



# THE LANDSCAPE OF MIDWIFERY CARE FOR ABORIGINAL COMMUNITIES IN CANADA

*A discussion paper to  
support culturally safe  
midwifery services for  
Aboriginal families*



**NACM**  
NATIONAL ABORIGINAL  
COUNCIL OF MIDWIVES

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# INTRODUCTION

Improving access to midwifery services and culturally safe maternal health services is a multi-layered issue that touches all aspects of a community's health.

Aboriginal midwifery care is identified as a best practice for maternal health care in Aboriginal communities across Canada<sup>1, 2</sup>. At one time, the essential foundation of every Aboriginal community, Aboriginal midwifery, the presence of midwives, and the choice of midwifery as a profession, have all declined significantly over the last several decades. This has had a negative impact both on the preservation of culture and on maternal newborn health outcomes in Aboriginal communities across Canada. Today, "Aboriginal women are suffering from the lack of equitable access to culturally appropriate midwifery, and this is resulting in higher risks of adverse pregnancy and poorer infant health outcomes when compared to the general Canadian population."<sup>3</sup> In fact, it is widely acknowledged that infant deaths in Aboriginal communities are at least twice the national average.<sup>4</sup>

Today, the majority of pregnant Aboriginal women from rural, isolated regions leave their communities to give birth in larger, centralized hospitals. They spend at least the last four weeks of pregnancy outside their communities, often without the baby's other parent or extended family for support.<sup>5</sup> Separation from these fundamental support systems, combined with a lack of maternal and newborn care that is culturally

safe, has been linked to a range of concerns from low birth weight, to maternal and newborn complications, including prenatal and postnatal mood disorders.

## Truth and Reconciliation Commission Call to Action #22:

**"WE CALL UPON THOSE WHO CAN EFFECT CHANGE WITHIN THE CANADIAN HEALTH-CARE SYSTEM TO RECOGNIZE THE VALUE OF ABORIGINAL HEALING PRACTICES AND USE THEM IN THE TREATMENT OF ABORIGINAL PATIENTS IN COLLABORATION WITH ABORIGINAL HEALERS AND ELDERS WHERE REQUESTED BY ABORIGINAL PATIENTS."**

Midwifery care that "brings birth home" to Aboriginal communities has been identified as a pathway that improves health and supports the regeneration of strong families. Aboriginal midwifery models honour Indigenous people, languages, and cultures as well as holding birth up as a deeply profound and sacred event. Aboriginal communities would benefit from the skills, values and knowledge that Aboriginal midwives and other Aboriginal health providers have to share.

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<sup>1</sup>Olson, Rachel and Carol Couchie. (2013). *Returning birth: The politics of midwifery implementation on First Nations reserves in Canada*. Midwifery. Volume 29, Issue 8, Pages 981-987.

<sup>2</sup>National Aboriginal Council of Midwives. (2012). *Restoration and renewal: Aboriginal midwifery in Canada* [Pamphlet]. Montreal, QC: Canadian Association of Midwives.

<sup>3</sup>First Nations and Inuit Health. Health Canada. 2013. Available from: [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)

<sup>4</sup>Midwifery and Aboriginal Midwifery in Canada, NAHO, 2004. Page 11; First Nations Inuit Health Branch, 2013

<sup>5</sup>Healthier mothers and babies. Canadian Public Health Association.

## Background: Rebuilding Culturally Safe Aboriginal Midwifery Care

In the past three decades, re-integrating and re-visioning midwifery care back into Aboriginal communities has been the mission and goal of Aboriginal midwives<sup>6</sup> and advocates for improving Aboriginal maternal, infant, and child health in Canada. During this time, midwifery in Aboriginal communities has taken on various forms depending on the geographic location, status of midwifery in the province/territory, and the vision of midwifery in the particular community. Aboriginal midwives were often confronted with multiple barriers including: jurisdictional impediments, funding issues, and lack of support for midwives.

Midwifery began to be regulated by provincial/territorial governments in the 1990s (see regulation timeline on page 8). Some provinces and territories, such as BC, Quebec and Ontario, included clauses in their Midwifery Acts specific to Aboriginal midwives and/or midwifery services in Aboriginal communities.<sup>7</sup> Currently, Ontario is the only province where Aboriginal midwives are practicing within the exception clause in the Midwifery Act 1991. More recently, in June 2016, the first funding applications were accepted by the province from Aboriginal midwives working under the exception clause. This public funding of Aboriginal midwifery practices is a promising policy shift. In addition, many Registered midwives that identify at First Nations, Metis, Inuit, Aboriginal or Indigenous are practicing across Canada within the provincial or territorial health care system. As Registered midwives, they serve Aboriginal and non-Aboriginal families and often incorporate traditional values and practices in their work. In this report, innovations by Aboriginal midwives working

in a registered model and under exception clauses will show that, in fact, delivering midwifery care to Aboriginal communities are highly diverse, creative, and innovative processes.

This Case Study and Key issues sections of this report showcases a number of innovative midwifery practices currently operating in Aboriginal communities across Canada. The report will detail specific structures and models of service delivery that have been adapted to suit the needs of Aboriginal communities accessing midwifery care. In the discussion of these practices, the challenges and successes will be highlighted. These practices come from a range of different midwifery legislations and structures, and therefore, an in-depth understanding of how these practices currently function and operate is fundamental to understanding the current challenges and successes of midwifery care in Aboriginal communities.

## About the National Aboriginal Council of Midwives

The National Aboriginal Council of Midwives (NACM) is a diverse group of approximately ninety-five Indigenous midwives, midwife Elders, and student midwives from all regions of Canada. Members include both registered midwives and midwives practicing under certain exception clauses of provincial health legislation. There are currently eleven midwifery practices in Canada dedicated to providing care in Aboriginal communities. NACM clearly articulates the need for midwifery as part of an overall health strategy for Aboriginal communities. Midwifery can also play a role in reconciliation, addressing the historical inequalities brought about by government practices and policies of assimilation, as well as the relationship to Western medical care.

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<sup>6</sup>Due to the national context of this report, the term 'Aboriginal Midwife' refers to midwives who identify as First Nations, Metis, Inuit, Indigenous or Aboriginal.

<sup>7</sup>NACM has compiled a description of regulations and Aboriginal midwifery provisions in each province and territory, available here: <http://www.nacmtoolkit.ca/indigenous-knowledge-and-governance-of-maternal-health/midwifery-regulatory-frameworks-including-references-to-aboriginal-midwifery/>

The mission of NACM is:

*“...to promote excellence in reproductive health care for Inuit, First Nations, and Métis women. We advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities consistent with the U.N. Declaration on the Rights of Indigenous Peoples. As active members of the Canadian Association of Midwives, we represent the professional development and practice needs of Aboriginal midwives to the responsible health authorities in Canada and the global community.”*

In the preface to their core values, NACM recognizes the broad significance of Aboriginal midwives to the community at large. Aboriginal midwifery is not limited to birth attendance and care during and after pregnancy, rather, “the good health and well-being of Aboriginal women and their babies is crucial to the empowerment of Aboriginal families and communities.” See NACM’s Core Values of Aboriginal Midwifery in the Appendix.

## About this Report

The objectives of the report are:

- To improve knowledge about how midwifery services are structured, delivered and funded with a specific lens on access for Aboriginal clients, their families and communities
- To guide and inform discussions and actions towards improving access to midwifery services for Aboriginal communities.

The report is divided into four main sections. The introduction, background and methods comprise the first section. The second section presents summary information on midwifery services across Canada. The third section is based upon interviews and data gathered from Aboriginal midwives, including three case studies that show the diversity, successes and challenges faced Aboriginal midwifery practices serving Aboriginal families. The final

section summarizes key issues that emerged from Aboriginal midwifery practices in the study as well as related policy recommendations.

**ABORIGINAL MIDWIFERY IS NOT LIMITED TO BIRTH ATTENDANCE AND CARE DURING AND AFTER PREGNANCY, RATHER, THE GOOD HEALTH AND WELL-BEING OF ABORIGINAL WOMEN AND THEIR BABIES IS CRUCIAL TO THE EMPOWERMENT OF ABORIGINAL FAMILIES AND COMMUNITIES.**

Due to the national context of this report, the term ‘Aboriginal Midwife’ refers to midwives who identify as First Nations, Metis, Inuit, Indigenous or Aboriginal.

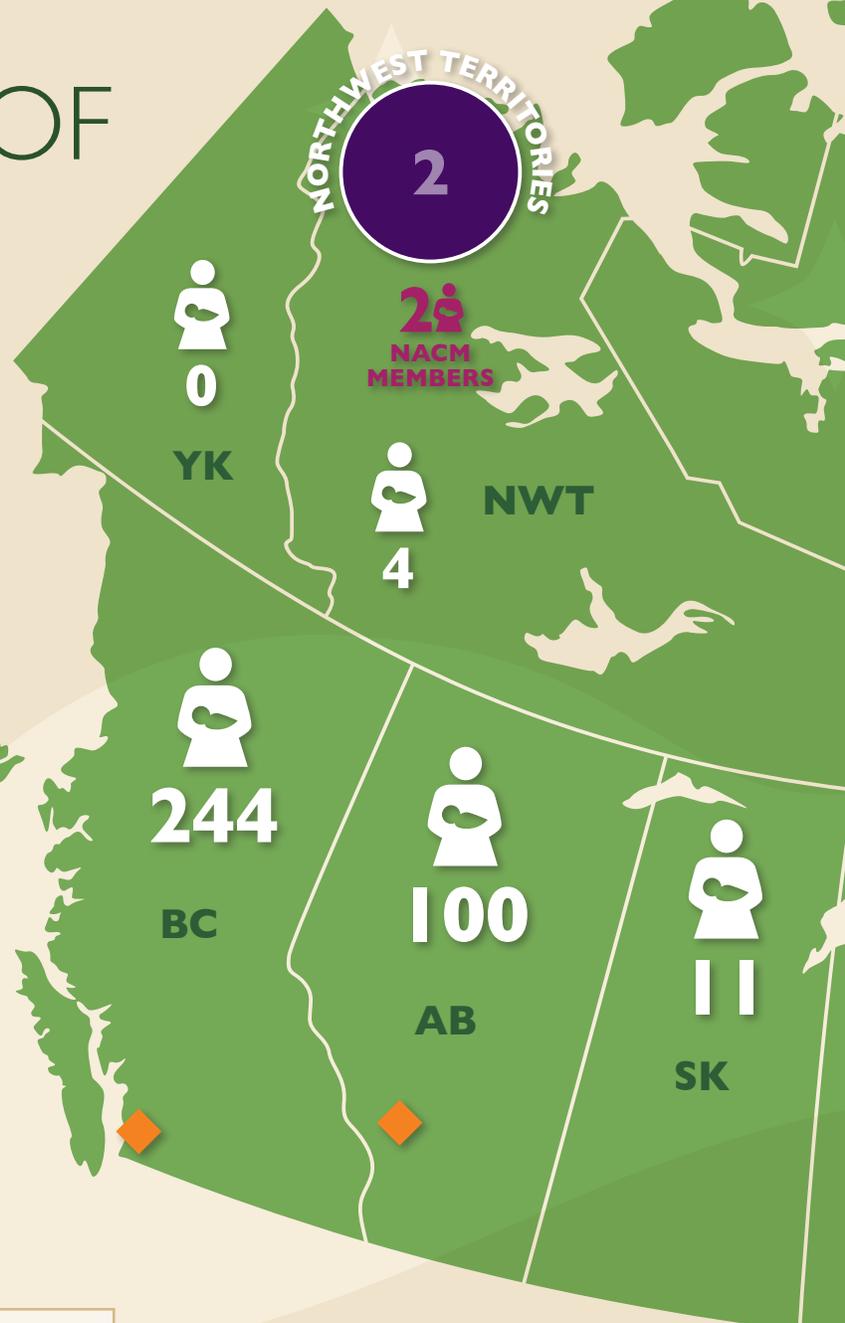
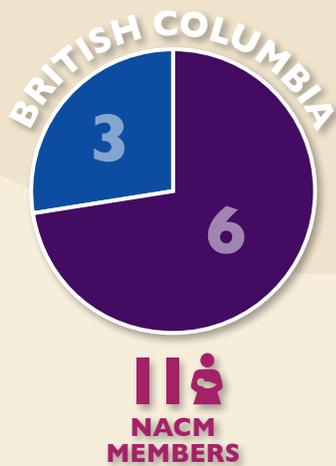
## Methods

The methods used for this report were a mixed methods approach. Data about midwifery arrangements and number of births attended were collected from provincial and territorial midwifery associations.

Individual, qualitative interviews were conducted with Aboriginal midwives, including midwives working under certain provincial exceptions as well as Registered midwives. Surveys were also distributed and either filled in with the researcher in the interview setting, or independently. Survey data was collected in SurveyMonkey, and exported and analyzed. Interviews were transcribed and coded according to themes. The following report integrates data from all of these sources.

In total, eight midwifery practices contributed to the study. One midwife from each practice was either interviewed or completed the survey independently, with the exception of one Aboriginal midwifery practice in which several midwives worked together to answer the survey. Data was collected between November 7, 2015 and March 14, 2016.

# LANDSCAPE OF MIDWIFERY IN CANADA

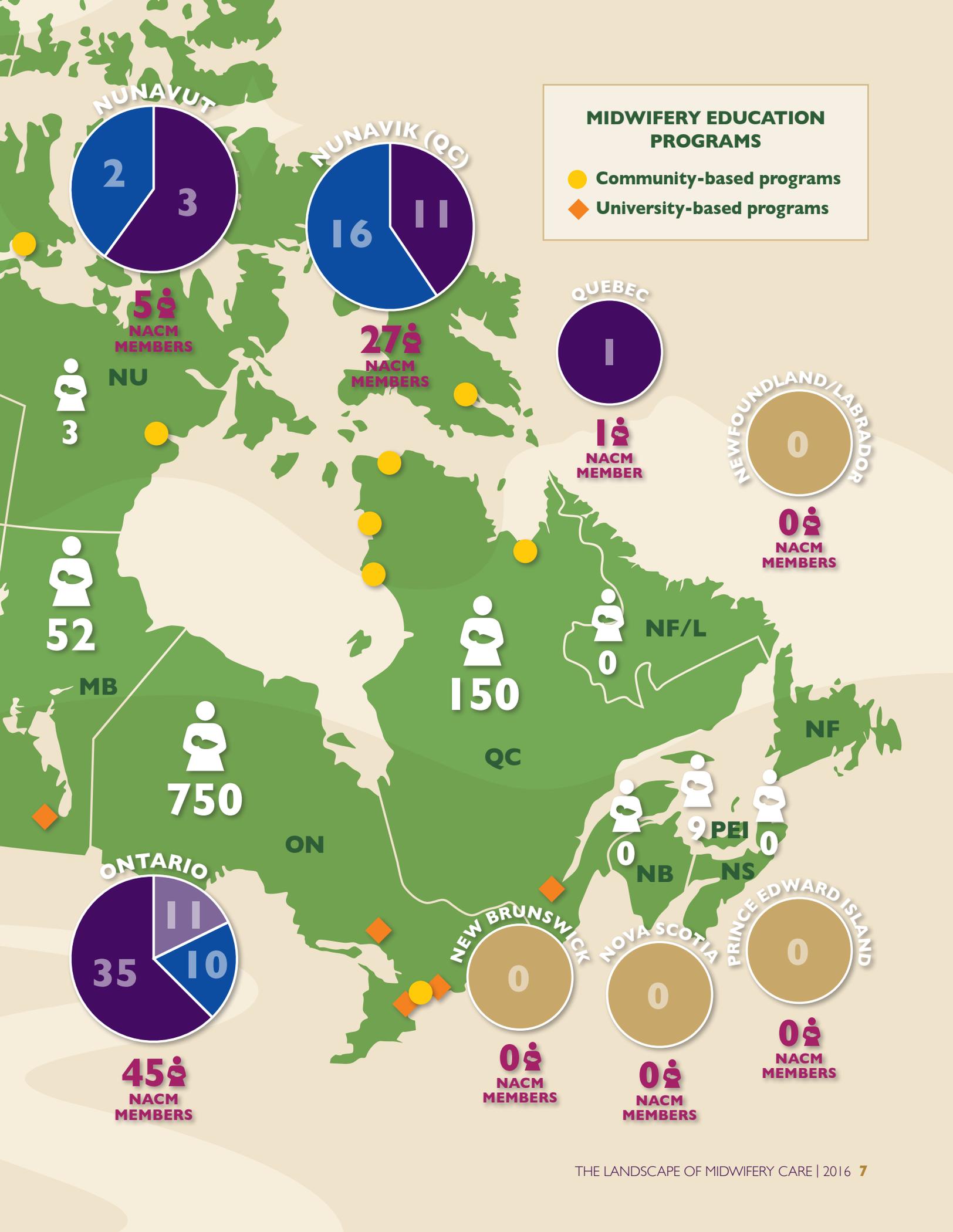


- NACM General Members (midwives)
- NACM Members working under provincial exception clauses for Aboriginal midwives
- NACM Student Members (midwives in training)
- Total NACM Members

**Total Registered Midwives**  
(including NACM members)

## MIDWIFERY EDUCATION PROGRAMS

- Community-based programs
- ◆ University-based programs



## REGULATION BEGAN

1994	1998	1999	2000	2005	2008	2009	2010	2011	2016	No Regulation of Midwifery
AB ON	BC	QC	MB	NWT	SK	NS	NB	NU	NL	PEI YK

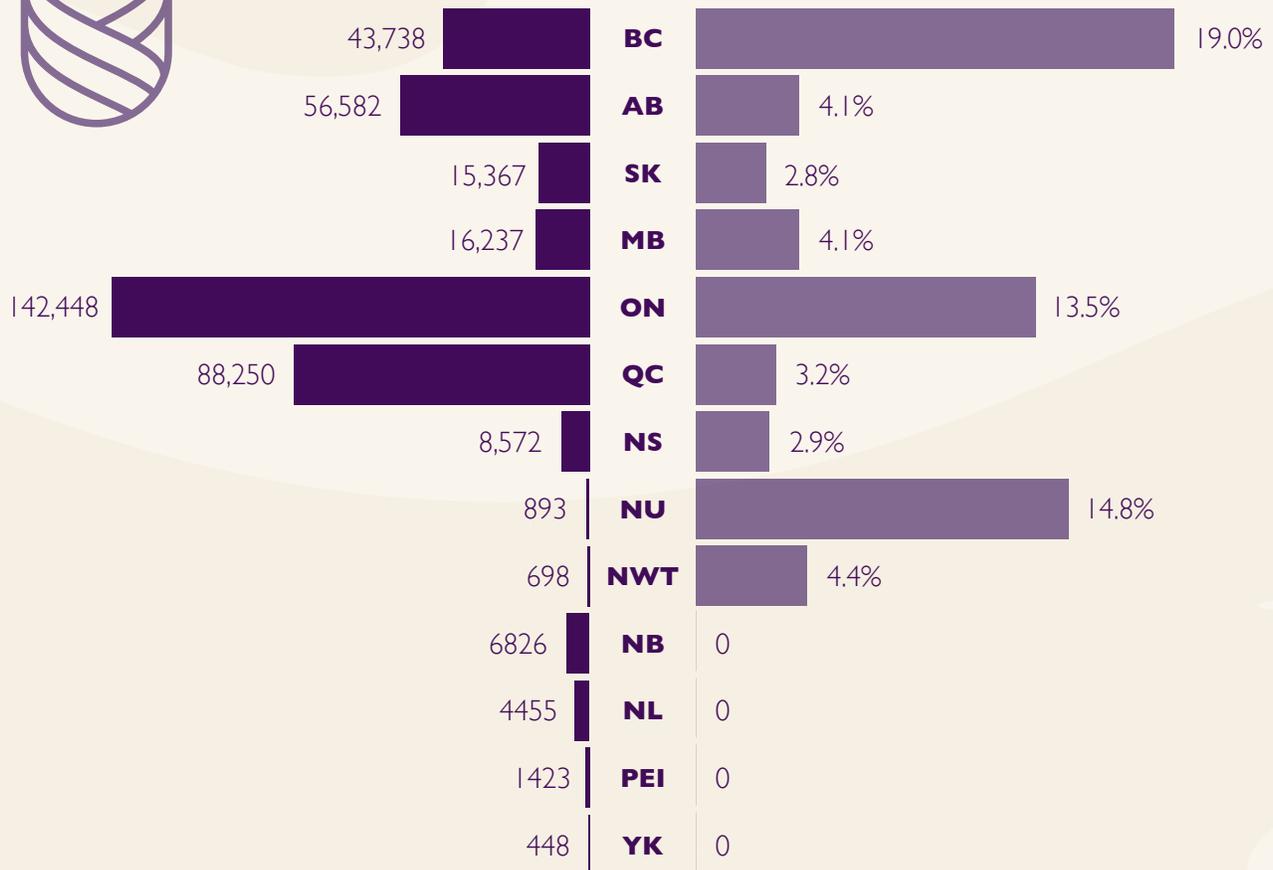
## PUBLIC FUNDING BEGAN

1994	1994	1998	2000	2005	2008	2009	2011	2016	No Public Funding of Midwifery
Nunavik (QC)	ON QC	BC	MB	NWT	SK	AB NS	NU	ON (expanded funding available for Aboriginal midwives working under exception clause) NL	NB PEI YK



### # BIRTHS ANNUALLY

### % BIRTHS ATTENDED BY REGISTERED MIDWIVES



## EMPLOYMENT STATUS of RMS

**BC, AB:** Independent practitioners

**SK:** Employees in 3 (of 13) Regional Health Authorities

**MB:** Employees of 4 (of 5) Regional Health Authorities

**ON:** Independent practitioners and salaried depending on funding model according to place of work

**QC:** Salaried independent professionals

**NS:** Employees of 3 (of 9) District Health Authorities

**NU:** Employees

**NWT:** Employees in 2 (of 8) Health and Social Services Authorities

**NB, NL:** To be determined

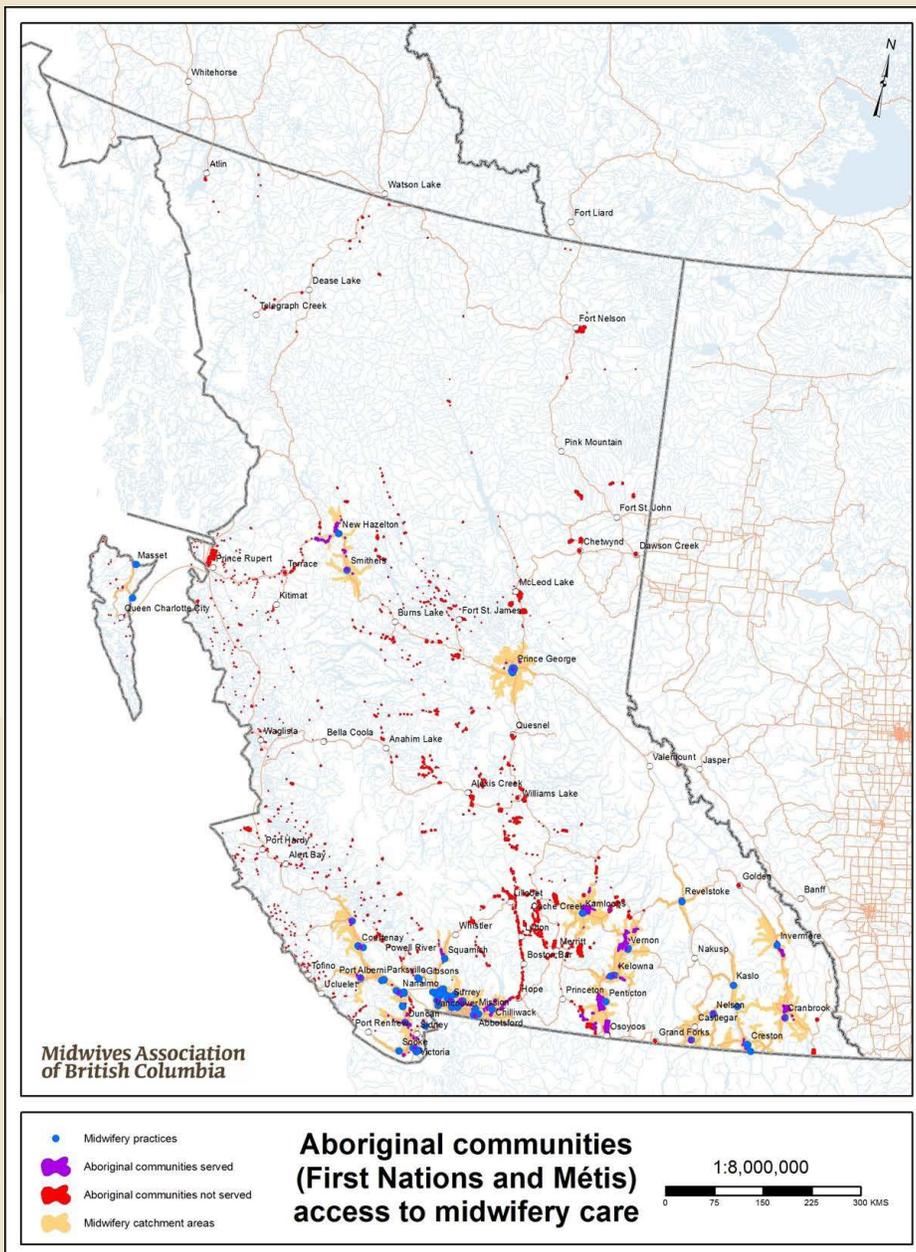
**PEI, YK:** Midwifery not yet a regulated profession

	University-based MIDWIFERY EDUCATION PROGRAMS	TOTAL ENROLLMENT in UNIVERSITY PROGRAMS	Community-based ABORIGINAL MIDWIFERY EDUCATION PROGRAMS
<b>BC</b>	University of British Columbia	60 students	
<b>AB</b>	Mount Royal University	52 students	
<b>MB</b>	University College of the North	14 students	
<b>ON</b>	McMaster University Laurentian University Ryerson University	370 students	Tsi Non:we Ionnakeratstha Ona:grahsta' Aboriginal Midwifery Training Program
<b>QC</b>	Université de Québec à Trois Rivières	60 students	
<b>NU</b>	Nunavut Midwifery Education Program, Arctic College	0 students	
<b>Nunavik (QC)</b>			Inuulitsivik Community Midwifery Education Program Tulattavik Community Midwifery Education Program

	CHOICE of BIRTH PLACE where midwifery clients can give birth	NUMBER of BIRTH CENTRES
<b>BC</b>	Home or hospital	0
<b>AB</b>	Home or hospital or birth centre	2 (not funded – private service)
<b>SK</b>	Home or hospital or private birth center	0
<b>MB</b>	Birth Centre or home or hospital	1
<b>ON</b>	Birth Centre or home or hospital	3
<b>Nunavik (QC)</b>	Birth Centre or home	n/a
<b>QC</b>	Birth Centre or home or hospital	13
<b>NS</b>	Home or hospital	0
<b>NL</b>	To be determined	0
<b>NU</b>	Home or birth centre	2
<b>NWT</b>	Home or hospital/health center	n/a
<b>NB, PEI, YK</b>	n/a	n/a

# Most Aboriginal families do not have access to midwifery care in Canada.

Although beyond the scope of this report, it would be useful in the future to map Aboriginal communities and the service areas of midwives to identify gaps in access to midwifery care. One province that has undertaken such mapping is British Columbia. It is clear that in BC, a large number of Aboriginal communities lack midwifery services. Aboriginal communities not served by midwifery care are indicated in red. Aboriginal communities with midwifery service are purple.



Reproduction of this map is courtesy of the Midwives Association of British Columbia.

# ABORIGINAL MIDWIFERY PRACTICES: INNOVATIONS AND CHALLENGES IN SERVICE DELIVERY

The following sections present case studies and information based on eight key informants who are Aboriginal midwives. The informants were chosen for diversity of geographic location, cultural background and type of midwifery practice.

Aboriginal midwives work in a number of models to serve Aboriginal families within the limitations and opportunities afforded by the various provincial and territorial policy and practice contexts. These practices have evolved from a range of different midwifery legislations and structures. Innovations exist in practices led by Aboriginal midwives working both in the registered midwifery model and midwifery models under exception.

**AS MORE ABORIGINAL WOMEN ENTER THE FIELD OF MIDWIFERY AND ARE ABLE TO GROW IN THEIR PRACTICE AND EXPERIENCE, THEY ARE GOING TO AWAKEN TO THIS INCREDIBLE DIMENSION OF KNOWLEDGE, POWER AND INTELLIGENCE THAT WILL HEAL OUR GENERATIONS.” – KASTI COOK, ABORIGINAL MIDWIFE.**

The following section highlights key issues experienced by midwives working to increase



access to midwifery for Aboriginal families. In each of the three Case Studies, specific challenges and successes will be highlighted to inform the development and adaptation of policies to better support the delivery and expansion of Aboriginal midwifery across Canada.

## Overview of Aboriginal Midwives and Midwifery Practices that were Key Informants in this Study

LOCATION OF MIDWIFERY PRACTICE (PROVINCE/ TERRITORY)	PRACTICE SETTING	WHEN WAS PRACTICE STARTED	MIDWIFERY PRACTICE REGULATION	FUNDING ARRANGEMENT	BIRTHS ATTENDED BY MIDWIVES
British Columbia	Northern & Remote	2015	Registered	Provincial per phase of care with subsidy from First Nations Health Authority (FNHA)	20-30 per year (attend 50-75% of all clients' births)
British Columbia	Rural & Urban	2014	Registered	Salaried midwife working on reserve (First Nation bills province per phase of care, and tops off with additional salary)	30-40 per year (attend 75% of all clients' births)
Nunavut	Northern & Remote	2010	Registered	Territorial health authority	>20 per year (attend less than 50% of all clients' births)
Northwest Territories	Northern & Remote	2015	Registered	Territorial health authority	>20 per year (attend less than 50% of all clients' births)
Ontario	Northern	Upcoming	TBD	To be determined – Employment arrangement with obstetrician	To be determined – Initial plan is to conduct prenatal and postnatal care in collaborative arrangement with obstetrician
Ontario	Rural & Urban	2011	Working under exception clause	Informal barter system with clients	>20 (attend over 75% of all clients' births)



## Case Studies: Challenges and Successes providing culturally safe midwifery care to Aboriginal families

### Case Study I: Kenhte:ke Midwives, , Kontinenhanónhnhha Tsi Tkaha:nayen (They are Protecting the Seeds at the Bay of Quinte), Ontario

*As Onkwehonwe Midwives, we are recognized and supported as Traditional Practitioners for the people, for our communities, for our Nations. We are knowledge carriers, we know this... we didn't learn it through books. Ours is an oral tradition and we honour our ancestors in reclaiming generations lost. We do this work for our families, for this generation and the coming faces.*

Kenhte:ke Midwives have been providing culturally safe care since May 2012. The team consists of an Aboriginal midwife, a retired maternity and special care nursery pediatric nurse and International Board Certified Lactation Consultant, and a young woman from the community who is an apprentice

midwife. The midwives travel to other Aboriginal communities to support birthing women. These communities can be up to six hours away.

An important feature of the Kenhte:ke Midwives is that they are recognized and supported by their community, through a Mohawk Council Resolution, Kenhte:ke Birth Advisory and other First Nations communities.

The freedom to operate within the Indigenous systems of governance and healing forms the basis for the Kenhte:ke Midwives practice. This means that their model of care and jurisdiction to provide care to their communities is not limited or constrained by provincial or federal systems.

**AS AN ONKWEHONWE MIDWIFE AND A TRADITIONAL PRACTITIONER, I HAVE BEEN GIVEN THE GIFT AS A KNOWLEDGE KEEPER AROUND THE CEREMONY OF BIRTH AND UNDERSTAND OUR ROLE IN CREATION AND THE LIFE CYCLE. I LIVE AND CARRY THE RESPONSIBILITY THAT GUIDES ME TO PROTECT THE SACRED SPACE. BY RECLAIMING THE SOVEREIGNTY OF BIRTH WE WILL STRENGTHEN OURSELVES, FAMILIES, CLANS, COMMUNITY AND NATION.**

The Kenhte:ke Aboriginal Midwives practice in community under the professional designation of the exception clause in the Ontario Midwifery Act.

This means that there is no structured funding source for their practice. As the midwife explains:

*There is no funding and minimal access to resources. We have to be creative and innovative to sustain the practice, for example, the barter system. We volunteer our time and services to provide the much needed Aboriginal midwifery care to Aboriginal families.*

The exclusion of the midwife working under the exception clause in any sort of funding arrangement from broader health care systems is a cause for concern. This case signals the need to improve the funding systems and policies which will better support the important work of Aboriginal midwives working under exception in their communities.

Except for the funding challenges, Kenhte:ke Midwives are an innovative practice and model of service delivery. There is one midwife in the practice, an apprentice midwife, one birth attendant and a recent addition of full spectrum doulas to the practice. The apprentice midwife is a fluent language speaker and knowledge keeper of culture and traditions with the goal of becoming a midwife. The senior birth attendant is a non-Indigenous retired nurse and lactation consultant with a passion

for normalizing birth. She also volunteers her time and shares her knowledge of western obstetrics.

*We all volunteer to provide Aboriginal Midwifery Care to those who seek us out. We are all on call 24/7. We do not advertise, it's by word of mouth.*

Each team member has primary clients and they run clinic around their personal schedules and are also on call 24/7 for their clients. They report to the midwife directly and the midwife sees these clients every other visit as the supervising midwife. The model is working successfully and the practice is able to accept more clients each year. The practice currently does not have administrative support, and this lack of support often means that the midwife spends up to sixty hours per month on various administrative tasks.

*Kenhte:ke Midwives provide different forms of care: from primary care for those who wish to have home births, to collaborative care for hospital births. In the event we have to transfer to hospital, we provide supportive care.*

Kenhte:ke Midwives also provides pre-conception counseling, well-woman care, hold community wellness circles, prenatal yoga, and sometimes utilize a centering pregnancy model. They are active and visible in the community by facilitating prenatal classes, traditional parenting classes, traditional medicine workshops, full-spectrum doula training and they also sit on different committees in/outside of the community.

The practice has also built a wide network that facilitates collaborative care for their clients, including: Traditional Practitioners, Traditional Language Speakers, Traditional Knowledge Keepers, Wellness Workers and Full Spectrum Doulas. The practice has also developed a collaborative network with doctors, naturopaths, obstetricians, paediatricians, dieticians, chiropractors, massage therapists, and more.

## CASE STUDY I

### Successes

- Culturally safe care
- Broad spectrum of services: prenatal, birth and postpartum care, pre-conception counseling, community wellness circles, prenatal classes, traditional parenting, traditional medicine, and doula training.

### Challenges

- No source of public funding
- No structured funding model
- No administrative support

## Case Study 2: Hay River Health and Social Services Authority Midwifery Program, Northwest Territories

Two midwives currently work at the Hay River Health and Social Services Authority (HRHSSA) Midwifery Program. The clinic is based in the health centre in Hay River, and currently also serves surrounding Aboriginal communities.

The midwives in Hay River are employees of the HRHSSA. The practice was established in 2015. They have established a Memorandum of Understanding to accommodate midwifery schedules within their employee status.

*It's between the health authority and the union – it's an MOU so that the normal union, collective agreement overtime – policies don't apply to us in our practice, so that we can flex our hours. Because everybody else has these scheduled hours and midwives can't.*

The midwives currently spend 50% of their time on call. The Hay River midwives work with nurses as second attendants.

*We work with the nurses – there are second attendants. So we've actually trained all the nurses. Basically all the nurses that work on the acute care floor [can] be a second attendant, so there [are] twenty of them. They're all trained in the basics. We're hoping that there's going to be a core of a few of them who really get on board and maybe eventually we can have a core group that is – people are actually experienced and have a certain finesse about being a second attendant that can – that would even be on-call. That kind of thing but the expectation is that any of the nurses on the floor can fill in that role if they're asked to.*

While the practice would like to be able to have a weekly clinic at a nearby First Nation, it has been challenging and they are currently working towards getting a MOU. As one midwife states,

## CASE STUDY 2

### Successes

- Full scope of midwifery care in a rural location
- Collaborative care with nurses as second attendants

### Challenges

- Jurisdictional barriers to providing care at clinic on reserve
- Building a midwifery practice in a community that previously did not have these services

“that is a challenge [getting MOU signed between First Nation, federal government, and territorial government] – That's where I said I wished the [federal government] were involved.”

The Hay River midwives also work collaboratively with other care providers and programs in their territory.

*There's a Healthy Families Program that we do a lot of referrals to. They focus on helping healthy early childhood development. And we have the diabetes program and we work actually quite closely with the family doctors, [for example] if we [have] somebody who has a thyroid problem the family doctors will manage that team. There's community counselling so we'll refer people to them [as well].*

The Hay River midwifery practice is a relatively new, promising practice that works within the territorial health care system, and is working towards expanding its services to Aboriginal communities nearby. Supporting midwives who work as territorial (or provincial) employees to work across regions is key to the successful implementation of midwifery services in the NWT, and across Canada.



### Case Study 3: Seabird Island Band Midwifery Services, British Columbia

The Midwifery program began in January 2014. It is currently structured as a solo midwife who is hired directly by the Seabird Island Band. This is an innovative program as it is one of the first programs that allow a midwife to be working directly for the First Nation. The midwifery clinic is housed within the health centre located on reserve.

Funding for this program is innovative in that the midwife assigns her provincial (Medical Services Plan) billings to the Band, and then her compensation comes from these billings, as well as a top up salary paid directly by the Band. There is no overtime in this position, and the salary remains consistent, regardless of the number of hours worked. She explains:

*I'm a solo practitioner. I'm on call all the time, unless I have scheduled and booked call coverage, which was negotiated to be provided by the local family doctor group, after the first year of my contract.*

The Midwife works closely with the Kwiyo:s (Respected Auntie) team in the Maternal Child Health program by providing free pre and postpartum education to families in seven communities. The Midwife also works with other members of the Health team to ensure mothers

and families have access to consistent, free, quality health care throughout the childbearing cycle. These include: Prenatal/postnatal education, community support for clients in drug and alcohol treatment, negotiating criminal justice system, obtaining status and federal health benefits.

While this practice is relatively new, the success of the midwifery program is apparent anecdotally in the community. In looking forward, the sustainability of a solo practice may need to be further examined, and the possibility of adding midwifery positions to the practice will be explored.

#### CASE STUDY 3

##### Successes and challenges

- Midwifery care on reserve
- Unique funding structure that allows midwife to work directly for a First Nation on reserve

##### Challenges

- Solo practice puts strain on the midwife
- Extended scope of care is welcomed (midwife offers counselling and referrals to other agencies including justice system) but hampered by lack of administrative support

# KEY ISSUES IN EXPANDING ACCESS TO CULTURALLY SAFE MIDWIFERY CARE FOR ABORIGINAL FAMILIES

The following section details key issues that emerged from the information collected from the eight midwifery practices in this study. Quotes in this section are from Aboriginal midwives working in the eight practices interviewed and surveyed for this study.

## Funding

Funding a midwifery practice in an Aboriginal community can be complex and varied. Funding solutions are often creative and draw from multiple sources in order to maintain midwifery practices.

An Aboriginal midwife in Ontario is seeking to work alongside a local obstetrician, focusing on First Nation clients. The midwife will be doing prenatal and postnatal care, and hopes to work into attending births. The initial funding arrangement will be through the obstetrician. She explains:

*Well, one option, which we – if we have to, we probably would resort to, would be for [the obstetrician] to hire me as an employee and her pay out of her billings. She would still have to bill for each visit and then give me a portion of it, for her to – that would be some complex mechanism we would have to figure out. But ideally we'd like to have funding for me to have a salary. Some other way to work along side*

## POLICY RECOMMENDATION:

To improve provision of midwifery services on First Nations reserves:

1. The Treasury Board of Canada should develop an occupational classification for midwives. This will enable Health Canada through First Nations and Inuit Health (FNIHB) to hire midwives to work in federal jurisdictions, in particular, on First Nation reserves (currently midwifery is not listed as a recognized profession under the Health Services Occupational Group Structure within the Treasury Board).
2. The Federal government should provide resources to develop a funding mechanism for primary care maternal and child health services to be delivered through midwifery care in federal jurisdictions across Canada.

## POLICY RECOMMENDATION:

To increase the number of Aboriginal midwives available to serve in Aboriginal communities:

1. Work with provincial governments and post-secondary institutions to support the development of Indigenous midwifery training programs across Canada. NACM recognizes that there are many locations that currently have no training programs in existence therefore recommend that the Federal government fund the development of new training programs in areas where there are currently none offered.
2. Extend Canada Student Loan forgiveness to registered midwives who work in rural or remote communities.
3. Promote midwifery education programs within Aboriginal communities.

*with her and for just to bill for the work that she does and for me to be paid for the work that I do.*

The variety of funding arrangements in the midwifery practices in this study signals the innovative ways in which midwifery services for Aboriginal communities could be funded. For Aboriginal midwives working under exception clauses, there have often been major barriers to public funding which has limited their ability to meet the demand from Aboriginal families seeking midwifery care. Recently, in June 2016, the Ontario government accepted its first round of applications for midwifery practices funding from Aboriginal midwives working under the exception clause. This is a promising policy.

NACM recognizes all models of care that Aboriginal midwives across Canada are providing to local communities. NACM also believes that both

provincial and federal governments should prioritize funding for those midwives who currently have no funding and those midwives who are Aboriginal and want to practice in Aboriginal communities. NACM recognizes the value of Indigenous knowledge that midwives hold and carry with them, and that this is a key element to the wellness of Aboriginal communities across nations.

## Increasing midwifery positions in Aboriginal communities

Three midwifery practices identified open positions in their practice, and these positions have been unfilled ranging from one week to four years. Four practices did not have any open positions. However, it is of interest to note that for some practices, their number of midwives is limited to the region's accepted number of midwifery positions. This means that while there are no open positions, the need for more positions to be available to midwives is greatly desired. In response to the question of the need for more midwives, despite no open positions, one midwife responded:

*No there can't be because – not because we want it that way but that's the law of the land... We just need, you know six or eight more midwives.*

When asked about the balance of midwives and whether it was adequate in her community, one midwife responded by referring to the number of roles the midwives fill in their practice:

*We do all well woman health<sup>8</sup> as well as full prenatal care as well as a lot of social counseling, community activities, etc. We could use more midwives to accomplish all this to a fuller degree – if we were just doing full perinatal care we might be enough – but whoever does just that?*

Another midwife explained how she built her practice:

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<sup>8</sup>Well woman care includes an annual exam that may include pelvic and breast examination, a pap smear, and may include other procedures and counseling about sexual and reproductive health.

*So I did a lot of outreach to different service organizations so that they have – lots of pre and post-natal programs, so I was going there and then there's a women's shelter, where they have pre and post-natal programs... So they had programs and I was connecting with them and going and before I started practicing – volunteering in an organized practice and I was doing outreach through them. I was just really creating a community outreach to find First Nations women who mostly hadn't been seeking midwifery care.*

A midwife is starting a collaborative practice with an obstetrician and she is arranging to focus on prenatal and postnatal care only, with discussion of birth attendance in the future. She explains:

*So she [an OB] actually approached me when we first met she just like a light bulb went off. She's like: "You're an Aboriginal midwife, I need somebody to take care of – help take care of my First Nations clients" – so the goal is for me – if I wanted to do births, she would support that but I'm kind of in a space right now where I would really enjoy being able to focus on prenatal care and postpartum care. Not that I don't want to do births, I just feel like I can do a lot more – I can do more for more women, just doing prenatal, postnatal care.*

All midwives stated that they currently have the opportunity to have students in their practice. They also all stated that they have precepted or are planning to precept a student in the near future. One midwifery practice stated that they are planning to target Aboriginal midwifery students to precept at their practice. The emphasis on growing more midwives is encouraging, and must be supported through the system of organizing student practice.

### **Out of region care**

Despite stating above that there were little jurisdictional issues regarding midwifery practices in this study, there are two distinct instances of

problems providing care out of region. The first is when the client travels out of region to seek midwifery care in another region, and the second is when midwives travel out of region to provide care to clients. As the midwives explain:

*So if somebody [FNIHB] decides – because Timmins is the designated regional receiving area, [and] there's a contract or a deal that they will go to Timmins because it's the closest place. However, if the woman doesn't want to deliver in Timmins for whatever reason – they've got family elsewhere where they can stay or you know they want to access midwifery care with us as Aboriginal midwives – they will not pay for their way out of the community. So they are forced to leave but they're telling them where they have to go... These are little details about transportation and I mean I think*

### **POLICY RECOMMENDATION:**

Where there is demand by Aboriginal families to access midwifery care, all levels of government and decision making bodies should work together to eliminate the institutional barriers that limit access to culturally safe care in families' local area.

1. Where this is not currently possible, the practice of sending pregnant client alone to give birth out of community must be revised by providing travel expense coverage for family members or trusted persons selected by the client.
2. All levels of government should coordinate to allow the pregnant client choice of referral centre if transport is necessary.
3. All levels of government should work with current authorities and decision makers to support and encourage travel arrangements that foster the transfer of care to midwives working in referral centres.

## POLICY RECOMMENDATION:

In health regions that currently limit the number of clients allowed into midwifery care in each region: all levels of government and decision making bodies should work together to eliminate or minimize the limits on access to midwifery care to meet the consumer demand by Aboriginal families.

*if you're going to fight us tooth and nail about getting pregnant woman out of the community and not let them stay, you need to at least be a little flexible.*

*Another [First Nation] is just across the river. They are technically part of a different health authority. We want to go and do clinical care there once a week because it's a half hour drive to get from the reserve into town. There's no medical clinic in town, they do have a health centre that is really lovely and has space that we could use and run clinic there. I know that our public health department wants to do the same thing and I think they have some kind of interest in having a medical doctor or a nurse practitioner go over there as well. But in order for us to regularly offer these services on the reserve, there needs to be an agreement in place with the other health authority. So between the two health authorities, as well as with the First Nations band, there needs to be an agreement in place. At this point there's not, so we can't go and do clinic there.*

As noted above, the issue of practicing “out of region” is an issue that is focused on Aboriginal midwives working within health care systems, and generally speaking does not apply to Aboriginal midwives working under exception.

## Hospital Privileges and Limits on Midwifery Care

Another issue that was raised was the struggle to obtain hospital privileges in northern, rural, and remote settings, where some doctors and obstetricians have placed a cap on the number of births that can be attended by a midwife in the region. Because of low birth numbers in these areas, the ability to access clients is key to the success of midwifery practices. However, as shown above, the scope of midwifery is often much broader than solely birth services. This being said, the role of midwives as primary care providers is crucial, and the ability to offer choice of birthplace to clients is unique to this profession. One midwife explains the dilemma:

*Our numbers are controlled. Basically the doctors own the farm; they say how many births we can have a year. There's a limit of 140 births for midwives in the region, in that hospital. There are five obstetricians that share the rest and because of their income, they don't want us to do a whole lot more than that. They will not let any more privileges go out to anybody and we have to turn away people all the time.*

It is important to note that this approach of obtaining hospital privileges rests very much within the realm of Aboriginal midwives working within the registered model and does not address the desires or goals of Aboriginal midwives working under exception clauses. As one Aboriginal midwife explains, “As Aboriginal Midwives, we are the ones who choose not to have hospital privileges! Hospitals are not within our jurisdiction.” This example shows that cultural diversity in choice of practice models. The practice of Aboriginal midwifery across Canada is diverse. Thus, supporting Aboriginal midwifery means addressing a broad and diverse set of needs and support systems.

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<sup>9</sup>A second attendant is a skilled person whose role is to provide assistance to the midwife during birth and immediately thereafter, and is trained to deal with obstetrical and neonatal emergencies. (College of Midwives of Manitoba, October 1999)

## Second attendants

Another innovation in midwifery practices in Aboriginal communities is expanding the scope of who can be a second attendant<sup>9</sup> at a birth. Working with nurses as second attendants in rural and remote practices is common. Furthering the training of doulas, traditional practitioners and interested community members to be birth attendants should also be a priority and supported.

### FURTHERING THE TRAINING OF DOULAS, TRADITIONAL PRACTITIONERS AND INTERESTED COMMUNITY MEMBERS TO BE BIRTH ATTENDANTS SHOULD ALSO BE A PRIORITY AND SUPPORTED.

In another private practice, student midwives often take on certain aspects of a second attendant. She explains:

*So it's usually one or the other and usually it's the student, so after the baby's born then she's free to go, after we get breastfeeding on board and then my second birth attendant comes in because she's also a lactation consultant – so if there's any issues, like if the baby has to go to the nursery for any reason, I'll bring my second attendant in. Because they know who she is and she gets things done and they'll listen to her.*

## Collaborative Care

Collaborative care is important to the success of midwifery practices in northern, rural and remote communities. The following table shows the level of support felt by the midwife respondents in relation to their colleagues and stakeholders. The next section will look at how collaborative care is organized in the various midwifery practices.

All midwife respondents said they currently provide collaborative care to their clients. Some of these collaborations are described here:

*We have significant collaborative relationships due to the shared concern to provide quality*

*care to the women and their newborns. Community Health Nurses: Locally and regionally. The nurses will consult midwives by phone for advice on aspects of prenatal care they may be encountering in those isolated communities. Obstetricians: available to the midwives for consultation any time the midwife deems it necessary. We have regular telephone sessions to develop care plans when women present high risk in the antenatal period. Pediatricians: available for phone consultation when necessary. Local GP: available for consultation, shared care if woman has a medical condition in pregnancy. If the woman develops a significant infection in pregnancy, the GP and Nurses will assume care for treatment and transfer back when the condition is stabilized.*

Another midwife said:

*Midwifery led care with support from GP's and nurses for teaching, consultation and emergencies – direct consultation with OB's in south.*

Many midwives are also very active in various committees locally, regionally, provincially, nationally, and internationally. Many respondents expressed the challenge of balancing midwifery practice with professional obligations.



# POLICY RECOMMENDATIONS

## **To improve provision of midwifery services on First Nations reserves:**

- The Treasury Board of Canada should develop an occupational classification for midwives. This will enable Health Canada and the First Nations Inuit Health to hire midwives to work in federal jurisdictions, in particular, on First Nation reserves (currently midwifery is not listed as a recognized profession under the Health Services Occupational Group Structure within the Treasury Board).
- The Federal government should provide resources to develop a funding mechanism for primary care maternal and child health services to be delivered through midwifery care in federal jurisdictions across Canada.

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## **To increase the number of Aboriginal midwives available to serve in Aboriginal communities:**

- All levels of governments must work together with post-secondary institutions and communities to support the development of Indigenous midwifery training programs across Canada. This training must incorporate Indigenous cultural components from local Indigenous communities and can build on currently existing models. NACM recognizes that there are many locations that currently have no training programs in existence therefore recommend that the Federal government fund the development of new training programs in areas where there are currently none offered.
- Extend Canada Student Loan forgiveness to registered midwives who work in rural or remote communities.
- Promote midwifery education programs within Aboriginal communities, including the training of doulas and traditional practitioners.

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## **In health regions that currently limit the number of clients allowed into midwifery care in each region:**

- All levels of government and decision making bodies should work together to eliminate or minimize the limits on access to midwifery care to meet the consumer demand by Aboriginal families.

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## **Where there is demand by Aboriginal families to access midwifery care, all levels of government and decision making bodies should work together to eliminate the institutional barriers that limit access to culturally safe care in families' local area.**

- Where this is not currently possible, the practice of sending pregnant client alone to give birth out of community must be revised by providing travel expense coverage for family members or trusted persons selected by the client.
- All levels of government should coordinate to allow the pregnant client choice of referral centre if transport is necessary.
- All levels of government should work with current authorities and decision makers to support and encourage travel arrangements that foster the transfer of care to midwives working in referral centres.

## Appendix I

# CORE VALUES OF ABORIGINAL MIDWIFERY

Recognizing that the good health and well-being of Aboriginal mothers and their babies is crucial to the empowerment of Aboriginal families and communities, Aboriginal midwives uphold the following Core Values:

**HEALING:** Aboriginal midwives enhance the capacity of a community to heal from historical and ongoing traumas, addictions, and violences. Aboriginal midwives draw from a rich tradition of language, Indigenous knowledge, and cultural practice as they work with women to restore health to Aboriginal families and communities.

**RESPECT:** Aboriginal midwives respect birth as a healthy physiologic process and honour each birth as a spiritual journey.

**AUTONOMY:** Aboriginal women, families and communities have the inherent right to choose their caregivers and to be active decision makers in their health care.

**COMPASSION:** Aboriginal midwives act as guides and compassionate caregivers in all Aboriginal communities, rural, urban and remote. The dignity of Aboriginal women is upheld through the provision of kind, considerate and respectful services.

**BONDING:** Well-being is based on an intact mother and baby bond that must be supported by families, communities and duty bearers in health and social service systems.

**BREASTFEEDING:** Aboriginal midwives uphold breastfeeding as sacred medicine for the mother and baby that connects the bodies of women to the sustaining powers of our mother earth.

**CULTURAL SAFETY:** Aboriginal midwives create and protect the sacred space in which each woman, in her uniqueness, can feel safe to express who she is and what she needs.

**CLINICAL EXCELLENCE:** Aboriginal midwives uphold the standards and principles of exemplary clinical care for women and babies throughout the lifecycle. This includes reproductive health care, well woman and baby care and the creation of sacred, powerful spaces for Aboriginal girls, women, families, and communities.

**EDUCATION:** Aboriginal midwifery education and practice respects diverse ways of knowing and learning, is responsive to Aboriginal women, families and communities and must be accessible to all who choose this pathway.

**RESPONSIBILITY:** Aboriginal midwives are responsible for upholding the above values through reciprocal and equal relationships with women, families and their communities.



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