
ARTICLE

A Qualitative Assessment of Factors in the Uptake of Midwifery Among Diverse Populations in Thunder Bay, Ontario

by Helle Møller, PhD, Martha Dowsley, PhD, Pamela Wakewich, PhD, Lisa Bishop, BHSc, Kristin Burnett, PhD, and Mackenzie Churchill, HBSc

Helle Møller, PhD (anthropology), is an assistant professor in the Department of Health Sciences at Lakehead University, in Thunder Bay, Ontario.

Martha Dowsley, PhD (geography), is currently with the Department of Geography and the Department of Anthropology at Lakehead University.

Pamela Wakewich, PhD (sociology), is currently with the Department of Sociology and the Department of Women's Studies at Lakehead University and with the Centre for Rural and Northern Health Research, also at Lakehead University.

Lisa Bishop, BHSc (midwifery), is a Master of Public Health candidate at Lakehead University.

Kristin Burnett, PhD (history), is currently with the Department of Indigenous Learning at Lakehead University.

Mackenzie Churchill, HBSc, is a Master of Public Health candidate at Lakehead University.

ABSTRACT

Introduction: Although the uptake of midwifery in Thunder Bay, Ontario, is above the provincial average, it is well below the World Health Organization–suggested level. Midwifery is especially underutilized by Indigenous women and by recent immigrant, refugee, and asylum-seeking women.

Objective: To explore factors shaping birth-attendant choices and decisions of diverse women in northwestern Ontario.

Methods: Drawing on data from a larger pilot study, this paper discusses factors in choosing midwifery for Indigenous, Euro-Canadian, and visible-minority (VM) women in Thunder Bay. Using in-depth interviews, we explored where the women obtained information regarding birth-attendant options, how and why they chose their caregiver, and their perceptions of the quality of their maternal care experiences.

Results: Participating women's birth-attendant choices and experiences were influenced by (1) health care provider and/or social network awareness of (and attitudes towards) midwifery; (2) personal knowledge; (3) access to midwifery; and (4) understanding of the pregnancy as being on a medical risk continuum or as a normal, healthy process. Additional influences for VM women include a lack of formally educated midwives and social status gained through having a physician in their country of origin. Additional influences for Indigenous women were the effects of colonization, discrimination, and racism.

Conclusion: Women (particularly VM and Indigenous women), their families, and health care providers in northwestern Ontario need more and easier access to midwives and to knowledge about their services and scope of practice. Also, increased focus on antiracist and culturally safe practice in health care provider curricula would help improve care for Indigenous women.

KEYWORDS

midwifery, health care providers, Indigenous population, ethnic groups, Ontario

This article has been peer reviewed.

Évaluation qualitative des facteurs exerçant une influence sur le recours aux sages-femmes chez les diverses populations de Thunder Bay (Ontario)

Helle Møller, PhD, Martha Dowsley, PhD, Pamela Wakewich, PhD, Lisa Bishop, B.Sc.S., Kristin Burnett, PhD, et Mackenzie Churchill, B.Sc.S.

RÉSUMÉ

Introduction : Bien que, à Thunder Bay (Ontario), le recours aux sages-femmes soit supérieur à la moyenne provinciale, nous nous situons bien en deçà du niveau recommandé par l'Organisation mondiale de la santé. Les sages-femmes sont particulièrement sous utilisées par les femmes autochtones, de même que par les immigrantes récentes, les réfugiées et les demandeuses d'asile.

Objectif : Explorer les facteurs qui façonnent le recours aux sages-femmes et les décisions des femmes issues de diverses populations du nord-ouest de l'Ontario.

Méthodes : Reposant sur les données d'une étude pilote de plus grande envergure, cet article analyse les facteurs qui exercent une influence sur le recours aux sages-femmes chez les femmes autochtones, les Eurocanadiennes et les femmes appartenant aux minorités visibles de Thunder Bay. Grâce à des entrevues exhaustives, nous avons exploré (1) les sources d'information consultées par les femmes concernant les options offertes par les sages-femmes; (2) la façon dont elles ont sélectionné leur fournisseur de soins et les critères ayant guidé leur choix; et (3) leurs perceptions à l'égard de la qualité des soins de maternité qu'elles ont reçus.

Résultats : Voici les facteurs ayant exercé une influence sur l'expérience des participantes et leur choix d'une sage-femme : (1) sensibilisation aux sages-femmes chez le fournisseur de soins de santé et/ou au sein du réseau social (et attitudes à leur égard); (2) connaissances personnelles; (3) accès aux sages femmes; (4) grossesse évaluée d'après un continuum de risque médical ou perçue comme un processus normal et sain. Parmi les autres facteurs ayant exercé une influence sur les femmes issues des minorités visibles, citons le manque de sages femmes ayant fait des études officielles et le statut social que confère le recours à un médecin dans le pays d'origine. Chez les femmes autochtones, les effets de la colonisation, de la discrimination et du racisme ont également exercé une influence.

Conclusion : L'accès aux sages femmes (et à des renseignements sur leurs services et leur champ d'exercice) doit être facilité et favorisé chez les femmes (en particulier les femmes autochtones et celles qui sont issues de minorités visibles), leur famille et les fournisseurs de soins du nord-ouest de l'Ontario. De plus, le programme de formation des professionnels de la santé devrait mettre un accent particulier sur les pratiques antiracistes et sûres au plan culturel, ce qui contribuerait à l'amélioration des soins offerts aux femmes autochtones.

MOTS CLÉS

Pratique sage-femme, fournisseurs de soins de santé, population autochtone, groupes ethniques, Ontario

Cet article a été soumis à l'examen collégial.

INTRODUCTION

The midwifery model of care promotes informed choice decision-making, choice of birthplace, and continuity of care.¹ Midwifery views birth as a normal rather than pathological process.² In the 2010 Canadian Maternity Experiences Survey, 71.1% of women who were cared for by midwives evaluated their overall experience as “very positive,” whereas only 52.3%, 58.3%, and 53.6% of women under the care of an obstetrician, family practitioner, or nurse or nurse practitioner, respectively, rated their experience as similarly positive.³ Midwife-attended women more often initiate breastfeeding;⁴ experience longer, more frequent prenatal visits;⁵ are less likely to receive epidurals, episiotomies, and inductions;^{3,6} have lower rates of cesarean section, electronic fetal monitoring, and narcotic analgesia; and have higher rates of vaginal births after cesarean births.⁶ Newborn health outcomes—Apgar scores and rates of resuscitation procedures—are similar or better for births under midwifery care.^{4,6}

In addition, midwifery is cost-effective. The low rate of intervention and the accessibility of home birth afforded by midwife care can maintain or reduce costs while improving outcomes.^{7,8} Still, midwives attend only 2%–5% of mothers in Canada giving birth.⁹ Ontario was the first province in Canada to legislate midwifery and has over 50% of the country’s midwives;¹ currently, 10% of births in Ontario are assisted by midwives.¹⁰ In our case study community of Thunder Bay, a city in northwestern Ontario, the percentage is approximately 25%.¹¹ This unusually high rate may be related to the limited range of maternity care available in the city (Thunder Bay local midwifery groups, personal communication, June 2013), and while this rate is substantively higher than the provincial average, it is still, according to the World Health Organization, well below the 80% rate for women who are within the midwifery scope of practice.¹²

Historically, the quality of birth experiences and outcomes in this region has been unfavourable for women (especially Indigenous women) from remote, rural, and northern communities, as well as for immigrant, refugee, and asylum-seeking or visible-minority (VM) women and women of low socio-economic status.^{13–17} Even where midwifery services exist, Indigenous women, VM women, and women of lower socio-economic status make use of midwifery at lower rates than other Canadian women.^{2,12,14} These disparities in access to midwifery services and birth outcomes fit social justice “criteria for health inequities”; they are “not only unnecessary and avoidable, but also unfair and unjust.”¹⁵

The aim of our study was to explore the factors (including medical, social, cultural, and psychological factors) that influenced women’s selection of a maternity care provider, in order to understand why midwifery is underutilized. We chose Thunder Bay (population approximately 100,000), which provides health services to many remote communities in the region, as our pilot case study. The ethnic diversity of the city and the relatively high general uptake of midwifery services,

Helle Møller, Ph.D. (anthropologie), est chargée de cours au département des sciences de la santé de l’Université Lakehead, établie à Thunder Bay (Ontario).

Martha Dowsley, Ph.D. (géographie), est affiliée aux départements de géographie et d’anthropologie de l’Université Lakehead.

Pamela Wakewich, Ph.D. (sociologie), est affiliée aux départements de sociologie et d’études féminines de l’Université Lakehead. Elle intervient également au centre de recherche en santé des régions rurales et du Nord, également à l’Université Lakehead.

Lisa Bishop, B.Sc.S. (pratique sage-femme), est candidate à la maîtrise en santé publique à l’Université Lakehead.

Kristin Burnett, Ph.D. (histoire), est affiliée au département d’études autochtones de l’Université Lakehead.

Mackenzie Churchill, B.Sc.S., est candidate à la maîtrise en santé publique à l’Université Lakehead.

coupled with the low utilization of midwifery by VM and Indigenous women (Thunder Bay local midwifery groups, personal communication, June 2013), made it well suited for our study.

METHODS

Coming from a social justice perspective, we took an exploratory approach in this qualitative study and used purposive quota sampling to identify and interview 30 women who had given birth in the previous three years about their birth experiences and pre- and postnatal care.¹⁸ Thirteen of the women self-identified as Indigenous (n = 11) or mixed Indigenous and Euro-Canadian (EC) (n = 2), four self-identified as VM women, and thirteen self-identified as EC (n = 12) or as mixed VM and EC (n = 1). We faced several challenges in recruiting VM mothers; visible-minority people are a small proportion of Thunder Bay's population. The Thunder Bay Multicultural Association worked with us to make contact with potential participants. However, language was a barrier for some women. Other women, particularly recent refugees, were somewhat wary of participating in health-related research, perhaps because of negative experiences in their countries of origin or their experiences of medical surveillance during the immigration process.¹⁹⁻²¹ Due to size and sampling (particularly in regard to VM women), the findings from this pilot study are not generalizable. However, they are suggestive of trends and issues that should be explored in greater depth.

Eighteen women had midwives present for their births, although not all for whom midwives were present had midwife-assisted births, due to birth complications. Seven experienced a transfer of care wherein a physician or obstetrician/gynecologist (OB/GYN) assisted the birth while a midwife was present and provided postnatal care. Twelve, including all four of the VM women, did not have midwives. Participants were recruited through local Indigenous organizations, cultural associations, word of mouth, and snowballing recruitment which likely contributed to the high number of women in the sample who have had midwife-assisted births. Interviews were semi-structured, conducted usually by two team members using an interview guide and in locations chosen by the participants. An information letter and consent form were reviewed and signed by the participants prior to the interview. With permission, interviews were recorded and later transcribed. One participant declined to allow audio recording but agreed to having notes taken. Interviewees were sent transcripts for review to ensure accuracy and the participants' comfort

with the transcriptions.

The project received approval from the Lakehead University Research Ethics Board. Data were coded with NVivo software (QSR International, Melbourne, Australia).²² We used a thematic network analysis to organize our findings into basic, organizing, and global themes.²³ As in the study by Brodrick, our basic themes are represented by segments of the original text or quotations.²⁴ The organizing themes represent related clusters of quotations, and the global themes are a way to synthesize the lower groupings. Reliability was ensured through intercoder agreement, which involved all team members participating in reading, coding, and analyzing transcripts.¹⁸

In this report, interviewees have been given pseudonyms for anonymity. When relevant, a demographic group identifier ("EC" for Euro-Canadian and "VM" for visible minority) is used. Indigenous women include First Nations, Métis, and Inuit women.

FINDINGS

Our analysis revealed three global themes: (1) care provision from a risk-centred perspective, (2) access to midwifery services, and (3) care provision from a woman-centred perspective (Table 1). Organizing themes were most frequently related to the woman's knowledge and attitudes about midwives, the woman's primary health care provider, or the woman's social network.

Care Provision from a Risk-Centred Perspective

Whereas a biomedical concept of risk is used to triage patients in health care, the assessment of risk is multidimensional and is shaped by social and cultural values and by expectations of "good" or "responsible" motherhood.²⁵ It is conceptualized on a continuum, depending on the health care provider and the mother's social location and previous experiences.²⁶ Several of the interviewed women (particularly the VM and EC women) and their social networks framed pregnancy and birth as inherently risky and espoused the view that maximum obstetric care should be the goal of the pregnant woman. The framing of birth as risky by the pregnant woman and her social network are two of the organizing themes of this section. The third organizing theme originates with the primary care practitioners who set the stage for viewing birth as degrees of risk. Although their motives vary, physicians influence the perception—by women and their social networks—of pregnancy as risky.

Table 1. *Global Themes, Organizing Themes, and Examples of Basic Themes from Thematic Network Analysis*

Global Theme	Organizing Theme	Examples of Basic Themes
Care provision from a risk-centred perspective	Women's knowledge of midwifery and its scope of practice	<p>"When we compared doctors, nurse, midwives...I think doctor was probably the highest level we have, and then we're pretty sure that if something came up, more than birth complications, the doctor will be better to assist you than midwives."</p> <p>"A lot of women die from giving birth because there are no physicians...no doctors, no nothing. So sometimes the baby is alive, the mom dies, and when the baby dies, mom survives."</p>
	Initial health care provider did not promote informed choices for maternal care	<p>"The GP said, 'Oh, if you want me to be your family doctor, I can be.' And I just said, 'Oh yeah, that would be great.' Yeah, and then I think I learned more later about different other options... like that you could go with the midwife."</p> <p>"[The] GP said, 'well...good luck with that [homebirth].'"</p>
	Social networks' negative perceptions of midwifery	<p>"[for many people] a midwife means that you have your baby at home....When we started telling people we were going to have midwives, our family was like, 'You can't do that. You can't have the baby at home. It's your first baby!'"</p>
Access to midwifery services	Timeliness of securing midwife care	<p>"So among my friends there's a kind of saying: as soon as you find out you're pregnant, the two people you call is a midwife and daycare, because both are so hard to get into."</p> <p>"I just knew you just call the midwives right away....A lot of people have tried to get them, and they can't."</p>
	Awareness of midwifery	<p>"I just...it was something that I didn't have a lot of information about, so I just kind of went with a physician....It's just what other people do."</p> <p>"I don't think they know how specialized and how high their [midwives'] training is....They think, 'oh, OB is the way to go'... they think that they're safer, in better hands because they're with a doctor."</p>
Care provision from a woman-centred perspective	Women's knowledge and experience of midwifery and its scope of practice	<p>"They have such a wealth of knowledge, especially with the informed choices...even if they kind of have an understanding of...what you want,...they're still going to educate you and make sure that you know."</p>
	Health care provider supportive of midwife care	<p>"I had a magnificent NP that told me that I would probably benefit more from a midwife than an OB."</p>
	Social network supportive of midwife care	<p>"My one friend...was pregnant and had a midwife....I talked to her about it...she told me; and actually, many girls at the daycare that I worked with had them, and they said that you get to basically see everything—100% control."</p>

Notes: GP, general practitioner; NP, nurse practitioner; OB, obstetrician.

Birth Understood As Risky by Mothers and Their Social Networks

One organizing theme under the risk-centred global theme is “mothers” and their social network’s understanding of birth as risky. Several women in our study reported that they initially saw birth as an inherently risky endeavor that needed to take place in hospital, whether or not a healthy pregnancy was being experienced. Tamara, an EC woman who gave birth to her second child with a midwife at home, said that she gave birth to her first child with a physician in hospital because “it was [how] society wants you to think you should have your baby...so that’s just the way I did it.” Some, particularly VM mothers, assumed that midwives were not fully trained or skilled health professionals and that the care from midwives would be inferior to that from

Giving birth was a female family-centred event that provided comfort and encouraged trust in the outcome.

physicians or obstetricians. When asked if she would tell us why she wanted a physician, Rose, a recent immigrant from Southeast Asia, replied,

For many reasons...when we compared doctors, nurse, midwives—I think doctor was probably the highest level we have, and then we’re pretty sure that if something came up, more than birth complications, the doctor will be better to assist you than midwives.

Rose had two healthy, uncomplicated births. The option of a trained midwife did not come up in either of Rose’s pregnancies, and Rose did not ask, as she preferred a doctor. “Back home,” as Rose put it, there was no possibility of choosing a doctor, and the woman helping with births in her family’s village was “just a woman.” She continued, “a lot of women die from giving birth because there are no physicians...no doctors, no nothing. So sometimes the baby is alive, the mom dies, and when the baby dies, mom survives.” Rose was 37 years old when she gave birth to her third child. Late in the pregnancy, she developed gestational

diabetes. It was managed without medical treatment and resolved with the birth, which was vaginal.

Leila, a VM woman who had a healthy, uncomplicated pregnancy and a vaginal birth, was also more comfortable with a doctor. Like Rose, she perceived doctors as being better educated and equipped to assist women giving birth, and she saw their ability to quickly intervene with medical technology as desirable. Although midwives were not formally educated in her country of origin, Leila had trusted the local midwife, who had been practicing for 40 years. Also, giving birth was a female family-centred event that provided comfort and encouraged trust in the outcome. Despite Leila’s less-than-positive experience with the doctor attending her last birth (“the doctor did not seem to know what they were doing”), Leila still wanted a doctor for future births. Piya, a VM woman who had given birth with the assistance of an OB/GYN, similarly wanted an OB/GYN to assist with any subsequent births although her initial experience had not been positive. Her reasons were the same as those of Rose. Both of Piya’s pregnancies were healthy but ended with a cesarean section due to a “tight cervix.” The first cesarean was unplanned, the second was planned.

Sianna, another VM woman, had heard many “horror stories” from women in her social network about their birth experiences. She also chose to give birth with a physician, because that was what “her family did.” She did not remember anyone in her family having given birth with a midwife. Sianna was very happy with her physician and the pre-, peri-, and postnatal care she received.

Even some Indigenous and EC women who chose to give birth with a midwife saw giving birth as inherently risky, as did Jessica, an EC woman who had a healthy pregnancy and an uncomplicated hospital birth assisted by a midwife. When asked whether a home birth would have been an option for her, she replied, “No. It’s too scary. I would have to have...all those gadgets and things around just in case...just in case something happened.” Agnes, another EC woman who also had a healthy pregnancy and an uncomplicated midwife-assisted birth, said, “I just felt that labour was going to be this horrendous thing that I had to be at the hospital for.”

Another organizing theme under the risk-centred global theme was that women’s social networks framed giving birth as risky, as Sianna’s experience shows. Some women mentioned generational differences in perspectives. The mothers or aunts of EC mothers who experienced

medicalized childbirth as the norm did not support the decision to have a midwife-attended birth. Tamara felt that there is

a misunderstanding in Canada or Ontario... that a midwife means that you have your baby at home....When we started telling people we were going to have midwives, our family was like, "You can't do that. You can't have the baby at home. It's your first baby!"

When Julie, an EC woman, told her mother (who is a physician) that she "was going with a midwife," her mother replied, "Well, you're not going to have the baby at home, are you?" Julie continued with the following:

I tried to share a little bit of why we chose to have a midwife. But at the time, I don't know if she necessarily heard me.... I think there are some tensions between...seemingly alternative and conventional medicine, medical care.

Cheryl, another EC woman who had chosen to have a midwife and wanted a home birth, experienced similar resistance from her partner.

My husband was not on board with homebirth....I tried to convince him. I just really wanted to... I don't think he had the education to know that homebirth is safe... he didn't really care to learn. It's just not commonly done...and everyone has an idea that the doctor and the hospital has the equipment necessary if something goes wrong....It was just a battle that I could not fight.

Perceptions among social networks, family, friends, and partners that childbirth is risky—combined with a lack of understanding of the medical care provided by midwives—encourage some women to seek other health care providers.

In addition to perceiving childbirth as being inherently risky, many mothers believed that any woman who is considered "at risk" could not be attended by a midwife. They assumed that even women with healthy or moderate-risk pregnancies must have a physician-assisted birth due

to their age and/or the possibility of developing gestational diabetes (like Rose) or carrying twins. This was the case for Amanda, an Indigenous woman who had gestational diabetes with her first child and developed type 2 diabetes between the births of her two children. It was also the case for Anna May, also Indigenous, who had had difficulty giving birth to the placenta for five of her six births but had otherwise had healthy pregnancies and uncomplicated births. Neither woman's general practitioner (GP) suggested midwifery as an option, and the women did not think they could have a midwife, due to their "risk factors."

Owing to their lack of knowledge about midwives' education and scope of practice, coupled with their having heard stories about unfavourable birth outcomes (particularly for VM women) when a physician was not used, some women who could have given birth with the aid of a midwife chose to have a physician or OB/GYN assist the birth instead.

Health Care Providers' Not Promoting Informed Choices for Maternal Care

Several women stated that their initial GP or nurse practitioner (NP), although not directly unsupportive, did not suggest or discuss the option of having a midwife. Janette, an EC woman, recounted the following exchange with her GP:

The GP said, "Oh, if you want me to be your family doctor, I can be." And I just said, "Oh yeah, that would be great." Yeah, and then I think I learned more later about different other options...like that you could go with the midwife.

Jane, a woman of mixed heritage (Indigenous and EC) who was 18 years old at her first birth, reported having had a healthy pregnancy. Her GP did not mention midwives as an option either. Instead, as he did not do obstetrics himself, "he said he was referring [me] to an obstetrician." This was also the case for 19-year-old Katelyn, an Indigenous woman who experienced a healthy pregnancy. Katelyn was referred to an obstetrician when her 12-week ultrasound examination showed that she was having twins. During previous visits, her GP had discussed smoking cessation and sexually transmitted diseases but not the option of midwifery care.

In our study, a common misconception, particularly

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Alice Neel (1900-1984)

Alice Neel was an American painter who defied conventional approaches to art. Peter Marzio, the Director of the Museum of Fine Arts, Houston, claimed that she could have been ignored during her career (from the 1920s to the 1980s), because “she was female, a portrait painter and an independent thinker with a sharp intellect.”¹ When she began to paint, the rise of the camera with its ability to provide accurate images had made portraiture a thing of the past. But she approached portraiture with a knowing, unflinching eye.²

Neel brought that reality of life alive in a series of pregnant nudes done between 1964 and 1978. This was a period when not only was it unheard of to paint pregnant women nude but feminists were critiquing representations of female nudes as simply being painted by men for the “male gaze”. However, Pamela Allara argues that Neel’s pregnant nudes “do not

evoke an erotic response...they arouse the most elemental of men’s fears, described...as the ‘ancient, continuing envy, awe, and dread of the male for the female capacity to create life.’”³ Active feminists were also suggesting that pregnancy resulted in a loss of control over women’s bodies and their destiny. So Neel’s “pregnant nudes address a double taboo – the subject’s absence in the history of Western art, and its conflicted status within feminist theory and practice.”⁴

Neel had a difficult personal life. She lost her first infant child to diphtheria and her husband took her second child off to Cuba leaving Neel estranged from both husband and child. Despite subsequent mental health issues her career began to flourish by the late 1930s. She later had two sons, by different men who moved in and out of her life, and who now manage her estate and the exhibitions of her work.



Figure 1
Pregnant Maria,
1964
Private Collection



Figure 2
The Pregnant Woman (Nancy Neel), 1967, Private Collection

Neel's nudes were real women she knew, women whose everyday life experiences show in their face and body. The pregnant nudes look at the viewer; the viewer engages with their eyes before seeing the pregnant body. It seems that Neel wanted to present the pregnant body as simply one aspect of women's body experience. Later in life she painted a self-portrait with all the rolls, wrinkles and folds that characterize an older woman's body.

Pregnant Maria (Figure 1) is described as a woman of Latin origin, sensuous, but not a sex object.⁵ She is obviously not a virgin; she lies on rumpled bedclothes with little distance between the viewer and her body. In fact her right foot comes off the end of the canvas. Neel, painting Maria in the 1960s, rejoined sex and pregnancy just at the time that feminists were trying to separate sex and pregnancy with the new drug known as 'the Pill'.⁵

The Pregnant Woman (Figure 2) is a painting of Neel's daughter-in-law Nancy during first pregnancy. The viewer can feel the intensity of Nancy's experience in her eyes. She, like all pregnant women, is on her own, living with the (uncomfortable) fullness of her belly and her breasts.

Claudia Bach (Figure 3) exhibits pride and sexual self-confidence in her body. She looks healthy and happy and wants the viewer to enjoy her appearance and openness. Pamela

Allara notes that the "beautiful proportions of her body is the forerunner of the 1980s ideal of the pregnant woman, focused exclusively on body weight and muscle tone and finally provided in the perfect visual image of Demi Moore"⁶ on the famous *Vanity Fair* cover.

Margaret Evans Pregnant (Figure 4) pregnant with twins, and barely able to sit on the little stool provided for the sitting, looks overtaken by her condition. She appears to be holding herself together. Does the mirror image behind her represent what she once was, or hopes for what will be again?

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Figure 3 (above)
Claudia Bach, 1975, Estate of Alice Neel,
New York



Figure 4 (left)
Margaret Evans Pregnant, 1978

among Indigenous and VM women, was that midwives could not attend women giving birth in hospital. Primary health care providers (GPs and NPs) did not always correct this misinformation. Leila, a VM woman, said that in regard to place of birth, her GP initially asked, “Do you want to be in a hospital or at home?” Leila replied, “well, there’s no point in being at home, because there’s no...[medical support]. I said, ‘okay, the hospital, in which everything is accessible and no matter what happened—they can just do everything, right?’” The GP’s question seemed to be an indirect way to

Women who chose to have a midwife generally had personal knowledge about midwifery either through research or through the experiences of family and friends.

ask whether Leila wanted a GP or a midwife. However, the GP did not present the option of midwife-assisted hospital birth, thus limiting Leila’s choices and shaping how she viewed risk when weighing her options.

Some women received positive responses from their caregivers when they voiced their preference for a midwife; others did not. Negative responses included skeptical statements such as “well...good luck with that,” made to Lisa, an EC woman, and “Well, I supposed you could use [a midwife],” in a tone of voice implying that having a midwife was not as preferable or as safe, made to a mother present at a moms and tots program. Such responses shape and support the general public’s perception of childbirth as risky. Even if a woman were supported in her choice of having a midwife, she might not be able to gain access to one (see “Discussion”).

Access to Midwifery Services

The second global theme involves access. Demand for midwifery services well outstrips their availability across Canada, even in Thunder Bay, where the uptake is above the provincial average. This issue came up in two ways, shaping two organizing themes: (1) the importance (timeliness) of securing midwifery services early in the pregnancy and (2) a lack of awareness of midwifery among the mothers

themselves and in the community generally.

Timeliness of Securing Midwifery Services

The women who actively chose midwifery were aware of the need to contact local midwifery clinics as soon as they knew they were pregnant. Julie said, “So among my friends there’s a kind of saying: As soon as you find out you’re pregnant, the two people you call is a midwife and daycare, because both are so hard to get into.” Lindsay, an Indigenous woman, commented, “I just knew you just call the midwives right away...A lot of people have tried to get them and they can’t.” In addition, several women in our study noted that they had to wait until well into their fourth month to confirm their spot in one of the midwifery practices. For Indigenous women living in remote areas and evacuated to Thunder Bay at 36–38 weeks’ gestational age, it is impossible to obtain a midwife.²⁷

Awareness of Midwifery

Several mothers indicated that not enough information was available about midwifery, its scope of practice, and where and how to gain access to it. As Rita, an EC woman said,

The midwives—perhaps they should do a little more PR [public relations], because I had to find out about it myself. Like nobody recommended [it] to me. After I found out, I started to see these people who are called midwives. But before that, I had no idea that having midwives was an option.

Women who initially did not choose a midwife as their birth assistant were often not informed about midwifery as an option when they first saw a health care practitioner and were not knowledgeable about midwifery. Jessica, an Indigenous woman, exemplified this, saying, “I just—it was something that I didn’t have a lot of information about, so I just kind of went with a physician...It’s just what other people do.” Miriam, another Indigenous woman, who herself had had a midwife, said that many of her friends, from a risk perspective, chose to have obstetricians (OBs). “I don’t think they know how specialized and how high their [midwives’] training is....They think, ‘Oh, OB is the way to go.’...They think that they’re safer, in better hands because they’re with a doctor.”

It appears that many people in Thunder Bay are

uninformed about midwifery as a practice and as an option. They do not know that midwives can assist women during pre-, peri-, and postnatal periods, or when women are having twins, are at risk of having gestational diabetes, or have difficulty giving birth to their placenta. Nor were many aware that midwives can consult an obstetrician and initiate a transfer of care while continuing to care for a woman who is pregnant or giving birth.²⁸ Some women are also unaware that midwives can assist women giving birth in hospital and help them gain access to epidural anaesthesia²⁸ or provide other pain medication through standing orders in some hospitals, including Thunder Bay Regional Health Sciences Centre (midwife Amy Larsen, personal communication, June 30, 2015).

Care Provision from a Woman-Centred Perspective

The last global theme best fits the ideal of midwifery. It contains the organizing themes of (1) mothers' knowledge of midwifery and its scope of practice, (2) health care providers who are supportive of midwifery care, and (3) social networks that are supportive of midwifery care, and deals with how women should—through their own knowledge, their health care provider's knowledge, and the support of their social networks—be informed about their options for maternal care.

Knowledge Among Mothers and Their Social Networks about Midwifery and Its Scope of Practice

One organizing theme under the women-centred global theme was that women who chose to have a midwife generally had personal knowledge about midwifery either through research or through the experiences of family and friends. Information had been sought from books, pamphlets, the Internet, and talks with health care providers. When asked why she chose a midwife for her care, Jane said she had researched midwives and found the following:

Everything they encompass is really great... like they have such a wealth of knowledge, especially with the informed choices....Even if they kind of have an understanding of...what you want...they're still going to educate you and make sure that you know....And even with the gestational diabetes...like with my second child...I was just kind of devastated....“Oh, what does this mean, and what happens to my

care?” But they were so great about it. They said, “We're going to follow you all the way through, and it doesn't change anything.”

As Rita similarly observed,

[A midwife is] compassionate and more supportive for the mother during the labour... They just seem to go above and beyond in care, where the doctor is more there to get the baby out. It's not so much about the woman's comfort....In terms of child labour, I just...I'd much rather go with somebody [who] went to school for that [midwifery], feels like they want to be there, their heart is in it.

That midwives give more time, provide continuity of care, have a specialty education, and share their knowledge with the mothers-to-be were deciding factors for the women who chose midwife-assisted births.

Health Care Providers Supportive of Care Provided by Midwives

The second organizing theme under the women-centred global theme was that some health care providers were supportive of care provided by midwives. Some of the women who used midwives saw a different care provider first who had a positive attitude towards midwife-assisted births (N = 5). As Cheryl (an EC woman) stated,

My GP, she's lovely....She completely respects my choice to go to a midwife. She totally respects that, and she was also a co-sleeping, big breastfeeding lady, so I think she understands where I come from that way. She's super. I really, really like her.

Summer, an Indigenous woman who had had two physician-attended births at a young age and had felt no support from her family or physician, had a new physician for her third pregnancy. She told us, “She's pretty good, Dr. X....She [asked], ‘Okay, so what were you thinking?’ And I was already thinking I wanted to see a midwife. So she said, ‘Okay, that's great.’”

A few NPs and GPs even suggested that mothers see a midwife even if the mothers voiced no desire to do so. Melody (Indigenous) recounted that her GP, who was about

to retire, said, “I’m not going to be here. So when you go through your pregnancy, I think it would be best if you [have a midwife],” and Tamara (EC), who was initially unaware of the option to have a midwife, said, “I had a magnificent nurse practitioner that told me that I would probably benefit more from a midwife than an OB.” The advice and information given by the initial health care practitioner is very important for women’s choice of care provider, particularly for women who have no prior knowledge about midwifery and for whom the default is a physician as it was for their mothers and their social networks.

Social Networks Supportive of Care Provided by Midwives

The third organizing theme under the woman-centred global theme revolved around the women’s social networks’ being supportive of midwifery. The majority of the women who had midwife-assisted births had family and/or friends who were aware of midwifery (n = 13/18). Rita, who was present for two of her sister’s midwife-assisted births, said, “That’s what really made me want to give birth with

Some of the Indigenous women we interviewed reported unfriendly, unhelpful, and/or discriminatory experiences with health care providers during pregnancy and birth.

a midwife.” When Summer was asked how she found out about the option to have a midwife for her third baby, she responded,

My close friends that had babies [said] that midwives was the way to go and they wouldn’t have it any other way now....I like the feeling, the vibe. The waiting room, even,...it’s just like you’re not waiting for a doctor for an hour in the waiting room.

As Rita remembered,

My one friend...was pregnant and had a midwife....I talked to her about it and asked her what it’s all about, and she told me. And actually, many girls at the daycare that I worked with had them, and they said that

you get to basically see everything...100% control...and I liked that fact; I liked seeing my charts. I liked knowing anything. If I had any questions, they answered it. I just love that hands-on and actually feeling like part of the birth and everything.

It is noteworthy that Rita suggested that giving birth under the care of a physician made her feel displaced from the birth. Being in control and having continuity of care were selling points for many of the women who chose to have a midwife, and that knowledge about the culture of midwifery often came from the women’s social networks.

DISCUSSION

Our study revealed several general factors that worked as barriers to the uptake of midwifery. These related to the global theme “Access to Midwifery Services” and included limited numbers of midwives and a lack of knowledge among women and their social networks about midwifery and its scope of practice. They also connected to the global theme “Care Provision from a Risk-Centred Perspective,” particularly in regard to primary health care providers’ not sharing information about midwifery. As other studies show, the endorsement of primary care providers may be affected by their level of familiarity with midwifery practice and research, the extent to which they privilege client-centred approaches to pregnancy and childbirth, and the culture of their hospital of practice.^{29,30} This is an important barrier to the uptake of midwifery, one that might be addressed through the increased development of interprofessional maternity care.³¹ Equally important in this study are the factors that VM and Indigenous women identified as barriers.

Factors Influencing Visible-Minority Women’s Birth Choices

Despite the diversity of beliefs, values, and preferences among VM women¹⁷ (as determined by migrant status, country or region of origin, duration of residence,²⁹ and cultural preferences for female birth care providers), the four VM women and one VM/EC woman (all of whom came from East or Southeast Asia and from different religious traditions [Hinduism, Buddhism, Christianity, and Islam]) all preferred physicians, obstetricians, and OB/GYNs to midwives. This appears to reflect the pervasiveness of the medicalization of childbirth, the social status gained through having a physician, the perception of increased

safety for mother and child, and midwives' low status and lack of training in the women's countries of origin.^{17,32} Thus, VM women in our study were unlikely to choose a midwife, owing to some or all of these understandings and to a lack of knowledge about Canadian midwives' educational background, expertise, scope of practice, and birth outcomes. These factors were very strong; two VM women reported that even experiences with discriminatory or unhelpful hospital staff did not change their preference for physicians or obstetricians for future births. The aforementioned lack of knowledge and information was an important factor in VM women's decision against midwife-attended birth.^{33,34}

Factors Influencing Indigenous Women's Birth Choices

The colonization and medicalization of childbirth (including evacuation from remote communities) over several generations has, in many Indigenous families, instilled a sense that physician-attended hospital birth is the "traditional" way to do things: "It's what people do." Mary noted that all of the children of her eight in-laws were born in hospital with the aid of a doctor because "that still that's the feeling that they get." Even if they had wanted to, it would not have been possible for this family to receive care from a midwife. There are currently no midwives in the family's community, and whereas transportation to an obstetrician is covered by the Ontario Health Insurance Plan, transportation for midwifery care is not, as a physician can provide the same services.³⁵

Some of the Indigenous women we interviewed reported unfriendly, unhelpful, and/or discriminatory experiences with health care providers during pregnancy and birth. For some Indigenous women ($n = 2$), these experiences were an incentive to seek the care of midwives for later births. Others experienced the health care system generally as, in Mary's words, "very racist," which led them not to seek health care unless absolutely necessary. For example, Mary's mother-in-law "did not feel respected as a woman, as an individual," so only when the "time came to give birth, she went to the hospital, had the baby, and came back home." The desire to have as little contact as possible with the health care system because of negative and discriminatory experiences was transferred to her children. The issue also came up in presentations of our preliminary findings to Indigenous community organizations from 2014 to 2015. These findings corroborate other studies, which report that Indigenous women's access to maternity care can be affected by racism, stereotyping, cultural differences, and

language barriers within the health care system.³⁶⁻³⁹ Other historical traumas, such as the damage done by residential schools to local knowledge about women, childbirth, and parenting, also affect access to care.³⁸ Although four of the twelve Indigenous women who participated in this study experienced midwifery by way of current friends or family, only one had information or knowledge that came from previous-generation family members. Most were accustomed to physicians being the choice, whether the experience was positive or not. Research indicates that Indigenous midwifery practices have been extremely successful in improving physical and psychosocial health outcomes, retaining health care providers, building community capacity, providing culturally safe reproductive care, and revitalizing Indigenous knowledge and land ties for women who would like them.⁴⁰⁻⁴² All the Indigenous women in our study who used midwives noted the holistic and personalized care that midwives offered. Thus, it is likely that if more Indigenous women were aware or informed by their care providers of the choice of having a midwife, there would be an even higher demand than there is currently.

CONCLUSIONS

Many mothers, even some midwife-assisted mothers, framed their birth along a risk continuum rather than as a natural process that may have complications. General knowledge about midwifery and its scope of practice was a barrier to the uptake of midwifery for all three demographic groups that participated in the study but especially for visible-minority (VM) and Indigenous women and their networks. The midwifery clinics are near to capacity, and our interviewees felt that information on midwifery was not readily available. More comprehensive information about childbirth choices provided by initial health care providers such as physicians and nurse practitioners would be valuable, especially given their influence over women's obstetrical risk determination and decision-making options. Additional funding for the expansion of midwifery services would help increase their availability for women later in pregnancy, particularly Indigenous women. And to support midwives' work towards challenging the status quo and supporting diversity both in service provision and access to care,⁴³ information sessions for Indigenous and multicultural organizations and women's groups would be invaluable. More information would be especially helpful for (1) VM women who do not seem completely satisfied with their physician-assisted births but still want a physician in the future and (2) Indigenous women who have accepted and

internalized the label of high risk. Educating high-school students about pregnancy and childbirth and teaching them about the range and scope of practice of health care practitioners who support women pre-, peri- and postnatally would increase the general population's knowledge about midwifery. This would be particularly important in a region where the average age of a woman giving birth for the first time is lower than the provincial average. Such coursework is not part of the new 2015 sex-education curriculum for grades eight to twelve.⁴⁴ Physician and nurse practitioner program curricula that have a greater focus on Indigenous history and cultural safety could help decrease experiences of discrimination. Likewise, a greater focus on midwifery research and practice and on collaboration between physicians, nurse practitioners, and midwives, as well as between professional groups at local hospitals, would help increase not only such collaboration but also other health professionals' knowledge of midwifery practice and research. In addition, research on VM women, their diverse preferences and choices in regard to giving birth, and the knowledge underlying those preferences and choices would be a welcome addition to this study.

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ACKNOWLEDGEMENTS

We would like to thank all the women in Thunder Bay who volunteered to talk to us and share their experiences, thoughts, and ideas about their births and choice of health care providers. We would also like to thank the local Indigenous and cultural organizations that welcomed us in their space and allowed us to introduce ourselves and the project to their communities. Last, we would like to thank the two Thunder Bay midwifery groups for sharing their knowledge about midwifery in Thunder Bay.