation for midwifery in BC is contained in Appendix 5.

Ontario

Midwives in Ontario are registered health care professionals who work together in group practices. Ontario was the first Canadian jurisdiction to register midwives and regulate their profession; the *Midwifery Act* was passed in 1991. Aboriginal midwives who practice in Aboriginal communities are exempt from the legislation under ss.8(3). The Ontario model of midwifery, which has set the tone for regulated midwifery in other Canadian jurisdictions, is based on three principles: continuity of care; informed choice; and choice of birthplace. There are over 250 midwives in the province and approximately 35 new midwives register each year. Most practice in the urban south, including Cambridge, Toronto, Thornhill, and Peterborough, which raises access issues for Aboriginal women. In addition, there is no guarantee of culturally appropriate care.

The province has several active midwifery associations, including the Association of Ontario Midwives (AOM) and the Ontario Midwifery Consumer Network (OMCN). Regulation is through the College of Midwives of Ontario and continuing education is mandatory. Notwithstanding the exemption clause for Aboriginal midwives, those Aboriginal midwives who choose to be members of the College are subject to its jurisdiction.

Quebec

Since September 1999 midwifery has been a legal profession in Quebec; there is an *Independent Midwifery Act*. Midwives are licensed through the Ordre des Sages Femmes du Quebec (OSFQ).

There are 55 midwives in the province and six birthing centres, including two in Northern Quebec where Inuit women are being trained. Inuit midwives in Quebec have had a difficult time in their relations with the provincial government (see Section 1). At the present time, Quebec's midwifery law recognizes Inuit midwives who are already trained, certified and working in Nunavik, but excludes those who are in training now and in the future. Nunavik health officials have been lobbying for changes to this legislation (Nunatsiaq News, February 15, 2002).

Manitoba

This province has an *Independent Midwifery Act*. Midwifery has been a regulated profession here since June 2000 and is regulated by the College of Midwives of Manitoba. The College is mandated to operate a standing committee to provide advice on issues related to midwifery care to Aboriginal women.

Midwifery is funded through the provincial health care system. As of November 2000 services were available in three urban regions but plans for expansion were under development (see Section 3). In 2001, there were 40 practicing midwives in the province. Women in the north, many of whom are Aboriginal, continue to be evacuated to Winnipeg and Thompson to give birth. A provincial goal is to bring birth back to all regions of Manitoba, especially northern communities (many of which are Aboriginal). The Manitoba Midwifery Consumer Network is active in promoting the profession.

Manitoba Health has retained a consultant on Aboriginal issues to determine how best to provide midwifery services to Aboriginal women and communities. Further, there are plans to offer a bachelors degree in midwifery through the University of Manitoba or through apprenticeship programs offered by the College of Midwives. The latter should be of particular interest to Aboriginal midwives, pregnant women, and their communities.

Newfoundland and Labrador

Midwifery legislation was passed in 1920 in the then-Dominion of Newfoundland. The board for licensing midwives ceased operations in the early 1960s due to the low demand for licenses; there was only one application in 1963. Thus, the *Act* is not active and midwifery associations have been lobbying for new, midwifery-specific legislation. A Midwifery Implementation Committee, appointed by the provincial government, recently concluded its work and expected to see legislation enacted. However, with a change of ministers in the health portfolio, this did not happen.

Meanwhile, a longstanding agreement between the provincial government, the Newfoundland Medical Board, and the Association of Registered Nurses allows midwives who are nurses to practice in Northern Newfoundland and in Labrador – areas with significant Aboriginal populations (Mi'kmaq; Innu; Inuit; and Labrador Métis). These midwifery services are funded through the provincial health system. However, most midwives work out of urban hospitals, so most pregnant Aboriginal women must travel from coastal Labrador to Goose Bay to deliver their

babies (See: Appendix 11).

Midwifery as regulated but not publicly funded

(See: Canadian Association of Midwives website)

Alberta

In Alberta, midwives are government regulated health practitioners, although they are privately, rather than publicly, funded. There is no separate midwifery act; instead the profession is regulated under the Midwifery Regulation to the 1995 *Health Disciplines Act*. Midwives are registered as “primary health care providers” and provide services “in a variety of settings.” The midwifery model in Alberta is also based on informed choice and continuity of care.

The new Health Professions Act will eventually replace the Health Disciplines Act altogether as various health professions in the province move towards self-regulation under their respective colleges. The goal of the Alberta government is to eventually bring midwives under the Health Professions Act as a self-regulating profession, governed in accordance with a Midwifery Regulation .

As of 2001, there were 14 registered midwives in the province. Midwives in two regional health authorities, Calgary and Westview, have hospital privileges with other regions expected to follow suit. Each of Alberta’s seventeen health regions has the authority to grant hospital privileges, and/or fund midwives. Prohibitive increases in liability insurance for midwives may threaten plans to increase midwives; insurance is a condition of registration and Alberta Midwives cannot afford to pay the increased premium from \$4000 to \$15,000, per midwife, per year (Canada Baby Works!, 2003). There is a growing urban Aboriginal population, but it is not likely that many Aboriginal women in Alberta have access to midwives; many Aboriginal women cannot afford to employ the services of a midwife, who may or may not provide culturally appropriate care.

Midwifery as funded but unregulated

(See: Canadian Association of Midwives website)

Nunavut

Midwives in the new territory of Nunavut are not regulated, although the territorial health program funds their services in the one birthing centre in Rankin Inlet. There is a shortage of midwives and a real need for Inuktitut-speaking midwives; as of 2001, there were only two midwives in this jurisdiction. Iqaluit has the only hospital in the territory but it has no midwives. There is a birthing centre at Rankin Inlet; otherwise, women fly to Iqaluit, Winnipeg, or Yellowknife to give birth. A Midwives Association is in development and Midwives and others in Nunavut are currently looking at ways to develop a community-based midwifery education program to meet the demand for Inuktitut-speaking Inuit midwives.

Midwifery as unregulated and non-funded

Saskatchewan

On May 5, 1999, the Government of Saskatchewan passed the Midwifery Act allowing regulated midwives to practice. The Act includes the option to birth at home. A pre-transitional council was suggested as projected midwifery numbers were insufficient to establish a provincial regulatory college of midwives. Unfortunately, the act has not been proclaimed or implemented.

There are few women who have access to midwifery care due to the scarcity of midwives yet the demand is great. Further, maternity wards have been disappearing at an alarming rate, increasing the number of Saskatchewan women who must travel significant distances to give birth. If the Act is proclaimed in the absence of funding and regulatory support, it will further cut the already small number of midwife-attended births. More birth attendants are needed in Saskatchewan as large numbers of family physicians continue to leave the practice of obstetrics. Now, high-risk specialist obstetricians are caring for many low-risk health women. This has major implications for Aboriginal women since the numbers of Cree, Métis, and other Aboriginal peoples are so high in Saskatchewan. The 2001 Statistics Canada, Aboriginal Identity Population Counts for Alberta is 156,225 or 5.3% of the total population.

Northwest Territories

The Midwifery Profession Act was passed in October 2003 and is expected to come into force sometime in 2004. Together with the standards of practice, it creates a regulatory framework for midwifery as an autonomous profession and a model of midwifery care that is consistent with the Canadian model. The government has already created two funded midwifery positions, and it is expected that more salaried positions will be created as regional health authorities express an interest in offering midwifery services.

At the present time, most women still leave their communities to deliver in Yellowknife or Inuvik. There are two practicing midwives in Fort Smith, both of whom are registered in other Canadian jurisdictions, who have been providing community birthing services in women's homes for ten years. More than half of the women accessing this midwifery care are Aboriginal women. The overall NWT population: "[has] an Aboriginal population of 18,730 or 50.5% of the total population" (2001 Statistics Canada).

Nova Scotia

Midwifery is not a licensed or funded health profession in this province. Thus, Mi'kmaq (and other) women are forced to purchase midwifery services from the few practicing midwives here. The provincial consumers' association is frustrated with inaction on the part of the provincial government re legislation and funding.

New Brunswick

Midwifery is not a licensed or funded health profession in this province. Thus, Mi'kmaq and Maliseet women cannot access midwifery services.

Prince Edward Island

There is only one midwife in this province and there is no legislation or public funding for midwifery as yet.

Yukon

As of 2001, the territorial government had committed to developing legislation and offering funding for midwifery. There is currently one midwife in the Yukon, whom clients pay directly. The Aboriginal population in the Yukon is 6,540 or 23% (2001 Statistics Canada), another jurisdiction with a high Aboriginal population.

Appendix 4: Midwifery Education Programs

Ontario Midwifery Education Program (OMEP)

The OMEP is offered at three institutions:

- Laurentian University (full-time program in English or French. French stream students must be bilingual)
- McMaster University (full-time program in English)
- Ryerson Polytechnic University (part-time program in English)

The program leads to the Bachelor of Health Sciences (B.H.Sc.) in Midwifery. At Laurentian, the emphasis is on providing northern residents with opportunities to study midwifery, and preparing midwives to practice in northern rural and remote communities. At McMaster, learning is problem-based and self-directed. The program at Ryerson uses a variety of learning formats, including distance learning through teleconferencing. Students from all three institutions begin their program with a one-week intensive at Laurentian in Sudbury. The program includes other intensives and clinical courses.

The course of study at McMaster is as follows:

Level 1:

- Topics in Biological Sciences
- Social and Cultural Dimensions of Health
- Introduction to Midwifery
- Critical Appraisal of Research Literature
- Life Sciences for Midwifery
- Women's Studies

Level 2:

- Midwifery Care 1 (intensive)
- Tutorials/Placement
- Pharmacotherapy
- Reproductive Physiology
- Elective and nine units from the Faculty of Health Sciences, Humanities and Social Sciences

Level 3:

- Midwifery Care 2 (includes an intensive)
- Midwifery Synthesis Paper
- Midwifery Care 3

- Community Placement

Level 4:

- Professional Issues (intensive)
- Midwifery Care 4
- Midwifery Care Clerkship

Admission requirements to the midwifery program vary according to whether applicants are mature students, current post-secondary students, or high school students. However, it is recommended that applicants have at least one year of university studies. A background in sciences and social sciences seems to be desirable. Only one of the three university programs mentions Aboriginal applicants; McMaster's admission requirements state: "Applicants are invited to identify themselves as being native." However, there are no designated seats or special admission streams for Aboriginal students. This may be partly because Aboriginal midwives are exempted from the regulations governing midwives in Ontario (this issue will be dealt with further in Section 2.2.)

In common with most university programs, midwifery students face significant financial burdens, which raises access issues. The tuition for an eight-month term at McMaster is \$4032. In addition, students are required to pay for books, supplies, equipment, learning resources, and, of course, living expenses. Students are also expected to cover their own travel and accommodations expenses for intensives and clinical courses.

Graduation from the OMEP does not guarantee admission to the College of Midwives. The College has approved the following core competencies for entry to the practice of midwifery:

- attendance at a minimum of 60 births, of which the student must be the primary caregiver for 40 of those births
- care throughout pregnancy, labour, and the postpartum period in 30 cases
- a minimum of 10 births in a hospital setting
- a minimum of 10 births in a home setting

University of British Columbia (UBC)

The UBC midwifery program is a four-year, full-time program modeled on the OMEP, leading to the Bachelor of Midwifery. The curriculum combines broad-based knowledge and understanding in the humanities, and social, and bio-medical sciences. It is organized around three overlapping themes: human growth and development; pregnancy and birth transitions; and effective care. Teaching techniques include seminars, labs, Web-based learning, distance learning, intensives and clinical experience. Students will also develop an understanding of childbirth through a number of different cultural perspectives.

The first two years of study take place on the UBC campus and in the Lower Mainland. Students have clinical placements throughout BC and are placed in more than one midwifery practice.

Students have to relocate for periods of three to six months to complete their clinical placements and they are responsible for travel and living expenses.

Université du Québec à Trois-Rivières

This program is full-time and lasts eight semesters, totaling four years including clinical experience. All teaching is in the French language, making the program the only exclusively French language program in the country. For Inuit not fluent in French, this poses a significant barrier to participation in this program. In addition, traveling to courses in the South, incur expenses (room and board, air travel) and long separations from family and community. It is again extremely costly to have such a program delivered in the North that includes professor salaries/room & board/travel, translation, adapting the curriculum to the needs of the communities, etc. On November 21, 2003, the Quebec College of Physicians recommended that midwives only be allowed to practice in hospitals—but only in conjunction with doctors who are caring for pregnant women and newborn children (canada.com., 2003).

Program Accreditation in the United States

There is no midwifery program accreditation process with a national scope in Canada. This differs from the United States with its Midwifery Education Accreditation Council (MEAC). MEAC's mandate is to create standards and criteria for the education of midwives that reflect the nationally recognized core competencies and guiding principles of midwifery care set by the Midwives Alliance of North America. One of MEAC's pressing concerns is the "current crisis in access to maternity care". The infant mortality rate for the general population in the United States has ranked 17th to 24th worldwide since 1954. The 2000 infant mortality rate was 6.9 deaths per 1,000 live births (1 death in about 145 live births). While infant mortality rates dropped for all racial and ethnic groups since 1983, the American Indian/Alaskan Native infants have consistently had a higher infant mortality rate than that of other racial or ethnic groups. In 2000, this rate was 8.3 deaths per 1,000 or 1 death in about 121 live births (America's Children, 2003). The infant mortality rate among First Nations populations in Canada remains higher (6.2 deaths per 1000 live births than that found in the general population (5.4 deaths per 1000 live births) (Young First Nations Children in Canada, 2003).

The accreditation process is similar to that used by the Association of Canadian Medical Colleges. To become accredited, each program must:

- carry out a self-evaluation
- submit to a thorough inspection by an outside examining committee
- submit its curriculum for review by midwifery educators
- repeat the process every three to five years

Accredited schools are across the US in Oregon, Maine, Florida, Texas, New Mexico (which has a distance education program), Vermont, Utah, and Washington.

Appendix 5: Contacts for Midwifery Education Programs

Midwifery Program
University of British Columbia
B54-2194 Health Sciences Mall
Vancouver, BC
V6T 1Z3
Phone: (604) 822-0352
www.midwifery.ubc.ca

Midwifery Education Program
Laurentian University
935 Ramsey Lake Rd.
Sudbury, ON
P3E 2C6
Phone: (705) 675-4822
nwissell@nickel.laurentian.ca
www.midwifery.laurentian.ca

McMaster University Midwifery Education Programme
c/o St. Joseph's Hospital
50 Charlton Ave. East
Fontbonne Bldg., Rm. 613
Hamilton, ON
L8N 4A6
Phone: (905) 522-1155, ext. 5273
www.fhs.mcmaster.ca/midwifery

Programme de baccalauréat en pratique sage-femme
Université du Québec à Trois-Rivières
Casier postal 500
Trois-Rivières, QC
G9A 5H4
Phone: (819) 376-5240, ext. 405
www.uqtr.quebec.ca/sage-femme/accueil.html

Ontario Midwifery Education Program
Ryerson Polytechnic University
350 Victoria Street
Toronto, ON
M5B 2K3
Phone: (416) 979-5104
www.ryerson.ca/midwifery

For midwifery education programs in the United States, see:

Midwifery Education Accreditation Council

220 W. Birch

Flagstaff, AZ

86001

Phone: (928) 214-0997

www.meacschools.org

North American Registry of Midwives (NARM)

5257 Rosestone Dr.

Lilburn, GA

30047

Phone: 1-888-842-4784

www.narm.org

Appendix 6: MIDWIFERY ASSOCIATIONS

Provincial Associations

Provincial associations are divided into two categories: consumers advocacy groups; and midwives associations. While most provinces have the former, only some have the latter. For example, there is no association of midwives in PEI.

The Newfoundland and Labrador Midwives Association (NLMA) was one of the first in Canada, formed in 1983. Its mission is: “to provide professional information for midwives and to promote the recognition of the role of midwives and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to legally provide research-based, total midwifery care as a choice for childbearing families in this province.”

The Midwifery Coalition of Nova Scotia (MCNS) is a consumer advocacy organization, which lobbies to have the profession recognized and funded in that province. (Thus there is some overlap with midwives associations.) Midwifery in Nova Scotia is neither legal nor illegal since there is no relevant legislation here. The MCNS also publishes a newsletter three times a year and is represented on the province’s Advisory Committee on Primary Health Care Renewal, established in 2001. Yet, the association is frustrated with the lack of positive change for midwifery in the province, despite promises from government.

Other provincial organizations include:

- Midwives Association of BC
- Alberta Association of Midwives
- Friends of the Midwives (Saskatchewan)
- Midwives Association of Manitoba
- Association of Ontario Midwives

In addition, midwifery licensing boards operate at the provincial level. These include:

- College of Midwives of British Columbia
- Midwifery Health Discipline Committee, Alberta
- College of Midwives of Manitoba
- College of Midwives of Ontario
- Ordre des Sages-Femmes du Québec
- Northwest Territories Health and Social Services

(Complete contact information is provided in Appendix 7.)

National Associations

Canadian Association of Midwives (CAM)

CAM is the national professional association for Canadian midwives. Its purpose is to promote, protect, and enhance the profession of midwifery and support midwives through a range of activities including but not limited to:

- promoting the inclusion of midwifery as a funded and self-regulated profession in all jurisdictions in Canada
- promoting and facilitating inter-provincial/territorial reciprocity for registered midwives in Canada
- coordinating communication
- providing information about midwifery
- developing evidence-based clinical practice guidelines

CAM also develops national position papers for midwifery practice. (See Appendix 6 for contacts.)

International Associations

International Confederation of Midwives (ICM)

Based in The Hague, the International Confederation of Midwives “advances the aims and aspirations of midwives in the attainment of improved outcomes for women in their child-bearing years, their newborns, and their families, wherever they reside.” Its motto is “Healthy Women, Healthy Babies, Healthy Nations.”

The ICM also released a statement called “Protecting the Heritage of Indigenous People (Cultural Safety)”. Coming out of an awareness of the impact of cultural beliefs on birth, the statement reads:

“The Confederation promotes the full participation of indigenous peoples in the development of health policies and the planning and implementation of health services during childbearing that are safe, acceptable, available, and used. This participation is based on respect for human dignity and a partnership model of professional midwifery practice. In recognition of the variety of cultural traditions and practices surrounding pregnancy and birth, the midwife will:

- be knowledgeable about such traditions and respect those practices that will not cause harm to women and childbearing families
- in instances where such practices can cause harm, work with the community to eliminate the harmful practices
- in partnership with women and childbearing families, provide leadership in establishing and maintaining maternity services that are culturally safe and free from discrimination.”

While the statement has its merits, its focus is on the individual midwife and her role. Further, it presents Aboriginal communities as the recipients of midwifery services, rather than the provider of such services themselves.

The ICM publishes a bimonthly journal and hosts an informative Web site (see Appendix 7 for contacts). The ICM also promotes International Day of the Midwife (IDM) every May 5th, a day it uses to highlight such concepts as safe motherhood.

Midwives Alliance of North America (MANA)

Founded in 1982 to represent American and Canadian midwives, the goals of MANA are to:

- expand communication and support among North American midwives
- form an identifiable and cohesive organization representing the profession of midwifery on a regional, national, and international basis
- promote guidelines for the education of midwives and to assist in the development of midwifery education programs
- promote midwifery research
- promote and support a woman's right to choose her care provider and place of birth
- promote public education and midwifery advocacy

In 1987, MANA created the North American Registry of Midwives (NARM), an international certification agency whose mission is to establish and administer certification for the credential Certified Professional Midwife (CPM). The NARM certification process recognizes multiple routes of entry into midwifery and includes verification of knowledge and skills and the successful completion of both a written examination and skills assessment. The CPM credential requires training in out-of-hospital settings.

Appendix 7: CONTACTS FOR MIDWIFERY ASSOCIATIONS

Consumer Advocacy Groups:

Midwifery Coalition of Nova Scotia
PO Box 33028
Halifax, NS
B3L 4T6
Phone: (902) 429-5112
Email: cjberry@netcom.ca
www.mcns.chebucto.org

Naissance Renaissance
110 Ste Therese #210
Montreal, QC
Phone: (514) 392-0308

Manitoba Midwifery Consumer Network
c/o Noreen Fehr
Box 788
Niverville, MB
R0A 1E0
Phone: (204) 388-4356

Midwives Associations:

Association of Midwives of Newfoundland and Labrador (AMNL)
P.O. Box 78
North West River, NL
A0P 1M0
www.ucs.mun.ca/~pherbert

Association of Ontario Midwives
789 Don Mills Rd Suite 201
Toronto, ON M3C 1T5
Phone: (416) 425-9974
Email: admin@aom.on.ca
www.aom.on.ca

Regroupement Les Sages-Femmes du Québec
BP 354, Succursale Cote-des-Neiges
Montreal, Québec H3S 2S6
Phone: (514) 738-8090
Email: sages.femmes.qc@sympatico.ca
CAM rep: Sinclair Lindsay-Harris

Midwives Association of Saskatchewan
226 7th St E
Saskatoon, SK
S7H 0X1
Email: mackenziep@skyway.usask.ca

Midwives Association of the Northwest Territories and Nunavut
P.O. Box 995
Fort Smith, NT
X0E 0P0
Email: gbecker@auroranet.nt.ca

Midwives Association of Manitoba
870 Portage Ave.
Winnipeg, MB
R3G 0P1
Phone: (204) 784-4077

Midwives Association of Saskatchewan
2836 Angus St.
Regina, SK
S4S 1N8
Phone: (306) 586-2241

Alberta Association of Midwives
Main PO Box 11957
Edmonton, AB
T5J 3L1
Phone: (780) 425-5464
www.albertamidwives.com

Midwives Association of British Columbia
Suite 336-5740 Cambie St.
Vancouver, BC
V5Z 3A6
Phone: (604) 736-5976
www.bcmidwives.com

Yukon Midwives
303 Hoge Street,
Whitehorse, YT Y1A 1V8

International Confederation of Midwives (ICM)
Eisenhowerlaan 138

2517 KN, The Hague
The Netherlands
Phone: 31-70-3060520
info@internationalmidwives.org
www.internationalmidwives.org

Midwives Alliance of North America (MANA)
4805 Lawrenceville Hwy
Suite 116-279
Lilburn, GA
30047
Phone: 1-888-923-MANA (6262)
Email info@mana.org
www.mana.org

Appendix 8: Contacts for Midwifery Licensing Boards in Canada

College of Midwives of British Columbia
Rm. F502
4500 Oak St.
Vancouver, BC
V6H 3N1
(604) 875-3580
admin@cmbc.bc.ca

Midwifery Health Discipline Committee
Health and Wellness Workforce Planning
Alberta Health and Wellness
22nd Floor, Telus Plaza North Tower
10025 Jasper Ave
PO Box 1360, Stn. Main
Edmonton, AB
T5J 2N3
(780) 422-2733
heather.cameron@gov.ab.ca

College of Midwives of Manitoba
235-500 Portage Ave.
Winnipeg, MB
R3C 3X1
(204) 783-4520
admin@midwives.mb.ca

College of Midwives of Ontario
2195 Yonge St., 4th Floor
Toronto, ON
M4S 2B2
(416) 327-0874
admin@cmo.on.ca

Ordre des Sages-Femmes du Québec
430 rue Ste-Helene, Bureau 301
Montreal, QC
H2Y 2K7
(514) 286-1313

ordresagesfemmes@qc.aira.com
Health and Social Services
Government of the Northwest Territories
Yellowknife, NWT, X1A 2L9

Appendix 9: *Health Professions Act, Midwives Regulation, Province of British Columbia*

B.C. Reg. 103/95
O.C. 269/95

Deposited March 15, 1995

Health Professions Act
MIDWIVES REGULATION

[includes amendments up to B.C. Reg. 448/99]

Contents

1 Definitions

2 Designation

3 Reserved title

4 Scope of practice

5 Reserved acts

6 Limitations on practice

7 Patient relations program

8 Sunset

Definitions

1 In this regulation:

"aboriginal" means relating to the Indian, Inuit or Métis peoples of Canada;

"aboriginal midwifery" means

(a) traditional aboriginal midwifery practices such as the use and administration of traditional herbs and medicines and other cultural and spiritual practices,

(b) contemporary aboriginal midwifery practices which are based on, or originate in, traditional aboriginal midwifery practices, or

(c) a combination of traditional and contemporary aboriginal midwifery practices;

"home birth demonstration project" means a study and evaluation of planned home births in British Columbia administered by the Ministry of Health;

"reserve" means a reserve as defined in the Indian Act.

Designation

2 (1) Midwifery is designated as a health profession.

(2) The "College of Midwives of British Columbia" is the name of the college established under section 15 (1) of the Health Professions Act for midwifery.

Reserved title

3 No person other than a registrant may use the title "midwife".

Scope of practice

4 (1) Subject to the bylaws, registrants may

(a) assess, monitor, and care for women during normal pregnancy, labour, delivery and the postpartum period,

(b) counsel, support and advise women during pregnancy, labour, delivery and the postpartum period.

(c) manage spontaneous normal vaginal deliveries,

(d) care for, assess and monitor the healthy newborn, and

(e) provide advice and information regarding care for newborns and young infants and deliver contraceptive services during the 3 months following birth.

(2) Subject to the bylaws, aboriginal registrants may practice aboriginal midwifery.

Reserved acts

5 (1) Subject to section 14 of the Health Professions Act, no person other than a registrant may, for the purposes of midwifery,

(a) conduct internal examinations of women during pregnancy, labour, delivery and the postpartum period,

(b) manage spontaneous normal vaginal deliveries, and

(c) perform episiotomies and amniotomies during established labour and repair episiotomies and simple lacerations.

(2) Subsection (1) does not apply on a reserve to an aboriginal person who practised aboriginal midwifery prior to the coming into force of this regulation.

Limitations on practice

6 (1) Registrants must

(a) advise clients to consult a medical practitioner for a medical examination during the first trimester of pregnancy, and

(b) consult with a medical practitioner regarding any deviations from the normal course of pregnancy, labour, delivery and the postpartum period that indicate pathology and transfer responsibility when necessary.

(2) No registrant is permitted to manage a planned home birth except as part of the home birth demonstration project.

(3) Subsection (2) does not apply on a reserve to an aboriginal person who practised aboriginal midwifery prior to the coming into force of this regulation.

Patient relations program

7 The College of Midwives is designated for the purposes of section 16 (2) (f) of the Health Professions Act.

Sunset

8 Section 6 (2) and (3) and the definition of "home birth demonstration project" in section 1 are repealed October 31, 2000.

[am. B.C. Regs. 472/98; 448/99.]

[Provisions of the Health Professions Act, R.S.B.C. 1996, c. 183, relevant to the enactment of this regulation: section 12]

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Appendix 10: Vision of *Onkwehon:we* Midwifery Care, Six Nations

Onkwehon:we Midwifery Care acknowledges our place within the Creator's mind and so accepts our responsibilities to our families, our communities, those yet to come, and ourselves.

Onkwehon:we Midwifery Care is based on a respect for all life and birth as a profound and sacred part of life.

Onkwehon:we Midwifery Care will enable women to reclaim control of birth for themselves as the centre of the circle of life.

Onkwehon:we Midwifery Care will provide continuous competent care, which respects and empowers the woman regardless of her social and cultural background. Each client has the right to design her birth plan in consultation with a midwife.

Through the integration of cultural ways, preventative care, and appropriate use of technology, Onkwehon:we Midwifery Care will provide safety, security, and protection in a caring and nurturing environment.

Onkwehon:we Midwifery Care respects the interests of women, families, and communities that are best served through the coordination of parallel Indigenous and western knowledge systems in the management of pregnancy and birth.

Appendix 11: Association of Midwives of Newfoundland and Labrador- Code of Ethics

Association of Midwives of Newfoundland and Labrador Code of Ethics approved January 2001

1. Midwives respect their relationship with women and their families, maintain confidentiality of information obtained, and only share pertinent information with the woman's permission or as legally required.
2. Midwives support and advocate for their professional Association. Midwives should not engage in any activity that would adversely affect the honour, dignity, or credibility of the profession.
3. Midwives, as members of a health care profession, act in a manner that enhances the reputation of, and inspires public awareness and confidence in, the profession.
4. Midwives continue their education, both formally and informally, to keep their practice current, and take examinations as required to demonstrate that their skills are at a safe level.
5. Midwives' primary responsibility is the well-being of women and their babies. Midwives use research-based knowledge to provide appropriate care.
6. Midwives respect the rights of women to make informed choices by providing them with complete, current and objective information, scope and limitations of practice, and making referrals when required.
7. Midwives do not discriminate on the basis of language, culture, age, socioeconomic status, gender orientation, religious persuasion, or location, when providing professional care. Although the decision regarding the place of birth should be ideally based on research findings, no woman in labour should be denied care wherever the birth is occurring.
8. Midwives always act so as to provide optimal health for the woman and the baby when providing advice and care during preconception, pregnancy, labour and birth, postpartum, and in the neonatal period.
9. Midwives promote, protect and support breastfeeding by providing research-based information. Midwives respect and support the woman's informed decision regarding infant feeding.
10. Midwives recognize and accept that loss may be a part of pregnancy and birth, and in doing so support the woman and her family in dealing with any loss according to their individual needs, and make appropriate referrals when required.
11. Midwives recognize that in situations where there are objections or conflicts of interest

between women and themselves they will assist the woman in finding another care provider (midwife or physician).

12. Midwives may not refuse to attend a woman during labour, nor cease providing care during labour unless there are appropriately regulated health professionals present to provide the necessary care.
13. Midwives show respect to other professional or lay caregivers chosen by a woman to support her during pregnancy, labour, and the postpartum period.
14. Midwives care for themselves and do not practice when their judgment is impaired by physical or social factors, e.g. tiredness, illness, misuse of alcohol or other drugs.
15. Midwives share their midwifery knowledge by being preceptors, mentors and educators to students, and by participating in peer review and research related activities.
16. Midwives provide vital statistics data required by law, and data required for the provincial assessment of midwifery. Midwives only provide data to sources approved by their provincial Association.
17. Midwives cooperate with government and voluntary agencies to determine women's needs for health services and to promote equal access to health care resources for childbearing women.
18. Midwives refuse to accept any gift, favour or hospitality which might be interpreted as a professional endorsement of a commercial product. Likewise, the midwife should not provide preferential treatment or consideration to the client on the basis of financial or other rewards.
19. Midwives ensure that their professional status is not used to promote commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services, and ensure that their professional judgment is not influenced by commercial considerations.
20. Midwives will adhere to professional standards when promoting the availability of their services.
21. Midwives will practice midwifery in accordance with Midwives Regulations and Policies of the Newfoundland and Labrador Midwives' Board.

**Appendix 12:
Job Advertisements for Midwives**

(A) Midwives (Burntwood Regional Health Authority Manitoba)
Pos ID: 372622 Openings: 1 Status:

Employer: Burntwood Regional Health Authority
Category: Midwife
Location: Thompson

Details: The Burntwood Regional Health Authority is looking for three (3) Midwives who seek challenge, change and innovative practice. Adaptable midwives dedicated to serving the diverse needs of the women of the Region. Midwives must be registerable with the College of Midwives of Manitoba.

(B) Anticipated Midwifery position at the Labrador Health Center (Health Labrador Corporation _ Newfoundland)
Pos ID: 369033 Openings: 1

Employer: Health Labrador Corporation
Category: Midwife
Location: Happy Valley _ Goose Bay

Details: The Health Labrador Corporation is responsible for a full range of services including community health, long-term care and acute care for all of Labrador north of Black Tickle, and serving a population of approximately 28,000. Accredited hospitals and long term nursing facilities in Labrador City and Happy Valley Goose Bay serve the region. There are ten nursing stations that serve the rural and coastal areas of Labrador.

You must be a graduate from an approved school of Midwifery.

The salary and benefit package for this position is in accordance with the NLNU (Newfoundland and Labrador Nurses Union) salary scale. Labrador Allowance benefits: without dependents \$2150 per annum; with dependents \$4300 per annum. Assistance is provided for relocation expenses.

This position is open to both male and female applicants.

Appendix 13: Resources

1. “The Helper”, a video about traditional Inuit midwifery, including footage of a contemporary birthing facility that integrates Inuit midwifery practices. In Inuktitut, although a version with English subtitles is available. Contact:
Pauktuutit Inuit Women’s Association
131 Bank Street, 3rd Floor
Ottawa, ON
K1P 5N7
Phone: 613-238-3977
2. “What Midwives Do”, a 15-minute video produced by the Midwives Coalition of Nova Scotia, available for \$16.00. Contact: Catherine Berry, PO Box 33028, Halifax, NS, B3L 4T6, phone: 902-429-5112, email: cjberry@netcom.ca
3. *Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities*. Aboriginal Nurses Association of Canada and Planned Parenthood, 2002. Part 2 – Sexual and Reproductive Health Issues of Concern to Aboriginal People – is particularly relevant. A Web version of the sourcebook is available at www.anac.on.ca/sourcebook
4. The book, *Paths to Becoming a Midwife: Getting an Education*, is available through www.MidwiferyToday.com, although it is for a U.S. readership.