celebrating birth

Aboriginal Midwifery in Canada

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
ᑲᓇᑕᒥ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓄᑦ ᐋᓐᓂᐊᖃᕐᓇᙱᓐᓂᓕᕆᔨᒃᑯᑦ ᑲᑐᔾᔨᖃᑎᒌᑦ

Report title: Celebrating Birth – Aboriginal Midwifery in Canada

© Copyright 2008 National Aboriginal Health Organization

ISBN: 978-1-926543-11-6

Date Published: December 2008

OAAPH [now known as the National Aboriginal Health Organization (NAHO)] receives funding from Health Canada to assist it to undertake knowledge-based activities including education, research and dissemination of information to promote health issues affecting Aboriginal persons. However, the contents and conclusions of this report are solely that of the authors and not attributable in whole or in part to Health Canada.

The National Aboriginal Health Organization, an Aboriginal-designed and -controlled body, will influence and advance the health and well-being of Aboriginal Peoples by carrying out knowledge-based strategies.

This report should be cited as:

National Aboriginal Health Organization. 2008. Celebrating Birth – Aboriginal Midwifery in Canada. Ottawa: National Aboriginal Health Organization.

For queries or copyright requests, please contact:

National Aboriginal Health Organization
220 Laurier Avenue West, Suite 1200
Ottawa, ON K1P 5Z9
Tel: (613) 237-9462
Toll-free: 1-877-602-4445
Fax: (613) 237-1810
E-mail: info@naho.ca
Website: www.naho.ca

Under the *Canadian Constitution Act, 1982*, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population. NAHO makes every effort to ensure the term is used appropriately.

Acknowledgements

The original Midwifery and Aboriginal Midwifery in Canada paper was published by the National Aboriginal Health Organization (NAHO) in May 2004. This updated version was developed with the cooperation and support of many people and organizations. The National Aboriginal Health Organization would like to thank the First Nations and Inuit Health Branch of Health Canada for their support. Thank you to Aleka Stobo, RM who arranged the first meeting for this project's involvement in the Aboriginal Midwives Gathering, which was part of the 2007 Annual General Meeting of the Canadian Association of Midwives. We would also like to thank the University College of the North, Catherine Carry, Sheryl Cornish, Pixie Cram, Emily Wilson, Dawn Marsden, Miranda Dyck, Rachel Olson, and Amber Skye for their additions to this paper.

This paper incorporates statements from some First Nations and Inuit midwives, and non-Aboriginal midwives who were interviewed by NAHO for this project. Métis content was provided by the Métis Centre of NAHO. We thank all of these women for sharing their stories and their insightful input into this paper. In particular, we would like to thank Darlene Birch, Ellen Blais, Katsi Cook, Carol Couchie, Sharyne Fraser, Meaghan Moon, Christine Roy, and the midwives of the Inuulitsivik Health Centre in Purvinituq, Nunavik (Northern Québec).

This report was created through financial contributions from First Nations and Inuit Health Branch, Health Canada.

I have a dream…

…of attending a birth in my own community at Nipissing, I will go to a woman's home where her extended family is there for support. Perhaps even my own daughter will accompany me to help with younger children. Perhaps the woman's mother is there to help prepare food and greet the baby in the Nishnawbe language. The father will light a fire outside and offer tobacco. We will boil cedar for the postpartum bath. …Nishnawbe women are the guardians of their culture, families and communities. They will want to be a leading force in the future development of midwifery on their homelands. The professional practice of midwifery reflects their traditional values. That is the compassionate and respectful care of the newly emerging mother and baby. This is the very future of our Nations" (Couchie & Nabigon, 1997).

"It's really nice to see true citizens of our territory, babies that are born on our land. It really does give them a sense of connection to the land, to our people. So I think that's very important, being born here on our land" (Julie Wilson).

"An empowered community is made up by empowered individuals and empowered families, and to me empowerment is feeling at home with who you are, and that begins with the moment of birth. So my own birth story is a great source of strength to me. And so when you ask the question about our children, I have to go the long way around and say it all begins with the way they get born" (Katsi Cook *in an interview authored by Wessman and Harvey*).

Table of Contents

Map: Midwifery & Aboriginal Midwifery in Canada 6

Introduction 7

What is a Midwife? 10

History of Aboriginal Midwifery in Canada 12

Contemporary Practices in Aboriginal Midwifery 19

Current Initiatives 21

Métis Initiatives 21

The Irnisuksiiniq– Inuit Midwifery Network (IIMN) 21

Pauktuutit Inuit Women of Canada 23

The Atlantic Policy Congress of First Nations Chiefs 24

The Public Health Department of the Cree Board of Health and Social Services of James Bay (CBHSSJB) 24

Canadian Association of Midwives (CAM) 24

The Society of Obstetricians and Gynaecologists (SOGC), An Aboriginal Birthing Strategy 26

Memorandum of Understanding Between Health Canada of the Government of Canada and the Department of Health and Human Services of the Government of the United States of America 27

Training Options 29

Aboriginal Midwifery Training Models 30

kanaci otinawawasowin Baccalaureate Program (KOBP) 31

Tsi Non:we lonnakeratstha Ona:grahsta' Aboriginal Midwifery Training Program 32

The Inuulitsivik Midwifery Education Program 33

Maternity Care Worker Certificate Program and Midwifery Training, Nunavut Arctic College 33

Non-Aboriginal Training Programs 34
Strategic Development Considerations 35
Midwifery Education & Accreditation 35
Canadian Midwifery Registration Examination 36
Exemptions for Aboriginal Midwives 37
Registration Requirements 38
Permitted Practices 40
Practice Audits 40
Review of Conduct 41
Recognition/Accreditation 42
Midwifery in the Community 44
Collaboration 45
Community Examples 48
Echoes from the Mainstream 51
Jurisdiction Issues 52
Evacuation Protocols 54
Conclusions 58
Review of Main Points 58
Identification of Issues 58
Need for an Enabling Environment 59
The Need for More Aboriginal Maternity Care Workers and Training Programs 60
Organizational Support 60
Conclusion 61
Glossary and Acronyms 63
Midwifery Education Programs in Canada 65

Ontario Midwifery Education Program (OMEP) ... 65

University of British Columbia (UBC) ... 66

Université du Québec à Trois-Rivières ... 67

Kanácí Otinawáwasowin (Aboriginal Midwifery) Baccalaureate Program ... 67

Resources ... 68

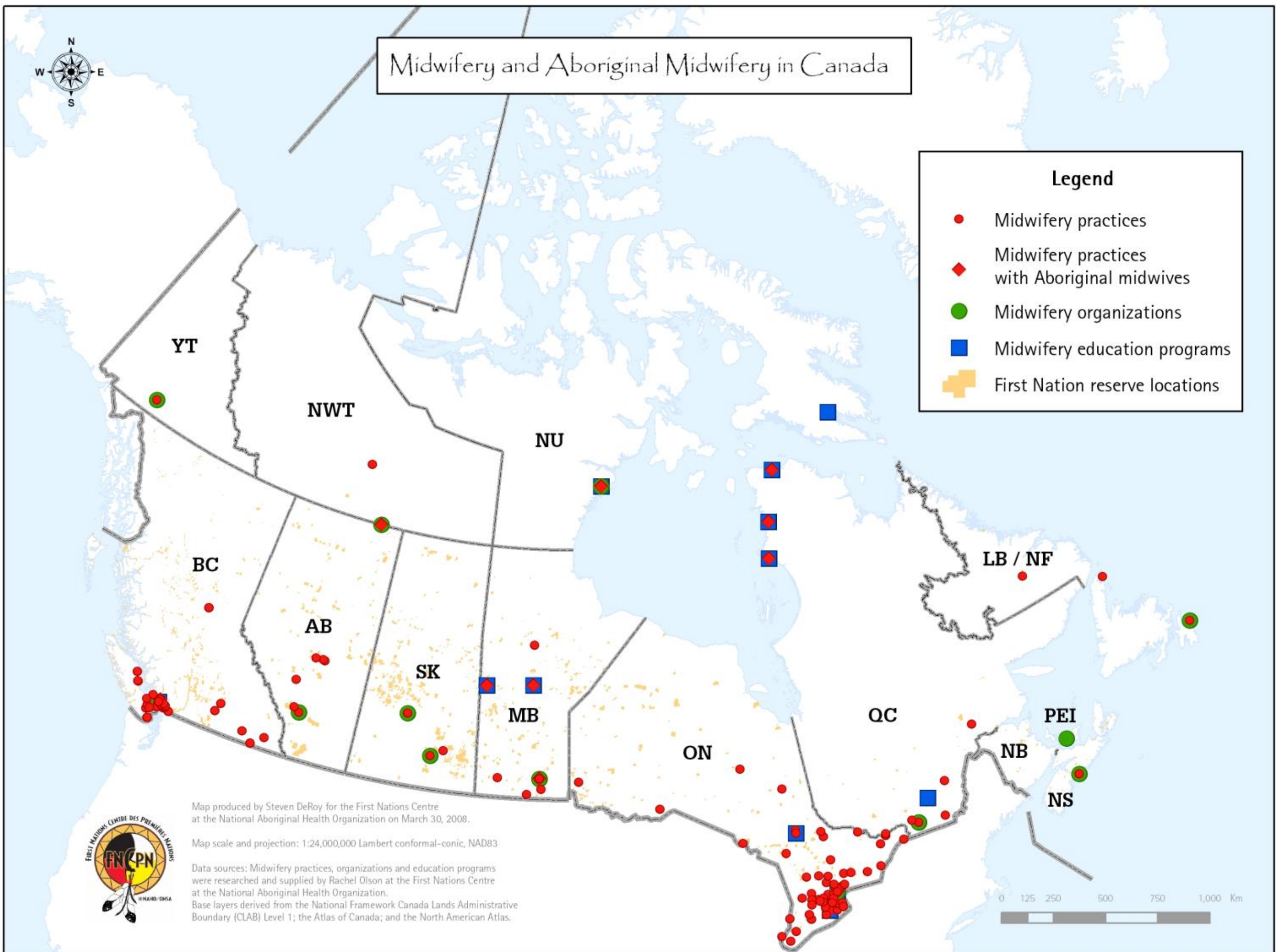
Articles and Books ... 68

Web sites ... 77

Videos ... 79

Table of Midwifery Legislation in Canada, By Province/Territory ... 81

Map: Midwifery & Aboriginal Midwifery in Canada



Introduction

This report is a response to calls and recommendations to improve Aboriginal (First Nations, Inuit and Métis) maternal and child health by increasing maternal health care. For example, in the 2005 Roundtable on Aboriginal Women and Girls Health (National Aboriginal Health Organization), the recommendations were to:

- Develop a health promotion plan to educate Aboriginal women about the benefits of midwifery.
- Produce resource materials on traditional birthing stories, including teachings on healthy pregnancy.
- Develop national standards for certifying midwives, inclusive and respectful of traditional midwives and existing training models, such as those found in Six Nations, ON and Puvirnituq, QC.
- Create joint ventures/affiliations with universities for accreditation.
- Obtain legal recognition of customary adoption.
- Provide birthing centres in every community.
- Develop a bibliography of contacts and information for access of funds, and develop midwifery initiatives as a community resource guide.
- Make midwifery accessible for all Aboriginal communities.
- Create and support networks for clinical discussions and exchanges between midwives.

This report addresses some of these recommendations by:

- Profiling the history of Aboriginal midwifery in relation to Aboriginal communities.
- Presenting an overview of the current status of midwifery in all jurisdictions of Canada.
- Discussing the gaps in current maternity care policy and practice in Aboriginal communities, as well as the critical need for maternity care services.

- Highlighting current initiatives supporting Aboriginal midwifery and best practices for birthing in remote and rural communities.
- Outlining ways of becoming a midwife, and recognition and accreditation issues.
- Presenting emerging models of community-based care, based on Aboriginal midwifery.
- Outlining strategic community development considerations.
- Providing a glossary and acronyms, a list of resources and a guide to midwifery legislation in Canada.
- Providing an associated map detailing midwifery practices, associations and educational programs in Canada.

NAHO hopes that these resources will provide some basic tools for further development of Aboriginal midwifery practices and programs among Aboriginal people, in Aboriginal communities and Canada-wide, for the benefit of Aboriginal families and maternal care.

Another version of this report was first published in 2004, and since then many significant developments have taken place for Aboriginal midwives. This paper is a reflection of these changes, while incorporating a large portion of the information that was in the first report.

A draft of the updated paper was first presented to Aboriginal midwives at the Canadian Association of Midwives Conference in November 2007. After this meeting, interviews were conducted in four First Nations and Inuit communities: Purvinituq, QC; Toronto, ON; The Pas, MB; and Six Nations, ON; as well as within various Aboriginal organizations.

A major shift reflected in this paper, is the shift from Euro-Canadian-centric writing to Aboriginal-centric writing, for documents intended for Aboriginal audiences. Essentially, this means that Aboriginal people, communities, histories and experiences have been written with Aboriginal perspectives as the centre or norm. Important Euro-Canadian histories and experiences are included and referred to, when appropriate.

A dominant theme during the development of this paper was the concept of returning birth to Aboriginal communities. The importance of this theme is reflected in the organization of this

document, which aims to provide a logical overview of Aboriginal midwifery in Canada, so that Aboriginal people can make informed choices regarding midwifery as a career, or the development of midwifery in their own communities.

All quotations from First Nations and Inuit midwives and midwives throughout this paper are a result of the primary research conducted in February and June of 2008 with the exception of excerpts from relevant documents, and quotes by Katsi Cook, which appeared in Talking Leaves Magazine, Volume 10, Number 1, Spring 2000.

Unfortunately, it was not possible to collect stories from the many Métis midwives practicing across Canada, in time for this report. There is little Métis-specific information on maternal child health and midwifery, which is the norm for other areas of Métis health research. The Métis Centre of the National Aboriginal Health Organization (NAHO) is working to address such gaps in research and programming. In 2008-2009, the Métis Centre conducted focus groups across British Columbia, which inadvertently uncovered feelings of loss experienced by new mothers struggling to connect with their culture and traditions. Several participants expressed that pregnancy and motherhood was a time of connection (or re-connection) with their heritage and culture, and that the loss of Métis traditional knowledge was both significant and painful. In future projects, the Métis Centre will be working to address this gap and recover lost knowledge of midwifery and maternal health, a pinnacle step towards ensuring Métis maternal child health becomes a priority in research and programming.

The voices of these midwives are presented throughout this report in order to provide further insight into their experiences, knowledge, and the importance of midwifery in contemporary First Nations, Inuit and Métis communities. Their voices weave together the unique and important initiatives that are taking place across Canada to support Aboriginal midwifery, and the role of these initiatives in improving maternal child health care for Aboriginal women. While these women do not represent the complete profile of Aboriginal midwives, their stories and experiences are a reflection of the power and great possibilities for midwifery in Aboriginal communities across Canada. We acknowledge that this work is not comprehensive and hope to be able to include the voices of more midwives in our future work. We hope you are inspired.

What is a Midwife?

> *"How do I define Aboriginal Midwifery? I don't think you can define it. I think that when an Aboriginal person is a midwife, and she is practicing midwifery, then she will define her practice the way she needs to and the way her community needs to. I think that if Aboriginal midwifery is anything it is community midwifery. It is community based and it is defined by that community. And it is not necessarily legislated, it could be anything. It is just whatever that community says, and who they say [is the midwife]* " (Carol Couchie).

During the Aboriginal Women and Girls Health Roundtable (NAHO, 2005), it was noted that "midwifery" is not a traditional term, and each nation has its own way of describing "a woman whose hands assist a child coming into the world." It was noted that there is a need for a new terminology that "accurately reflects a cultural approach to this important role." It is important to look at the words used for midwife in various Aboriginal languages. Nuu-chah-nulth call a midwife "she who can do everything." The Coast Salish translate the term midwife as "to watch, to care." For the Chilcotin, midwives are "women's helpers." In Michif, a midwife is "la faam kaa kaachitinaat li bebii", which means "the woman who catches the baby." All these terms testify to women's power in this central area of life. Inuktitut terms for midwife are "the one who waits for the birth" and "the helper." The Cree word for midwife is "the one who delivers." In Ojibwe, the term means "the one who cuts the cord".

According to Julie Wilson, Aboriginal midwifery is:

> *"…an Aboriginal person, usually a woman who provides traditional Aboriginal midwifery services to her own people. So she would incorporate a lot of the traditional practices, ceremonies, and medicine into her community. She would be a member of her community and she would work for her community. So she's not an independent care provider. She's been chosen from her community to stand up and to provide this service. So she works for her own people."*

The phrase *Aboriginal midwifery* is now widely used across Canada and encompasses a number of different approaches and experiences of women with midwifery knowledge. From traditional midwives who were taught by their Elders in their communities, to women who have completed

formal degrees in midwifery, or those who incorporate a blend of the two, Aboriginal midwives are diverse and the differences in their training, experience and practice must be acknowledged when speaking of Aboriginal midwifery. At the same time, Aboriginal midwives are all women of First Nations, Inuit or Métis descent, and share the common histories and experiences of being indigenous to Canada. In this way, defining who is an Aboriginal midwife and what that means becomes a complex task that requires some generalization based on the common experiences of Aboriginal women, while recognizing the diversity that exists among women who identify themselves as Aboriginal midwives. To date, there is not one standard definition of Aboriginal midwifery that is widely accepted.

More generally, the international definition of a midwife is:

> *"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery" (International Confederation of Midwives Council).*

History of Aboriginal Midwifery in Canada

> *"A long time ago, every community had midwives. At the same time, everyone, every woman and even every man, was taught what to do at a birth because the Crees were nomadic, and they lived on the trap lines and they were on the move all the time, so a birth could happen any time, anywhere. Every adult had to have some basic skill, including the husband. Sometimes, a woman would go into labour and the only person there to help her was her husband, so they had to be taught. This was very important. At the same time there were women who gained experience, became more and more experienced, and really became the midwives. Sometimes people would go get them, but only if the birth seemed to be a bit more complicated. If the birth was going really nice and fast, they would give birth with the people that were around them, and if they felt they needed to, they would go and get the midwives"* (Christine Roy).

In the past, traditional midwives assisted with both the ceremonial and the physical aspects of birth. A Stony Creek Elder quoted by Carroll and Benoit in 2001 explained that "in the 1930s, midwives used medicines for dealing with rituals; they helped with the in-between. The traditional art of midwifery was learned from mother and grandmother. Today modern medicine and doctors have taken over."

Of the accounts that do exist on traditional Métis midwifery, both similarities and differences can be drawn in comparisons with First Nations and Inuit communities. Early trading Métis communities often had help available from two sources: traders with training in European medicine, and First Nations medicine and medical chests. As with many First Nations and Inuit communities, there was often one woman or midwife in Métis communities in charge of the reproductive health of women and babies. This role was taught, not inherited, and often it was held by a childless woman who became like a "godmother" to most of the children in the community (Heritage Community Foundation, Date unknown).

During pregnancy, Inuit women increased their intake of caribou, char, muktuk, and seal; they limited their consumption of berries and did not eat aged food at all. In some Arctic societies, Inuit men helped their wives give birth; children, too, were involved (when no one else was available). Birth occurred in a snow house or an animal skin tent and women who assisted were

called Sanaji (in some dialects of the Inuktitut language). The Sanaji is the helper who first touches the baby, and becomes the one who is entitled to "create" the child by bestowing certain skills and characteristics on the newborn.

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

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

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

A number of historical studies in North and Central America (e.g. Yarrow, 1881; Simpson, 1892; Jones, 1893; Gilmore, 1930) provide similar evidence for Indigenous birthing practices in New Mexico, Alaska, Honduras, and along the Missouri River. Some of these reflect the biases of the time. They tell us, however, about the wide-ranging methods Indigenous peoples developed to ensure safe births. One common practice is the use of plants to alleviate post-partum haemorrhage. The Zuni used hot stones to expedite labour. Alaskan Indian women gave birth in a hole, dug two feet deep and lined with moss. In Honduras, birth was a community event; "sitting or standing about the room are from five to twenty women, interested spectators, smoking and talking, and occasionally squeezing the patient's abdomen..." (Jones, 1893).

Ceremony also had a place in Aboriginal birthing. An ethnologist described Hopi birth ceremonies in 1892 (Owens). After birth, the mother washed her head in suds made of roots.

An attendant washed the baby in the same water and rubbed it all over with ashes, except its head. The mother was not allowed to see the sun or put on her moccasins until the fifth day. Then on the 10th and 15th days respectively, she repeats the washing ritual that took place after birth. On the 20th day, a more elaborate three-part ceremony was held, involving: the purification of the mother; the naming of the baby; and the presentation of the baby to the sun. Community feasts were part of this ceremony, as was the godmother of the child, usually his or her paternal grandmother or paternal aunt.

In British Columbia (BC), Aboriginal midwives were charged with passing moral and ethical values from one generation to the next, in addition to guiding the birth process.

According to the author of *The new midwifery: reflections on renaissance and regulation*:

> *Canada's oldest midwifery traditions stem from aboriginal peoples. Midwives have been part of virtually every aboriginal community and some midwives continue to practice today. English and French colonial oppression damaged many aspects of First Nations health culture but resistance to this oppression has managed to maintain some of the ancient wisdom of midwifery* (Shroff, 1997).

In the same book, Carol Couchie and Herb Nabigon describe some of the encounters between Europeans and Aboriginal midwives:

> *"When Europeans began to come and live here at the height of the fur trade they brought no women with them. Many of these European men took Aboriginal women as wives. It was well known that survival was almost impossible without an Aboriginal woman's help. As time passed they began to have families and perhaps it is here that these men learned of our midwifery skills, as they have recounted them in their correspondence. Over the years, as these men began to adapt to the environment, they began to bring over their own women to live here and raise their families. Many of the skills and human resources that they borrowed from First Nations communities in Canada included midwives and midwifery skills. They knew and wrote about our midwifery expertise. They knew and wrote about the medicines we used for birth. In isolated areas Aboriginal healers and midwives were the only ones to call*" (Schroff, 1997).

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

From World War I on, hospital births came to be much more accessible to ordinary people, and by the 1950s, almost all births in North America occurred in hospitals. The public grew to believe that midwife-attended births were unsafe. As the medical profession reinforced this perception, midwifery was outlawed in many jurisdictions "for the sake of the health of the country" (Parkland Memorial Hospital School of Nurse Midwifery). Comparisons of the difference in practices and outcomes between doctors and untrained midwives increasingly discredited the safety of midwifery. The decline was further accelerated by the development of anaesthetics. Female suffragettes and doctors successfully fought for the right of all women to have access to anaesthetics, but they could only be provided by doctors/hospitals. Those formal midwifery services that were available were incorporated in limited nurse-midwife programs generally set up for rural and urban poor populations. Canada and the United States are the only industrialized countries in which midwifery was thoroughly discredited.

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

which are difficult to quantify. The loss of traditional birthing practices has been linked to the loss of cultural identity.

The First Nations and Inuit Regional Health Surveys Report (AFN, 1999) provided data that highlighted the need for a program emphasizing maternal health. While services have been inadequate, the need for services remains high.

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

- Stillbirth and perinatal death rates among Indians are about double the Canadian average; among Inuit living in the Northwest Territories, they are about two and a half times the Canadian average (RCAP, 3(3), 127).
- Although dramatic improvements have been made in Aboriginal neonatal health, in 1979-81 and 1991-93, the Aboriginal post-neonatal mortality rate was roughly three and a half times that of the national population (CICH, 2000(6), 173).
- Breastfeeding rates in the Aboriginal population are 54 per cent compared to 75 per cent for the Canadian population (RHS, 1999).
- Aboriginal parents are much more likely to rate their child's health as poor/fair (16 per cent compared to two per cent for the Canadian population) (RHS, 1999).
- Many Aboriginal women are isolated, impoverished… suffering from low self-esteem; [they] experience inadequate nutrition during pregnancy…general self-neglect; and lack of appropriate and affordable housing (RCAP, 3(3), 103-31).

In a 2005 Roundtable on Aboriginal Women and Girls Health (National Aboriginal Health Organization), participants identified priority issues for reproductive and maternal health:

- A lack of culturally appropriate supports and facilities for pregnancy and birthing.
- A lack of culturally relevant education, training and apprenticeship for midwives.
- Inadequate funding and bursaries to support training.
- Long waiting lists to access midwives.
- Liability and liability insurance issues for midwives.

- Current evacuation practices prevent fathers, grandfathers and extended families from sharing in the birth of babies and negatively impact bonding from birth.

While improvements to maternal child health care have been made, the key issues remain the same. In a literature review done for the report, *Exploring Models of Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment*, by the National Aboriginal Health Organization in 2006, issues were identified that remain at the forefront of maternal child health care for Aboriginal communities. These are:

- Less than adequate, often inconsistent maternal child health care (lack of continuity of care, informed choice, choice of birthplace, access to quality of care.
- Impact of community size and geographical location as a barrier to access to care, limited programs and services, long distances, lack of medical equipment.
- Recruitment and retention problems of physicians, nurses, specialists in remote/isolated and sparsely populated areas.
- Extremely high costs associated with health care delivery.
- A majority of pregnant women in rural/remote/isolated areas must still deliver outside their communities (medical evacuation of 'at risk' pregnancies in some areas, in other 'all' pregnant women).
- Majority of human and fiscal resources spent on treatment and not on prevention, education, and health promotion.
- Serious lack of First Nations and Inuit health care workers.
- Communication difficulties due to language and cultural barriers, hindering cultural safety.
- Barriers to an integrated holistic model of maternal health care resulting in lack of access to and knowledge of First Nations and Inuit midwives and traditional healers.
- Environmental degradation impacts negatively on food and medicine sources.

- Racism.
- Roles and responsibilities of father siblings, family and community in childbirth.
- Roles of midwives and Community Healthcare Representatives (CHRs) can play in pre-conception, pre and postnatal care and throughout the lifespan.
- Role of Elders in transmitting knowledge and wisdom on women, men and children's health.
- Lack of programs to track where midwives are, what services they offer, are there First Nations and Inuit health professionals, where they are practicing, in what field. (NAHO, 2006).

It is important to see that improving maternal child health care is a multi-layered issue that touches all aspects of a community's health, as well as acknowledging the social determinants of health that impact maternal child health care. For example, maternal child health is a holistic concept for many Métis, both historically and currently. Research from the Métis Centre has shown that Métis often connect physical health with broader determinants such as income, housing, spirituality, and community. Similarly, maternal child health is seen as connected to both the health of the family (regardless of family structure) and the health of the community. The health of the baby is seen as indivisible from such determinants.

Canada is currently facing a shortage of maternity care providers that grows more acute every year (Kornelson et al., 2005; Milne, 2001). The shortage is felt most acutely in rural and remote communities and has fostered an increased acceptance of midwives as appropriate care providers for low risk pregnancies. For Aboriginal communities, this development provides opportunities for the restoration of midwifery and community births.

Contemporary Practices in Aboriginal Midwifery

> *"I never cry at births anymore, I am such an old dog that is so hardened. I have been to 600 deliveries, and that is a lot of sleepless nights. I have seen a lot of bad things happen. And it is not about me anymore, it is about the family. But when I was in Inujuak for the first time and saw three generations of people at (the birth of) this little 16 year old girl who had worked for a day and a half to finally have her baby. They turned the lights on that signals everybody to come in, and the whole community is coming through to shake her hand. And I wept. This is so incredible. This is what I worked all my life to do. And isn't it cool? I get to do this really really wonderful thing"* (Carol Couchie).

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

Although traditional birthing practices are as diverse as the number of Aboriginal nations, it is important to consider common themes among them in order to place Aboriginal midwifery within its appropriate context. In general, all nations believe that being born is a sacred event—it is the entrance of a new spirit into the world.

> *"There are teachings that the birthing experience can tell you about the purpose of that child's life. One of my roles as a midwife is to notice, from all the different signs in the birth, what this baby's here to do, and what ceremonies the mother and father have to do to make sure that baby grows a certain way, what attentions need to be paid to this child, any particular weaknesses or strengths. Based on the knowledges from different medicine ways, you have an interpretive framework to use. That's essentially what we're trying to maintain and build upon and carry with us as one of the things we use in our families so that our people can live"* (Katsi Cook *in an interview authored by Wessman and Harvey*).

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

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

According to Evelyn Bomberry, maternal and child health care starts at the moment of conception:

> *"We do a lot of traditional teachings as well with the moms and in that we begin with the traditional medicines that we use to cleanse the mom and baby. We believe that as soon as you conceive the baby that you begin teaching that baby, so there's a lot of traditional ways that the mothers should be following and we teach all of that. There's very simple things like not sitting in a chair and crossing your legs. Things like that we teach them that this is our traditional beliefs*" (Grandparent's Council, Six Nations).

Within the context of risk, it is also important to note that different cultures have different views of risk and how it relates to their lives. In one study of risk in Inuit communities, it was found that risk was seen as a necessary part of everyday life, and that worrying about negative consequences was as harmful as the possible outcomes (Briggs, 1991).

Current Initiatives

A number of initiatives are taking place across Canada in supporting Aboriginal midwifery. The initiatives are taking place in a variety of arenas and by various organizations. From federal government, to non-governmental organizations, and various associations, both Aboriginal and non-Aboriginal, these developments vary in their focus and approach. They all contribute to the development and support for Aboriginal midwifery in Canada and its future. The following is a review of some of this important work.

Métis Initiatives

It is important to note that midwifery is re-emerging as a priority for Métis, and that a few Métis-specific initiatives do now exist. Today, the majority of maternal child health programming for Aboriginal Peoples is specific to First Nations and/or Inuit. Although Métis currently account for 33 per cent of Canada's Aboriginal population (2006 Census), they are often not included in the planning of many Aboriginal programs and services. This is due in part, to the status of Métis in Canada, as Aboriginal under the Constitution, but without the title to lands and resources that First Nations and Inuit people have obtained through treaty and legislation. As a result, Métis Peoples spend significant time and resources struggling for recognition and for programs and services. Métis have the right to birthing and maternal child health programs and services that are culturally safe and appropriate.

The Irnisuksiiniq– Inuit Midwifery Network (IIMN)

IIMN is an information-sharing network. It seeks to contribute to the long-term goal of Inuit providing maternity care services to their communities with Inuit maternity care workers and Inuit midwives who combine cultural (traditional) knowledge and practices with effective, contemporary maternity care models. The Network's primary goal is to increase support for and assist in the expansion of the practice of Inuit midwives and maternity care workers through information-sharing mechanisms.

The IIMN is a project developed by the Ajunnginiq (Inuit) Centre under the umbrella of Aboriginal midwifery knowledge-based activities of the National Aboriginal Health Organization (NAHO). NAHO has three Centres - First Nations, Inuit and Métis - that focus on

their populations, work with their respective partners and collaborate on initiatives that involve all three populations.

The IIMN is a knowledge transfer initiative that shares information from internal and external sources to the network's participants. Knowledge transfer can facilitate knowledge translation: evidence, based on research, effectively used to develop better policy, programs and services. The project contributes to all five of the Ajunnginiq Centre's areas of focus:

- Improve and promote Inuit health through knowledge-based activities.
- Promote understanding of the health issues affecting Inuit.
- Facilitate and promote research and develop research partnerships.
- Foster participation of Inuit in the delivery of health care.
- Affirm and protect Inuit traditional healing.

The IIMN is primarily a Web-based technology service. Ajunnginiq Centre staff gather and disseminate a wide variety of relevant midwifery resources to the network in a number of ways. Via the trilingual Web site at www.inuitmidwifery.ca; a 'low tech' e-mail listserv - inuitmidwifery@naho.ca, fax (if requested), or phone, are the ways in which one can retrieve information from the network.

The IIMN serves as an access point for Inuit midwifery and maternity care information (resources, news, research, articles, reports, training, events, stories, etc.) and offers no-cost Web-publication of articles, presentations, stories and other resources. Through a quick email, phone call or fax, practitioners and developers in the field can request information reaching over 80 network participants around the country with a wide range of knowledge and skills. Participation is free and open to anyone with an interest in advancing Inuit midwifery and maternity care. The Ajunnginiq Centre also assists network participants with proposal development for projects, document review, audio-visual projects, and policy and resource development teams.

Pauktuutit Inuit Women of Canada

Pauktuutit is the national non-profit association representing all Inuit women in Canada. Incorporated in 1984, Pauktuutit ensures a voice for Inuit women on issues concerning Aboriginal Peoples in Canada and ensures their participation in federal policies and programs.

Pauktuutit's vision is to be a dynamic, visible, influential organization, supporting Inuit women and providing leadership, voice and excellence for the betterment of Inuit women, their families and communities. Pauktuutit is committed to advancing a National Inuit Midwife Strategy.

This Strategy will:

- Identify the needs, benefits, barriers, and best practices that are relevant to the profession in all Inuit regions.
- Provide a comprehensive review of the current training, legislation, certification, and curriculum related to midwifery in the four Inuit regions.
- Integrate traditional Inuit knowledge into the delivery of maternal care services in the North.
- Promote the broader objective of promoting healthy pregnancies and healthy communities (Pauktuutit, n.d.).

In addition to this, Pauktuutit Inuit Women of Canada has a wealth of detailed information collected from a research project done on Inuit midwifery. They interviewed 75 Elders between 1992 and 1993 and collected over 500 birth stories. This research is stored in a database and is currently being used to incorporate traditional knowledge and understandings into contemporary tools for pregnant women and their families. An example of this is the recently published prenatal calendar.

The goal of this initiative is to develop and implement policies and programs that return birth to Inuit communities.

The Atlantic Policy Congress of First Nations Chiefs

This organization recently received funding approved under the Aboriginal Health Transition Fund to explore the provision of midwifery services for First Nations communities in Nova Scotia.

The Public Health Department of the Cree Board of Health and Social Services of James Bay (CBHSSJB)

The Awash program of the CBHSSJB has been exploring the implementation of midwifery services for James Bay Cree communities. They have undergone an extensive consultation process with their communities and have developed strategies for midwifery education and implementation. This initiative will be discussed in more detail in Section Five of this paper.

In general, the Awash team promotes the health and safety of young children, from birth to 9 years old, and their families. The services include: interventions for pregnant women, infants and young parents (including prenatal, and postnatal services for families in difficulty, midwifery services, and breast-feeding initiatives); prevention of infectious diseases (vaccine preventable diseases, tuberculosis, rabies and zoonoses, and nosocomial infections); and dental health (research and prevention services).

It is important to point out that this initiative comes from women in the Cree communities for which the program will be developed. As Christine Roy, the midwife working with the Awash program states, "it has been initiated by the Cree Health Board, but it comes from Cree women who are saying, "Listen, this knowledge is going and we have to bring this back." And the same time, blend this with modern midwifery. But how can we blend these together and create a model that really speaks to us?"

Canadian Association of Midwives (CAM)

The Canadian Association of Midwives/ Associations canadienne des sages-femmes (CAM/ACSF) is the national organization representing midwives in Canada. In recent years, Aboriginal midwives have approached CAM for their support for Aboriginal midwifery and recognition of their unique roles and needs, as well as the needs of their communities. In

response to these requests, a resolution was passed at the CAM Annual General Meeting in November 2005. This resolution stated that CAM would:

> *"….take an active role in entering into dialogue with First Nations, Métis and Inuit communities and organizations about issues related to appropriate recognition, legislation, regulation, funding and education for Aboriginal midwives in Canada."*

The CAM Board drafted plans to develop a consultative process with Aboriginal midwives, including traditional and registered, members and non-members of CAM. First Nations and Inuit Health (FNIH) funded a project that engaged Aboriginal midwives and communities in a dialogue with CAM to explore the needs and interests of Aboriginal midwives and their communities.

The next steps for CAM after this initial consultation process have been identified as:

- CAM will continue to collaborate with Health Canada in providing a venue to host Aboriginal midwifery gatherings at its annual conference, and invite First Nations, Inuit and Métis midwives as conference speakers and participants.
- On behalf of CAM, the Project Lead will continue to pursue in-depth personal conversations with Gathering participants and other First Nations, Inuit and Métis midwives as to the relationship between CAM and the developing Aboriginal midwifery organizations.
- The CAM Board will actively explore the policies and infrastructures created by other national or provincial midwifery organizations to invite, integrate and support Aboriginal membership and representation within their organizations.
- The CAM Board will accordingly develop proposals for policy and infrastructure changes that could strengthen Aboriginal membership and Aboriginal voices within CAM. These proposals may involve new committees, changes to Board or Executive structures, and/or creation of an advisory council, and will be offered as potential scenarios to stimulate, invite and concretize further discussions with Aboriginal midwives about membership and/or representation within CAM (CAM, June 2007).

The Society of Obstetricians and Gynaecologists (SOGC), An Aboriginal Birthing Strategy

In addition to its National Birthing Strategy, the SOGC has proposed an Aboriginal Birthing Strategy for Canada. This strategy will have the same core elements as the national with additional mechanisms and considerations to address the "unique requirements and expectations of First Nations, Inuit and Métis people." It is stressed that an Aboriginal birthing strategy is needed to "generate action to improve the health of Aboriginal children, to address health inequities and create a framework for comprehensive, collaborative partnerships" (SOGC, 2007).

The proposed strategy will focus on the following key issues in its development: partnerships and collaboration, cultural competency/cultural safety, financial commitment/resources. The core elements in the strategy are:

- Listen to women's voices: In the Aboriginal context, the need to listen must be expanded to include not only the pregnant women, but also the Elders, the family, the community values that will largely define the maternity experience. This element is key to the success of an Aboriginal Birthing Strategy. A multilateral process must be established to ensure these voices guide the ongoing development and implementation of a birthing strategy.

- Facilitate Maternity Care stakeholder engagement, collaboration and networking: It is necessary to create a mechanism by which midwives and other health care practitioners with specific knowledge or interest in health care in Aboriginal communities are able to share their experience, and seek support and guidance.

- Establish a process for collection of data and information: There are currently serious inadequacies in the statistical information regarding prenatal, postnatal, and birthing care in Aboriginal communities. Data collection is essential to problem solving and these gaps must be addressed.

- Standardized clinical practice for all maternity care providers: Clinical Practice Guidelines provide health care practitioners- wherever they are- to access best practice information. "Standardized" need not rule out traditional methods and culturally sensitive practices that have endured for generations in Aboriginal communities.

- Adopt standardized curriculum for post-secondary (pre-licensure) education.
- Establish inter-professional, post-graduate (post-licensure) education to manage risks, to improve patient safety, and to facilitate collaborative woman-centered practice.
- Establish multidisciplinary collaborative maternal and newborn care models: The need for innovation in the delivery of maternity care in Aboriginal communities is urgent. Often these communities are rural and remote; health care providers may feel isolated from their peers.

Memorandum of Understanding Between Health Canada of the Government of Canada and the Department of Health and Human Services of the Government of the United States of America

A five-year memorandum of understanding was first implemented by the Government of Canada and the Government of the United States in 2002. The MOU "mutually recognized that the health status of First Nations and Inuit in Canada and American Indians and Alaska Natives in the United States share many of the same characteristics and challenges" (Government of Canada, 2007). On November 1, 2007 the respective governments renewed this agreement for another five years. The renewal of the MOU affirms the commitment of Canada and the United States to continue working over the next five years to improve the health status of their respective Indigenous populations.

This MOU on Indigenous Health has led to tangible progress in the last five years on many important health issues such as maternal and child health, disease prevention and mental health and addictions," said Minister Clement. "The renewal of this MOU demonstrates Canada's commitment to continue working collaboratively with our American counterparts, Aboriginal partners, and others to improve the quality of life and promote a prosperous future for all Aboriginal peoples."

The agreement aims to improve the health of Indigenous peoples in Canada and the US by sharing experiences and best practices in policy development, research and the provision of health services between officials, community members, researchers and health service providers.

Government and Indigenous representatives have developed a broad Plan of Action, which calls for activities in the areas of, but not limited to, Maternal and Child Health, Disease Prevention and Environmental Health, and Suicide and Substance Abuse Prevention. Indigenous midwifery has been identified as a first point of discussion between the two parties.

As a first event in the renewed MOU, Health Canada and the Indian Health Service hosted an Invitational Gathering on North American Indigenous Birthing and Midwifery. This three day event was held in Washington DC in May 2008, with the purpose of learning, discussing and considering how the respective governments can promote awareness and strengthen the practice of Indigenous midwifery in the United States and Canada.

The gathering's primary objectives are to share information and promising practices, understand the underpinnings of indigenous midwifery, and discuss potential areas and approaches to collaboration.

Training Options

> *"Being a midwife brought me around the circle, where I wanted to work with women. You have time to work with women, if they want to, begin a healing path for themselves. To come full circle, and be able to stand there at other women's births and in that way, be at my own birth. It felt that way for me, because I never got to hear my own birth story. To me, that is something that is a big pull for me, and for many of our women is that we don't know our story. We don't know it and we should know it. We have the right to know our own story right from the beginning. For me, those women can now talk to their children and say this is what happened at your birth, it was a full moon and the wind was blowing and there were stars up in the sky and these are all the things that happened. That informs that baby right from the start*" (Ellen Blais).

In Canada, midwives come from varying backgrounds in terms of experience and education. While most midwives do not fit neatly into one category due to the complexity of their work, the Midwives Alliance of North America (NAMA) does define three general types of midwifery that each relate to a different type of training:

Direct Entry Midwife: A direct-entry midwife is an independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide the Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings.

Traditional/Lay Midwife: The term "Lay Midwife" has been used to designate an uncertified or unlicensed midwife who was educated through informal routes such as self-study or apprenticeship rather than through a formal program. This term does not necessarily mean a low level of education, just that the midwife either chose not to become certified or licensed, or there was no certification available for her type of education (as was the fact before the Certified Professional Midwife credential was available). Other similar terms to describe uncertified or unlicensed midwives are traditional midwife, traditional birth attendant, granny midwife and independent midwife.

Nurse-Midwife: A Nurse-Midwife is an individual educated in the two disciplines of nursing and midwifery (MANA, 2008).

While Aboriginal Midwives in Canada fit into all three of the categories listed above, it is only recently that Aboriginal women trained in traditional birthing practices have started to have their expertise officially recognized through the development of new and integrated models of training and care.

Aboriginal Midwifery Training Models

> *"We need to train midwives as much as possible. We need people to have an opportunity to go and work in remote settings, to live there, to be a part of that, because we need the people who live there to be trained. So if we can put people in every two or three months, and that student midwife who is there and that is her practice and she is developing it, and she is learning how to catch those babies with an experienced midwife there, in that apprenticeship model then eventually, you don't have to send people up there any more. And even if that young woman quits, and moves to another smaller community, that knowledge goes with her. It is the democracy of knowledge. You bring back that knowledge that once belonged to our communities and give it back to them. And it stays there. Those people don't go home. They are home"* (Carol Couchie).

Aboriginal midwifery training is a very important issue when speaking of Aboriginal midwifery in Canada. Many communities are looking at ways of developing this training that is best suited to their home communities and their current infrastructures, capacities, and community support. Aboriginal midwifery has the goal of safe and culturally appropriate birthing that emphasizes respect for life and the empowerment of women. In both Ontario and Québec, community based training programs exist where Aboriginal midwives learn from practicing midwives, at local birthing centers. These centres aim to deliver culturally relevant maternal care. This process reflects ancient Aboriginal practices, as well as the place of older women as repositories of medical and spiritual knowledge. Moreover, in areas of Canada such as Nunavut, traditional midwives continue to pass their Indigenous knowledge and skills on to the next generation of midwives, as they have always done.

It is noted that midwifery education and midwifery practice are inextricably linked, and when considering midwifery in communities, considering models of educating midwives in those communities is an integral part of this process. The following are descriptions of the four main Aboriginal midwifery training programs in Canada today.

kanaci otinawawasowin Baccalaureate Program (KOBP)

An example of a process to set up an education program is the kanaci otinawawasowin Baccalaureate Program (KOBP) in Northern Manitoba. kanaci otinawawasowin (its meaning is "sacred midwifery" in Cree) is an Aboriginal midwifery education program currently being offered at the University College of the North in The Pas and Norway House, Manitoba. The steering committee that developed the program stated that its overall goal was to "establish a comprehensive and sustainable midwifery program in Manitoba that reflects a blend of traditional Aboriginal and western methods of practice, and the necessary support systems, for persons of Aboriginal ancestry" (Peters, 2006). The program is a four year degree program that incorporates a mentoring model of instruction. This program is rooted in Aboriginal values and tradition. It trains midwives in the competencies required for registration with the College of Midwives in Manitoba.

First titled the Aboriginal Midwifery Education Program, KOBP was a multifaceted initiative that involved many partners and stakeholders. For two years, the committee used a two-pronged approach to develop the program (Peters, 2006). Firstly, it undertook extensive consultations with Aboriginal communities. These consultations aimed to:

- Seek input into the content and teaching methodologies of the program.
- Learn from elders about traditions and practices that should be incorporated into the program.
- Obtain community and political support.
- Identify suitable teaching sites.
- Recruit potential students (Peters, 2006).

It also consulted experts in Aboriginal education and looked at how to adapt existing models of midwifery curricula. The committee purchased curriculum from both the Ontario Midwifery Education Consortium and Otago Polytechnic University School of Midwifery in New Zealand.

The program was then transferred to the University College of the North as the delivery site as an accredited degree program. Some of the key learning's from this process were that it is of "critical importance to have all key stakeholders involved right from the beginning." Also, the importance of community consultations is key to effect change in birthing policies in communities. Finally, it showed that "even significant challenges can be overcome providing that there is a will to do so at many levels" (Peters, 2006).

Tsi Non:we lonnakeratstha Ona:grahsta' Aboriginal Midwifery Training Program

The Tsi Non:we lonnakeratstha Ona: grahsta' Aboriginal Midwifery Training Program was the first formal training program for First Nations midwives in Canada. The vision of the program is to "provide an educational opportunity for Aboriginal women to gain skills and knowledge in Aboriginal midwifery and to participate in the resurgence of Aboriginal midwifery in Aboriginal communities" (Miller, 2006).

The entrance criteria for the program are: the student must be of Aboriginal ancestry; female, a high school graduate, or equivalent, at least twenty one years of age, have a valid drivers license, no criminal record, and be able to demonstrate a connection with their Aboriginal community, whether it be urban or rural.

The program is four years in length with 11 ½ months of training in each year. The program consists of coursework that address Aboriginal women's unique health issues and intensive clinical experience with Aboriginal families, requiring students to complete 25 births to graduate. The program combines western obstetrical practices and standards of the Ontario College of Midwives, with traditional Aboriginal practices and standards. All training components are completed at the Maternal and Child Centre with Aboriginal midwife instructors. Graduates are qualified to work in Ontario and with Aboriginal communities but are instructed to seek formal recognition and authorization to practice from their home communities.

The Inuulitsivik Midwifery Education Program

The Inuulitsivik Midwifery Education Program is an academic and clinical education program for Inuit women working in their own communities on the Hudson Bay Coast of Nunavik (Northern Québec). The program uses "modular competency based curriculum consistent with clinical content of southern midwifery education programmes." It has been "adapted for northern realities and [has] an expanded scope of practice" (Epoo and Van Wagner, 2005). The program emphasizes learning in ways appropriate to Inuit culture, and focuses on the role of the midwife in community health, especially in the areas of sexual health and well woman care.

The program also focuses on emergency management and has created an Emergency Skills course. In the north, there is an expanded scope of practice for midwives and this includes training in skills such as using a "vacuum, manual removal of placenta, intubation and umbilical vein catherterization of the newborn" (Epoo and Van Wagner, 2005).

Maternity Care Worker Certificate Program and Midwifery Training, Nunavut Arctic College

Maternity Care Workers are prepared to assist midwives, support mothers and newborns and provide childbirth and parent education programs. Graduates of this program can qualify to take the Midwifery Diploma and Midwifery Degree Program. The requirements are that you must be 18 or older, have a grade 12 Diploma or equivalent and strong Inuktitut/English skills.

This initiative began as part of the Closer to Home strategy. Nunavut recognized the need to train Maternity Care Workers and Midwives for birthing centres in Nunavut. It is stated that the Department of Health and Social Services Closer to Home strategy is committed to expanding the number of birthing centres in Nunavut and the training of Maternity Care Workers and Midwives. It highlights how important it is that this service is culturally appropriate and relies on Inuit knowledge of maternal care and birthing.

Nunavut Arctic College's Kivalliq Campus has developed a one year Maternity Care Worker Certificate Program in Rankin Inlet and is developing and pilot testing a second year Midwifery Diploma Program. The program will be transferable for advanced credit towards the University College of the North's four-year Midwifery Degree program in Manitoba.

Non-Aboriginal Training Programs

> *"I think they (midwifery practices and education programs) need to happen simultaneously. You have to do both. Because you can't teach students without women. Students can't learn without babies to deliver and people to look after. So if it is a program this small, you really have no choice. You have to do both. It is the heart of the education. It is the ladies, and the babies, and going to births, and all that kind of stuff. Because how else are you going to learn? You can't learn to be a midwife from a book. You can learn lots from books, but not that"* (Carol Couchie).

In the rest of Canada, midwifery is generally an accredited four-year program at post secondary institutions. Midwifery education programs, institutions and contact information are listed on pages 65-67.

Strategic Development Considerations

Midwifery Education & Accreditation

Developing models of education have been described above in Section Three. Therefore, this will not be discussed in great detail. It is noted that midwifery education and midwifery practice are inextricably linked, and when considering midwifery in communities, considering models of educating midwives in those communities is an integral part of this process. An example of a process to set up an education program is the kanaci otinawawasowin Baccalaureate Program (KOBP) in Northern Manitoba. In a recent meeting at KOBP, it was stated that:

> "*…it is important for midwives to develop relationships and make connections to ensure the development of credibility in the community. The ideal is that the midwives become immersed in the community and midwifery education becomes an option of choice for young girls. There was also mention of a need to respect the student's spiritual beliefs while also providing information around traditional spiritual and cultural beliefs, feminism and issues of choice"* (Birch and Moon, 2008).

First titled the Aboriginal Midwifery Education Program, KOBP was a multifaceted initiative that involved many partners and stakeholders. For two years, the committee used a two-pronged approach to develop the program (Peters, 2006). At the beginning, it undertook extensive consultations with Aboriginal communities. These consultations aimed to:

- Seek input into the content and teaching methodologies of the program.
- Learn from elders about traditions and practices that should be incorporated into the program.
- Obtain community and political support.
- Identify suitable teaching sites.
- Recruit potential students (Peters, 2006).

It also consulted experts in Aboriginal education and looked at how to adapt existing models of midwifery curricula. The committee purchased curriculum from both the Ontario Midwifery Education Consortium and Otago Polytechnic University School of Midwifery in New Zealand.

The program was then transferred to the University College of the North as the delivery site as an accredited degree program. Some of the key learning's from this process were that it is of "critical importance to have all key stakeholders involved right from the beginning." Also, the importance of community consultations is key to effect change in birthing policies in communities. Finally, it showed that "even significant challenges can be overcome providing that there is a will to do so at many levels" (Peters, 2006).

Canadian Midwifery Registration Examination

As of spring 2008, all applicants for midwifery registration in Canadian jurisdictions outside Québec will be required to pass the Canadian Midwifery Registration Examination (CMRE). This includes graduates of Canadian midwifery education programs, as well as internationally educated midwives being assessed for registration in Canada. The use of this exam in Québec is still to be determined. The purpose of the CMRE is to ensure that all entry-level registered midwives in Canada can practice to the same competency standards. Its goal is to protect the public and ensure a consistent standard of care across Canada.

In 2003 the Canadian Midwifery Regulators Consortium launched the HRSDC-funded National Midwifery Assessment Strategy (NAS) project. Among other activities, NAS supported midwifery regulators and educators from across Canada in creating the Canadian Competencies for Midwives. NAS research also resulted in a clear directive to create a national registration exam to ensure a consistent evaluation of midwives' competence to practice in Canada. In April 2005, the Consortium contracted with Canadian exam development experts, Assessment Strategies Inc, to support the development of the national exam, using the Canadian Competencies for midwives and a range of existing provincial midwifery exam resources as a starting point. Since that time many Canadian midwives and midwifery educators from each regulated jurisdiction have been involved in the development of the exam via blueprint development, item writing, exam piloting, item validation, and verification of translations. The exam was implemented for internationally educated applicants in BC, Alberta and Manitoba in

the spring of 2006. It will be implemented for all applicants in BC, Alberta, Manitoba, and Ontario by 2008, and in Québec, if and when their legislation permits (Canadian Midwifery Regulators Consortium, Fall 2007).

Exemptions for Aboriginal Midwives

> *"We're practicing under an exemption, which is a big difference than most of the other programs and we're holding tight to that model, Aboriginal midwifery model. And it's a struggle because there's many different programs starting up, which is great, its fantastic, but I think not being with the college of course has some drawbacks with funding sometimes, but with our grandparents and our advisory and our community being the ones that we have to answer to, it's stricter and harder to please than any other way you could possibly go, they really keep you in line- especially when you live here" (*Laurie Jacobs).

All prospective midwives must apply for registration with the governing body of their respective province in order to practice midwifery. The Nunavut, British Columbia, Ontario and Québec legislation provide an exemption from registration for Aboriginal midwives.

The British Columbia, Manitoba, Nunavut, Ontario and Québec Acts make some reference to Aboriginal midwifery. The British Columbia Midwives Regulation provides a general definition of Aboriginal midwifery, recognizing that it includes First Nations, Inuit and Métis peoples and encompasses both traditional and contemporary practices. These practices are not defined in the Regulation, providing a level of autonomy to Aboriginal midwives to adapt their practices to the changing needs of their communities.

The Manitoba *Midwifery Act* is the only statute that includes a provision for the establishment of a standing committee to advise the college on issues related to midwifery care to Aboriginal women.

With respect to the Nunavut and British Columbia legislation, the exemption is only available for midwives who practiced Aboriginal midwifery prior to the coming into force of the Act, creating a "grand mothering effect." In Ontario, Aboriginal midwives providing care to Aboriginal communities are exempt from the *Regulated Health Professions Act*. The Ontario *Midwifery Act*

allows Aboriginal midwives who provide traditional midwife services to use the title "Aboriginal midwife." The Québec statute allows Aboriginal midwives to practice without being registered members, provided that the nation, group or community has entered into an agreement with the government. The Québec government has also passed *An Act respecting health and social services for Cree Nation Persons* through which midwifery services may be provided. In addition, midwives who conduct home deliveries for Cree Native persons are excluded from the Regulation Respecting Standards and Conditions of Practice for Conducting Home Deliveries.

According to Carol Couchie and Herb Nabigon, exemption isn't enough:

> *The Ontario government needs to think seriously about supporting self-government and promoting health by providing more than token acknowledgement of our traditional healing practices – like the midwifery exemption clause. They must support education programs and services for First Nation's women and their families (*Schroff, 1997).

Registration Requirements

Midwifery is a regulated profession in all jurisdictions except for New Brunswick, Newfoundland and Labrador, Nova Scotia, Nunavut, Prince Edward Island and the Yukon. The Nova Scotia government passed midwifery legislation in 2006, but it has not yet been proclaimed in force. A midwifery bill was tabled in the Legislative Assembly of Nunavut and is currently in second reading. The final version of the legislation may contain different provisions than those presented in the Table of Midwifery Legislation in Canada (p.87).

The following key points emerge from a review of the legislative framework of midwifery in Canada:

- With few exceptions, Aboriginal midwifery is not recognized in the midwifery legislation. Where there are references, the general approach has been to exempt persons practicing Aboriginal midwifery from registration requirements. There is a lack of appreciation of the need for culturally appropriate care for Aboriginal women.
- Many provinces require registered midwives to carry professional liability insurance. The cost of insurance may be prohibitive for persons seeking to practice Aboriginal midwifery and reduce access to midwifery services for Aboriginal women. For example,

midwives in Manitoba who are not employed by a regional health authority are required to carry liability insurance of not less than $7,000.00 per occurrence or $14,000.00 per year.

- The scope of practice is generally limited to "normal" pregnancy, labour and delivery.

The legislative and regulatory scheme is very similar across jurisdictions. This is most evident in the provisions related to the establishment of colleges, committees, councils, registration, permitted practices and the review of conduct.

All provinces impose eligibility requirements on prospective applicants. The basic requirements are similar across jurisdictions but there are some variations. For most provinces, registrants must satisfy competency requirements through the successful completion of a midwifery education program or equivalent qualifications. The proposed Nunavut legislation would allow a person who is not a graduate of a midwifery program to be registered upon completion of training or examinations. This will be beneficial to Inuit women who are not able to enroll in formal midwifery programs. The Manitoba and Ontario regulations also outline specific clinical experience requirements.

In most jurisdictions, it appears that if the registrant can satisfy the board or committee that he or she is qualified to practice, registration will likely be granted. In Alberta, competence may be demonstrated by being registered with a profession in another jurisdiction that has similar competence requirements.

Most provinces are fairly flexible in allowing for different classes of registration. The Alberta, Manitoba, Nunavut and Ontario legislation allows for temporary registration. The proposed Nunavut legislation and the Manitoba statutes permit the registration of non-practicing midwives. The Ontario registration system is perhaps the most comprehensive of all of the provinces, allowing for three classes of registration: general, student and supervised practice.

In Québec, a permit is granted to a midwife who is certified to practice under the perinatal project at the Centre de santé Inuulitsivik. These midwives can only practice in a centre operated by the institution administering the project.

In Alberta, Manitoba and Québec, there is a requirement that midwives carry professional liability insurance as a condition of registration. As a result, the cost of insurance may be prohibitive for Aboriginal midwives. In Ontario, this requirement may be satisfied by being a member of the Association of Midwives.

In all jurisdictions, an application for registration may be refused and the midwife may apply for a review of this decision.

Permitted Practices

The scope of practice in all jurisdictions is also similar. Detailed information regarding practices and medication that may be administered are set out in the regulations. Midwives are permitted to care for women during *normal* pregnancy, labour, delivery and post-partum. The legislation does not define what "normal" means and appears to place the authority to define the scope and availability of midwifery services in the hands of the medical profession.[11]

Midwives also provide counseling and support, prescribe and administer drugs and conduct screening and diagnostic tests. If medical conditions arise that are beyond the scope of permitted practices, the midwife must consult with a physician and may be required to transfer primary responsibility for care to the physician.

Practice Audits

Practice audits are usually conducted to ensure compliance with the relevant legislation and applicable regulations and standards of professional conduct. The procedure for conducting practice audits and degree of power afforded to investigators varies across jurisdictions.

In some jurisdictions, such as Nova Scotia and the Northwest Territories, there are no formal practice audits. Investigation is generally carried out for matters that have been referred to the Registrar through the complaints process. In Québec, a council of midwives or a midwifery

---

[1] Elizabeth Massey (1993). *By Her Own Authority: The Scope of Midwifery Practice Under the Ontario Midwifery Act, 1991*. 31 Alta. L. Rev. 349.

services coordinator will assess the quality of the acts performed by the midwife and make recommendations.

In Alberta, British Columbia, Manitoba, Nunavut and Ontario, the process is more formal. An investigator is authorized to enter and inspect the premises of the midwife and require the production of records. A warrant is generally not required for the audit; however, most statutes provide that the audit must occur at a 'reasonable time'. In Alberta, notice is required and consent must be obtained if a practice visit is required.

In Ontario, the College of Midwives of Ontario makes a random selection of the names of members required to undergo a practice audit. Ontario is unique in that it requires members to provide the committee with information relating to the care upon request. Midwives in Ontario must participate in continuing education and professional development, peer case reviews, quality of care evaluations and self-assessments.

Review of Conduct

In all jurisdictions in which midwifery is regulated, there is a mechanism in place to deal with complaints and the review of conduct. Complaints about the conduct of a midwife must be made in writing to the governing body. The matter will then be investigated and a determination will be made. The committee responsible for complaints is given fairly wide discretion in its decision-making powers. This includes reprimand, suspension, fines, and the imposition of conditions on practice. Some provinces encourage resolution and the use of alternative dispute resolution.

Throughout the complaints process, the midwife is entitled to receive notification and has the right to appeal a decision of the committee. The matter could escalate to the point where a hearing may be held before a panel and, ultimately, may be appealed a court.

The British Columbia *Health Professions Act* places upon health professionals a duty to report to the registrar if they believe that another health professional is incompetent, has engaged in sexual misconduct or is suffering from an ailment that impairs their ability to practice.

The Northwest Territories *Midwifery Profession Act* is unique in that it provides examples of behaviour that constitutes unprofessional conduct. Unprofessional conduct includes:

demonstrating a lack of knowledge, skill or judgment, conduct that is detrimental to the best interests of the public and conduct that contravenes the Act or regulations.

Recognition/Accreditation

> *"Inuit midwives have been practicing it for thousands and thousands of years. Why not continue it? Why should we have to be so dominated by this Western system and not practice our own ways? We have survived for over five thousand years. Why not learn from the Inuit midwives? Doctors and non-Inuit midwives know a lot: traditional midwives and Western midwives working together is the best way. They can embrace each other's knowledge and experience. Why not? Why should we have to be cut off when they have over 5,000 years of knowledge and experience? Why? Just so that their knowledge can be upper and bigger? No. They want to work together. This is what inspires me" (*Melanie Paniaq, Pauktuutit Inuit Women of Canada).

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

> *"For me, in terms of being a midwife...[it] is how I relate and inform myself through going to that birth, or working with that woman … where are we at with the moon right now? What is going on outside? Is it snowing? Is there a storm? What's happening? I totally trust my intuition to guide me forward spiritually in terms of where that woman is at, in addition to what she is telling me. And I am taking every aspect of that into account when working with that woman. So being a midwife to me is a very deeply spiritual path and I am always honoured to be at the births I have been welcomed to be at"* (Ellen Blais).

In some nations, birthing practices were shared and midwifery was not viewed as a profession with specialized education and training. For these reasons, some Aboriginal midwives and

pregnant women see the medicalization of childbirth as yet another manifestation of colonization.

> *"There's a common misconception in Ontario that Aboriginal midwives are not able to enter the registered model of midwifery and that their only practicing under the Aboriginal model because it's the only model that they were able to practice under. But that's definitely not true, even for myself having been in a registered model, I chose to give up my registration to practice under the Aboriginal model. It's an issue of autonomy, it's an issue of not having to be regulated by a government College of Midwives, by not having to be told how you're going to practice or....... some outside government body to create your policies, your procedures, to provide really definite direction into how your going to provide care to your people. The women who practice here at the centre, they believe that it's our right as Aboriginal people to provide care to our own community members. They're the ones that direct and guide us on how we should practice and provide midwifery care. It's not an outside body.......We are Aboriginal midwives because we choose to practice under the Aboriginal midwifery model and we choose not to be registered. It's definitely not a lesser than model.... It's a model that works for our people and our community and we believe it's a superior model for Aboriginal communities"* (Julie Wilson).

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

Midwifery in the Community

> *"I think it was the grassroots that started the whole movement of midwifery among European women, and that is where it bubbled up from. It was women and midwives who were trained from other countries, or nurses who were fed up with what was going on. It was grassroots that started things along the Hudson's Bay coast, and it was grassroots that started things in Six Nations, and it is because of all those grassroots people that I got to go to school and become a midwife and learn this. So it really, really is important. The people need to want it, and to understand it. And they don't need to understand midwifery completely but they need to know they want something different for their families. That is part of the whole healing. A lot of people don't even know what it is they are missing, because it has been gone so long. But once they start to get it back, that memory comes back. And then people start to cry. Ladies that were taken away from their families to have their babies, and didn't have their partner there, or their grandmother and all of that kind of stuff, they start to cry and we know with tears that that is healing"* (Carol Couchie).

Community support for midwifery is key to the discussion of bringing birthing back to communities. Infrastructure and other components are as important, but if you do not have the support or will of the community, the success of the program will be compromised. This section looks at some of the main issues that communities may encounter and will need to address in order to begin the journey towards bringing midwifery back to their home places.

In her operational definition of maternal child health care, Dawn Smith describes the context for community maternal care:

> *"Maternal child health care includes interventions at individual, family and community levels aiming to improve capacity for safe and health pregnancy, birth and transition to parenting. It occurs from the preconception period until several months past birth, when women, infants and families are integrated effectively with early childhood programs and services. Women of childbearing age are the key targets for programs and interventions, but neonates, and infants, families and communities are also the foci of interventions."*

In her paper, Smith stresses the need for maternal child health care to include: community control or involvement; cultural safety or appropriateness; the opportunity to develop a trusting relationship with a primary care giver; and include home visiting as a multiple intervention approach (2002).

Collaboration

> *"*[People say] *we don't do obstetrics on a regular basis and we don't feel confident providing obstetrical care when we see a birth once every couple of years. You cannot keep your skills up with doing so little obstetrics. And that is what is happening in a lot of northern communities and remote communities… a lot of professionals are losing their skills, because they are not doing obstetrics any more. So having a professional who is well trained and has great skills in obstetrics is a big asset. Because you will always have pregnant women in communities… When you are working in a remote region it is extremely important to have a good strong team. Midwives need to work closely with their team. The midwives, the doctors the CHRs, everyone needs to work together to provide the best care to all women"* (Christine Roy).

At the 2006 Canadian Association of Midwives meeting in Ottawa, Sara Tedford Gold, John O'Neil, and Vicki Van Wagner gave a presentation entitled *Returning Birth to Remote Communities: collaboration and the roles of Inuit and non-Inuit midwives in visions for sustainable change*. In this presentation, they suggested that the concept of collaboration must be reframed within the context of community participation and ownership in Inuit communities. They asked the following questions when considering collaboration within these contexts:

What is collaboration in the context of the Inuit struggle to return childbirth to their communities?

- How does collaboration challenge notions of expertise?
- Community participation in the development of best evidence and practice guidelines?
- How can various stakeholders contribute to building local capacity for participation?
- What are community perceptions of various models of care and various providers?

- What are current barriers between community and providers?
- Who is to represent the community?
- Can stakeholders commit to a collaborative model?
- How do stakeholders foster an environment where mutual trust and respect are possible in the context of a colonialist history in the North?

The answers to these questions are not straightforward, and must be considered and addressed throughout the process of establishing a collaborative model of care within Aboriginal communities.

Sara Tedford Gold, John O'Neil and Vicki Van Wagner also identified key elements in improving continuity of maternity care in remote Nunavut communities. These focused on developing a model of maternal child health that is comprehensive, collaborative, and community based (2005). The comprehensive approach is described to "reflect a broad continuum of integrated perinatal services and begin with the development of perinatal education and resources as defined by communities." The concept of the collaborative approach can be described as being "policymakers, planners and providers must foster collaboration by recognizing and supporting the range of providers involved in maternity care." The players involved in this approach are identified as "traditional midwives, southern trained midwives, nurses, perinatal educators and resource providers, maternity care workers, Elders, and consulting physicians/obstetricians." The importance of the approach being community based emphasizes that "it must recognize the importance of place and be informed by Inuit knowledge, experience, expertise and Inuit Qaujimajatuqangit. And it must include local training opportunities and community based funding processes" (Gold et al., 2005).

A national initiative entitled the Multidisciplinary Collaborative Primary Maternity Care Project (mpc2) addresses the availability and quality of maternity services. The project focused on "multidisciplinary collaborative solutions that improve the availability of care across the continuum and build capacity in the primary maternity heath care that is woman-centered" (mcp2, 2005). The project engages stakeholders in considering alternate models of primary maternity care, and disseminates information about these, along with their guidelines and

implementation tools. mcp2 has five working groups that focus on the topics of: model development, research/evaluation, communications, and harmonization/legal. Members of these working groups sit on the National Primary Maternity Care Committee.

The following is an example of a multidisciplinary collaborative primary care model that incorporates traditional Inuit midwifery, the Inuulitsivik Health Centre in Puvirnituq, Québec.

> *"We knew because the leaders knew that things would improve for us as a community as long as we agreed with and were involved with what was going on. Because we didn't have information in those days and we knew that the professionals had that information and we needed that information to be given to us. The hospital had to be a tool for the Inuit to get the information that they need to improve their health and their lives. Every professional that came to work at Inuulitsivik, we told them, the vision and the mission of the Inuulitsivik health centre is the training of the local people. But training in a way that is useful and understandable and concrete and hands on"* (Aani P. Tulugak).

In 1986, Inuit women began the maternity program in Puvirnituq for those women who wanted to give birth in their own community, rather than in Moose Factory or Montréal. Since then, maternities have opened in Inukjuak (1998) and Salluit (2004) in the region. Midwives are the primary care givers for all women in these communities. A registered midwife works at "the Maternity", as it is popularly known, and has trained local women as community midwives. An interesting feature of this program is that a committee decides whether a pregnant woman can deliver locally or should leave for delivery. At 34 weeks, a chart review and care plan is carried out by the Perinatal Committee. The committee is chaired by a midwife, and includes student midwives, nurses, and at least one physician. The registered midwife, or a physician and a community midwife assist local births. Community midwives also provide women with useful advice on infant nutrition and postnatal care.

In its first two years, staff managed 84 per cent of 350 births in eight communities and achieved perinatal mortality rates comparable to or lower than the rates for Québec as a whole (Royal Commission, 1996). They have reduced transfers to the south from 91 per cent in 1983 to less than 9 per cent in 1998. The rates of prematurity declined from 11.7 per cent in 1983 to 7.4 per

cent in 1997. The C-section rate is also far below the national and provincial averages, showing a 2.4 per cent rate versus 23 per cent in southern Québec (mcp2, 2005).

This model is seen as the champion of Aboriginal midwifery in Canada. Their work has led this field, and they remain an inspiration for not only Aboriginal midwives, but also Aboriginal communities who are seeking to return birthing back to their communities.

One of the first steps in the pathway to revitalizing midwifery in Aboriginal communities is to make midwifery known and understood. As Carol Couchie stated above, some people "do not even know what they have been missing, it has been gone so long." Through community outreach and education about midwifery and a midwife's scope of practice, communities can then take that knowledge and begin to gain support for the necessary movement that must occur for midwifery to be successful in their community. At the same time, it is important that other people involved in health care, including health professionals and government representatives understand and know the facts about midwifery as well. There still exist a lot of misconceptions about midwifery and this is common across Canada. Because the government, health care workers, and community members are all part of this equation, it is important that everyone has the same understanding of midwifery, so that when the discussions begin for implementation, everyone fully understands and appreciates the work and contribution midwifery can bring to a community.

Community consultations are a key part of this process. As with the Cree Board of Health and Social Services of James Bay, community consultations are seen as the necessary first step in developing a plan for midwifery in their communities. These consultations combine education surrounding midwifery, as well as determining community readiness and will for midwifery.

Community Examples

Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Centre

Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Centre of the Six Nations of the Grand River was established in 1996. It offers training to Aboriginal midwives from Six Nations, and they are able to work under the exemption clause that permits them to provide services to Aboriginal families on and off reserve. The centre consists of Aboriginal

midwives and support staff and seeks to provide a balance of traditional and contemporary midwifery services and programs. The establishment and ongoing operation of the practice is community driven, and is structured so that the community is able to provide support and direction for the services that are provided at the centre. This is done through an advisory committee that guides the centre's work and activities. The committee oversees the operations of the centre, and consists of representatives from five communities, Six Nations Elected Council, and traditional community members. In addition, the centre also has a Grandparent's Council comprised of traditional Elders and leaders from the community. The Grandparent's Council provides oversees the traditional components to the programs and services of the centre, providing direction and feedback to midwives and staff.

The establishment of the centre was a community driven process. It began when key community members identified the need for the community to regain control over the birth of their people. They held a Birth Search Conference and completed a needs assessment study to clearly demonstrate the need and desire for the centre. Once this was completed, community members searched for funding and developed a proposal. In late 1995, the Six Nations Council entered into a funding agreement and the Maternal and Child Centre was established as a department within Six Nations Council Health Services. The centre is partly funded by the Ontario Ministry of Health. In 1996, midwifery training commenced and midwifery services were accessible to community family. In 2000, two women from the community received a Band Council Resolution (BCR) recognizing them as Aboriginal midwives. The Aboriginal Midwifery Training Programme accepted its first class of students, and they graduated in 2003.

Midwifery Services in The Pas, Manitoba

After legislation of midwifery in the Province of Manitoba, midwives were recruited and hired by the Regional Health Authorities as employees to provide primary care services.

In The Pas, one of the two main physicians who attended deliveries was retiring, and they sought out a midwife to replace his role as one of the two primary health care providers for pregnant women in the area. An Aboriginal midwife was hired and she began her practice, working in the town and on the reserve of The Pas with the Aboriginal and non- Aboriginal community. She is able to provide midwifery services to the community on reserve due to the fact that the nursing

station on the reserve was transferred over to the provincial jurisdiction through the 64 agreement. Since it is a provincially run nursing station, she has the jurisdiction to practice as a midwife for that community. In 2006, the first class of the Aboriginal Midwifery Education Programme was established with The Pas as one of the main teaching sites, working with the midwifery practice already in place in the area.

Seventh Generation Midwives, Toronto, Ontario

Seventh Generation Midwives (SGMT) in Toronto opened in January 2006. SGMT is a "group of midwives who offer maternity care to women from the city of Toronto, particularly those from the downtown area, and from the Aboriginal community" (www.sgmt.ca, 2008). They incorporate "traditional teaching and ceremony into prenatal care, labour and birth, and postpartum care" (Benoit et al., 2006).

In 2002, the Toronto Aboriginal Midwifery Initiative (TAMI) began. It continues the work of the Birthing committee that had been in place since 1998. TAMI is made up of midwives, midwifery students, and others who are interested in "making culturally sensitive maternity care and midwifery services more accessible to the Aboriginal community of Toronto" (www.sgmt.ca, 2008). After receiving funding for SGMT, TAMI is now an advisory committee to the midwifery practice.

Rankin Inlet Birthing Centre

The Rankin Inlet Birthing Centre was established in response to Inuit women wanting to deliver closer to their homes, families, and social networks. The centre provides low-risk obstetrical services to the women of the Kivalliq Region. Midwives provide prenatal care and attend deliveries and if necessary physicians are involved on a consultant basis. Physicians participate in weekly Perinatal Committee meetings wherein all prenatal patients are reviewed. Prenatal risks are reviewed and decisions are made whether the woman should deliver in Rankin Inlet or be referred to Winnipeg.

In 1993, the Rankin Inlet Low Risk Birthing Project started as a result of woman lobbying by women from the then Keewatin Region. The former Keewatin Regional Health Board and a Federal Government NHRDP Grant funded a three-year project. The project granted low risk

pregnant women the choice to give birth at the birthing centre in Rankin Inlet with midwives from the south. A maternity care worker was also hired with the intent to assist the midwives and to participate in a future training program for Inuit midwives. As shown above in Section Three, the Maternity Care Worker Certificate Program and Midwifery Training is actively taking place today.

The Project was incorporated in 1996 into the health care system as a new program and became known as the Rankin Inlet Birthing Centre and is now part of the new health centre in Rankin Inlet. Since 1996 there has been an ongoing difficulty to recruit and retain midwives, delaying the opportunity for expansion and program development.

In March of 2005, there was renewed activity to fulfill the recommendations from the project and stable staffing was in place which made it possible to move forward again. A Midwifery Implementation Committee has also been formed to examine and plan the expansion of midwifery services in Nunavut.

Echoes from the Mainstream

> *"I try to keep alive the work that my grandmother did, she who delivered me in her big white iron bed at her farmhouse, and who learned what she knew from her mother. I'm third or maybe even fourth-generation midwife in my community. I'm delivering babies to children of babies my grandmother delivered, and so the continuity of that is very meaningful"* (Katsi Cook *in an interview authored by Wessman and Harvey*).

It stands to reason that the basic elements of good maternal care will be similar across cultures. The words of Katsi Cook and other Aboriginal midwives within this document are echoed in the Canadian Model of Midwifery Practice, identified in *Canadian Competencies for Midwives*, published by the Canadian Midwifery Regulators Consortium (2006). The key elements of the Canadian Model of Midwifery Practice are described as follows:

Health and Well-being: Midwifery care in Canada is based on a respect for pregnancy and childbirth as normal physiological processes. Midwives promote wellness in women, babies, and families, taking the social, emotional, cultural and physical aspects of a woman's reproductive experience into consideration.

Informed Choice: Canadian midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner.

Autonomous Care Providers: Canadian midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients. When midwives identify conditions requiring care that is outside of their scope of practice, they make referrals to other care providers and continue to provide supportive care. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care.

Continuity of Care: Canadian midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualized care. Individual or small groups of midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A midwife known to the woman is available on-call throughout her care.

Choice of Birth Setting: Canadian midwives respect the right of each woman to make an informed choice about the setting for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals.

Evidence-based Practice: Canadian midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care (Canadian Midwifery Regulators Consortium, 2006).

In the development of any midwifery program or practice, these are powerful principles to consider.

Jurisdiction Issues

> *"I think there is a responsibility there. As a native woman, who is on the front lines, looking after Aboriginal women every day, there is a responsibility of the federal government to pay attention to the fact that we have a very high morbidity and mortality rate in our communities. It is like a fourth world. Not quite, but Canada should not have*

morbidity and mortality like we do in our communities. Bottom line. And we need to develop leadership in this area of looking after women and children. To have a post-colonial vision of what our families could be. To bring back that memory. If I wanted to talk about ceremony or sacredness, all the things that make people feel good about who we are as native people, it should be that kind of vision. And the federal government should be taking some leadership and some responsibility in going there with us. They need to listen to what we are asking them for. Especially when it is good, and it might solve a few problems, and we have research that says it is solving problems for the last 15-20 years" (Carol Couchie).

Jurisdictional issues are perhaps the trickiest part of the puzzle that is midwifery, and trying to acquire midwifery services in communities. Primary health care is mainly the responsibility of the provincial and territorial governments, while for First Nations, reserves are federal, and most primary health care is under the jurisdiction of the First Nations and Inuit Health Branch, of Health Canada. For Métis, even though they are recognized federally as Aboriginal People, they have no Métis-specific rights to federal services. As a result, primary health care is accessed by Métis through the provinces, with little funding devoted to Métis-specific health needs. The situation differs from province to province, and community-to-community, so it is important to find out where the primary care of a community lies, and how midwifery services may be incorporated into the primary care system in place there. There are also other agreements in place, that are unique to certain communities or regions in Canada, so it is important to understand if your community has some kind of health transfer agreement, and if midwifery can be added to the agenda of primary care services for your community.

For federally run nursing stations, there is an issue of midwives working for FNIHB, since they do not hire midwives. This issue was brought up during the Aboriginal Women and Girl's Health Roundtable held at NAHO in 2005. This was articulated in the Final Report as:

"…Developing an action plan must begin by recognizing that midwives need to be employable. The following issues were identified as barriers to employability:

- FNIHB does not hire midwives. Therefore there are no Health Human Resources strategies, and no pay scales.

- Job descriptions and skills need to be transferable.
- Jurisdictional issues impose barriers to practice.

A first step to removing these barriers would require a commitment from FNIHB to collaborate with assigned individuals or teams to negotiate transferable job descriptions and salary ranges for midwives" (NAHO, 2005).

Some nursing stations are run provincially, and are staffed by Regional Health Authorities (RHA). If you live in a province where midwives are employed by RHAs and the nursing station is run by the province, then it is possible to have a provincially funded midwife working in your community.

At present, Norway House, one of the two sites of the kanaci otinawawasowin Baccalaureate Program (KOBP) is seeking to establish a midwifery practice in the community. The community had to go through an extensive application process to be chosen as a teaching site for the program. Chief and council also passed a Band Council Resolution (BCR) stating their support for midwifery to return to the community. The community presently has a federally run hospital. The RHA (who employs the Aboriginal midwives) and FNIHB are currently drafting an MOU to work out the agreement and logistics of having midwifery care in the community. One of the lessons learned in this process was to make sure that the legal representatives of both parties be fully informed and participants of this process from the onset. While this has been a long and tenuous process, all parties are confident that once the details have been worked out, this agreement will serve as a model for other First Nations to access midwifery care in their communities.

Evacuation Protocols

"It started changing when the nurses arrived because they started sending women for child birth, like away from their communities. You had to have your baby in the nursing station or you had to go down south. They felt powerless after" *(Nellie Nungak).*

The issue of evacuation of pregnant women from rural and remote communities is integral to the discussion of midwifery for Aboriginal populations. An overview of the current status of

maternal and child health care in Aboriginal communities was carried out in August 2002 by Dawn Smith.

Smith identified that the cornerstone of maternal child health care for Aboriginal communities has been the medical evacuation of women from remote, isolated, and semi-isolated communities to tertiary care centers at 36 weeks. The women give birth in major urban areas, separated from their families and communities. Smith demonstrated that the following evidence does not support the practice of evacuation:

- When women are separated from the support of families and friends, there is an increase in small, premature infants, as well as maternal and newborn complications, even though the majority of women have come to maternity centers with a good standard of care (Kornelson et al., 2005; NAHO, 2005; Klein et al., 2002a).
- Postpartum depression is more likely in women experiencing high stress and low support during the perinatal period (Armstrong et al., 2000).
- The ability to successfully establish breastfeeding may be compromised.
- Family relations are strained and paternal attachment during the critical first week is negatively impacted (Armstrong et al., 2000).
- Communities and extended families are denied the opportunity to celebrate birth.

The Rural Maternity Care Research Group at the University of British Columbia, headed by Dr. Jude Kornelson and Dr. Stefan Grzybowski, discusses in detail the issues surrounding rural maternity care and the policies of evacuation into referral communities. In their 2005 report, *Rural Women's Experiences of Maternity Care: Implications for Policy and Practice*, they detail the policy and research issues surrounding sustainable rural maternity care. In their discussion, they explore the topic of risk assessment and management in maternity care, and how this develops into policy and practice in maternity care, especially the issue of birthing in remote communities. They conclude that while "risk assessment is a useful tool for truly high-risk situations, its efficacy is questionable at best when applied broadly to parturient women" partly because of a "lack of understanding of how psychosocial factors support or detract from the course of pregnancies."

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

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

The Society of Obstetricians and Gynaecologists of Canada (SOGC) published a paper in March 2007 entitled, A Report on Best Practices for Returning Birth to Rural and Remote Aboriginal Communities. The report reviews "current policies in place in Aboriginal communities that recommend evacuation of all pregnant women at 36 to 37 weeks to deliver in a Level 2 hospital." The report makes six recommendations aimed at increasing opportunities for Aboriginal women to deliver within their own communities, or closer to home. These recommendations are:

- Physicians, nurses, hospital administrators, and funding agencies (both government and non-government) should ensure that they are well informed about the health needs of First Nations, Inuit, and Métis people and the broader determinants of health.
- Aboriginal communities and health institutions must work together to change existing maternity programs.
- Plans for maternal and child health care in Aboriginal communities should include a "healing map" that outlines determinants of health.
- Midwifery care and midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities.
- Protocols for emergency and non-emergency clinical care in Aboriginal communities should be developed in conjunction with midwifery programs in those communities.

- Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the community (SOGC, 2007).

Conclusions

"Birth is the fundamental ceremony of our tribes. It is the most sacred ceremony that we have. And it is innate in women's bodies. So nobody has to say a prayer, nobody has to smudge, nobody has to set out a rattle, or do anything. It just happens. So we have never lost it. It always happens, babies are always born, and women are always doing that, and they are caring for them. We don't have to get back birth because it has never left us, but we have to get back in control of that ceremony. We have handed over the control of that ceremony to other people, and it has to be brought back home to us" (Carol Couchie).

Review of Main Points

The current policy and practice in regard to maternity care services are:

- Not supportable in terms of a growing body of evidence.
- Inconsistent with internationally accepted "best practices" and no longer sustainable in terms of financial and human resource costs.
- The growing acceptance of midwifery in Canada and abroad presents an opportunity to address long-standing grievances of Aboriginal people concerning the evacuation of all women from their communities to give birth.

The re-establishment of maternity care services in communities, and the recruitment of Aboriginal women into the profession of midwifery, has the potential to:

- Improve birthing outcomes for Aboriginal women.
- Contribute to the self-determination aspirations of Aboriginal communities, and allow for the emergence of new models of community-based maternity care in Aboriginal communities.

Identification of Issues

Sandra Kanck, an Australian MP said in 2001, "The lack of government funding and policy commitment has eroded birth choices for women in rural and regional areas. If maternity

services have been undermined for white women, then they are almost non-existent for Indigenous women" (Kanck, 2001).

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

Need for an Enabling Environment

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

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

The Need for More Aboriginal Maternity Care Workers and Training Programs

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

Organizational Support

Currently, there is no association for Aboriginal midwives in Canada. Since 2002, national gatherings of Aboriginal midwives have been taking place. At the first meeting, the midwives identified the need for an Aboriginal Midwives Association that could:

- Validate the long tradition of Aboriginal midwifery.
- Articulate the diverse concerns of Aboriginal midwives.
- Advocate for recognition of Aboriginal midwifery.
- Educate others about the importance of Aboriginal midwifery.
- Support Aboriginal women who want Aboriginal midwifery services.

Discussion about creating a national association are still developing and no formal association has yet been created by Aboriginal midwives in Canada. The need is acknowledged and recognized; however, the form and place of the association is still in discussion.

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

There is a lack of research on Aboriginal midwifery. Until there is both qualitative and quantitative research on a substantial scale, a wider audience will not understand the nature,

value, and diversity of Inuit, Métis and First Nations midwifery. The right of Aboriginal communities (to Own, Control, Access and Possess (OCAP)) information about their peoples is fundamentally tied to self-determination and to the preservation and development of their culture. OCAP's principles apply to research, monitoring and surveillance, surveys, statistics, cultural knowledge including its creation, and management (Schnarch, 2004). For Métis, addressing the gap in Métis-specific research and programming is a necessary first step in moving towards self-determination in health, and ultimately, towards improved Métis well-being. Safe motherhood and newborn care that is culturally relevant, culturally meaningful, and competent is a basic human right and must become a priority within Canada for Aboriginal peoples. The principles surrounding this right may be articulated differently for Métis, First Nations or Inuit people, but it remains integral to the wellbeing of all Aboriginal People in Canada.

This lack of research, about Aboriginal midwifery, coincides with a lack of research in the field of Aboriginal maternal and child health. While these studies are not specific to midwifery, they certainly speak to the issues that are raised in conjunction with midwifery practice. Of the research that exists on Aboriginal midwifery, very little is specific to Métis midwifery: While some Métis midwifery knowledge and traditions have been documented, future discussions with Métis Elders will bring forward more comprehensive information. This, in turn, will provide an evidence base for developing Métis midwifery policies, programs and services, and influence greater Métis inclusion in Aboriginal health service planning.

Conclusion

In conclusion, the issues of Aboriginal midwifery today are as complex as the knowledge and histories of Aboriginal communities. It has been shown that midwifery touches issues beyond the birthing process, and has become an example of community self-determination and pride in bringing back birth and birthing knowledge into communities. It respects the ways of the ancestors, in all their power, and uses tools from western understandings of health and healing in order to provide the best care to Aboriginal families. In midwifery, there is a hopeful voice for Aboriginal people and the health of the people. When looking at midwifery, you do not have to go far to hear powerful stories that bring tears to people's eyes, and you do not have to go far to feel the strength and power that these women possess. It is a healing journey, and a hopeful one.

The development of Aboriginal midwifery in Canada is an ever-changing entity, and it is one that should be understood and honoured.

Glossary and Acronyms

AMNL: Association of Midwives of Newfoundland and Labrador.

AOM: Association of Ontario Midwives; professional organization in the province.

ANSM: Association of Nova Scotia Midwives; a provincial association of midwives.

Caesarean section: surgical birth procedure, which must be performed by a licensed physician.

CAM: Canadian Association of Midwives: the national professional association for Canadian midwives.

College of Midwives (of BC, Manitoba, Ontario): Licensing bodies for midwives in various provinces.

DONA: Doulas of North America, an international organization that trains and certifies doulas.

Doula: a Greek word, meaning “woman who serves”. Today it refers to a woman experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during, and just after childbirth. Doulas do not provide medical services, unlike midwives.

Epidural anaesthesia: practice of freezing a woman’s lower body for pain relief during childbirth.

Episiotomy: practice of enlarging vaginal opening through cutting during childbirth.

FAS/FAE: Fetal Alcohol Syndrome/Fetal Alcohol Effects, both caused by maternal alcohol drinking during pregnancy, leading to permanent physical, psychological, and cognitive damage in the fetus.

HIV/AIDS: HIV is the virus that causes AIDS, acquired immune deficiency syndrome.

ICM: International Confederation of Midwives, headquartered in the Netherlands.

IDM: International Day of the Midwife; a day of focus on international midwifery in early May of each year, promoted by the ICM.

Ikajuqti: Inuktitut word for women who assist other women to give birth.

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

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

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

MMCN: Manitoba Midwifery Consumer Network.

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

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

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

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

Pauktuutit: Inuit Women’s Association.

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

TBAs: Traditional Birthing Assistants.

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

Midwifery Education Programs in Canada

Ontario Midwifery Education Program (OMEP)

The OMEP is offered at three institutions: Laurentian University (full-time program in English or French; French stream students must be bilingual):

Laurentian University

935 Ramsey Lake Rd.

Sudbury, ON

P3E 2C6

Phone: (705) 675-4822

nwissell@nickel.laurentian.ca

www.midwifery.laurentian.ca

McMaster University (full-time program in English):

McMaster University Midwifery Education Programme

c/o St. Joseph's Hospital

50 Charlton Ave. East

Fontbonne Bldg., Rm. 613

Hamilton, ON

L8N 4A6

Phone: (905) 522-1155, ext. 5273

www.fhs.mcmaster.ca/midwifery

Ryerson Polytechnic University (part-time program in English):

Ryerson Polytechnic University

350 Victoria Street

Toronto, ON

M5B 2K3

Phone: (416) 979-5104

www.ryerson.ca/midwifery

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

University of British Columbia (UBC)

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

The first two years of study take place on the UBC campus and in the Lower Mainland. Students have clinical placements throughout BC and are placed in more than one midwifery practice. Students have to relocate for periods of three to six months to complete their clinical placements and they are responsible for travel and living expenses.

This program is currently developing strategies to recruit more Aboriginal persons into their program.

University of British Columbia

B54-2194 Health Sciences Mall

Vancouver, BC

V6T 1Z3

Phone: (604) 822-0352

www.midwifery.ubc.ca

Université du Québec à Trois-Rivières

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

Kanácí Otinawáwasowin (Aboriginal Midwifery) Baccalaureate Program

University College of the North

The Pas, Manitoba

Telephone: (204) 627-8629 or 1-866-627-8500 extension 8629.

Resources

Articles and Books

1. Armstrong, K., Fraser, J., Dadds, M. & Morris, J. (2000). Promoting secure attachment, maternal mood, and child health in a vulnerable population: a randomized controlled trial. *Journal of Pediatrics and Child Health, 36(6), 555-562*.

2. Asetoyer, C., Cronk, K., & Hewakapuge, S. (2003). *Indigenous Women's Health Book, Within the Sacred Circle: Reproductive Rights, Environmental Health, Traditional Herbs and Remedies.* Lake Andes, SD: Native American Women's Health Education Resource Center.

3. Assembly of First Nations (1999). *First Nations and Inuit Regional Health Survey: National Report*. Ottawa, ON: Author.

4. Association of Midwives of Newfoundland and Labrador (n.d.). *Current Midwifery Situation in Canada.* www.ucs.mun.ca/~pherbert

5. Association of Midwives of Newfoundland and Labrador (n.d.). *History of Midwifery in Newfoundland and Labrador.* www.ucs.mun.ca/~pherbert

6. Association of Ontario Midwives (1997). *Fact Sheet: Cost Effectiveness of Midwifery Care*. Toronto: Author.

7. Bailey, J. A. D. (2002).*The Experiences and Education of Midwives in Three Canadian Provinces: Saskatchewan, Ontario and Nova Scotia*. MA thesis for Mount Saint Vincent University, Halifax, NS.

8. Bennett, M. (2005). *Annotated Bibliography of Aboriginal Women's Health and Healing Research.* Victoria, BC: Aboriginal Women's Health and Healing Research Group. http://www.nearbc.ca/aboriginalhealth/index.php?q=records&action=view&id=3015

9. Benoit, C. (1991). *Midwives in Passage: the Modernization of Maternity Care*. St. John's, NL: Institute of Social and Economic Research.

10. Benoit, C., Carroll, D. and Rachel, E. (2006). To Watch, To Care - Stories of Aboriginal Midwifery in Canada. *Journal of Midwifery Research and Practice*, 5.

11. Benoit, C., & Carroll, D. (2001). *Aboriginal midwifery in British Columbia: A Narrative Still Untold*. In P.H. Stephenson, S. Elliott, L.t. Foster, and J. Harris (Eds.), A Persistent Spirit: Towards Understanding Aboriginal Health in BC. Vancouver, BC: UBC Press.

12. Benoit, C., & Carroll, D. (2001) *Aboriginal Midwifery in Canada: Blending Traditional and Modern Forms*. Network Magazine, 4.

13. Benoit C., Bourgeault, I., & Davis-Floyd, R. (2005). *Reconceiving Midwifery*. Montréal, QC: McGill-Queen's University Press.

14. Birch, D., and Moon, M. (February, 2008). *Program Delivery and Teaching in Norway House*. Thompson House, MB: University College of the North.

15. Briggs, J. L. (1991). Expecting the Unexpected: Canadian Inuit Training in an Experiential Lifestyle. Ethos, 19, 259-287.

16. Callaghan, H. (2001). Aboriginal Birthing Practices in Australia: Past and Present. *Birth Issues, 10 (3/4), 92-99*.

17. Canadian Association of Midwives (2007). *Dialogues on Aboriginal Midwifery: A Consultation Process*. Montréal, QC: Author.

18. Canadian Midwifery Regulators Consortium (2007). Canadian Midwifery Registration Examination: Full Implementation. Winnipeg, MB: Author. http://cmrc-ccosf.ca/files/pdf/CMREbrochureENfall07.pdf

19. Carnochang, T., & Haworth-Brockman, M. J. (2004). Midwifery in Manitoba: An Agenda for Research. *Journal of Midwifery Research and Practice*, 3, Number 1.

20. Carr, I. (2004). *Some Obstetrical History: Dying to Have a Baby – The History of Childbirth*. Winnipeg, MB: University of Manitoba, Department of Obstetrics, Gynecology and Reproductive Sciences.

21. Carroll, D. and Benoit, C. 2001. Aboriginal Midwifery in Canada: Blending Traditional and Modern Forms. *Canadian Women's Health Network Magazine, 4, 1-4.*

22. Carry, C. (2006). *Inuit Midwifery in Canada: Supporting Its Restoration through Information Sharing*. Ottawa, ON: Ajunnginiq Centre, National Aboriginal Health Organization. http://www.inuitmidwifery.ca/documents/InuitmidwiferyinCanada.pdf

23. Chamberlain, M., Barclay, K., Kariminia, A., and Moyer, A. (2001). Aboriginal Birth: Psychological or Physiological Safety. *Birth Issues, 10 (3/4), 81-85.*

24. Davis-Floyd, R. (July, 2004). *Daughter of Time: Postmodern Time.* Keynote presentation at The Midwifery Way: a National Forum Reflecting on the State of Midwifery Regulation in Canada, Halifax, NS.

25. Douglas, V. K. (2006*). Childbirth among the Canadian Inuit: a review of the clinical and cultural literature*. Oulu, Finland: International Union for Circumpolar Health and the Nordic Society of Arctic Medicine.

26. Ekho, N. (2000). *L'éducation Des Enfants, Entrevues Avec Des Aînés.* Inuit; V. 3. Iqaluit, Nunavut: Nunavut Arctic College.

27. Epoo, B. and Van Wagner, V. (July, 2005*). Bringing Birth Back to the Community: Midwifery in the Inuit villages of Nunavik.* ICM 27th Congress, Brisbane, Australia. http://www.inuitmidwifery.ca/documents/200507NunavikICMkeynotefinal.pdf

28. French, V. (1986). Midwives and Maternity Care in the Roman World. In Helios Rescuing Creusa: *New Methodological Approaches to Women in Antiquity. Helios, New Series* 13, 69-84. http://www.indiana.edu/~ancmed/midwife.htm

29. George, J. (1999). No exemptions for aboriginals under new midwife law: Quebec. *Nunatsiaq News.* http://www.nunatsiaq.com/archives/nunavut990625/nvt90611_10.htm

30. George, J. (1999). Good news and bad news for aboriginal midwives. *Canadian Women's Health Network Magazine*, 2, 1-3. http://www.cwhn.ca/network-reseau/2-3/inuit.html

31. Gilmore, M. R. (1930). Notes on the Gynecology and Obstetrics of the Arikara Tribe of Indians. Ann Arbor, MI: Papers of the Michigan Academy of Science, Arts and Letters, 14, 71-81.

32. Gold, S. T., O'Neil, J., and Van Wagner, V. (2005). Examining Midwifery Based Options to Improve Continuity of Maternity Care Services in Remote Nunavut Communities (Executive Summary). Ottawa, ON: Irnisuksiiniq - Inuit Midwifery Network http://www.inuitmidwifery.ca/documents/20060309Tetfordarticlefinalshortform.pdf

33. Griers, J., (Ed.) (2003). *History of Midwifery. Nursing and Midwifery History, UK*. Sheffield, UK: University of Sheffield.

34. Health Canada (2007). *Government of Canada renews Memorandum of Understanding on Indigenous Health with the United States of America.* 2007-154. Ottawa, ON: Author.

35. Heritage Community Foundation (2008). Métis midwives and traditional healing. *Alberta Online Encyclopedia: The Métis in Alberta.* Retrieved from http://www.albertasource.ca/metis/eng/culture_lifeways/lifestyles_midwives.htm

36. Hiebert, S. (2004). *Ncn Otinawasuwuk [Receivers of Children]: Taking Control of Birth in Nisichawayasihk Cree Nation*. Winnipeg, MB: University of Manitoba. Available from the Library and Archives Canada. http://www.collectionscanada.ca/thesescanada/indexe.html

37. Houd, S., Qinuajuak, J., and Epoo, B. (2004). The Outcome of Perinatal Care in Inukjuak, Nunavik, Canada 19982002. *International Journal of Circumpolar Health, 63, Suppl. 2, 239-241*. http://ijch.oulu.fi/issues/63suppl2/ICCH12_Houd.pdf

38. Huber, K. (n.d.) *A Rebirth for Midwifery in Saskatchewan: A Comparative Study with New Zealand*. Saskatoon, SK: Native Law Centre, University of Saskatchewan.

39. Johnson, D., Jin, Y., and Truman, C. (2002). Influence of Aboriginal and Socioeconomic Status on Birth Outcome and Maternal Morbidity. *Journal of Obstetrics and Gynaecology Canada*, 24, 633-640.

40. Jones, P.M. (1893). Indian Obstetrics in Central America. *Brooklyn Medical Journal*, 7, 97-100.

41. Kanck, S. (May, 2001). Status of Women MOI. http://www.sa.democrats.org.au/Browse/StatusOfWomen.htm

42. Khan-Neelofur, D., Gulmezoglu M., & Villar J. (October, 1998). Who should provide routine antenatal care for low-risk women, and how often? A systematic review of randomized controlled trials. *WHO Antenatal Care Trial Research Group, Special Programme of Research, WHO, Geneva, Switzerland*. 12 Suppl. 2, 7-26. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9805721&do

43. Klein, M., Johnston, S. and Christilaw, J. (2002a). Health care centralization risks safe maternity care and community sustainability. *Society of Rural Physicians of Canada*. http://www.srpc.ca/Media/2002-04-03-Liverpool.html

44. Klein, M., Spence, A., Kaczorowski, J., Kelly, A. & Gryzbowski, S. (2002b). Does delivery volume of family physicians predict maternal and newborn outcome? *Canadian Medical Association Journal*, 166, 1257-1263.

45. Kornelsen, J. (2000). Pushing *for Change: Challenges of Integrating Midwifery into the Health Care System*. Vancouver, BC: University of British Columbia.

46. Kornelson, J., and Grzybowski, S. (2005). *Rural women's experiences of maternity care in British Columbia: implications for policy and practice*. Ottawa, ON: Status of Women Canada.

47. Kreiner, M. J. (2005). *Stakeholder Perceptions of Midwifery Integration into the Health Care System in Manitoba*. Winnipeg, MB: University of Manitoba. Available from Library and Archives Canada. http://www.collectionscanada.ca/thesescanada/indexe.html

48. Lynch, C. and Young, D. (1998). Doulas: Holding Women. *The Indian Health Service Primary Care Provider*, 23, 155-157.

49. MacDorman, M. F., and Singh, G. K. (1998). Midwifery care, social and medical risk factors and birth outcomes in the USA. *Journal of Epidemiology and Community Health*, 52, 310-317.

50. Maternal and Neonatal Health Program. *Best Practices*. 2002. http://www.mnh.jhpiego.org/best/

51. Miller, R. (September 2006*). Tsi Non:we Ionnakerststha Ona:grahstra' Six Nations Maternal Child Centre: A community Better Practice*. Presentation made at the 7th World Indigenous Women & Wellness Conference Vancouver, BC. Canada.

52. Milne, J. K. (2001). Human resources crisis in obstetrics and gynaecology [editorial]. SOGC News. October, 1.

53. Moffitt, P. M. (2004). Colonization: A Health Determinant for Pregnant Dogrib [Dene] Women. Journal of Transcultural Nursing, 15, 323- 330. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15359066

54. Munday, R. (2004). *Midwifery*. Epi North: the Northwest Territories Epidemiology Newsletter, 16, no. 1, 1113. http://www.hlthss.gov.nt.ca/content/Publications/Newsletters/Epinorth/2004_Vol_16_Issue_1.pdf

55. National Aboriginal Health Organization (2005). *Aboriginal Women and Girls' Health Roundtable, Final Report*. Ottawa, ON: Author.

56. National Aboriginal Health Organization (2005). *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Assessment.* Ottawa, ON: Author.

57. National Aboriginal Health Organization (2006). *Inuit Midwifery in Canada: Supporting its restoration through information-sharing*. Poster presentation. Ottawa, ON: Author.

58. Native Women's Association of Canada (June 2007). Aboriginal Women and Reproductive Health, Midwifery, and Birthing Centres. An Issue Paper. Prepared for the National Aboriginal Women's Summit, Corner Brook, NL.

59. New Zealand College of Midwives. *Midwifery Practice in New Zealand*. http://www.midwife.org.nz/index.cfm/practice

60. Nunatsiaq News (February 15, 2002). *100th baby born in Inukjuak.* http://www.nunatsiaq.com/archives/nunavut020215/news/nunavik/20215_2.html

61. Ootoova, R. (1994). No title (interview with Martha Akumalik) Trans. P. Quassa. Pond Inlet, NWT: Pond Inlet Oral History Project.

62. Ontario Aboriginal Health Advocacy Initiative (2003). *The Midwifery Act. In Resource Manual*. Toronto: Ontario Federation of Indian Friendship Centres. http://www.ofifc.org/oahai/resorcemanual.html

63. Owens, J. G. (1892). Natal Ceremonies of the Hopi Indians. *Journal of American Ethnological Archeology*, 2, 163-175.

64. Page, L. A. (2000). Midwifery in Canada: A New Midwifery for the New World. Originally published by the International Confederation of Midwives in *International Midwifery*, 13, 6-7.

65. Parker, J. D. (1994). Ethnic Differences in Midwife-Attended US Births. *American Journal of Public Health*, 84, 1139-1141.

66. Parkland Memorial Hospital School of Nurse Midwifery (2000). *History of Midwifery in the U.S.* Dallas, TX: The University of Texas Southwestern Medical Center.

67. Paulette, L. (1995). Midwifery in the North. *Research study prepared for the Royal Commission on Aboriginal Peoples*.

68. Pauktuutit Inuit Women of Canada (n.d.) *Poster presentation: Midwifery - Traditional pregnancy and midwife practices*. Ottawa, ON: Author.

69. Peters, Y. (2006*). Aboriginal Midwifery Education Program. Project Summary*. Ottawa, ON: Health Canada.

70. Royal Commission on Aboriginal People (1996). *Gathering Strength, Vol. 3, Final Report*. Ottawa, ON: Author.

71. http://www.ainc-inac.gc.ca/ch/rcap/sg/sim2_e.html

72. Safe Motherhood Inter-Agency Group (2002). *Skilled Care During Childbirth; Information Kit*. http://www.safemotherhood.org/

73. Schnarch, B. (2004). Ownership, Control, Access and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities. *Journal of Aboriginal Health*. Ottawa, ON: National Aboriginal Health Organization. http://www.naho.ca/firstnations/english/pdf/OCAP4.pdf

74. Scurfield, C. M. (2002). Midwifery Legislation in Manitoba. Winnipeg, MB: University of Manitoba. Available from Library and Archives Canada. http://www.collectionscanada.ca/thesescanada/indexe.html

75. Shroff, F. M. (Ed.) (1997). The *New Midwifery: Reflections on Renaissance and Regulation*. Toronto, ON: Women's Press.

76. Simpson, J. K. (1892). Midwifery Among the Alaskan Indians. *Occidental Medical Times*, 6, 61-62

77. Smith, D. (2002). *Comprehensive Maternal Childcare in First Nations and Inuit Communities*. Ottawa, ON: First Nations and Inuit Health Programs Branch, Health Canada.

78. Society of Obstetricians and Gynaecologists of Canada (2007). *An Aboriginal Birthing Strategy for Canada*. Ottawa, ON: Author.

79. Society of Obstetricians and Gynaecologists of Canada (2007). *A report on best practices for returning birthing to rural and remote Aboriginal communitie*s. Report No. 188. Ottawa, ON: Author.

80. Society of Obstetricians and Gynaecologists of Canada (SOGC). 2003. *Advances in Labour and Risk Management-ALARM* http://www.sogc.org/sogcnet/alarmpromo_e.shtml

81. Statistics Canada (2001). Aboriginal Identity Population Counts. Ottawa, ON: Author. http://www.12.statcan.ca/english/census01/products/highlight/Aboriginal/PrintFriendly.cfm

82. Tsi Non:we Ionnakeratstha Ona:grahsta', Six Nations Maternal and Child Centre (n. d.). Power point presentation available at http://www.naho.ca/french/pdf/ABirthingPlace-SixNations.pdf

83. UNICEF (1995). *End Decade Database – Maternal Mortality*. http://www.childinfo.org/eddb/mat_mortal/index.htm

84. Van Wagner, V. (2005). *Bibliography of Evaluation Studies Relating to Inuit Midwifery*. http://www.inuitmidwifery.ca/documents/200505EvalstudiesonMidwiferyfinal.pdf

85. Wagner, M. (1998). Midwifery in the Industrialized World. http://www.babycottagehealth.com/article.htm

86. Wessman, J., and Harvey, N. (2000). An Interview with Katsi Cook. *Talking Leaves*, Spring.

87. Wilson, E. (January, 2003). The Old is New Again: Diversity in Birthing Practices. Paper presented to the National Aboriginal Health Organization, Ottawa, ON.

88. World Health Organization. Ensure Skilled Attendance at Delivery. *World Health Day: Safe Motherhood, April 7, 1998*. http://www.who.int/archives/whday/en/pages1998/whd98_06.html

89. Yarrow, H. C. (1881). Medical Facts Relating to the Zuni Indians of New Mexico. *Rocky Mountain Medical Review*, 1, 192-194.

Web sites

1. Aboriginal Nurses Association of Canada
   http://www.anac.on.ca/

2. Canadian Association of Midwives
   http://www.canadianmidwives.org/

3. Canadian Association of Midwives- Aboriginal Midwifery
   http://www.canadianmidwives.org/aboriginal_midwifery.htm

4. Capers Bookstore (books on family health, pregnancy, birth, fertility, midwifery, breastfeeding, etc.)
   http://www.capersbookstore.com.au/

5. Irnisuksiiniq - Inuit Midwifery Network
   http://www.naho.ca/inuit/midwifery/index-e.php

6. International Confederation of Midwives, Netherlands
   http://www.internationalmidwives.org/

7. Midwives Coalition of Nova Scotia
   http://www.mcna.chebucto.org/

8. Midwifery Education Accreditation Council, US
   http://www.meacschools.org/

9. Multidisciplinary Collaborative Maternity Care.
   http://www.mcp2.com/

10. Ontario Midwife Education Program, McMaster University
    http://www.fhs.mcmaster.ca/midwifery/

11. Ontario Midwife Education Program, Laurentian University
    http://www.midwifery.laurentian.ca/

12. Midwifery program, University of British Columbia
    http://www.midwifery.ubc.ca/

13. Midwifery Today (Publications about midwifery)
    http://www.MidwiferyToday.com/

14. Ontario Midwife Education Program, Ryerson Polytechnic University
    http://www.ryerson.ca/midwifery/

15. World Health Organization-The International Definition of a Midwife
    http://www.who.int/reproductive-health/mpr/rhr_02_17_11.html

Videos

1. *The Helper,* a video about traditional Inuit midwifery, including footage of a contemporary birthing facility that integrates Inuit midwifery practices. In Inuktitut, although a version with English subtitles is available.

Contact Pauktuutit

> 131 Bank Street, 3rd Floor
> Ottawa, ON
> K1P 5N7
> Phone: 613-238-3977

2. *What Midwives Do*, a 15-minute video produced by the Midwives Coalition of Nova Scotia, available for $16.00. Contact: Catherine Berry, PO Box 33028, Halifax, NS, B3L 4T6, phone: 902-429-5112, email: cjberry@netcom.ca

3. *Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities*. Aboriginal Nurses Association of Canada and Planned Parenthood, 2002. Part 2 – Sexual and Reproductive Health Issues of Concern to Aboriginal People – is particularly relevant. A Web version of the sourcebook is available at www.anac.on.ca/sourcebook

4. *Paths to Becoming a Midwife: Getting an Education*, is available through www.MidwiferyToday.com, although it is for a U.S. readership.

5. *Bringing It All Back Home for Community Health* : video. Rankin Inlet, Nunavut. Toronto : Health Council of Canada, 2006.Website: http://healthcouncilcanada.ca/videos/2006/Rankin_Inlet2006.wmv

6. *Birth Rites*. Video. Birth Rites draws powerful comparisons between birth in outback Australia and the icy regions of Canada. These two indigenous cultures have a shared history of dispossession as well as social and health problems. Both countries have routinely evacuated women from their hometowns to birth alone in far away hospitals. The Inuit midwives have made a breakthrough with the first Inuit controlled Birth Centre in remote Puvirnituq (Canada). In Australia, the women's stories expose for the first time the devastating personal and cultural repercussions of this "separation policy". JAG1 Films Pty Ltd. To order: PO Box 53 Margaret River Western Australia 6285 PH: 08 9758 7404 FAX: 08 9757 3180 jagfilms@westnet.com.au

7. *Ancestral Women*. Video. Christine Roy, a Canadian midwife embarks on a journey that starts in Bolivia, meeting fellow Quechua and Aymara midwives. She will find an ancestral knowledge inside the practice of this beautiful task. It is a marvellous trip, a documentary, that takes us to the very roots of the oldest most important profession in the world: Midwifery. Rosana Matecki, Producciones Kiiskakuna. Documentary 48 minutes HD Video, color Canada. 2007.

8. *Waapimaasuwin: Giving Birth in Iiyiyu Istchii*. Video. Kiiskuna productions, for the Cree Board of Health and Social Services of James Bay. Upcoming release.

Table of Midwifery Legislation in Canada, By Province/Territory

	Alberta	British Columbia	Manitoba
Definition/references to Aboriginal midwifery	No references.	The Midwives Regulation defines Aboriginal as Indian, Inuit or Métis peoples. Aboriginal midwifery is defined as traditional aboriginal midwifery practices, contemporary aboriginal midwifery practices and a combination of the two.[1]	A standing committee advises the College of Midwives of Manitoba on issues related to midwifery care to Aboriginal women. [2]
Registration of midwifery	Applicants must provide evidence of competence by fulfilling education and experience requirements, completing examinations or holding a certificate/ diploma. Competence may also be demonstrated by being registered with a profession in another jurisdiction recognized by the regulations or the council that has similar competence requirements. Other requirements include meeting citizenship and good character requirements and obtaining professional liability insurance.	Registration must be granted to everyone who applies, satisfies the registration committee that he or she is qualified, and pays the fee. The registration committee may refuse to grant registration or impose terms and conditions. An applicant may apply to the board for a review if their application has been refused.[1]	Registration is granted upon meeting competency requirements, establishing that the person's name has not been removed from a register for the practice of midwifery in Canada or elsewhere, establishing that he or she has not been suspended, and paying a fee. An applicant must have successfully completed a midwifery program of studies and an assessment process. The Midwifery Regulation also outlines the specific clinical experience requirements for registration. Students enrolled in a midwifery education program may be registered provided they pay the

[1] Midwives Regulation B.C. Reg. 265/2005, s.1.

[2] *Midwifery Act,* C.C.S.M. c. M125., s.8(5).

[1] *Health Professions Act,* R.S.B.C. 1996, c.183, s.20.

	Temporary registration may be granted for a period of one year if it is considered to be appropriate. Midwives are required to carry professional liability insurance with an insurer acceptable to the Health Disciplines Board. The registrar must give reasons for its decision if an application is refused, deferred or limited and the applicant may request a review.[1]		fee and meet any other requirements. Applicants who are qualified to practice in another province are eligible for temporary registration. Non-practising midwives may be registered if they meet the eligibility requirements but do not intend to practice midwifery in the three-month period after the date of application. Applicants have a right to appeal a refusal of registration.[3]
Exceptions	No references.	Aboriginal midwives who practiced aboriginal midwifery prior to the regulation coming into force are exempt from registration.[4]	No references
Permitted practices	Midwives may provide comprehensive prenatal, labour, birth and postpartum care for normal pregnancies, counselling, education, support and other activities as set out in the regulations. Some of the practices provided for in the Midwifery Regulation include assessments, perform screening and diagnostic tests and prescribe and administer drugs.[5]	The Midwives Regulation outlines the scope of practice to be performed by the midwife and imposes various limitations. Permitted practices include caring for women during normal pregnancy, labour, delivery and post partum, counselling and support, conduct internal examination, administer drugs, and conduct screening and diagnostic tests.[1]	Midwives may prescribe drugs, perform minor surgery, and order diagnostic and screening tests. A midwife may engage in the practice of midwifery as a primary health care provider and have direct access to clients. They can also consult with other health care providers.[2]

[1] *Health Professions Act*, R.S.A. 2000, ss.28, 30, 31; Midwifery Regulation, Alta. Reg. 328/1994, ss. 2, 3, 4.

[3] *Supra* note 2 at ss. 12, 13, 16; Man. Reg. 68/2000, ss. 4, 6, 7, 8, 9.

[4] *Supra* note 1 at s.5(2).

[5] *Supra* note 3 at s.3 (*Health Professions Act*), s.8 (Midwifery Regulation).

Practice Audits	A council must establish a continuing competence program for the maintenance of competence and enhancement of professional services and may provide for practice visits. If a practice visit is required, notice must be given and consent must be obtained.[3]	Inspectors may be appointed by the inquiry committee to inspect the premises, records and practice of a health professional without a court order. The inquiry committee may authorize a person to enter premises, require production of records, assets, etc. and seize records, assets, etc.[4]	A practice auditor may review the operation of a midwifery practice and report his or her findings to the registrar. The auditor may conduct the inspection at a reasonable time and, without a warrant, may enter the office of a midwife to determine compliance with the Act, require production of records and remove items for examination. A court order may be obtained if there has been an unsuccessful attempt to enter the premises or there are reasonable grounds to believe that entry would be denied.[5]
Review of conduct	The practice review committee may conduct a review of the practice of a midwife and refer the matter to the Midwifery Committee if there are competence problems or the midwife does not cooperate. The referral is treated as a complaint. Complaints may be made in writing to a complaints director. Some of the actions that a complaints director may take upon receipt of	Complaints must be made in writing to the registrar who then provides an assessment to the inquiry committee. The inquiry committee will investigate the matter and take any action it considers appropriate. If the midwife fails to comply with a direction given by the inquiry committee, a discipline committee hearing may be held. The Act provides various powers to the discipline committee such as	Midwives are expected to comply with the standards of practice concerning transfer to a physician, out-of-hospital births, in-hospital births, record-keeping and continuing competency. A complaint is made in writing to the complaints committee that will then conduct an investigation. The complaints committee is given fairly wide discretion in determining what action should be

[1] *Supra* note 1 at ss.4, 5, and 6.

[2] *Supra* note 2 at s.2(2); *Supra* note 5 at s.12.

[3] *Supra* note 3 at ss.50, 51(3) and (4).

[4] *Supra* note 1 at ss.28, 29.

[5] *Supra* note 2 at s.53(2) and 54.

	a complaint include: encouraging resolution; referring the matter to an alternative dispute resolution process; conducting an investigation; and dismissing the complaint. Investigators are given fairly broad powers in carrying out an investigation. All parties must be notified at every stage in the proceedings.[1]	cancelling the registration, reprimanding the registrant and imposing a fine. The registrant may appeal a discipline committee decision to the Supreme Court. Health professionals have a duty to report to the registrar if they believe another health professional is incompetent, has engaged in sexual misconduct or is suffering from an ailment that impairs their ability to practice.[2]	taken. The matter may be referred to the inquiry committee for a hearing.[3]

[1] *Supra* note 3 at 51.1-72 (*Health Professions Act*); *Supra* note 5 at ss.11 and 12.

[2] *Supra* note 4 at ss.32-40.

[3] *Supra* note 2 at ss.18-26, 34, 42, 43(1); Supra note 5 at s.15.

	New Brunswick	Newfoundland & Labrador	Nova Scotia
Definition/references to Aboriginal midwifery	Currently no midwifery legislation.	No midwifery legislation. There is a long-standing agreement between the provincial government, the Newfoundland Medical Board and the Association of Registered Nurses.	No reference.
Registration of midwifery			Applicants must have a bachelor's degree in a Canadian university midwifery program or equivalent educational qualifications. The Registrar will not grant registration if not satisfied that applicant meets the requirements. Notification of the refusal is provided in writing and the applicant has an opportunity to appeal. [1]
Exceptions			No reference.
Permitted practices			Practices include monitoring and assessment of the mother and baby throughout all stages of pregnancy and delivery, invasive procedures and screening and diagnostic tests.[2]

[1] *Midwifery Act*, S.N.S. 2006, c.18, ss. 15, 18, 19(3). This Act has not yet been proclaimed in force. It is scheduled to be proclaimed in the spring of 2008.

[2] *Ibid*. at s.2, 31.

Practice Audits			There are no formal practice audits. However, the Registrar may investigate matters referred by the Council as well as matters for which written complaints have not been filed. The midwife may be required to submit to a physical or mental examination, produce records and submit to an audit or investigation.[1]
Review of conduct			The Registrar investigates complaints and decides on the appropriate course of action. The registrar may suspend a member or impose restrictions if it receives information that the member is incompetent, guilty of professional misconduct or if it is found to be in the public interest. The matter may be referred to a panel for a hearing.[2]

[1] *Ibid*. at s.38.

[2] *Ibid*. at ss.38-55.

	Nunavut	Northwest Territories	Ontario
Definition/references to Aboriginal midwifery	Registration is not required if a person practiced traditional Inuit midwifery before the coming into force of the Act. Traditional Inuit midwifery is not defined.	No reference.	The *Regulated Health Professions Act* (RHPA)[1] does not apply to Aboriginal healers and midwives providing care to Aboriginal communities.
Registration of midwifery	A midwifery registration committee is to be established to review and decide applications for registration. Eligibility requirements include good character, Canadian citizenship, and midwifery education. Midwives are required to carry professional liability insurance. There is also the opportunity to obtain a non-practising certificate or a temporary certificate. The temporary certificate cannot exceed 90 days. An applicant who is not a graduate of a midwifery program is eligible to be registered in the Midwifery Register and receive a general certificate if he or she completes training or examinations required by the Committee and consents to terms and conditions on their certificate. Registration is not required if a person practiced traditional Inuit midwifery before	Applicants must have a degree, diploma or certificate in midwifery, be of good character, competent, have a satisfactory professional reputation and be registered or eligible to be registered in another province. Annual renewal of a certificate is granted if the applicant holds valid certification in adult and infant cardiopulmonary resuscitation and neonatal resuscitation. If an application for registration is refused, written notice and reasons must be provided. The applicant may appeal the refusal to the Supreme Court. A registered midwife is required to carry professional liability insurance.[2]	The Regulation provides for three classes of certificates of registration: general, students, and supervised practice. All applicants must have a bachelor's degree in midwifery, a degree or diploma from a specified program or equivalent qualifications. Applicants must also have the required clinical experience. There are other requirements specific to the class of registration one wishes to acquire. A certificate may be revoked if a member fails to carry on active practice in accordance with the specific requirements set out in the Regulation.[3]

[1] *Regulated Health Professions Act*, S.O. 1991, c.18, s.35.

	the coming into force of the Act.[1]		
Exceptions	Registration is not required if a person practiced traditional Inuit midwifery before the coming into force of the Act.[4]	No references.	There is an exception for Aboriginal midwives with respect to the use of the title “midwife”. An Aboriginal person who provides traditional midwife services may use the title “aboriginal midwife”, a variation or equivalent in another language and hold him or herself out as being a person qualified to practise in Ontario as a midwife.[5]
Permitted practices	Practices include counselling, supporting and advising women during all stages of pregnancy and the post-partum period, assessments and prescribing drugs.[6]	Practices include counselling and education, assessments, vaginal births, conducting screening and diagnostic tests, and prescribing and administering drugs.[7]	Permitted practices include assessment and monitoring during pregnancy, labour and the post-partum period, managing labour and conducting deliveries, prescribing drugs and taking blood samples.[8]
Practice Audits	Practice auditors are appointed by the Committee to determine whether a registered midwife is in compliance with	Upon receipt of a complaint, the Complaint Officer shall designate an investigator to investigate the complaint. The investigator may make oral or	Members must provide the Committee with information relating to the care given to clients

---

[2] *Midwifery Profession Act,* S.N.W.T. 2003, c.21, ss.8, 9,10,13; Midwifery Profession Act Regulations, N.W.T. Reg. 002-2005, ss.2, 3, 4, 5.

[3] Registration, O. Reg. 867/93, ss.2-5,9,10.

[1] Bill 20, *Midwifery Profession Act*, 4th Sess., 2nd Leg., Nunavut, 2007, ss. 6, 7-16.

[4] *Supra* note 21 at s.6(2).

[5] *Supra* note 20 at s.8(3).

[6] *Supra* note 21 at s.3.

[7] *Supra* note 22 at ss.2, 4.

[8] *Midwifery Act*, S.O. 1991, c.31 at 3, 4.

	the Act, regulations and standards of competence. They may, at a reasonable time, enter and inspect the office of a midwife. Inspection powers include inspecting any thing, questioning people, inspecting computers and requiring copies. The auditor's findings are reported to the Committee who is to decide on the appropriate course of action.[1]	written inquiries of any person who may have information and demand production of documents, records and other materials.[2]	upon request. Members must participate in continuing education and professional development, peer case reviews, quality of care evaluations and self-assessments. The College makes a random selection of the names of members required to undergo a practice audit. The audit may include the provision of forms and other documents, examination of records and an interview with the member.[3]
Review of conduct	A person may give notification to the Registrar that an act or omission of a midwife may constitute unprofessional conduct. The Registrar reviews the notification and refers it to the President. The President will then conduct an investigation and make a determination. In some circumstances, the President may refer the notification to an alternative dispute resolution process. The matter may be referred to the Board of Inquiry for a hearing.[4]	After an investigation is carried out, the investigator must provide a report to the Complaints Officer who will either dismiss the complaint or refer it to the Board of Inquiry for a hearing. The Continuing Competency Program for Registered Midwives in the NWT, established by the Midwives Association of the Northwest Territories and Nunavut, was adopted in the Regulation. The Code of Conduct for Registered Midwives in the NWT was also adopted by regulation. Unprofessional conduct includes engaging in	The Professional Misconduct Regulation[2] sets out acts of professional misconduct related to (1) the practice of the profession and the care of, and relationship with, clients; (2) record keeping and reports; (3) business practices; and (4) miscellaneous matters for the purpose of s.51(1)(c) of the Health Professions Procedural Code which is part of the RHPA. If a panel finds that the member has committed an act of professional misconduct, it may revoke or suspend registrations, impose conditions, require that a member appear before the panel to be reprimanded or require payment of a fine.

[1] *Supra* note 21 at ss.25-27.

[2] *Supra* note 22 at 23, 24.

[3] General, O. Reg. 240/94 at ss.9, 10, 13, 14, 15.

[4] *Supra* note 21 at 28-50.

		conduct that: demonstrates a lack of knowledge, skill or judgement; is detrimental to the best interests of the public; harms the standing of the midwifery profession; and contravenes the Act or regulations. [1]	

[2] Professional Misconduct, O. Reg. 858/93 at

[1] *Supra* note 22 at 8, 9, 17, 17(2), 25-32.

	Prince Edward Island	Quebec	Saskatchewan[1]	Yukon
Definition/references to Aboriginal midwifery	No midwifery legislation.	The *Midwives Act*[2] allows Aboriginal midwives to engage in the practice of midwifery where a Native nation, community or group of communities have entered into an agreement with the Government. The midwife is not required to be a member of the Ordre des sages-femmes du Québec. Pursuant to *An Act respecting health services and social services for Cree Nation Persons,*[3] the regional council may offer midwifery services and may enter into a service contract with a midwife.	No references to Aboriginal midwifery. In its current form, the Act only deals with administration. The sections dealing with registration and conduct have not yet been proclaimed.	No midwifery legislation

[1] *Midwifery Act*, S.S. 1999, c. M-14.1.

[2] *Midwives Act,* R.S.Q. chapter S-0.1, s.12(2).

[3] *An Act respecting Health Services and Social Services for Cree Nation Persons,* R.S.Q. c. S-5, s.63.1.

Registration of midwifery		A person who is certified to practice under the perinatal project at the Centre de santé Inuulitsivik becomes the holder of a restricted permit by the Bureau. This person can only practice in a centre operated by the institution administering the project. Midwives must hold professional liability insurance. [1]		
Exceptions		It is not illegal practice for one to practice under an agreement between the Government and a Native nation. Midwives who conduct home deliveries for Cree Native persons are excluded from the Regulation.[2]		
Permitted practices		Permitted practices include monitoring and assessing, deliveries, emergency procedures, medication, and examinations[3]		

[1] *Supra* note 37 at s.52; *An Act Respecting Health Services and Social Services*, R.S.Q. c.S-4.2, s.259.2.

[2] Regulation respecting standards and conditions of practice for conducting home deliveries, R.Q. c. S-0.1, r.2., s.

[3] *Ibid*. at ss. 6-8.

Practice Audits		A council of midwives monitors and assesses the quality of the acts performed by the midwives and makes recommendations as to the standard of care. If there is no council of midwives, the midwifery services coordinator will carry out these functions.[1]		
Review of conduct		Complaints are addressed by a local quality service quality and complaints commissioner. If there is a complaint that raises disciplinary issues, it will be brought to the attention of the department concerned, who will investigate the matter. The board of directors may take disciplinary measures including reprimand, modification or withdrawal of rights. The reasons for such action must be specified. The midwife may contest the decision within 60 days. There is also a conciliation and arbitration procedure that may be used.[2]		

[1] *Supra* note 39 at s.225.3.

[2] Regulation respecting the conciliation and arbitration procedure for the accounts of midwives, R.Q. c. C-26, r.155.4.1.