

THE PINARD

Newsletter of the Canadian
Association of Midwives

MIDWIVES ACROSS *Canada!*

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PRESIDENT AND CO-CHAIRS' MESSAGE

This newsletter features the stories of six members of the Canadian Association of Midwives. We hope you will enjoy reading about how each has come to midwifery and made it their own. CAM's members are its greatest asset and it is important to remember to celebrate the daily moments of midwifery. Not only are midwives the reason that CAM exists, they are also the engine that drives and grows the association.

As this newsletter goes out to all members, we also want to share with you the rationale behind the membership fee increase in 2018. Since 2008, CAM has been supporting the general operations of the National Aboriginal Council of Midwives (NACM) which includes office space, a part-time dedicated staff person, funding for the annual Gathering and travel to attend political meetings and conferences. Some years NACM also receives project funding, but these grants are often limited and dedicated strictly to project activities. The work that NACM has done with this limited funding and the dedicated commitment of their members has been nothing short of remarkable. CAM and NACM recognize that there are other important areas for growth in Canadian midwifery that require resources but this year we are focusing on this area.

NACM and CAM continue to work together on numerous activities. The foundation of our joint work is mutual respect for each other's autonomy and respective decision-making processes while closely supporting each other administratively and financially. At the 2017 CAM Annual General Meeting, NACM and CAM signed a Memorandum of Understanding that outlines in more detail our principles of partnership and how we support one another. We recommend that you review this document ([link to document online](#)).

CAM and NACM see the work that we do together as an important part of the reconciliation needed in this country to begin addressing hundreds of years of colonialism, violence, and inequitable treatment of Indigenous Peoples. With this commitment at the heart of CAM's priorities, the CAM Board of Directors made the decision to increase the membership fee by \$30 per full CAM member and to dedicate the entirety of this amount to NACM. CAM will not receive any funding from this increase. By supplementing the basic operational funds that NACM normally receives from CAM with an additional \$30 per full member, NACM will receive approximately \$40,000 in **ADDITIONAL** resources to support their operations. As a Board, we feel that this is one small step in the reconciliation process with our sister organization and that these funds will help support increased capacity at NACM.

We would like to thank each and every member for your work as midwives and your solidarity with the National Aboriginal Council of Midwives.

Katrina Kilroy, CAM President
Melissa Brown, NACM Co-chair
Carol Coochie, NACM Co-chair



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Ashley Kaye

Midwifery HAS FINALLY ARRIVED IN NEW BRUNSWICK!



“I was still a student in 2009 when they first started talking about regulating midwifery in New-Brunswick. So, it’s been a long wait.” says Ashley Kaye RM (Laurentian, 2013) from her temporary office at the Fredericton Downtown Community Health Centre. With the recent regulation of midwifery in New Brunswick, Ashley is one of only two New Brunswick registered midwives presently working to implement midwifery services in Fredericton with hopes of expanding these services to the rest of the province.

A native of Petitcodiac, New Brunswick, Ashley was 23 when she left the Maritimes to study midwifery in Sudbury, Ontario. In 2013, with few midwifery positions available in Atlantic Canada, she landed a locum in Halifax, Nova Scotia which eventually turned into a full-time position. While honing her clinical skills, Ashley joined the Midwives Association of New Brunswick (MANB) and slowly started to advocate for midwifery regulation in her home province.

In 2008, New Brunswick’s Midwifery Act led to legislation being put in place that theoretically allowed for midwives to start working. Unfortunately, the government did not move to fund midwifery services through its provincial insurance program. Technically, midwives could work, but there was no regulatory body to govern them and no way for them to get paid unless they chose to practice privately, which meant having their clients pay out of pocket and buying their own (expensive) insurance.

Midwifery ground to a halt in New Brunswick until the return to power of the Liberal government in 2014. In October of that year, MANB met with then newly elected New Brunswick Minister of Health, Victor Boudreau, whose party had added Registered Midwifery to their platform, to propose that a pilot program be set in place by the end of 2015. Ashley explains that MANB presented a case for midwifery as a way to allevi-

ate stress in the maternity care system while also improving choice and services for pregnant people. “I guess we must have made our case because they did push forward with getting midwifery funded by Medicare and they reinstated the Midwifery Council of New Brunswick, our regulatory body.”

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Implementing Midwifery in Fredericton: an exciting challenge

In December 2016, New Brunswick’s Department of Health announced that New Brunswick would open a demonstration site for midwifery in Fredericton, comprised of four midwives, under the management of the Horizon Health Authority. Midwifery was officially instated into the NB health system in May of 2017, with the hiring of a first registered midwife, New Brunswick native, Melissa Langlais. Ashley joined her in Fredericton in mid-June. A third midwife is on her way and there are plans to hire a fourth midwife.

Since that time, both Ashley and Melissa have worked extensively with various departments of the Fredericton area hospital to put in place policies to help midwives work effectively. Ashley’s primary focus has been to educate Fredericton’s health professionals about midwives’ scope of practice, “what they can expect from midwives, and how we can work together and complement each other”.



MANB midwives Melissa Langlais and Ashley Kaye meet with NB Minister of Health Victor Boudreau and then CAM president Joanna Nemrava.

Ashley explains that the scope of midwives in New Brunswick is much like that of a family physician during pregnancy and birth. Midwives are authorized to prescribe medications related to pregnancy. They can order blood work and ultrasounds, but only for pregnancy-related conditions. Midwives can admit and discharge their clients from hospital if they are in labor or post-birth, and look after the newborn and mother for the first 6 weeks post-partum. "So, we can essentially do all the things a family physician can do within the scope of pregnancy."

In mid-October, both midwives were thrilled to finally start accepting clients. Drawing from an existing waiting list of 25-30 clients, Ashley and Melissa have made a conscious decision to only accept clients due in December and beyond while they navigate the logistics of providing prenatal care in their new surroundings. This will also provide both midwives the time needed to develop a relationship of trust with each of their new clients.

And the rest of New Brunswick?

Officially, Fredericton's midwifery practice is a demonstration site for the province. The New Brunswick government is therefore waiting to see the level of demand in Fredericton before rolling out midwifery services to the rest of the province. The systems and policies presently being put in place in Fredericton could be extended across the province, but MANB recognizes that it will likely require continued pressure on the government to ensure that access to midwifery across NB becomes a reality.



Fredericton midwives Melissa Langlais and Ashley Kaye

Érica Goupil

Midwife, professor, RESEARCHER

“There are many ways to promote midwifery in Quebec and Canada.”

Érica Goupil, RM (UQTR, 2011), is part of a growing generation of young Quebec midwives working to strengthen the foundation of their profession in their province. Érica’s situation is unique in that she is attempting to accomplish this as a clinician, a researcher as well as a professor. In addition to being a midwife at the Maison de naissance la Rivière, in Nicolet, Érica is enrolled in a PhD program at the Centre d’études interdisciplinaires sur le développement de l’enfant et de la famille (CEIDF), at the Université du Québec à Trois-Rivières (UQTR), and since the fall, is also a substitute professor in the Midwifery Education Program at UQTR.



Originally from Saint Lazare de Bellechasse, Érica grew up in a family of five children. Her mother, an end-of-life care nurse, passed on her belief in the ability of the human spirit to heal and adapt to the different passages of life. While applying to the Midwifery Education Program at UQTR in Quebec, Érica was shocked to learn that many families in Quebec could not access midwifery services due to the limited number of midwives in the province. In 2007, Érica enrolled at UQTR, motivated by the need to defend the rights of women and families as they become parents.

While pursuing classroom studies and clinical placements in birth centres, Érica also worked at Mes Sages, a publication of the Regroupement des Sages-femmes du Québec (RSFQ), and helped produce educational kits at UQTR. She also worked as a research assistant at the CEIDF. In her fourth year, fearing she would be unable to find employment after graduating from UQTR, she joined the student midwives of her cohort to protest the limited number of practice locations in Quebec.

Maison de naissance and burnout

Shortly after completing her degree, she joined the Maison de naissance la Rivière team in Nicolet. A rewarding yet trying period followed. “I felt I didn’t know enough,” she admitted. Érica arrived at a time where there was a lot of work and few midwives. “It was a very intense summer from a work standpoint.”

Érica was forced to deal with difficult clinical situations very early in her career. During her first birth as a midwife, she had to install a vacuum on a baby’s head, whose heart rate was decelerating and would not increase. “Welcome to midwifery!” Then, in the fall, she contributed to opening a clinic in Victoriaville and replaced the existing midwife, which involved a great deal of solitude, significant travel and a large workload to manage. “My schedule was 28 hours a week, but I was working many more than that.” Érica learned the

hard way about the effects of an excessive workload. In 2012, health problems led her to take an eight month leave of absence.

Interdisciplinary PhD in Family Studies

Érica believes that research is essential to the growth of midwifery in Quebec and Canada. In 2015, during her maternity leave she enrolled in the PhD program in psychology, family studies concentration, at UQTR’s CEIDF. This new program offered at UQTR allowed Érica to bypass the master’s degree and begin her PhD directly from her bachelor in midwifery. Her PhD work focuses on studying the role of midwives in the development of parenting. “I think citizen awareness begins in the perinatal period and increases as the family grows.” It was then that she made a conscious decision to focus her energies on developing the necessary tools to ensure the growth of the profession. “That’s where my passion lies right now!”

A passion for teaching

A set of circumstances – specifically a professor’s departure – led to Érica taking on a position as substitute professor in the Midwifery Program at UQTR. Since fall 2017, Érica teaches courses to fourth-year students as well as midwives who are in the process of immigrating and are enrolled in the bridging program. “I love working with them and I sincerely believe that they feel the same about me.” Érica explains that teaching is as satisfying as being a midwife. She also sees parallels between her role as a guide with both groups. Her current wish is to maintain a strong relationship with the clinic so that her teaching can reflect the evolution of the practice as well as that of the work organization issues and policies. “My dream is to be a clinical professor and researcher, and I believe it can be done but in an appropriate environment, not in the current structure.”



Sarah Martineau

From **PARAMEDIC** to **midwife**

Sarah Martineau (Ryerson, 2017) initially chose to become a paramedic instead of a midwife because it was a shorter, 2-year course. “Back then, when I was young and energetic, I thought being a paramedic sounded way more exciting, so I did that.” Now 41, after working a decade in Toronto’s downtown area as a paramedic, she is three months into her new registrant year at the Midwives Collective of Toronto and excited to be doing the work she does. “I went from a career where you’re with people in the worst part of their lives to a career where you’re with people during one of their greatest moments of strength.”

In 2012, Sarah was accepted to Ryerson University’s midwifery education program where she opted for Ryerson’s unique part-time stream - a five-year program that attracts mature students - while continuing to work part-time as a paramedic. As a student, after being involved in cases where clients’ babies were apprehended and witnessing births with poor outcomes, she quickly realized that midwives sometimes provide care in less than ideal situations. “I think for many students, it’s very eye-opening to realize that midwifery is not always about happy endings.”

The 2SLGBTQI community

As a person of Indigenous heritage “my mom is from Trinidad and my dad is from Moose Factory, a First Nations community in northern Ontario”, as well as a proud member of the 2SLGBTQI community, Sarah brings to her new profession a keen sensitivity of marginalized individuals and communities.

While in her second year at Ryerson, Sarah discovered other 2SLGBTQI midwives during a ‘Queer Beer’ event at CAM’s Annual conference in Saskatoon, where she had the opportunity to discuss shared issues such as gender diversity and being a queer healthcare practitioner.

“For me, it was just about building relationships and trying to figure out how to be a health care practitioner who comes from a different background than my clients will be coming from and how to navigate that. It can be messy sometimes in midwifery because the midwife-client relationship can be quite intimate, so I was trying to learn at the time how much of my own personal life I could disclose to people.”

These informal meetings led to her involvement in CAM’s National Advisory Committee on Gender Diversity and Equity which recently worked with CAM to ensure that Toronto’s ICM Congress be a safe space for queer and gender diverse midwives coming from all over the world.

As a mother of two children, Sarah feels that midwifery services for queer parents have evolved in Ontario since she was

herself a midwifery client. “There have been many changes in the past ten years, like the CAM Inclusivity Statement”. She adds that the Association of Ontario Midwives (AOM) has also been working to make sure that midwifery care is accessible to all types of families and making queer families more visible. She suggests that providing fertility counselling and fertility services could also be a great way for Canadian midwives to increase support to queer families in the future.

New Registrant midwife

“I feel like every birth is still a learning opportunity”, says Sarah about her first months as a new registrant midwife. Since being hired at the Midwives Collective of Toronto in September, Sarah has had to adjust to the added level of responsibility. “No one’s checking on me much, no one’s making sure that I’m doing it all right.”

Throughout this first year, Sarah is able to reach out to a mentor and is fully supported by her new team of colleagues. Midwives at the Midwives Collective of Toronto work to their full scope, maintaining care when clients require or choose to have an epidural; anesthetists perform the epidurals, but midwives monitor the procedure and the client remains in midwifery care. If an augmentation or an induction of labor is needed, the medication is under a physician’s directive, but midwives monitor the induction, maintain care and support the delivery of the baby.

One of Sarah’s greatest challenges since starting her new job has been to support clients with complicated social situations. She explains that certain clients are well resourced and can count on support outside of midwifery, whereas others have no other resources to call upon. “I find that complicated, but interesting; that’s the type of work that I enjoy doing.” Another challenge has been to not bring her work home. “I think that’s something I’m going to have to figure out soon because I don’t want to overwork and get burnt out early. I want to be able to have a long career!”

Dorothy Green

ONKWEHÓN:WE

Midwife



Yontkéhtats Dorothy Green is Kanienkehá:ka' (Mohawk), Wolf Clan and an Onkwehón:we (original) midwife who established Kenhtè:ke Midwives in 2012 in her home community on the Tyendinaga Mohawk Territory, located just east of Belleville, Ontario. She is a mother of three, grandmother of 13 and great grand-mother of one. Dorothy carries the responsibility and ancestral knowledge inherited from both maternal and paternal grandmothers and great-grandmothers in the care and nurturing of birthing women, their families, and the community.

CAM: What inspired you to become a midwife?

"I saw the need to provide culturally appropriate care that sustains our way of life by birthing our children in the hands of our own people, on our land, using our language, traditions, culture and traditional medicines. It is our responsibility to ensure the protection and safety of our children and the well-being of our families". From a young age, I always knew I wanted to be a doctor and help people.

Birth stories are important and have an impact on who we are as human beings and how we view the world around us. They affect our relationships and how we bond and connect with each other. My own birth story involved my mother giving birth to me in a military hospital. So, when it came time for me to start my family in the 70's, there were no prenatal classes, doulas, midwives or lactation consultants. In my own experiences, I was induced, shaved, given an enema, IV antibiotics, an epidural, had my legs in stirrups and my hands strapped down and given an episiotomy. In my first attempt to nurse, I gave in to the pain of bleeding cracked nipples and a crying baby and bound myself with a towel and let my milk dry up. In 1982, I birthed on my own terms and nursed successfully for 6 months. During this time, community women were contacting me and asking me questions about pregnancy and birth. In November 2006, I resigned my position with the federal government after 22 years and returned to school to become an Aboriginal midwife.

CAM: Where did you study to become a midwife?

In 2007, I entered the 4 year concurrent Aboriginal Midwifery Programme at Tsi Non:we lonnakeratstha Ona:grahsta' "The Birthing Place; The Place They Will Be Born" at Six Nations Maternal & Child Centre and graduated in 2011 with a 'Diploma with Honours of Aboriginal Midwife'. This was the first Aboriginal birthing center in Canada, and it offers an Aboriginal midwifery education program with Aboriginal midwives since

opening in 1996. The reason I chose this program is because it teaches us that our own Indigenous evidence-based knowledge systems (language, culture, traditions, and medicines) are intact and teaches them in coordination with contemporary knowledge systems.

CAM: What led you to open an Aboriginal Midwifery Practice Group (AMP)?

I held a Traditional Birthing Seminar in Tyendinaga with the assistance of community programs early in 2007 to determine if this is something the community wanted. This led me to begin my training. I petitioned the community and met with Chief and Council to establish band council resolutions in the provision of Aboriginal Midwifery Services in the community. After graduating, I worked for six months as an Aboriginal Midwife at Six Nations Birthing. Then in March 2012, I returned home to the Tyendinaga Mohawk Territory and established Kenhtè:ke Midwives, Kontinenhanónhnhha Tsi Tkahà:nayen "They are protecting the seeds at the Bay of Quinte". We set up the practice in my home and out of my car as we provided midwifery care to Indigenous women in other Haudenosaunee communities. For the last 5 years our birth team has consisted of myself and two dedicated women, Tewahséhtha Brant, an apprentice- student midwife, and Mary McBride, a birth attendant. Kenhtè:ke Midwives operated for over five years with very limited resources and funding. Each of us worked to support ourselves and our families and provided care to families utilizing the barter system. Then after years of proposal writing, advocating for recognition of Aboriginal Midwives, and lobbying with the Provincial government an announcement was released in February 2017. The Ministry of Health and Long Term Care (MOHLTC) announced Kenhtè:ke Midwives would be 1 of 6 funded Aboriginal Midwifery Practices in the province to receive funding.



We are now able to provide dedicated midwifery care and services and are training Apprentice Onkwehón:we Midwives. We are a non-profit organization with a newly formed Board of Directors.

CAM: What is the scope of care of Ontario’s Aboriginal midwives?

We follow the standards of practice developed by the College of Midwives of Ontario. As Primary Healthcare Providers, Onkwehón:we midwives provide culturally appropriate maternal and newborn care to Indigenous families by harmonizing evidence-based traditional and contemporary knowledge systems. The community, the family, and the expectant woman are offered a choice of services that complement and support personal beliefs and customs. We respect the strength and knowledge of birthing women and honour birth as a deeply profound and sacred ceremony.

The goal is to return control to Indigenous people, families and communities in the safety and protection of our children. We choose not to have hospital privileges. The hospital is not our jurisdiction and so, we provide supportive care. These lines are never crossed.

CAM: What challenges are Indigenous midwives now facing in Ontario?

I think one of the challenges is for registered midwives, government organizations, the healthcare system and the public to understand there are different streams of midwifery training and practice. There are midwives who choose to study midwifery in the university programs to become registered midwives (RM), who identify as Indigenous, and who provide care to the general population including Indigenous families.

Then there is us, Indigenous midwives who practice under the exemption and provide midwifery care ONLY to Indigenous families, meaning only 1 person needs to identify as Indigenous. We are trained by our own people, Indigenous Midwives who are the knowledge keepers in women’s health, reproduction and and carry the responsibility of looking after the whole life cycle. We live and work in our communities, keeping our language, culture and traditions alive.

Currently, the biggest challenge in Kenhtè:ke is that we do not have primary healthcare services and even with the MOHLTC funding we need additional resources for Traditional Medicines, Traditional Practitioners, and Mental Health and Addictions workers and counsellors.

“Midwives have the potential to make a significant contribution to the health of women and their families, as this empowerment begins in the womb. In our society, women are the center of all things. We have been given the ability to create; we are life givers and nurturers; we have responsibilities to our ancestors, our nations, clans, communities and future generations to come. Traditionally, women received formal instruction on all things. It isn’t that way today... but, collectively, we are changing that... one birth at a time.”

– Dorothy Green, Onkwehón:we midwife



Megan Wilton, RM

Teaching **EMERGENCY SKILLS** to **midwives** in Manitoba... and Tanzania



Megan Wilton, RM (McMaster 2007) has been working as a midwife in her home province of Manitoba for the past 10 years. Mother of two young children, Megan is also an Emergency Skills facilitator and Treasurer of the Midwives Association of Manitoba (MAM). CAM recently caught up with Megan in Mtwara, Tanzania, where she was volunteering as an emergency skills facilitator as part of CAM-Global's *Improved Service Deliver for Safe Motherhood (ISDSM)*.

CAM: Why did you become a midwife?

I was interested in a career where I could provide education and informed choice decision-making. I really love all the opportunities midwifery provides me for continued learning and growth.

CAM: Tell us what it is like to be an Emergency Skills facilitator?

I love facilitating. The association offers the course three times a year and I usually facilitate once or twice a year. I find the ES program is really focused on the work midwives do outside of the hospital. It is important for us as a profession to take a leadership role in our own education and continuing education. Personally, the best part is laughing together with the other participants as we create scenarios that are actually very serious in real life. It helps us.

CAM: How do you find facilitating in Tanzania?

It is awesome! A lot of things are really similar to facilitating at home. At first, people are a little shy about getting into the scenarios, but then they really open up and get into it. There was definitely a language barrier for me, as my Swahili is not great, and so as a group we spoke 'kiswaenglish'. All of the participants had had at least one experience with eclampsia, which is not even something that we emphasize in the emergency skills training in Canada, due to better prenatal care. They have not seen as much shoulder dystocia as we do in Canada. I believe this is due to a few reasons: the babies

are often smaller, and women are primarily delivering in a supine position - very close to McRobert's position -, and standard practice is to wait for restitution of the fetal head before attempting to deliver the shoulders.

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KNOWLEDGE.

There is a lot of didactic teaching in the course, which is both good and bad. Some of the midwives have only two years of education, where they haven't had the chance to study abnormal birth before they start practicing. So, this may be the first time they are seeing the theory side of things. The difficult part is trying to balance our class time so that we have enough time to cover the material both in theory and in practice. The teaching ratio is slightly different than it is in Canada, so we usually need a bit more time for practicing clinical scenarios. Unfortunately, it is not always possible for every student to get a full practice of every clinical scenario.

Sometimes midwives have the knowledge but don't have the resources to implement that knowledge. For example, in the case of post-partum hemorrhage, some of them do not have a second line drug. The curriculum has been adapted to this context, but even so, the difference in facilities within Tanzania can be striking; in some places, there is not a working blood pressure machine. Until the status of women and access to healthcare are improved, they will continue to see severe pre-eclampsia and eclampsia, and until then they must be able to respond to it as best they can.



CAM: What do you like about working in Manitoba?

In Manitoba, we are required to give 50% of our care to priority populations that are traditionally underserved by the health system, for example folks living in poverty, under 19, Indigenous, newcomers to Canada, etc. I really feel like midwives can play an important role in reaching out to the community to support people who otherwise would not be receiving adequate prenatal care. Though controversial, I like working in an employee model. One of the positive elements is that we really count our hours. So if you are working more than 40 hours in a week, you bank it for overtime. This helps me to have a better work-life balance.

CAM: Tell me a bit more about your scope of practice in Manitoba

Our scope of practice varies a lot from one community to the next. Some midwives have oxytocin and epidural privileges at their hospital, but most do not. We prescribe contraception and treat STIs. In our new regulations, we are allowed to treat our clients' partners as well, which is extremely useful for treating STIs in pregnancy and makes us a very valuable community health provider. In Winnipeg, most midwifery practices are located within community health clinics, and so midwives really play a key role in the community. This also helps integration with other care providers because clients can get complete care in one place.



Tanya Momtazian

Midwifery in rural BC



BRITISH
COLUMBIA



“You really do learn a lot when you get out of your midwifery comfort zone and see care from different perspectives.”

For the past 10 years, Tanya Momtazian RM (UBC 2007) has worked as a midwife in Nelson, British Columbia. Tanya tutors University of British Columbia (UBC) midwifery students and is the Vice-President of the College of Midwives of BC (CMBC).

A native of Calgary, Alberta, Tanya spent several years advocating for the sexual and reproductive health and rights of young people. When she heard about the UBC's Midwifery Program she liked the fact that midwifery was a young profession that included an advocacy component, as well as being a health profession which did not focus on sickness. After placements in various regions of BC, Tanya settled in Nelson where her parents were living nearby for part of the year and where midwifery was well integrated into the community and the local hospital.

Apple Tree Maternity: a solution to work-life balance

In 2007, Tanya started working at Kootenay Community Midwives with a team of two other midwives. In 2011, a local physicians' organization undertook a patient journey mapping process which led to the creation of Apple Tree Maternity, an alternative model used successfully by Vancouver's South Community Birth Program where physicians and midwives work together to answer the community's maternity care needs.

The mapping process uncovered gaps in the community on issues related to breastfeeding and mental health. At that time, the community's family doctors were struggling to keep their maternity services sustainable. For the Kootenay Community Midwives, with a team of only two and a half midwives, the situation was also feeling unsustainable. A meeting between

the two groups led to the idea of a shared practice. The hope was that a collaborative clinic would offer its staff a better work life balance, more flexibility, and address some gaps in care in the community.

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**ONE OF
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midwives**
in BC to attain
**SPECIALIZED
PRACTICE
certifications.**

In 2013, Apple Tree Maternity was born. The clinic follows the midwifery model of care; services include home births, intrapartum labour support and home visits. The presence of physicians also adds services such as additional prescriptions (thyroid medication, anti-depressants). The new clinic's clientele includes a broad range of social backgrounds, some of whom live in severe poverty. Tanya appreciates caring for these people. It reminds her of why she decided to become a midwife.

“I just recently had a mom that is living in pretty severe poverty (...). It was a very challenging labor, 4 days of induction and very long process and she ended up having a C-section, but she came out

of that birth another woman, very strong and very able and grounded.”

Specialized practice certifications

Tanya was one of the first midwives in BC to attain specialized practice certifications. After completing an online Master's of Public Health from Johns Hopkins University in 2012, she was compelled to further pursue professional development after the creation of Apple Tree Maternity.

Supported by the obstetrical and nursing team at Nelson's Kootenay Lake Hospital, Tanya completed a Surgical Assist Training with C-Section (SATC) fellowship. She explains that in many larger centers, there are often residents or other family doctors present that can assist, but that in a small rural center, "it's actually very helpful to have an extra set of hands that can do these skills, especially in an emergency". She and a fellow midwife now do surgical assists for approximately 20% of the roughly 180 Apple Tree births a year. "I've done two assists in the last week!" Kootenay Lake Hospital is the major referral center for the region, and Apple Tree Maternity is responsible for about two thirds of all the births at the hospital.

Tanya holds a certification in acupuncture to reduce pain in labour and the immediate postpartum. Tanya's interest in acupuncture was sparked by a traditional Chinese medicine doctor with whom Kootenay midwives worked with. Her presence at Tanya's own birth convinced Tanya that acupuncture would be a great service to offer the community. To become certified, Tanya travelled regularly to Vancouver for several months to study theory and physiology with Chinese medicine doctors. She then had to practice what she had learned with several patients, recording all the points that she used, who she used them on and why. She then submitted a report to her professors to obtain her certification, and

to the College of midwives of BC to have her certification recognized. Tanya frequently uses acupuncture to treat slow progress, malposition, reduce pain related to back labor, and to help reduce her client's levels of anxiety.

Tanya holds a **certification in acupuncture to reduce pain in labour** and the immediate postpartum.

To meet the additional demands of Apple Tree's new clientele, Tanya also obtained a specialized practice certification in Contraception Management from the British Columbia Institute of Technology (BCIT) and followed that up with training to insert intrauterine contraception (IUC). Tanya explains that she is not inserting many IUDs anymore because midwives do not currently have a billing code for this service which is considered a 'delegated act', an act that is not within a midwife's scope but that is allowed by the physicians' group. Tanya is also certified for sexually transmitted infection (STI) treatment, also an online course with BCIT.

As many as forty of BC's midwives now have an expanded scope of practice. The most common certification is contraception management, followed closely by surgical assist (18 approved and others in the approval process). Tanya is optimistic that other specialized certifications will soon be offered, such as induction and augmentation of labor, which would enable midwives to independently prescribe oxytocin and prostaglandin to induce labor.

