

MIDWIFERY

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Midwifery

INTRODUCTION

Canadian midwives are primary health-care providers who care for women during pregnancy and birth, and up to six weeks postpartum (Canadian Institute for Health Information [CIHI], 2010). Midwifery is a small profession, with approximately 1,500 members, including both student and practising midwives (CAM, 2018a). Midwifery is a relatively new addition to the Canadian healthcare workforce, and not all provinces and territories currently regulate the profession. Nevertheless, midwives are rapidly becoming a popular choice among pregnant women in Canada. The Canadian model of midwifery care has been a source of pride and satisfaction for practising midwives and for the women who receive their care (O'Brien et al., 2011). It has produced high levels of client satisfaction, positive clinical outcome statistics (Hatem, Sandall, Devane, Soltani, & Gates, 2008; Hutton et al. 2016). In Ontario, for example, the satisfaction rate for midwifery number is close to 99% (Association of Ontario Midwives [AOM], 2007). Midwifery care is associated with fewer instrument-assisted births, lower C-section rates, and reduced hospital stays (Hatem et al., 2008). Recognizing the advantages of midwifery care and seeking to address the growing demand for midwives, health-care systems across the country are looking to increase the number of practising midwives.

In this chapter, we provide an overview of the profession of regulated midwifery. We begin with a brief history of the profession followed by the review of the educational requirements and definition of the scope of practice. After discussing the current trends in the profession, we identify some challenges that faced by practicing midwives in Canada. We identify retention of midwives, work-life balance, and remuneration as three major disconcerting issues faced by midwives in Canada today.



HISTORY OF THE PROFESSION

EARLY MIDWIFERY IN CANADA

The history of midwifery in Canada largely resembles the history of colonialism. Indigenous¹ Peoples had long and rich histories of providing health and wellness care to their communities, which included what we would define as midwifery care (National Aboriginal Council of Midwives [NACM], 2018). Colonization resulted in significant changes in how Indigenous midwifery was provided to Indigenous people as a result of the systematic and purposeful destruction of Indigenous ways of knowing, all in the name of nation building (Kaufert & O'Neil, 1990; Lawford & Giles, 2012a).

Midwifery care also changed dramatically in settler communities. Before the 20th century, most Canadian women in settler communities received assistance during pregnancy and childbirth from local women who served as midwives. These women were either trained as nurse-midwives and brought from abroad to

¹ We use the term Indigenous in this reader. The constitutionally defined term remains Aboriginal.

Canada or had no formal training in obstetrics. Most lived in the communities they served and had experience providing care for women during pregnancy and childbirth. In addition to helping with labour and delivery, they could also serve as nurses, housekeepers, and doulas and received in-kind payment for their services (Bourgeault & Fynes, 1997).

In the early to mid-20th century, this type of lay midwifery experienced a rapid demise. The growing popularity of formal medical training made midwifery services less appealing to Canadian women in affluent communities. Home birth was largely replaced with hospital birth under the supervision of physicians who offered pain relief medications (Bourgeault & Fynes, 1997). At the same time, medical practice laws made the practice of midwifery illegal in some provinces (e.g., Quebec) and in a legal grey zone in others (e.g., Ontario) (Bourgeault, 2006).

Midwives faced challenges organizing professionally due to language, literacy, and cultural barriers (Bourgeault, 2000). Midwifery nearly disappeared from the Canadian health professional landscape as a result

MIDWIFERY IN REMOTE COMMUNITIES

Although maternity care services were not officially recognized as a professional practice, the need for them prompted the government to introduce midwifery services in some northern, rural, and remote areas. In Alberta, the United Farm Women of Alberta and the United Farm Men of Alberta lobbied the provincial government to provide midwifery services to women in rural communities (Bourgeault & Fynes, 1997). As a result, in 1944, a three-month program opened in Edmonton that offered training in obstetric skills to nurses. Similar programs later opened in Nova Scotia (1967) and Newfoundland (1978).

Though midwifery neither became an official speciality or nursing nor firmly established in provincial health-care systems, the federal government did rely on nurse-midwives recruited mainly from abroad. Most nurse-midwifery services were offered in federal nursing stations to Indigenous women and those living in remote areas. Because physicians were not generally attracted to these areas, there was no real opposition to the introduction of midwifery services in these places.

Pregnant First Nations women living in rural and remote areas have been evacuated south for labour and delivery the early 1900s (Lawford & Giles, 2012a). The practice became more widespread in the mid 20th century under the guise of trying to reduce maternal and infant mortality rates, but it arguably contributed to further colonization of birth practices (Kaufert & O'Neil, 1990; Lawford & Giles, 2012b). The evacuation policy reduced the need for midwifery services in Indigenous communities. As a result, these services largely disappeared from these communities.

THE REINTRODUCTION OF MIDWIFERY IN CANADA

There were some attempts to reintroduce nurse-midwifery throughout the 1970s, mainly by British-trained nurses who had immigrated to Canada and found it odd that there was no regulated midwifery here. These efforts, however, did not bring any meaningful results. Lay midwives emerging from the home-birth movement led efforts in a number of provinces to legalize midwifery practice. Many had formal training, but they also gained experience as childbirth educators and birth attendants who sometimes assisted the few physicians delivering babies at home (Bourgeault, 2006). Generally, these women were paid directly by clients for their services, though their midwives had no formal professional recognition. As midwife-attended home births rose in popularity, a number of criminal cases were brought against midwives in Canada (Bourgeault & Fynes, 1997).

LEGALIZATION OF MIDWIFERY

The first Canadian province to introduce midwifery legislation was Ontario. When the Ontario government began a health professions legislation review process in 1983, lay and nurse-midwives banded together to request legal recognition for midwifery. The Ontario government appointed a Task Force on Implementation of Midwifery in response. The Task Force submitted its report in 1987 and recommended that midwifery should be a recognized and regulated profession in Ontario, independent from medicine or nursing and with its own regulatory college and a direct-entry educational program. It further recommended that midwives should practise in the community and in hospitals as primary care providers.

TABLE 1: Status of midwifery by province and territory

Province/territory	Legislation/regulation	Public funding	Employment status	Remuneration	Registered midwives
British Columbia	1998	Yes	Independent contractor	Per course of care	313
Alberta	1998	Yes	Independent contractor	Per course of care	111
Saskatchewan	2008	Yes	Employee	Salary	14
Manitoba	2000	Yes	Employee	Salary	77
Ontario	1994	Yes	Independent contractor and employee model for Indigenous midwives	Per course of care	817
Quebec	1999	Yes	Independent contractor	Salary	198
New Brunswick	2016	Yes	Employee	Salary	6
Nova Scotia	2009	Yes	Employee	Salary	9
Prince Edward Island	–	N/A	–	–	–
Newfoundland and Labrador	2016	Pending	Pending	Pending	0
Yukon	–	N/A	Pending	Pending	0
Northwest Territories	2005	Yes	Employee	Salary	4
Nunavut	2011	Yes	Employee	Salary	8
				Total	1198

Source: CAM (2018). Midwifery Across Canada. <https://canadianmidwives.org/midwifery-across-canada/>

Midwifery became legal in Ontario on November 1, 1991. On December 31, 1993, it officially became a self-regulated and publicly funded health profession in Ontario. An exception in the *Midwifery Act* recognized the right of Indigenous midwives to continue to practise in their communities without the oversight of the regulatory college (Association of Ontario Midwives AOM, 2018). Other provinces introduced midwifery regulation after Ontario, although some established a different remuneration model.

Midwifery services are currently available in all Canadian provinces and territories except Prince Edward Island, Newfoundland and Labrador, and the Yukon. PEI passed legislation but at the time of writing had not yet been proclaimed (Goodwin 2018). Newfoundland and Labrador was planning a pilot study in Gander in 2018 with the plan for midwifery to be

integrated across the province in 2019 (Quinn 2018). Yukon is working towards legislation that is said to be on track for the end of 2019 (Mangat 2019).

EDUCATION AND TRAINING

To be eligible for registration and licensure as a practising midwife, an individual must complete a midwifery education program (MEP) and write the Canadian Midwifery Registration Examination (CMRE).² Internationally trained applicants must demonstrate equivalency of their education and practice to Canadian standards or complete a bridging program to upgrade gaps in practice and education before writing the CMRE. Once they have passed the CMRE, applicants are eligible to apply for licensure with a midwifery college and complete the registration process to begin practising as registered midwives.

2 Quebec has slightly different licensure requirements (see <http://www.osfq.org/grand-public/definition-dune-sage-femme/?lang=en>).

MIDWIFERY EDUCATION PROGRAMS IN CANADA

There are six MEPs in Canada, and one in stasis pending revision in Manitoba. The first MEP was established in 1993 in Ontario and is a direct-entry program, meaning applicants do not need prior education in nursing or any other field to enter an MEP. The Ontario MEP is a collaboration between three universities (Laurentian, McMaster and Ryerson) and the largest MEP in Canada, admitting 30 students at each site per year (90 students total per year). Although MEPs do not require prerequisite degrees, the admissions process is highly competitive³ and many incoming students have already completed some undergraduate- or graduate-level education before they apply (Wilson, Neiterman, & Lobb, 2013). MEPs in Canada are around four years long. Graduates receive Bachelor of Midwifery (BMW), Bachelor of Health Sciences (BHSc) or Bachelor of Science (BSc) degrees.

The first year of a program is typically devoted to classroom education. Starting in the second year, students attend clinical placements—usually in at

least two different settings so they can experience diverse conditions. The final year of a program usually focuses on clinical clerkship, when students work in the community under close supervision from an experienced midwife. During this time, student midwives learn how to provide care at home, in hospitals, and in birth centres (if available in the province where training is taking place). By the time students graduate, most should have attended approximately 60 births and served as primary caregiver for at least 40 of them. Table 2 presents an overview of MEPs in Canada.

COMMUNITY-BASED PROGRAMS

There are three community-based MEPs in Canada:

- *Tsi Non:we lonnakeratstha Ona: grahsta'* Aboriginal Midwifery Training Program in Ontario;
- *Nunavik Community Education Program*, offered in Northern Quebec to midwives who plan to work in Inuit communities; and
- *Nunavut Midwifery Education Program*, offered at the Arctic College.

TABLE 2: University-based midwifery education programs in Canada

School	Program length (years)	Degree	Language	School opened	Number of students for 2011
Alberta					
Mount Royal University	4	BMW	English	2011	14
British Columbia					
University of British Columbia	4	BMW	English	2002-2003	10
Manitoba					
University of Manitoba in partnership with McMaster University ⁴	4	BMW	English	2006	-
Ontario					
Laurentian University	4	BHSc	English and French	1993	20
McMaster University	4	BHSc	English	1993	27
Ryerson University	4	BHSc	English	1993	18
Quebec					
Université du Québec à Trois-Rivières	4.5	BSc	French	1999	24

Source: CIHI, 2013.

³ For example, the ratio of applicants to admissions to the Ontario MEP is 8:1 (Neiterman & Lobb, 2014).

⁴ In 2016, the University of Manitoba partnered with McMaster University to offer midwifery education to 13 students. These students will graduate with a midwifery degree from McMaster. Discussions are underway to establish a program based out of the University of Manitoba.

All three programs heavily emphasize learning about Indigenous cultures and providing midwifery and maternity care services that respond to community needs. In the Nunavik community MEP, emphasis is also placed on learning in Inuktitut, and in a style consistent with an Inuit vision of culture and wellness (NACM, 2018).

INTERNATIONALLY EDUCATED MIDWIVES

There are additional educational programs that ensure midwives trained in other jurisdictions are ready for practice in Canada (CMRC, 2018a):

- International Midwifery Pre-Registration Program at Ryerson University in Ontario;
- Internationally Educated Midwifery Bridging Program at the University of British Columbia; and
- Université du Québec à Trois-Rivières in Quebec.

A unique feature of the Canadian model of midwifery practice is that Canadian midwives work as primary care providers both in the hospital and in the community. In most other healthcare systems, midwives practise under the supervision of physicians or nurses (Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010). Some internationally educated midwives find it hard to adjust to a model where they are primary care providers. A related challenge some internationally trained midwives face is adjusting to low-technology midwife practices when working in the community (Bourgeault et al., 2010).

REGULATIONS AND STANDARDS

Professional regulation in Canada is organized provincially and territorially with different dates for legislation, which are detailed in Table 1. The designations “midwife” and “registered midwife” are protected in Canada. To provide midwifery care, midwives must be registered with the regulatory college in their province or territory (CMRC, 2018a).⁵

National coordination is provided by the Canadian Midwifery Regulators Council (CMRC), which is a network of provincial regulatory authorities that works to ensure universal standards of midwifery practice across Canada. The CMRC identifies its goals as

providing “leadership in maintaining a strong regulatory framework through our work in setting the Canadian midwifery competencies, establishing national standards for midwifery practice, administering the national Canadian Midwifery Registration Examination, and approving educational and bridging programs” (CMRC, 2018a). Working with CAM and the Canadian Association of Midwifery Educators, the CMRC offers a “three-pillar approach to excellence in midwifery regulation, education and practice” (CMRC, 2018a).

SCOPE OF PRACTICE

Midwives who are registered with the regulatory college are legally allowed to perform specific actions reserved for midwives. Ontario’s 1991 *Midwifery Act*, for example, stipulates that the scope of practice of midwives includes “the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies, the provision of care during normal pregnancy, labour and postpartum period and the conducting of spontaneous normal vaginal deliveries” (Ontario, 1991). While each regulatory college has its own requirements, all cite similar scopes of practice as that set out in Ontario’s *Midwifery Act*.

PRINCIPLES OF MIDWIFERY CARE

While there are slight variations in midwifery practice across Canada’s provinces and territories, all Canadian midwives are primary care providers who adhere to seven core principles, as outlined by CAM (2018b):

1. Professional autonomy

“Canadian midwives are autonomous primary health-care providers who provide comprehensive care during pregnancy, labour, postpartum and the newborn period. Midwifery in Canada is a direct-entry profession and is self-regulated. Midwifery services are publicly funded and integrated within the Canadian healthcare system. Midwives work in home, hospital and community settings, including maternity and birth centres. Midwives access emergency services as needed. Where available, midwives maintain hospital privileges for the admission of clients and their newborns.”

⁵ Indigenous midwives are an exception to this clause.

2. Partnership

“Midwives engage in a non-authoritarian and supportive partnership with clients throughout their care. Midwifery recognizes the intimate client-care provider relationship as being integral to the provision of care that is responsive to the unique cultural values, beliefs, needs and life experiences of each client. Research suggests that the nature of the relationship between a client and healthcare provider is one of the most significant determinants of positive outcomes. For Aboriginal communities, the inclusion of extended families and the integration of culturally safe care increases positive health outcomes...”

3. Continuity of care provider

“Midwifery provides continuity of care provider, whereby a known midwife or small group of midwives provides care throughout pregnancy, labour and the postpartum period. Sufficient time is offered during routine visits for meaningful discussion and ongoing health assessment. This approach creates the opportunity for building a relationship of familiarity and trust, and facilitates informed choice discussions. The presence of a known and trusted caregiver during the birth experience enhances client safety and satisfaction, and is an aspect of midwifery care that is highly valued. Continuity of care provider results in excellent health outcomes, increased client satisfaction and cost-effective care.”

4. Informed choice

“Midwives recognize the right of each person to be the primary decision maker about their care. Midwives encourage and enable clients to participate fully in the planning of their own care and the care of their newborns. Informed choice requires cooperative dialogue and encourages shared responsibility between client and midwife or midwives. Midwives share their knowledge and experience, provide information about community standards and offer evidence-based recommendations. Midwives encourage clients to actively seek information and ask questions throughout the decision-making process. Midwives recognize and respect that clients will sometimes make choices for themselves and their families that differ from their midwife’s

recommendation and/or community standards. In such circumstances, midwives will continue to provide the best possible care.”

5. Choice of birth place

“Everyone has the right to choose where they will give birth, and midwives are responsible for providing care within their scope of practice to their clients in the setting of their choice. People may choose to give birth in their homes, hospitals, birth centres or health clinics safely with midwives in attendance. Midwives are an essential part of quality maternity care that supports people to give birth as close to home as possible in urban, rural and remote communities.”

6. Evidence-based practice

“Midwives support physiologic birth. Midwifery practice is informed by research, evidence-based guidelines, clinical experience, and the unique values and needs of those in their care. Aboriginal communities value the traditional knowledge that has been passed down orally and experientially through generations of midwives and use this knowledge in practice for optimal birth outcomes.”

7. Collaborative care

“Midwives are autonomous healthcare providers who work independently and in collaboration with other healthcare professionals as needed. Where it meets the unique needs of a specific community, population or geographical area, midwives may work collaboratively within creative interdisciplinary models of practice ... The principles of continuity, informed choice, partnership and choice of birthplace remain essential elements of midwifery care within a collaborative practice.”

As is clear from these principles, midwifery practice emphasizes informed choice and places a woman at the centre of her own care. Midwives’ activities include:

- Doing episiotomies and amniotomies;
- Administering injections;
- Performing vaginal exams;
- Inserting urinary catheters;
- Taking blood samples from women and babies;

- Ordering and performing some diagnostic tests; and
- Prescribing certain drugs.

The pharmacopeia includes antibiotics as well as medications prescribed for pregnancy discomfort, labour and delivery pain relief, and the general management of care.

PRACTICE SETTINGS

Midwives work in a range of practice settings from private offices, health centres, birth centres, community clinics, and hospitals. Salaried midwives usually work in shared practices, which enables them to share on-call schedules. They generally do not hold private offices and usually have admitting privileges that allows them to offer hospital birth as well as out-of-hospital birth.

In some provinces, Registered Midwives work in teams of at least two and have admitting privileges in at least one hospital or birth centre. The primary midwife provides the majority of care for her clients; the second provides backup where the primary midwife is unable to attend to a client. The second midwife also usually attends at least one prenatal visit and assists during birth. A full-time midwife attends around 40 births as a primary midwife and an additional 30–40 births as a second midwife, although these numbers can vary. In British Columbia, for example, a full-time midwife attends 40–60 births as a primary midwife and another 15–20 births as a second midwife (CMRC, 2014). Outside of Ontario and Quebec, midwives are generally assisted in hospitals by nurses on staff.

COVERAGE OF SERVICES AND REMUNERATION

Midwifery practices and payment schemes are organized differently in various provinces and territories (CAM, 2013). In Alberta, British Columbia, and Ontario, registered midwives are considered independent contractors and are paid per course of care. These midwives generally work in private clinics, which are usually shared with other midwives. Midwives are responsible for covering office expenses and coordinating care within their clinics, although they sometimes receive funding from their provincial government to cover overhead costs. Office expenses

include staff salaries, rent, equipment, and supplies. Midwives also require liability insurance, certification, vehicle expenses, and group benefits. The CMRC estimates that about 32–34% of the annual salary of midwives in British Columbia is spent on work-related expenses (CMRC, 2018a).

In other provinces, midwives are employed by regional health authorities. The regional health authorities pay midwives' salaries and cover overhead expenses, including office equipment, supplies, and professional liability insurance (CMRC, 2018a). The Manitoban government has considered implementing the fee-for-service model used in Ontario and British Columbia, though one study suggests the employment model is more conducive to integrating midwives into the health-care system and targeting their priority populations (Thiessen, 2014).

DEMOGRAPHICS

According to CIHI, 99.9% of Canadian midwives are female (2017). Table 3 summarizes the age distribution of Canadian midwives.

While the supply of midwives is growing, the number of midwives is not keeping up with the demand. Table 3 presents the supply of midwives across Canada.

INDIGENOUS MIDWIVES IN CANADA

Indigenous midwives make up a distinct group within the midwifery profession in Canada. This distinction recognizes their inherent rights as Indigenous people. Pre-contact, Indigenous communities relied exclusively on midwifery services for their maternity care. Colonization of Canada and Indigenous communities led to changes in the provision of care to pregnant and birthing women. The practice of flying women south for birth placed Indigenous women at a particular disadvantage because it meant they were giving birth far from home—detached from their families and communities (Lawford & Giles, 2012a, b).

Since 2002, Indigenous midwives across Canada have been formally working together to raise awareness about the maternity care needs of Indigenous communities and to discuss the specific needs of Indigenous midwives. The National Aboriginal Council of Midwives (NACM), established in November 2008, is the official body representing Indigenous midwives in Canada (NACM, 2018). NACM has



TABLE 3: Number of active registered midwives by province/territory 2014–2018

Province	2014	2015	2016	2018
British Columbia	237	247	273	361
Alberta	86	94	111	115
Saskatchewan	16	11	15	15
Manitoba	55	52	52	82
Ontario	656	678	711	877
Quebec	157	155	221	217
New Brunswick	–	–	0	3
Nova Scotia	10	10	10	9
Prince Edward Island	–	–	–	0
Newfoundland and Labrador	–	–	0	1
Territories	25	26	31	10

Source: CIHI, 2017.

approximately 70 members, including practising Indigenous and registered midwives, Elder midwives, and Indigenous midwifery students from diverse communities and regions. NACM members serve First Nations, Inuit, and Métis people and their families (NACM, 2018).

The long-term goal of NACM is to ensure all Indigenous communities have access to midwifery care (NACM, 2018). NACM continues to work toward achieving this goal at a national level and currently lists 12 Indigenous practices across Canada. These significantly improve the provision of care to Indigenous women in their respective communities. Table 4 lists these practices and the year they opened.

The Indigenous midwifery community strongly emphasizes the importance of cultural and community practices in Indigenous midwifery. To become a midwife, students enroll in university-based MEP or pursue community-based midwifery programs.

Midwives who practise in Indigenous communities enable women with low-risk pregnancies to choose community-based birth either at home or in birth

centres. The re-introduction of community birthing through birth centres at the Inuulitsivik Health Centre in Nunavik, Quebec, for example, shows a significant reduction in transfers out of the community—from 91% in 1983 to less than 9% in 1998 (NACM, 2018). Data from the Inuulitsivik Health Centre for 2000–2007 found that 86% of Nunavik women were delivering their babies in Nunavik (Wagner et al., 2012).

KEY ISSUES FOR THE PROFESSION

SUPPLY CHALLENGES

Around the world, 75% of babies are born with the assistance of midwives (Hawkins & Knox, 2013). In Canada, the total number of midwife-led births was only 10% in 2015–2016 (CAM, 2018a). All provinces that recognize midwifery are looking to expand the number of midwives but face challenges due to limited learning opportunities for future midwives. Canada has only six midwifery education programs, which graduate approximately 150 midwives per year. This is not enough to keep pace with the growing demand for midwifery services (Hawkins & Knox, 2013).

TABLE 4: Indigenous midwifery practices in Canada

Name	Year opened
Quebec	
Inuulitsivik Health Centre, Nunavik	1986
Tulattavik Health Centre, Nunavik	2009
Nunavut	
Rankin Inlet Birthing Centre	1993
Cambridge Bay Birth Centre	2010
Northwest Territories	
Fort Smith Health and Social Services Midwifery Program	2005
Manitoba	
Kinosao Sipi Midwifery Clinic, Norway House Cree Nation	2006
Ontario	
Seventh Generation Midwives Toronto	2005
Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Centre	1996
Kontinenhanónhnha Tsi Tkaha:nayen, Tyendingaga Mohawk Territory	2012
Neepeeshowan Midwives, Attawapiskat	2012
K'Tigaaning Midwives, Powassan	2013
Ionteksa'tanoronhkwa "child-cherishers" Homebirth Midwives, Akwesasne	2013

Despite the growing popularity of midwifery, access to midwives is not universal across Canada. Ontario, the first province to legislate midwifery in 1994, has 817 registered midwives and three midwifery education programs, while Nova Scotia has only nine midwives and no educational opportunities for students (CAM, 2018a; Canadian Midwifery Regulators Council [CMRC], 2018a). In some provinces, access to midwifery is limited due to a lack of regulation and funding (Hawkins & Knox, 2013).

Provision of services in rural and remote communities is particularly challenging for Canadian midwives. Remoteness of communities, availability of transportation, and access to communities—especially during the spring and fall—are just some of the challenges midwives face serving clients in rural and remote communities.

WORK-LIFE BALANCE

The “caring dilemma” is a paradox of the nursing profession, which expects nurses to provide care in a society that devalues caring work (Reverby, 1994). Bourgeault, Luce, and MacDonald applied this concept to midwifery, suggesting that the caring dilemma in midwifery presents significant barriers for midwives who care for their clients at the cost of neglecting their own families (2006). The continuity-of-care model requires midwives to be on-call for a considerable amount of time: labour and birth are unpredictable, and midwives stay with their clients for the entire process. Many midwives have expressed concerns that they often have to sacrifice time with their own families and miss important family events due to the unpredictable nature of their work (Bourgeault et al., 2006).

Midwifery policy stakeholders recognized the tension the continuity-of-care model creates in the lives of midwives when midwifery practices were established in Ontario (Bourgeault, 2000). Because the continuity-of-care model is seen as the cornerstone of midwifery practice, a proposed solution was to organize midwives into collaborative group practices. Many midwives have organized themselves into such practices, where support from their colleagues allows them to have more control over their working hours.

The shortage of midwives—especially in less populated, rural areas—may influence the availability of support from colleagues. Midwives in these areas continue

to struggle with balancing work and family and experiencing the caring dilemma and burnout.

RETENTION

Recent studies looking into attrition from the MEP in Ontario suggest some student-midwives withdraw from their studies due to concerns about their ability to balance work and family while practising (Neiterman, Wilson, & Lobb, 2013; Wilson et al., 2013). Some of the students referred to the profession of midwifery as “woman-centred, but not woman-friendly.” (Neiterman & Lobb, 2014). This suggests the Canadian model of midwifery practice seeks to accommodate the needs of women who are clients but neglects the wellbeing of those who offer midwifery services (Neiterman & Lobb, 2014).

No systematic studies examining retention among practising midwives in Canada have been conducted. Provincial registries, however, show somewhat alarming statistics. The number of inactive members of the college range from 8% (seven of 85 members) in Alberta to 13.6% (30 of 221) in British Columbia (Lobb, Neiterman, Hakemzadeh, & Zeytinoglu, 2013).

These numbers are particularly worrisome because midwifery is a relatively small profession, which means the loss of even one midwife is significant. Generally, one midwife provides care to 80–100 women per year (40–60 women as the primary midwife and another 20–40 as the secondary midwife). The 94 midwives in Ontario (out of 584 registered) who were not practising in 2013 could have provided care to thousands of women and saved thousands of taxpayer dollars (Lobb et al., 2013). In Manitoba, the number of non-practising registered midwives has continued to increase over time—from five in 2001–2002 to 12 in 2007–2008 (Thiessen, 2014). A more recent annual report by the College of Midwives of Manitoba showed that the number of non-practising midwives had increased to 17 in 2010–2011 (Thiessen et al. 2015). The increased number of non-practising midwives in Manitoba has been attributed to job stress, maternity and sick leaves, and retirement (Thiessen, 2014).

Work-life balance is a central issue associated with retention in the midwifery workforce. In 2012, the AOM established a work-life balance task force that considered solutions for resolving the tension between work and personal life that midwives face (AOM,

2013). It seems that the Canadian model of midwifery practice is partially responsible for creating a work-life balance problem for the Canadian midwives, but the value of this model to women and to midwives is important—which makes this midwifery model hard to challenge.

Other initiatives, such as the introduction of group practices, may help reduce attrition from midwifery practice. Further research is required to understand which strategies would be most beneficial.

PAY EQUITY IN ONTARIO

In 2013, the AOM filed a human rights complaint with the Human Rights Tribunal of Ontario, arguing gender discrimination in pay equity (Gordon, 2013). When the remuneration scheme for midwifery practice was set up in 1994, it was agreed that midwives would be paid slightly less than family physicians and slightly more than nurse practitioners. But midwives' salaries have not kept up with the salaries of physicians or nurses.

According to some estimates, midwives are currently earning only about half of what their work is actually worth (Gordon, 2013). The AOM argued that this salary gap is inherently gendered—given that midwifery is overwhelmingly a female-dominated profession and because male-dominated professions in Ontario's public sector (such as correctional officers and police officers) have seen salary increases during the same period. In September 2018, the court ruled in favour of Ontario midwives and supported their claim for gender discrimination in pay. Currently, the court is deciding on the damages that should be paid to midwives to compensate for decades-long discrimination (Mojtehedzadeh, 2018).



CONCLUSION

Regulated midwifery is a relatively new profession in the Canadian health-care workforce and is growing too slowly to meet rising demand. While midwives provide the majority of maternity care worldwide, in Canada, less than 10% of women receive midwifery services (CMRC, 2018b). This disparity is likely due to a combination of Canadian women's unfamiliarity with the high-quality care midwives offer and lack of access to midwifery services.

Access to midwifery services is distributed unequally among and within Canadian provinces. While most provinces do recognize and regulate midwifery, midwifery continues to be unregulated and/or unfunded via provincial health-care plans in some jurisdictions. In provinces where midwifery services are regulated and legislated, midwife shortages create additional barriers to receiving midwifery services. Access is particularly challenging for women in rural and remote areas, and for Indigenous women who live on reserves.

Retention seems to be emerging as a central issue for sustaining—and growing—Canada's midwifery workforce. While evidence suggests burnout and work-life balance issues lead midwives to leave the profession, there is no systematic research looking into retention trends. A recent legal challenge in Ontario between midwives and the provincial government related to gender discrimination in pay adds another layer to the discussion of retention and growth of midwifery all across Canada.

ACRONYMS

AOM	Association of Ontario Midwives
CAM	Canadian Association of Midwives
CIHI	Canadian Institute for Health Information
CMRC	Canadian Midwifery Regulators Council
CMRE	Canadian Midwifery Registration Exam
MEP	Midwifery education program
NACM	National Aboriginal Council of Midwives

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