Comprehensive Midwifery: The role of the midwife in health care practice, education, and research

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AN INTERACTIVE GUIDE TO THE THEORY AND EVIDENCE OF PRACTICE

Elaine Carty, MSN, CNM, DSc, Nadya Burton, PhD, Lorna McRae, RM, Allison Campbell, MA, BA, BMW, RM, Cristina Mattison, MSc, PhD(c), Terri Rypkema, MEd, RCC, Kris Robinson, , Lesley Page, CBE, PhD, MSc, BA, RM, HFRCM, Mary Nolan, PhD, MA, BA, RGN, Michelle Butler, PhD, MSc, BSc, RM, RN, Vicki Van Wagner, RM, PhD, Andrea Robertson, Mary Renfrew, BSc, RN, RM, PhD, Jayne E Marshall, PhD, MA, PGCEA, ADM, RM, RN

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A Word on Language

Photo Art by Hana Lang

This e-book is a collection of works by authors of different backgrounds, nations, and professions. Unlike many textbooks, we have allowed and encouraged our authors to maintain their individual voice in their writing. Readers should approach each chapter as a separate entity.

Consistent with policy statements of Canadian midwifery organizations, we endeavour to use language that is respectful of transgender, queer and intersex communities in this book about

midwives and midwifery care. Within some chapters there is gendered language since our contributing authors often draw on their own or others' previously published work and we must necessarily maintain the integrity of that work. As well, some chapters reflect the historical and present day global reality that midwifery is about caring primarily for women and that in many countries both midwives and recipients of care have been rendered largely invisible because they are women, or identified as women.

This e-book was created at McMaster University, which sits on the traditional Territories of the Mississauga and Haudenosaunee Nations, and within the lands protected by the "Dish With One Spoon" wampum agreement. We are currently working with Indigenous editors to ensure our language and content is respectful and equitable, and will update this text with any and all changes necessary to fulfill this need.

Cover art: *Beginnings* by Annette M. Martin

PART I

Midwifery in a Health Care Context

Edited by:
Karyn Kaufman, DrPH
Professor Emerita
Faculty of Health Sciences
McMaster University

1. Birth & its Meanings: Representations of Birth in Art

Elaine Carty, MSN, CNM, DSc (hc), CM

Each second, approximately 4.3 births occur throughout the world. Some births bring happiness, others sadness. Many are wanted, many unwanted. Most babies are born into poverty, a few into wealth. Whatever the circumstances, those giving birth know and feel its importance. Those who observe birth, whether they are a midwife, **sage-femme**, **birth attendant**, partner, friend, family or stranger, know they have been part of a process that ensures our species continuing existence and exemplifies human essence.

> Being born is important
> You who have stood at the bedposts
> And seen a mother on her high harvest day,
> The day of the most golden of harvest moons for her.

You who have seen the new wet child
Dried behind the ears,
Swaddled in soft fresh garment,
Pursing its lips and sending a groping mouth
Toward nipples where white milk is ready.
You who have seen loves payday
Of wild tolling and sweet agonizing.
You know being born is important
You know that nothing else was ever so important to you
You understand that the payday of love is so old,
So involved, so traced with the circles of the moon,
So cunning with the secrets of the salts of the blood
It must be older than the moon, older than salt.
Being Born Is Important
Carl Sandburg (2)

Birth has been **represented** by human beings since pre-historic times in poetry, prose, drawing, painting, sculpture, film, video, photography, theatre, textiles, social media, music and every other human expression imaginable. Through each such representation we attempt to convey and discern meaning. Midwives and midwifery students can learn a great deal about birth's meanings around the world by engaging with the many human creative expressions around birth that they will encounter. It is very important to be aware that each person's unique perspective influences how they respond to representations around childbirth and how they attribute meaning. These differing perspectives influence the writer, artist, or photographer who produces artifacts as well as those who see the work. Barbara Bolt in her book Art Beyond Representation reminds us that the act of making

the work is performative and that aspect must be considered in addition to the finished work. (3) Burton in her book Natal Signs, examines the framework of Michel de Certau and points out that the border separating production and consumption is porous; the consumer of any work is inevitably engaged in a form of secondary production. (4) As midwives, we must be aware that our unique interpretations are passed on to our clients, our communities and ultimately to our policy makers.

When engaging with representations of childbirth, it is vital to consider not just the content of the work but also how it is used and for what purpose. Is art political? This debate has existed in the art world for a very long time. If being political means engaging with power and power relationships – whether that is the interaction between subjects in the work, between artist and subject, between artist and artist – then yes all art is political. Power is embedded in the everyday; the way everything in society works. It is imperative to examine how representations question power relations, 'unsettle assumptions, and break boundaries.' (4) The more work done in trying to understand perspectives of those who write about childbirth from a personal, historical or anthropological framework, make art or poetry, the better midwives will be able to be 'with woman.'

Nonetheless, no one can 'know' how others have or will experience childbirth. So how can a student of midwifery, in this time, in this place, understand the complex intersection of physiology and culture? How can anyone contemplate what childbirth was like 4000 years ago in Mesopotamia or even what it means to the woman seeking midwifery care today?

This chapter will provide an opportunity to engage with representations of birth and its meaning. In observing works, many art historians emphasize the relationship between the aesthetic, the sensory or emotional values elicited, as well as the

intention or reading of the work. To be present when looking and/or listening to representations of childbirth, involves asking questions about the work that explore these relationships. In each of the following sections, there are a number of questions to help you reflect on the included representations. A work may make us stop, look or listen carefully, feel moved, experience joy or sadness. We may be able to say we like or dislike a piece of art or poem or comic and yet be unsure why that is so. Often, we need to look at an art piece several times or reflect on a work of fiction or poetry over time before we understand our reaction to it.

Representations of Birth Throughout History

Although pregnancy, birth and motherhood/parenthood have been topics of discussion and representation by humans for thousands of years, this section will discuss four particular periods in history that illustrated the importance and meaning of birth in their time in quite different ways.

Reflect

Throughout this chapter, there are several examples of artworks that represent birth and parenthood. When they appear, ask yourself the following questions:

What is my first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?
What purpose did/does the work serve?
Is there a title to the work?

What is the subject matter?
Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in my practice? (5)

Early Representations of Fertility & Birth

We have evidence that species of early humans were creating two and three-dimensional images 40,000 years ago. (5) Cave paintings of animals and human hands dating to 35,000BCE have been found on the island of Sulawesi in Indonesia. Who painted them, their feelings, thoughts associated with the work, why they were painted, and the meanings they had at the time are all lost to history. However, meaning becomes somewhat clearer when we observe three-dimensional sculptures that appear to represent fertility and birth. 'Venus figurines' is a term used to describe small, between two and eight inches (5-20cm), sculptures of women. Although sculpted during the pre-historic period, the term Venus was more recently applied by archeologists to reflect Venus, the Roman goddess of beauty. These sculptures are usually similar in size, appearing fully fleshed with large bellies and breasts, and little facial detail. Archeologists debate whether these small sculptures represent fertility or are a religious symbol of the time. (6)

One of the most famous of these is the Venus of Willendorf, or Woman of Willendorf, named for the Austrian town in which it was discovered in 1908 (Figure 1-1). The 11 cm high statuette is estimated to have been made between 24,000 and 22,000 BCE.

She is compelling because of her large size, which would be called obese today. It is postulated by many that her voluptuousness implies fertility.

Figure 1-1. Venus of Willendorf, located at the Nturhistorisches Museum in Vienna, Austria. Photo by Matthias Kabel. *https://en.wikipedia.org/wiki/File:Venus_von_Willendorf_01.jpg*

Did You Know?

The creation of figurines in a female form pre-dates the

Roman goddess Venus by over twenty thousand years, although in modern times many of these figurines are commonly referred to as Venus.

Another form of artistic representations of fertility and birth is found in early rugs from Turkey, Kurdish rugs, Qashqai, Lori, and Shah Savan rugs of Iran and the Balusch and Turkoman rugs of Central Asia. All have a motif that has been described as a fertility/birth symbol, a simplified graphic design of a pregnant female, symbolizing a veneration of birth and generation of life. (7) There are many symbols from many traditions that symbolize fertility and childbirth in rugs and textiles, and just as many textile specialists who say it is difficult to interpret the meaning of symbols developed thousands of years ago. Nonetheless the fertility/birth symbol in textiles has some common characteristics that have been described: a central diamond, sitting on point, with pairs of curved or hooked lines projecting from the top and bottom points (Figure 1-2). The diamond represents the body of the pregnant woman and the lines her arms and legs. In some versions, a small diamond sits inside the larger one or the motif is expanded with more hooked or curved lines.

External Link

Variations of Kilim symbols have been used as the cover motifs for the journal Birth, an interdisciplinary journal from the United States. You can view the cover

Figure 1-2. Persian rug displaying fertility/birth symbols. Photo by the author.

here: http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1523-536X

Birth in Renaissance Europe (14th to the 17th centuries)

In the time of the Renaissance, in post-plague Europe, the physiology of childbirth had not been well studied, and very little had been written about it. Birthing was women's work, it was private, and it was dangerous given the high rates of maternal and infant mortality. Birth, although risky, was celebrated and elaborate preparations were begun months before the baby was due. The very real fears around childbirth resulted in an abundance of items that might provide protection and/or mediation around the process of reproduction. Talismans, birth trays (Figure 1-3), and paintings were often displayed in the home

in the hope of ensuring good birthing outcomes for mother and baby. (8)

Figure 1-3. Birth tray featuring the common visual of an infant boy. Painted by Bartolomeo di Fruosino (c. 1428). This file has been identified as being free of known restrictions under copyright law, including all related and neighboring rights.
https://commons.wikimedia.org/wiki/File:Bartolomeo_Di_Fruosino_-_Desco_da_parto_(verso)_-_WGA01342.jpg

Women were encouraged to look at beautiful images, in particular pictures of the pregnant Madonna (Figure 1-4), the Birth of the Virgin, or the Birth of Saint John the Baptist (Figure 1-5) so they could imagine themselves having a successful birth

and healthy baby like the subjects of the paintings. (9) The paintings and birth trays depicted the period immediately after birth at home; a very congenial atmosphere with the woman surrounded by midwives and friends. There are often as many as ten women in the depictions of birth. The artists depicted their subjects in narrative form so the paintings reveal the activities that might have taken place over a period of days. The women are all fully clothed in the dress style of the day and there is no indication of the messiness of birth. A common visual element in the paintings is a female helper carrying food and drink into the room on a wooden tray after the birth.

Did You Know?

Demographers suggest that between 40-50% of people in Europe died in recurring episodes of plague (Black Death) between the 14th and 17th C. In the late 1330s, Florence Italy had a population of 120,000 but by 1427 it had dropped to 37,000 as a result of deaths from the plague.

Reflect

What is my first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?
What purpose did/does the work serve?
Is there a title to the work?
What is the subject matter?

Figure 1-4. Piero Madonna del parto, painted by Pietro di Benedetto dei Franceschi (c. 1410-1420). Photo by Edisonblus.
https://commons.wikimedia.org/wiki/File:Piero_Madonna_del_parto.jpg

Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in my practice? (5)

Reflect

How do these Renaissance portrayals of birth compare to the birth room in hospital today?

Hand painted birth trays (Figure 1-3) were a common gift to a newly married couple, and were meant to be passed on through generations. On one side of the tray there was often a birth scene and on the other a painting of a baby boy. As with paintings of successful births, it was believed that if the woman was surrounded by, and focused on, images of baby boys, she would produce a male child and a woman's value was often measured by her ability to produce a boy child.

Although death was common during the 14th-17th century, and many funerary monuments built, there were few tombs honoring women and specifically women who died in childbirth. In fact there is only one 'contemporary Western representation of death in childbed, whether in obstetrical texts, sacred or secular manuscripts, or monumental art' (8, p.30) and that is the carved relief of the death of Francesca Tornabouni, surrounded by her midwife and attendants. It was completed by Andrea Verrocchio in 1477, and is currently located in the Bargello Museum in Florence. Francesca's husband, Giovanni, funded this unique monument as a display of his devotion and grief. Note the anxious facial expressions and arm and body movements of the attendants (Figure 1-6).

The Italian artist Francesco Furini (mid 17th century) painted a childbirth death scene from the Hebrew Bible story of Jacob

Figure 1-6. The death of Francesca Pitti Tornabuoni after childbirth. Marble relief by Andrea del Verrocchio (c. 15th century). Photo by Wolfgang Sauber. *https://commons.wikimedia.org/wiki/File:Bargello_-_Verrocchio_Tornabuoni_2.jpg*

and Rachel, titled The Birth of Benjamin and the Death of Rachel (Figure 1-7). This painting is similar to the Tornabuoni relief in that Rachel is surrounded by her midwife attendants, her body is slumped over like that of Francesca Tornabuoni and the attendants have anxious facial expressions and tense body positions. Visual representations of death in childbirth are rare today but childbirth deaths are more commonly depicted in literature.

Reflect

What is my first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?

Figure 1-7. The Death of Rachel by Francesco Furiini. Photo provided by the Wellcome Trust.
https://commons.wikimedia.org/wiki/File:The_birth_of_Benjamin_and_the_death_of_Rachel._Oil_painting_Wellcome_V0017370.jp

What purpose did/does the work serve?
Is there a title to the work?
What is the subject matter?
Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in my practice? (5)

Did You Know?

In Renaissance Europe, so little was known about the physiology of birth, its complications or how to treat them that wealthy women would often compose a will when they found out they were pregnant. Families would also take out an insurance policy against a bad outcome.

Late 19th Century, early 20th Century Women Artists and Birth

Art by women began to be taken seriously by art historians and society in the late 19th century. Before that time, it was difficult for women to obtain adequate training and gain professional recognition and status comparable to men. (20) Consequently, many of the earlier representations of the birth room and its many female attendants were made by male artists based on family conversations about the activities that went on. Moving forward to the late 19th and early 20th Century, women were becoming more recognized as competent and talented artists Pregnancy, however, was remarkably underrepresented in the many topics represented in the visual arts until the work of Paula Modersohn-Becker, Frida Kahlo and Alice Neel became respected and commonplace. The art history literature is replete with analyses and critiques of their work. In these works, we feel an intimacy; we are face to face with the subjects, who in fact are the artists in some of these works.

Paula Modersohn-Becker (1876-1907)

Paula Modersohn-Becker was born and raised in Germany but moved to France to study painting at the age of twenty-four. She is considered to be the first female painter to paint female nude self-portraits. She compares her own naked body to 'her soul laid bare' (11, p.14) in a letter to her husband Otto in 1903. Her nakedness then 'becomes a metaphor for honesty or openness' (11, p.14) One of her most well-known self-portraits is a portrait of herself as a pregnant woman, although she had yet to become pregnant (Figure 1-8). This painting is one of the first examples of self-representation; a painting about pregnancy by a woman who is imagining how she would look if pregnant.

> The painting, then, is a metaphor for how she felt about herself as a young artist: fecund, ripe, able for the first time in her life to create and paint freely in the manner that she wished. What she is about to give birth to is not a child but her mature, independent, artistic self. Traditionally, nude portraits of women had been painted for the delectation of the male gaze, but here Paula creates a new construct: a woman who is able to nurture herself outside the trappings of marriage, who does not need a man to be fulfilled. (12)

Modersohn-Becker became pregnant at the age of 30, one year after completing, Self-Portrait on Her Sixth Wedding Anniversary. Eighteen days after giving birth to her daughter, Modersohn-Becker died of an embolism (Figure 1-9).

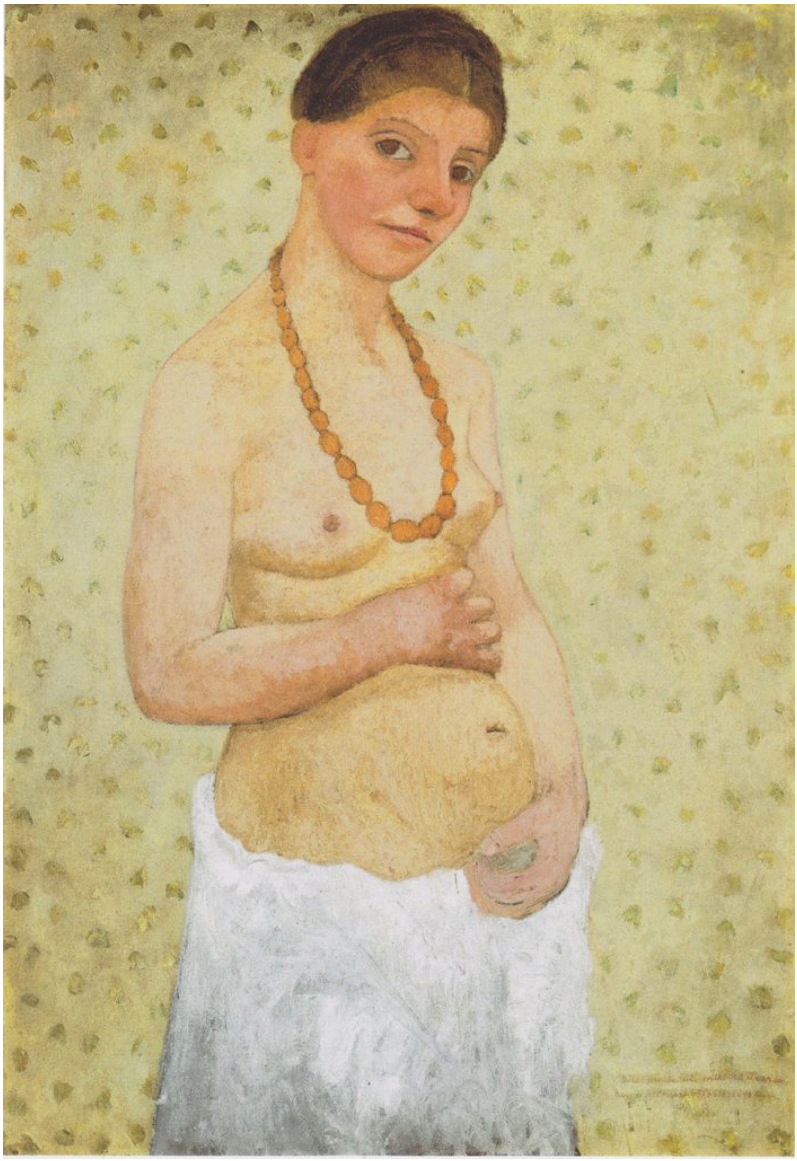

Figure 1-8. Self-Portrait on her Sixth Wedding Anniversary, by Paula

Modersohn-Becker, c.1906. *https://commons.wikimedia.org/wiki/File:Paula_Moderson-Becker_-_Selbstbildnis_am_6_Hochzeitstag_-_1906.jpeg*

Figure 1-9. The gravestone of Paula Modersohn-Becker. Photo by Conchord. *https://commons.wikimedia.org/wiki/File:Modersohn_Grave.JPG*

Reflect

How do the events of Modersohn-Becker's life and death impact your response to her painting?
What is your first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?
What purpose did/does the work serve?
Is there a title to the work?
What is the subject matter?

Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in your practice? (5)

Did You Know?

Following the birth of her daughter, Modersohn-Becker experienced pain in her legs. To treat the pain, her doctor advised her to stay in bed. After more than two weeks immobilized in bed, the doctor advised her to begin walking again. Shortly after taking her first few steps, still experiencing leg pain, she died of an embolism. (12,13)

Did You Know?

The poet Rainer Maria Rilke wrote a long poem about his friendship with Modersohn-Becker and his inability to come to terms with her death. You can read Rilke's 'Requiem for a Friend' in *Requiem and other Poems* (1949).

Alice Neel (1900-1984)

Alice Neel was an American painter known for defying the conventions and politics of the day. Although Modersohn-Becker painted soft and beautiful pregnant nudes in the early 1990's it wasn't until Neel, in the 1960's that pregnancy was again in the

lexicon of artists. In 1964, after several family and friends became pregnant Neel began painting her sharp, realistic, non-romantic pregnant nudes. She painted seven pregnant nudes between 1964 and 1978 and approached these paintings and all her portraiture with a 'knowing and unflinching eye.' (15) Her subjects were women she knew, whose stories were familiar to her. They are painted looking directly at the viewer – which was in contrast to many of the female nudes in European and Asian art who look away from the viewer and the viewer who perhaps has an erotic interest. She wanted to paint in defiance of the male gaze. Nonetheless, her work on pregnancy was not considered an appropriate subject by some feminists because 'it threatened to provide evidence for the charge – certain to send women back to their suburban prisons – that 'anatomy is destiny.''(15,16)

Neel, who was a single mother and whose own history with motherhood is complicated, came to painting her pregnant nudes when she was past menopause, bringing a distance and perspective to the work. Her 1978 painting of Margaret Evans, the wife of a friend of Neel's, who is carrying twins reflects Neel's view of pregnancy as a fact of life with its joy and its wretchedness, a condition where women are grounded and not for sale. (17)

External Link

The works of Alice Neel can be viewed on her website: http://www.aliceneel.com/gallery

Frida Kahlo, (1907 – 1954)

Kahlo was a Mexican artist whose life was dominated by disability, illness and pain, all of which are represented in her artistic work. She was married to fellow painter Diego Rivera, a love that brought both ecstasy and pain to her life. Kahlo very much wanted to have children and became pregnant several times but the pregnancies each ended in miscarriage. In this context, she painted her experience of a miscarriage while in the United States. Miscarriage was not publicly talked about in the 1930s; it was a source of shame, so her courage in painting this topic reflected her need to speak the unspeakable in the way she knew how. (18)

External Link

Kahlo's painting Henry Ford Hospital (The Flying Bed) can be viewed online here: https://www.wikiart.org/en/frida-kahlo/henry-ford-hospital-the-flying-bed-1932 or http://www.fridakahlo.org/henry-ford-hospital.jsp

Reflect

What is my first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?
What purpose did/does the work serve?
Is there a title to the work?

What is the subject matter?
Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in my practice? (5)

21st century representations

Today, we are inundated with vivid portrayals of pregnancy and birth. Not only through traditional representations in art, fiction, and poetry but also through explicit images in reality television and online. Today's media allows pregnancy and birth to be presented with more complexity and enables a wider range of experiences to be represented than could be in the past. Technology lets us participate in, reimagine and, even reuse representations of normal birth, complicated birth, pregnancy and birth with a disability, LGBTQ2 experiences, pregnancy loss, science fiction and **avatar births**.

In less than 50 years, the portrayals of pregnancy and birth have changed from artist's representations in text, sculpture and painting to include actual, vivid images we see on television, internet blogs and websites. Anyone with an internet connection can watch a video of labour and birth from beginning to end and view births in hospital, at home, a birth centre, in water, or in standing, squatting, or sitting positions. Social media platforms such as Twitter, Instagram and Facebook all facilitate text, photos and short videos of childbirth. From a distance, even as a stranger to those that post, we can get a glimpse into the meanings of birth for those individuals who post photos and videos.

Luce et al. (19), after reviewing several television episodes showing births, concluded that because of the appeal of

'emergency' births with complications, women may enter their own birth experience with fears generated by what they have witnessed. Those fears, she postulates, promote the medicalization of birth.

This fear of childbirth has grown as a topic of research over the past five years. Does access to copious sources of information increase or decrease women's fears? A Google search of personal stories of birth turns up tens of millions of possible results. How do childbearing clients sort through that information to find, not just accurate information, but stories from others 'like them'? If one is poor, culturally conservative, religious, what is the impact? Stoll and Hall (20) in their study of over 4,000 students at the University of British Columbia found that 'young women whose attitudes toward pregnancy and birth were shaped by the media were 1.5 times more likely to report childbirth fear.' (20) European renaissance women feared childbirth because of what they did not know; today we may fear childbirth because of all we do know.

Viewing other ways of being

The shifting landscape of representations of childbirth is opening up new ways of seeing and thinking about birth. Only in recent years have we seen representations of bodies and relationships that do not fit the traditional ideal. Disability, and LGBTQ2 experiences are beginning to be depicted.

Disability experience

Individuals with a disability have been marginalized in our society and as such, they are rarely the subjects of art. To some in society, those with disabilities are not meant to be sexual, let alone be

pregnant or a parent. (21) Marc Quinn was one of the first to challenge that view through large-scale sculpture. (22) Quinn has made several sculptures of Alison Lapper, while she was pregnant. Lapper is an English artist who was born with **phocomelia**. Quinn was drawn to Lapper as representing someone who overcame her circumstances. When she became pregnant she was urged to have an abortion so her child would not become a burden to society. She persisted, breastfeed her baby boy, took him to school on her wheelchair, fought for disability rights, and currently earns a living as an artist for the Mouth and Foot Painting Artists. She received an Honorary Doctorate from the University of Brighton in 2014.

Quinn's marble sculpture of Lapper was part of a rotating contemporary sculpture display in Trafalgar Square, London, UK (Figure 1-10), and it publicly celebrated the beauty of a different body. Met with both criticism and praise, the sculpture asks the viewer to question the narrow bounds of accepted social norms.

Did You Know?

A large-scale inflatable reproduction of Alison Lapper Pregnant featured as a centrepiece of the London 2012 Paralympic Games opening ceremony.

Reflect

What is my first response to the work?
When and where was the work made?
Where would the work originally have been seen/heard?

Figure 1-10. Alison Lapper Pregnant, sculpture by Marc Quinn, 2006. Photo by Brian Robert Marshall. *https://commons.wikimedia.org/wiki/File:Fourth_plinth,_Trafalgar_Square,_London_-_geograph.org.uk_-_440045.jpg*

What purpose did/does the work serve?
Is there a title to the work?
What is the subject matter?
Are there gender/power considerations with respect to the subject and maker of the work?
How has my response to the work changed over time?
How could I use this piece of work in my practice? (5)

For clients living with a disability, one of the most difficult aspects of learning how to be a parent, or cope with labour, is

Photo by annie. https://commons.wikimedia.org/wiki/File:Alison_Lapper_Pregnant_Paralympics_opening_ceremony.jpg

that there are very few images of parents with disabilities and very few opportunities to meet other parents who have similar needs. (23) There is no lack of images illustrating devices such as baby monitors, high chairs, and strollers for the parent who is able bodied. However, for parents with a disability it is very difficult to find suggestions for assistance, let alone teaching materials that might address their experience. (Figure 1-11).

LGBTQ2 experiences

Only recently has the health literature begun to address the pregnancy and childbearing needs of individuals who identify or present as lesbian, gay, bisexual, transgender, queer or double spirited. Midwifery and doula websites in Canada and elsewhere provide guidelines for sensitive care. Many of the guidelines are based on the philosophy outlined by Canadian Association of

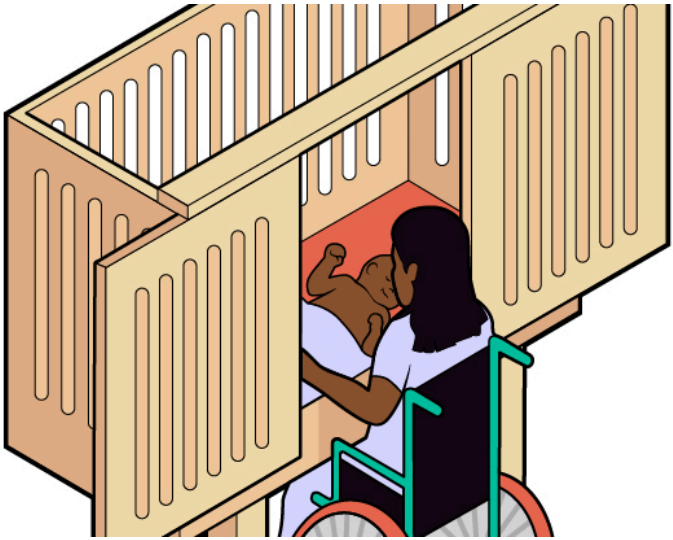

Figure 1-11. Illustration of accessible crib use.

Midwives position statement on Gender Inclusivity and Human Rights. (24)

The experience of transgender pregnancy in particular has been described in newspapers and academic text. The photographic images and written text of Thomas Beatie (Figure 1-12) and Yuval Topper's pregnancies are examples of representations available to us as we imagine the meaning of pregnancy to these men, their families and to society in the future. The opening of the Museum of Transgender Hirstory & Art, Chicago and the publication of graphic novels such as *Pregnant Butch* are examples of changes that provide tangible support for the accomplishments and possibilities for transgendered parents.

Figure 1-12. Thomas Beatie attending Stockholm Pride in 2011. Photo by Frankie Fouganthin.
https://commons.wikimedia.org/wiki/File:Thomas_Beatie_p%C3%A5_Stockholm_Pride_2011.JPG

Representations

We now live in a time when representations of the body in general and the pregnant body in particular are no longer so constrained by social convention. That is not to say that many representations don't raise questions of ethics or cultural appropriateness. How to interpret the explosion of representations is a challenge for all women and caregivers. Interpretation is influenced by the society we live in. The meaning of pregnancy and of birth is shaped by the society each client lives in resulting in great differences in meaning between rural Nunavut in Canada, urban New York City, or the less developed country of Sierra Leone. Societies are shaped by how women are viewed, how sexuality is viewed and the role

of religion in the society and the life of the individual, and each of these will impact on the meaning of birth to a client.

Birth is important. As women have more agency over the expression of representations of this life-changing event, they will be able to experience a meaning that fills them with feelings of strength and comfort. Sharon Olds (25) poem, *The Language of the Brag*, expresses the joy she feels in using her body in childbirth while utilizing male imagery to describe her strength and feeling of victory.

External Link

Read Sharon Old's poem *The Language of the Brag* here: http://www.poetrymagazines.org.uk/magazine/record.asp?id=2160

Conclusion

As members of a practice profession, midwifery students have an obligation to learn as much as possible about what affects clients, and themselves. As you develop your professional competencies, you have an obligation to interrogate your philosophy, knowledge, skills and attitudes on a regular basis.

As midwifery students, you work 'with women' at a time in life that can be celebratory or foreboding or both. You are with a client who has one of many possible family configurations, may have one or more sexual orientations, who may have strong ethno-cultural beliefs, and who may live a life of poverty or privilege. Carry with you the perspectives of each of these varied contexts

and enjoy the challenge of understanding those you work with as you and they discover the many meanings of childbirth.

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2. Midwifery Care & Human Rights

Lorna McRae, RM; Karyn Kaufman, DrPH

> A human is not isolated like an island, but is interconnected with families and communities. (1, p.15)

The work of midwives around the world is based on human connection. The relationship between midwives, families and communities is both a powerful and a privileged connection that is ideal for furthering social justice. Quality midwifery care incorporates values and philosophy that arise from a human rights perspective, a perspective that takes account of social determinants of health and their contribution to health.

This chapter explores several aspects of what it means to incorporate a human rights perspective into the work of midwifery. It will provide an overview of selected statements found in midwifery **codes of ethics** that underline the necessity for a human rights perspective and describe a human rights approach, what is meant by social determinants of health and how

they relate to **health inequities**. It will also provide a specific focus on the Aboriginal Peoples of Canada.

Midwifery Codes of Ethics

There is a moral imperative for midwives to care for mothers and babies regardless of their context or circumstances. As stated by McRae, (2) 'there is an ethical imperative based on the principles of fairness and the universal human right to the highest attainable standard of health to rectify health disparities.' (p.182) This ethical stance establishes a human rights approach to women, newborns and families around the globe, an approach that is echoed in codes of ethics for midwives.

Midwifery Professional Associations

International Confederation of Midwives (ICM)

The ICM is the international midwifery association that speaks globally for and about midwifery. Its Code of Ethics for Midwives (the Code) (3) 'acknowledges women as persons with human rights, seeks justice for all people and **equity** in access to health care, and is based on mutual relationships of respect, trust and the dignity of all members of society.' (p.1)

The Code directs midwives to develop partnerships, facilitate informed decision-making, and 'empower women/families to define issues affecting the health of women and families within their **culture**/society.' (3, p.1) The Code also states that 'midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances.' (3, p.2) This is a clear call to act in non-

discriminatory ways. In addition, the Code states that midwives 'together with women, work with policy and funding agencies to define women's needs for health services and to ensure that resources are fairly allocated considering priorities and availability.' (3, p.1) Here we have support for midwifery advocacy at all policy levels to improve approaches to care for women, their babies and families. Together, the selected statements from the ICM illustrate the centrality of a human rights approach to the provision of midwifery services. Given the extensive data about the global health, economic, social and political inequities for women (and children), the work of responding to inequities in our daily practice is critically important.

External Link

The International Congress of Midwives website is http://internationalmidwives.org/

Canadian Association of Midwives (CAM)

CAM is the professional association that represents midwives and the profession of midwifery across Canada. One of its expressed values is the belief that midwives must 'respect and embrace human dignity, diversity and equity in every facet of their work with clients and colleagues.' (4) CAM advocates at the national level for the potential of midwifery to enhance the wellbeing of individuals, families and society thereby acknowledging its ethical and organizational responsibility to contribute to improved health for all.

External Link

The Canadian Association of Midwives website is https://canadianmidwives.org

Provincial Midwifery Associations

Midwifery services in Canada are provincially/territorially legislated and each jurisdiction has a professional association that advocates for midwives. The basic principles of informed choice, pregnancy as a state of health, continuity of care, and choice of birthplace are imbedded in descriptions of midwifery care across the country and reflect similar values and philosophy. For example, the following statement is from The Association of Midwives of Newfoundland and Labrador (5): 'Midwifery care should be a choice for all women with uncomplicated pregnancies, regardless of geographic location, socioeconomic status, age, cultural background, gender orientation or religious persuasion.' (p.1)

Observing the right of women to participate in decision making about care supports non-discrimination since midwives must listen to women and provide time for women to find their own voice. In short, it recognizes the human rights of women seeking care.

Midwifery Regulatory Bodies

Each Canadian province and territory that regulates midwifery has a designated organization (most often a regulatory College) whose primary purpose is public protection. Therefore, a

regulatory body functions in the public interest by setting registration/re-registration criteria and publishing standards and policies regarding professional behaviour and clinical practice. The regulating authorities together form the Canadian Midwifery Regulators Council and it makes the following statement about the importance of Canadian midwifery to health and well-being (6): '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.' (p.1)

Putting this general statement into practice means having an understanding of human rights and determinants of health, and the ability to truly take the context of women's lives 'into consideration.'

The College of Midwives of Ontario regulates the largest group of midwives in Canada. A clear statement about protecting human rights is included in its Code of Ethics. (7)

> Each midwife is accountable for their practice, and in the exercise of professional accountability, shall: Provide care which respects individuals' needs, values and dignity, and does not discriminate on the basis of **race**, ancestry, place of origin, colour, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. (p.1)

Given that this statement comes from a midwifery regulator it imposes a direct responsibility upon midwives to uphold and protect the human rights of clients and their families.

The examples mentioned are illustrative of statements found in codes of ethics at the international, national and provincial/

territorial levels of the profession. Midwifery is not different from other health professions in advancing a code of ethics for its members. Similar statements can be found for nurses, (8) physiotherapists, (9) physicians (10) and indeed many more professions. Midwives collaborate with several other professions and though our actions and attitudes may differ at times, the common ground is in codes of ethics where statements about respect, dignity and human rights are readily found.

Human Rights & Social Determinants of Health

International, national and provincial midwifery Codes of Ethics provide a dynamic platform from which to participate in upholding human rights and increasing equitable outcomes for all mothers, newborns, families and their communities. Sanghera, et al., writes, 'A human rights approach is based on accountability and on empowering women, children and adolescents to claim their rights and participate in decision making, and it covers the interrelated determinants of health and well-being.' (10, p.42)

This section will now turn to furthering a conceptual understanding of the inter-related nature of human rights, social determinants of health and health inequities. The following concepts are important for this understanding:

Health inequalities: Differences, variations and disparities in health status and risk factors of individuals and groups that need not imply moral judgement. Some inequalities reflect random variations (i.e. unexplained causes), while others result from individual biological endowment, the consequences of individual choices, social organization, economic opportunity, or access to health care. (12)

Equity: The absence of unfair and avoidable or remediable

differences in key indicators among social groups. It is both a process and a goal. It involves the recognition of difference in treating everyone fairly. Sometimes it means treating people differently in order to achieve equality. (13)

Human Rights

The Canadian Human Rights Commission states, 'Human rights define what we are all entitled to – a life of equality, dignity and respect; a life free from discrimination. You do not have to earn them. It's the same for every man, woman and child on earth' (12, p.1). Equality, dignity and respect for all regardless of income, education, race, **ethnicity**, age, ability and social status remains an elusive ideal but one towards which everyone can work.

Did You Know?

John Rawls, an American political philosopher, developed a theory to help illustrate the many social, political and economic factors that influence the practical application of human rights, justice, and fairness in our society. His 'veil of ignorance' thought experiment is explained clearly in this video: https://www.youtube.com/watch?v=5-JQ17X6VNg

The Canadian Human Rights Act protects persons from **discrimination** based on race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability, a conviction for which a pardon has been granted or a record suspended. There is abundant evidence nationally that

when these aspects of human rights are not upheld there are negative effects on socioeconomic status and health. (14,15)

A further protection was advanced by the Canadian Association of Midwives (CAM) in 2015 in the organization's Statement on Gender Inclusivity & Human Rights, (16) which reads in part:

> We are committed to including trans, gender queer, intersex and marginalized communities in our central dialogue and ensuring that CAM is inclusive in its statements, actions and in all aspects of its work. These priorities are not established by the needs of the majority but by the importance of the inclusion of all people. (p.1)

The document continues:

> We are aware that transphobia disproportionately affects those with other, often intersecting, marginalized identities such as racialized persons, self-identified **Indigenous people**, those living as colonized people, those living with the legacy of residential schools, differently abled people and all living with the effects of the social determinants of health. (p.1)

The Role of Reflection

The CAM Statement is a clear example of a professional commitment to using a human rights approach to address discrimination and the resulting inequities in health care experienced by individuals. Having an intentional human rights perspective requires a commitment to the principles of **praxis** (the

continual interplay between reflection and action), the personal (that who we are and where we come from matter deeply in addressing health inequities), and partnership (community building amongst individuals with varied demographic backgrounds). (17)

Reflection on our personal and our communities' experiences stemming from our race, class, sex, abilities, gender orientation and identity, and sexual orientation is essential when considering the challenges and opportunities in working together towards greater equality and protection of human rights for all. Considering questions such as 'Who am I?' and 'Where did I come from?' is work that is psychologically and spiritually challenging. Our personal and professional relationships of power and privilege are not static. We age, our abilities may temporarily or permanently change, and our incomes increase or decrease. Other aspects of our identities, such as the colour of our skin, or the kind of family we were born into, don't change. Our perspective is both limited and expanded by the specificities of our lives, which, if unexamined, can lead to a failure to see our interconnectedness. Our knowledge of power and privilege should and must inform a strong ethical and human rights approach to our work as midwives.

In an effort to genuinely discuss the everyday trauma and resilience of people facing inequities, I respectfully and proudly use my history in my family and communities to illustrate that where we come from matters deeply. My history includes being the 10th of 14 children, raised in a context of poverty. When I look at family photos the caricature of poverty is evident in our mismatched clothing, our unkempt hair and the dirt under our fingernails. However, those deeply ingrained and stereotypical images of poverty tell nothing of my richly complex and dynamic family. When talking and thinking about people and communities

that are marginalized and have poor outcomes, we need to look more deeply. Nancy Scheper-Hughes, (18) writing about mother love and infant mortality in an impoverished area of Brazil, says,

> I am searching for a more intimate, less alienating way to talk about social class formation… one that takes into account cultural forms and meanings as well as the political economy. Although the foresters could be described as a 'displaced rural proletariat' or even as a new formed 'urban class,' they are both of these and yet a good deal more. They are poor and exploited workers, but theirs is not simply a 'culture of poverty,' nor do they suffer from a poverty of culture. Theirs is a rich and varied system of signs, symbols and meanings. (p.91)

People are negatively impacted by racism, classism, sexism, ableism, ageism and other identities. Stereotypes result from believing that all people with a particular characteristic are the same. Stereotyping is revealed in our responses to marginalized groups and is an insidious and powerful force within society. To reiterate – who we are and where we come from matters and we must know ourselves to engage in a human rights approach to midwifery care.

Reflect

Read the following thorough discussion of Power and Privilege by Maisha Z. Johnson: http://everydayfeminism.com/2015/07/what-privilege-really-means/

What are three areas of privilege in your current

circumstance?
Can you recall an instance when you used privilege to increase or decrease your sensitivity to people you interact with in your current circumstance?

Right to Health

The right to health is viewed as fundamental and is recognized by several legal codes and treaties relating to human rights, including the International Covenant on Economic, Social and Cultural Rights; the Convention of the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination against Women, The Declaration on the Rights of Indigenous Peoples, the Convention on the Rights of Persons with Disabilities and the International Covenant on Civil and Political Rights. (11) When considering health as a right, it is important to take account of the World Health Organization (WHO) (19) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (p.1). However, determining whether an individual or group or country is 'healthy' is daunting. There is no perfect measure of the several dimensions of health that are included in the WHO definition.

Despite its limitations, a frequently used measure of the health of a population is life expectancy. The WHO Global Commission on Social Determinants of Health (CSHD) begins a report (20) with a sombre statement, 'our children have dramatically different life changes depending on where they were born. In Japan or Sweden, they can expect to live more than 80 years; in Brazil, 72 years, India, 63 years; and in one of several African countries, fewer than 50 years.' (p.26)

External Links

The International Convention on Economic, Social, and Cultural Rights can be found here: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

The Convention on the Rights of the Child can be found here: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

The Convention on the Elimination of All Forms of Discrimination against Women can be found here: http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf

The Declaration on the Rights of Indigenous Peoples can be found here: http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

The Convention on the Rights of Persons with Disabilities can be found here: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

The International Covenant on Civil and Political Rights can be found here: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

Even within Canada, which enjoys a high ranking (tied 9th with New Zealand out of 188 countries) on the Human Development Index, (21) where a long and healthy life is one of the primary measures, Statistics Canada reports (22) 'gaps between Aboriginal groups and the general Canadian population varied from 5 years to 14 years in 2001.' (p.22)

Using studies from nations like Canada that are termed 'developed,' Galea et al., (23) published findings from a meta-analysis about the number of deaths attributable to social factors. From over 400 studies, 47 of which met their evidence criteria, they concluded the number of deaths attributable to six social and interrelated factors (low education, poverty, low social support, area-level poverty, income inequality and racial segregation) was similar to the number of deaths from pathophysiological and behavioural causes. Findings from countries at all levels of income show that health and illness follow a social gradient: the lower the socioeconomic position, the worse the population health. (20)

The health sector in every country can use internationally and nationally recognized human rights mechanisms for pressuring regional, national and international bodies for social, economic and political reforms and policies to decrease health inequities. The right to health applies to all women and their babies. Midwives can provide care that attends not only to the physical survival of the birthing parent and baby, but also to their psychological and emotional well-being through the life course. (24)

Despite the stance that health is a right, the evidence is clear that there are unequal outcomes related to many aspects of who we are, where we live and how well we live. We are born into communities and develop multiple identities, which intersect with social, political and economic realities. Health is affected by these realities, thus the focus on understanding the impact of these social factors/determinants of health.

Social Determinants of Health

The WHO Commission on the Social Determinants of Health

outlines an evidence informed framework for understanding the mechanisms of health inequities and the actions that can be taken to decrease those disparities (Figure 2-1). (20)

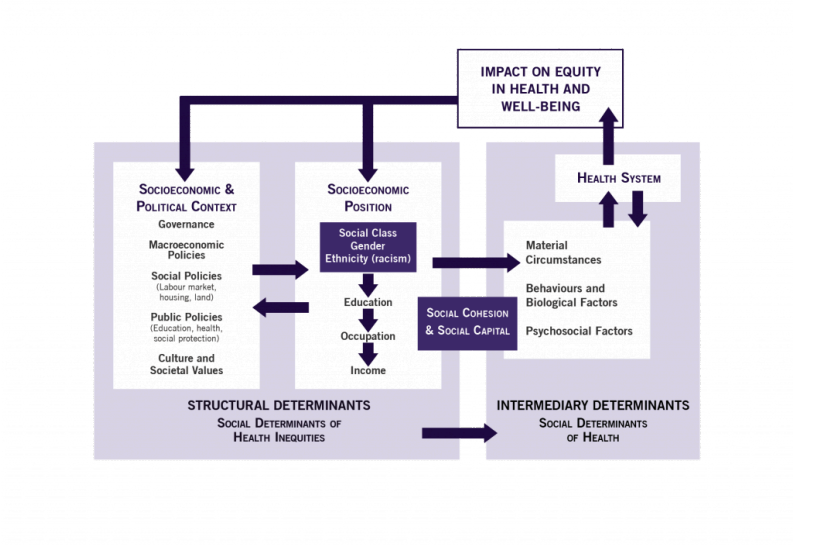

Figure 2-1. Social determinants of health and health inequities. After (20).

The far left side of the diagram shows elements of the socioeconomic and political context that are

> broadly defined to include all social and political mechanisms that generate, configure and maintain social hierarchies, including the labour market; the educational system, political institutions and other cultural and societal values. … Structural mechanisms are rooted in the key institutions and processes that are part of the socioeconomic and political context. (19, p.9)

Key institutions, as referred to in the above quote, hold a great deal

of power in all societies. However, that power is not absolute and can be challenged, successfully. Duflo and Banerjee (25) outline some of the examples of their randomized experiments to create institutional change that offer a measure of optimism. They note the success of creating change through actions such as publicizing corrupt practices or threatening audits.

Often, small changes make important differences. In Brazil, switching to a pictorial ballot enfranchised a large number of poor and less educated adults. As a result, the politicians they elected were more likely to enact policies that assisted the poor. In China, even very imperfect elections led to policies that were more favourable to the poor. In India, when quotas for women on village councils were enacted, women leaders invested in public goods preferred by women. A 2016 example from Canada is the prolonged, but successful, nine-year legal battle waged by Dr. Cindy Blackstock and the First Nations Child and Family Caring Society of Canada about the underfunding of child welfare services on reserves compared to funding for children who lived off reserve. The Canadian Human Rights Tribunal rejected the government's arguments that the Canadian Human Rights Act should not override decisions about funding to **First Nations** communities. (26)

The second left column of the framework depicts the elements of socioeconomic position: income, education, occupation, social class, gender, race/ethnicity. The interactions of these elements with the socioeconomic and political context are together conceptualized as structural determinants within the larger portrayal of social determinants of health inequities. They are shown to directly impact the third column (right side of the diagram).

The circumstances depicted in the third column are what we each see and experience to some degree or other. The differences

in material circumstances (housing, neighborhood quality, food security, water), psychosocial circumstances (individual and community stressors, social supports, coping abilities), and behavioral and biological factors (nutrition, physical activity, consumption of tobacco and alcohol, genetics, diseases) directly affect health and well-being. Also evident in the diagram is the cyclical nature of this relationship. Persons who experience poorer health may experience a loss of socioeconomic position, often due to job limitations, reduced income, poorer housing, etc., which, in turn, continues to impact health outcomes.

The diagram makes clear that the health system is only one factor that can contribute to reducing health inequities. This is not to minimize the importance of ethical and respectful care from midwives and others, but all providers need to recognize that, 'Structural societal factors, such as poverty, gender inequality, and other forms of discrimination (such as racism) and inequality directly and indirectly affect reproductive, maternal, newborn, child and adolescent health and generate health inequities.' (26, p.36) Interventions to mitigate these adverse factors are complex and require a host of changes to, for example, reduce poverty, end child marriage, and stop violence against women and children.

The relationship between social factors and health has been shown by Richard Wilkinson (28). Wilkinson's research found parallels between studies of weight gain in babies and studies of deaths and income distribution in adults. In each group the importance of meeting social needs was found to be significant. For the infants, it was interaction with loving caregivers that was shown to be critical to their weight gain and development. Researchers used indicators from the International Index of Health and Social Problems, such as life expectancy, teen births, obesity, mental illness, homicides, imprisonment, infant mortality, to demonstrate that the greater

the income differences within a society, the less well-being there is for all members of that society.

An added perspective to incorporate into considerations of social determinants of health is that of life course. This term is used by epidemiologists, economists, political theorists, statisticians and health care providers. (24, 28–33) While it seems evident that the past is always present, life course theory holds that one's health status reflects both historical and contemporaneous conditions. This perspective is evident in Reading and Halseth (35).

> Social determinants can include cultural, economic, and political forces which interact in a multitude of ways to contribute to or harm the health of individuals and communities. The impact of these forces during childhood can have long-lasting health implications through the life course since material deprivation can influence child and adult circumstances and behavior. The interactions between these various forces are important parts of the health and disease puzzle. (p.5)

Contributing to Action

The material in this section has introduced theoretical perspectives about the inter-related nature of human rights, social determinants of health and health inequities. The hope is that it provides a greater understanding of problems where human rights are compromised, inequities persist and there are continuing consequences for human health. Through this increased

understanding of health inequities midwives can contribute to solutions.

The Public Health Agency of Canada, the National Collaborating Centre for Determinants of Health, the Canadian Population Health Initiative, the Canadian Public Health Association, the Institute of Population and Public Health, and the Population Health Promotion Expert Group of the Pan-Canadian Public Health Network worked together to construct a framework for actions to reduce health inequities (Figure 2-2).

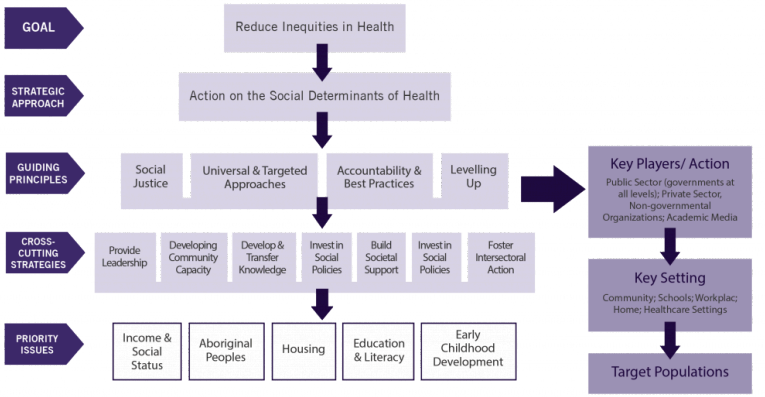

Figure 2-2. Framework for actions to reduce health inequities. After (36).

The strategies for change arise from considering the social determinants of health and cut across multiple sectors in order to address priority issues, which include Aboriginal peoples and early childhood development. These are issues that engage midwives, individually and collectively. Midwives can be part of

actions that lead toward equity. While there is much work to do, an evidence informed approach is our responsibility.

A Focus on the Aboriginal Peoples of Canada

Social determinants of health have special resonance for the Aboriginal Peoples of Canada, among whom indicators of health status demonstrate persisting inequalities, including a gap in life expectancy between Aboriginal groups and the general Canadian population. Statistics Canada data from 2011 showed that the probability of living to age 75 for both men and women who were age 25 and were Registered Indians, non-status Indians or **Métis** was 10-19 percentage points lower than for all men and women of comparable age. (38)

Further evidence of disparities comes from the Community Well-Being (CWB) scale for First Nations, developed by Indian and Northern Affairs Canada, which measures education, labour force participation, income and housing. It indicates that Aboriginal communities represent 65 of the 100 unhealthiest Canadian communities. (38) The effects of these inequitable social determinants of health are evident in the poorer physical, mental, and emotional health of many Indigenous peoples. The complex interaction between various social, political, historical, cultural, environmental, economic and other forces are increasingly understood to shape health for individuals that must be addressed through a social determinants approach. (39)

In 2013, the Assembly of First Nations developed the framework in Figure 2-3. It is highly specific to First Nations and created to address the fact that First Nations people have poorer health outcomes than most Canadians.

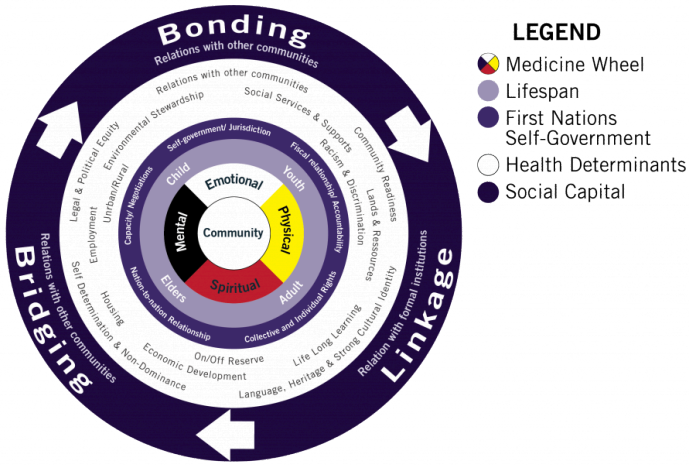

Figure 2-3. First Nations holistic policy and planning model. After (38).

The framework includes a circle with many health determinants. These have been echoed by Indigenous studies scholar Yvonne Boyer (1) who examined historical and current Canadian legal policies and their impact on health. She identified six determinants of health: poverty, poor quality housing and overcrowding, poor water quality, geography and its impact on access, environmental factors, and colonialism. The impact of the Canadian policy of colonialism on Indigenous people is supported by Kreiger and Beckfield's epidemiologic review of how political systems and priorities shape inequalities. (33) Special emphasis is given to geography by Sarah de Leeuw (41) who suggests that, 'geography as a physical and material entity – place, weather, land, space, ecology, territory, landscape, water, ground, social and the like – is

a remarkably powerful determinant of Indigenous peoples' health that is not, cannot, and should not be encapsulated with a 'social' determinants of health framework.' (p.90)

Midwifery Initiatives to Address Inequities

This brief overview of conceptualizations about determinants of health for Aboriginal Peoples of Canada cannot do justice to the topic, and can serve only as an introduction to some actions within Canadian midwifery to address inequities. In 2015, the Midwives Association of British Columbia secured provincial funding for all its members to enrol in the Indigenous Cultural Competency core health training course designed by the Provincial Health Services Authority to enhance knowledge of Indigenous peoples, increase self-awareness, and strengthen service providers' skills to work with Indigenous Peoples.

At a broader level, the National Aboriginal Council of Midwives (NACM) 'advocates for the restoration of midwifery education, the provision of midwifery services, and the choice of birthplace for all Aboriginal communities, consistent with the UN Declaration on the Rights of Indigenous Peoples' (41, p.3); and 'promotes excellence in reproductive health care for **Inuit**, First Nations and Métis women' (43, p.1).

External LInk

Visit the NACM website here: http://aboriginalmidwives.ca/

Did You Know?

In 2007, UNDRIP was adopted by the UN General Assembly with 144 states endorsing the Declaration. Canada, Australia, New Zealand and the United States voted against it. In 2010, Canada endorsed it as an aspirational document but then did not adopt the action-oriented outcome document in 2014. (44) On June 15, 2017, the joint AFN-Canada Memorandum of Understanding on Joint Priorities was signed, committing the Government of Canada to work in partnership on a number of priorities including full and meaningful implementation of United Nations Declaration on the Rights of Indigenous Peoples, including co-development of a national action plan and discussion of proposals for a federal legislative framework on implementation. (45)

External Link

NACM has created several resources on the significance of Aboriginal midwifery.

Videos:

Aboriginal Midwifery can be found here: http://www.isuma.tv/en/national-aboriginal-council-of-midwives/aboriginal-midwifery-video

The Job of an Aboriginal Midwife can be found here: http://www.isuma.tv/en/national-aboriginal-council-of-midwives/aboriginal-midwives

Downloadable PDFs:

Restoration and Renewal of Aboriginal Midwifery can be found here: http://aboriginalmidwives.ca/sites/aboriginalmidwives.ca/files/pamphlet-three-double_panels.pdf

Aboriginal Midwifery in Practice can be found here: http://aboriginalmidwives.ca/sites/aboriginalmidwives.ca/files/pamphlet-two-double_panels.pdf

NACM is working to bring to fruition the spirit of Article 23 of UNDRIP that states (1) 'Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them.' (p.164) 'As a strong national Indigenous midwifery organization, NACM has an important leadership role in maternal-child and Indigenous health in Canada and globally. There are several ways NACM members individually and collaboratively contribute to the broader goal of equitable access to care and self-determination of Indigenous people's health.'(41, p.12)

The return of birth to Aboriginal communities is of special interest because of long standing practices in many Aboriginal communities to transport pregnant women away from their home community to a large centre to await the birth. Women often spend several weeks separated from family and friends in unfamiliar surroundings, away from their usual food and language and social support network. A project to return birth to an Aboriginal community is an impressive example of a specific and sensitive intervention. An assessment of the experience of Inuit women in Nunavik, Quebec from 2000-2007 revealed low rates of intervention with safe outcomes in the more than 1300 young, largely multiparous, Inuit group. The local birth facilities involved a team approach with midwives, physicians and nurses, with 85%

of births attended by midwives. This model of care developed over a long period and has been a sustained community-professional collaborative effort to screen appropriately, to support women who must be transferred for medical reason, to return birth to remote communities and to build midwifery skills in Aboriginal women. (46,47)

External Links

NACM has created a variety of media to describe Aboriginal midwifery and its impact on Aboriginal midwives themselves, and the communities they serve. Interview clips (mp3) with seven Aboriginal midwives can be found here:
http://aboriginalmidwives.ca/resources

Conclusion

This chapter has shown the central place of human rights within the professional codes of ethics set out for midwives. Enacting those codes requires that midwives understand how health inequities are linked with social determinants and failures to observe the right to health. We must be explicit that our codes of ethics are inextricably linked to actions that reflect the human right to health and dignity. An approach to midwifery provision of care, regulation of the profession and education of future and current midwives can use an intentional human rights perspective to reveal social, economic and political injustices. With careful, sensitive and specific interventions midwives can be a vital

resource for improving outcomes for childbearing clients and newborns, and furthering sustainable local, national and global development goals. These goals matter deeply to each of us and to our communities.

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3. Midwifery Matters

Mary Renfrew, BSc, RN, RM, PhD, FRSE

This chapter will focus on the contribution that midwifery can make to the health and care of childbearing women, newborn infants , and families worldwide. It describes and defines midwifery, and summarizes the evidence on the impact of midwifery on survival, health and well-being. It identifies current data on important health outcomes, and presents a framework for understanding the different dimensions of the quality care that health systems should provide. The chapter also will examine why, when midwifery has been shown to be so fundamentally important, it is not already fully implemented in every country. Current global developments and challenges are outlined, and the need for strong advocacy for the development of midwifery is described. The chapter draws in large part on evidence published in The Lancet Series on Midwifery (1–4) and on a key WHO report. (5) More detail can be found in those documents.

Introduction

Midwifery matters for all childbearing women, their babies, and their families, wherever they live in the world, and whatever their circumstances. Evidence shows that skilled, knowledgeable and compassionate midwifery care reduces maternal and newborn mortality and stillbirths, keeps mothers and babies safe, and promotes health and well-being. (1,2) In so doing, midwifery has a positive impact on the wider health system, and the economic sustainability of communities and countries. (3,4)

Midwifery achieves this impact by providing care for women and babies – all women and babies, both with and without complications – across the continuum from pre-pregnancy, pregnancy, labour and birth, and in the early weeks after birth. Good quality midwifery care offers a combination of prevention and support, early identification and swift treatment or referral of complications, respectful and compassionate care for women and their families at a formative time in their lives. Midwives work to strengthen women's own capabilities and the normal processes of pregnancy, birth, postpartum, and breastfeeding (Table 3-1).

Table 3-1. Definition of midwifery from The Lancet Series on Midwifery (1, p.1130)

> Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimizing normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families.

Midwifery is an essential part of any health system, and work to reform health systems will be strengthened by the implementation of good quality midwifery. (6) Working in partnership with other care providers – doctors, nurses, community and public health workers – midwives help to ensure that the woman, her baby and her family receive the right care at the right time. Even in settings where there are no midwives, or where midwives' scope of practice is limited, women and babies need midwifery care. In these settings, care should be provided by others – whether doctors, nurses, community health workers, or others – who have essential training in midwifery skills. It is likely to be necessary in such situations for healthcare staff to work together to ensure that women and babies receive the full scope of care that they need.

The international definition of the midwife is shown in Table 3-2, demonstrating that anyone holding the title 'midwife' should meet the internationally-agreed standards for education and competence in practice.

Table 3-2. International definition of the midwife (7, p.1)

> A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the International Confederation of Midwives' (ICM) *Essential Competencies for Basic Midwifery Practice* and the framework of the ICM *Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

Maternal and Newborn Health and Care: Current Trends

Survival of Childbearing People and Newborns

Although pregnancy and birth are often straightforward and joyous events, complications for the woman, fetus, and newborn do occur, and can result in disability or death if appropriate care is not provided swiftly. Despite the worldwide gains in reducing maternal mortality in recent years, levels of mortality and morbidity for women and infants remain unacceptably high in many parts of the world with poor quality care being a major contributing factor. As a consequence the rights of childbearing women and infants to health and to life are severely compromised. (8,9)

The statistics that follow demonstrate the scale of the challenge

to reduce stillbirths and maternal and newborn mortality. Behind these numbers lie the stories of the deaths of women and babies, each of which is a tragedy with a lasting impact on the partner, other children, grandparents, wider family and community. While the majority of these deaths occur in low- and middle-income countries, preventable deaths also happen in high-income countries.

Maternal Deaths

Although there has been a decline of over 40% in maternal deaths since 1990, an estimated 303,000 women still die each year as a result of complications of pregnancy and childbirth, mostly in low- and middle-income countries. (10) Excessive blood loss, high blood pressure and overwhelming infection are responsible for more than half of these deaths, most of which are preventable. (11)

Newborn Deaths

Around 2.7 million babies die in the first 28 days after birth, accounting for 45% of all under-five-year-old deaths. (12) Almost one million of these deaths occur on the day of birth. By the end of the first week of life a total of nearly two million babies will have died. Again, most of these deaths are preventable. More than 80% of all newborn deaths and stillbirths result from the complications of prematurity (being born too early), complications during labour and birth such as **birth asphyxia**, and neonatal infections. Evidence is available on ways to prevent or treat these conditions.

Stillbirths

An estimated 2.6 million third trimester stillbirths occurred worldwide in 2015. Stillbirth rates have declined more slowly since 2000 than either maternal mortality or mortality in children under five. (13) The loss to mothers and families is profound, and the long-lasting grief can be compounded by shame and even a sense of failure.

Did You Know?

Although the majority of these deaths occur in low- and middle-income countries, preventable deaths also happen in high-income countries.According to 2011 data from the US National Center for Health Statistics, when compared to seventeen other industrialized countries, the United States experienced the highest neonatal mortality rate at 4.04 per 1000 births. (14) Comparing maternal mortality rates between industrialized countries with over 300,000 births/year, the USA had the second highest rate of mortality with 16.8 maternal deaths per 100,000 births. (14)

Gene Declercq, PhD, created Birth by the Numbers, and summarizes these statistics in this video: https://youtu.be/a_GeKoCjUQM

The Health and Well-being of Childbearing Women & Infants

Essential as it is that lives be saved, it is also important that the huge majority of women and infants who survive childbirth have

the appropriate care and support to enable a healthy and happy start to life.

Around 138 million women and 136 million infants survive childbirth. Of these, it is estimated that around 20 million women will experience acute and/or chronic clinical or psychological morbidity, such as incontinence, pain, and mental health problems, which can have a lasting effect on not only maternal but also infant physical and psychological health and well-being. (15) Additional burdens may result in the event of ongoing health care costs or an inability to work or inability to care for family members. (16)

A contributing factor to clinical and psychological morbidity is inappropriate use of interventions in childbirth, such as routine **episiotomy**, unnecessary cesarean births, which require the additional intervention of anesthetic procedures, and routine use of supplementary fluids for breastfed infants. Some health care systems have developed in a manner that focuses primarily on the identification of risk and the use of technological interventions. In such systems, interventions that are beneficial for women or babies with complications can be used routinely, resulting in those without complications being exposed to unnecessary and potentially harmful interventions. For example, lives can be saved by a cesarean birth when it is needed, but provide no benefit and potential harm to those who do not. The dangers of technological solutions becoming a key goal of the system, is demonstrated by the high rates of cesarean births in low- and middle-income countries, including Brazil (52% in 2010 (17)) and China (54-64% in 2008-2010 (18)), as well as by the high rate in the USA (32.8% in 2012). The consequence of a technology and intervention based approach is that the needs of pregnant women babies and families are not met and the opportunity to provide high-quality care is

missed. There is also increasing concern about the sustainability of over-medicalized health systems.

A contributing factor to clinical and psychological morbidity is the inappropriate use of interventions in childbirth, such as routine episiotomy (a surgical incision of the perineum), unnecessary caesarean sections together with the necessary anesthetic procedures, and routine use of supplementary fluids for breastfed infants. Some health systems have developed to focus primarily on the identification of risk and the use of technological interventions. In such systems, interventions that are beneficial for some women and babies with complications can be used routinely, resulting in women and babies being exposed to the risk of potentially harmful interventions. It is not hard to understand that low- and middle-income countries looking for models of care to implement might be influenced by the apparent benefits of technological solutions. Lives can so obviously be saved by a caesarean section when it is needed. The dangers of technological solutions becoming the key goal of the system, however, are demonstrated by the escalating rates of caesarean section in Brazil (52% caesarean section rate in 2010 (17)) and China (54-64% caesarean section rate in 2008-2010 (18)), and by the escalating rates of interventions in the US. The consequence is that the needs of women, babies and families are not met and the opportunity to provide high quality care is missed, and there is increasing concern about the sustainability of over-medicalized health systems.

Breastfeeding

Breastfeeding makes a fundamentally important contribution to the health of the newborn and its development, as well as to the

mother's own health. (19) Breastfeeding rates are low in many countries, however. Despite the global recommendation that all babies should be exclusively breastfed until six months of age, the rate in low- and middle-income countries is only 37%. (19) Rates are even lower in high-income countries. (19) Breastfeeding rates, in common with many other indicators of health and well-being, are related to social inequalities.

External Link

The Lancet Series created a map of the global distribution of breastfeeding at 12 months, which you can view here: http://www.thelancet.com/cms/attachment/2062646895/2065058658/gr1_lrg.jpg

A baby's chances of being breastfed are affected by broad socio-economic and cultural trends; increasing urbanization, the marketing and availability of breastmilk substitutes, intergenerational patterns of feeding, and increasing employment rates for women in the absence of workplace and social support for breastfeeding, all have an influence. (20,21) The care and support that women receive from the health system can make a difference and can improve rates of breastfeeding. (22) This can include individual support by midwives and other health professionals, and by working to systematically remove harmful practices, such as routine supplementation with breast milk substitutes, limiting breastfeeding, and separating mothers and babies in hospital and community settings. The global effort mobilized under the Baby Friendly Hospital Initiative (BFHI), also known as the Baby Friendly Initiative (BFI), was launched in 1991 by the World Health Organization (23) and UNICEF (24) with

the aim of implementing practices that promote and support breastfeeding in all facilities providing maternity care and of removing harmful practices. There is an accredited programme that a maternity facility can take to support successful breastfeeding and be designated as baby-friendly. (24) The initiative has had a proven impact in increasing the likelihood of exclusive breastfeeding during the first six months of life. One such example is Cuba, where 49 of the country's 56 hospitals and maternity facilities have received the Baby-Friendly designation. Between 1990 and 1996 the rate of exclusive breastfeeding at four months of age nearly tripled from 25% to 72%. (24)

Longer Term Impact of Pregnancy & Birth

Birth is a very important stage in the journey of a child's life, but what happens before and after birth will shape each child's future. The first 1000 days of a child's life – from conception to age two – are critical in the establishment of a foundation for longer-term health, development, and well-being. In that time, the child's brain and nervous system are developing more rapidly than at any other time of life. The essential connections between physiology and psychology are being laid down; hormonal responses to stress and to both positive and negative feelings are learned.

In the early days, weeks and months of life the child will learn to form close and loving relationships, to develop confidence in his or her own abilities, to cope with adversity, and the essential skills of being a healthy and happy human being – or not, depending on the circumstances into which the child has been born. (25–27)

The short-term importance for the social and psychological well-being of mothers and their babies that results from receiving supportive high-quality care during pregnancy, birth and beyond

is shown in newer research. However, there remains a paucity of longer-term population data on the social, emotional, developmental and mental health clinical outcomes. These longer-term outcomes are rarely measured or monitored, which places limits on our understanding of the impact of different systems of care. It is clear, however, that no matter the circumstances, the care and support provided through pregnancy, birth and postpartum plays an important role in the client's ability to love and care for their child. (26)

While the importance of pregnancy, birth and beyond for the social and psychological well-being of babies and women is now better understood, population data on the prevalence of social, emotional, developmental and mental health outcomes is much harder to obtain than shorter-term clinical outcomes. These outcomes are rarely measured or monitored, which currently limits our understanding of the impact of different systems of care. What we do know, however, is that whatever the circumstances, the care and support of the mother through pregnancy, birth and after birth can play an important part in the mother's ability to love and care for her child. (26)

Underlying some of these challenges is a disturbing problem of disrespect and even abuse of women and their partners/family members within the health care system. There are reports of being shouted at or scolded, abandoned when in need of care, being subject to discrimination, and having non-consented interventions. (28,29) Such treatment breaches professional standards and is a serious infringement of the human rights of childbearing women and their babies, and may stop women from seeking the care they need. These outcomes are not often measured, whether through routine data collection systems, or in specific surveys. Therefore, it is very difficult to know the

prevalence of such incidents in different countries, and whether the situation is improving or worsening.

In summary, it is essential to know about the trends in key outcomes if students, practitioners and the profession of midwifery are to properly understand the needs of the clients, infants and families in their own and other settings. Comparing outcomes with other, similar settings, and monitoring changes across time is also important. As the Scottish physicist William Thomson Kelvin (1924-1907) said: "If you do not measure it, you cannot improve it."

What do all Childbearing Women, Children and Families Need?
How can Midwifery Contribute?

The challenges we have just described inevitably raise important questions, such as: How do we improve the current situation? How can we consistently provide the compassionate, respectful care for women, babies and families that is so important at this vulnerable and formative time? How do we keep women and babies safe from harm? How should resources best be spent – on large hospitals, or on community services? How do we provide the right level of interventions such that they are available when needed but not overused? How do we make sure we reach all women and babies, and ensure that the most vulnerable are not excluded from access to good quality services? Who are the best caregivers for childbearing clients and newborn infants – midwives, obstetricians, nurses, or community health workers?

These are just some of the questions that health planners and health professionals must answer when planning services,

deciding how to allocate resources, and managing the education of health professionals. These questions are fundamentally important, and sometimes contentious. People often have different opinions, and may argue that funds should be invested in one aspect over another. For instance, some may champion the needs of women, while others may focus on ill babies.

Evidence is essential to answer questions, but sometimes the evidence is not available in the form that we need, or not available at all. There are many randomized trials of treatments of complications, for example, but there are far fewer studies on how to prevent those complications happening in the first place. Very few studies have attempted to examine all the different aspects of quality needed to meet the needs of women and babies.

Quality Care for Women, Babies & Families – The Evidence-informed Framework

These questions were considered as part of the work of the global collaboration that developed The Lancet Series on Midwifery, the most far-reaching and high profile analysis of midwifery to date. (1–4) This work has been warmly welcomed by the international health care community, and is being used by national and global organizations to inform new strategic developments.

Did You Know?

The Lancet Series on Midwifery was developed collaboratively by an international, multidisciplinary group that included the input of researchers, advocates for women and children, clinicians from a range of disciplines, and policy-makers.

External Links

The Lancet Series on Midwifery has created the following YouTube videos to summarize the series and describe the framework for quality maternal and newborn care (QMNC):
https://www.youtube.com/watch?v=JjJ2zpgbF9A
https://www.youtube.com/watch?v=_s1TIt05Ycc
https://www.youtube.com/watch?v=WwdqjpPqzVk
https://www.youtube.com/watch?v=2pfskj_xbGE
https://www.youtube.com/watch?v=UiXvtddT7r4

International responses to the series include this video: https://www.youtube.com/watch?v=RY-FBPjU9Vk

Early in the process, it was recognized that to examine the impact of midwifery, it needed to be measured against a gold standard quality of care, but that one did not exist. Previous studies had not examined all the evidence needed and had not conducted analyses in ways that could best answer some of the key questions. The authors of the Lancet Series on Midwifery had to start by agreeing to a set of core principles to guide the new analyses (Table 3-3).

Table 3-3. Cores principles used in analyzing evidence in The Lancet Series on Midwifery

- Focus on the needs of women, infants, and families
- Examine care across the continuum from pregnancy to the early weeks after birth
- Employ a human rights-based approach: all women and babies regardless of context or circumstances
- Consider all relevant outcomes – survival, health, well-being
- Examine needs in all settings – low-, middle-, high-income
- Take a long-term view – quality care and services; no quick fixes
- Distinguish between what, how and who in analyzing interventions
- Consider interdisciplinary, cross-sectoral working in the context of the health system
- Consider a diverse workforce
- Examine the specific contribution of midwives
- Use diverse sources of evidence in a rigorous and transparent approach
- Develop an evidence-informed consensus

The authors then combined different kinds of evidence – reviews of women's own views and experiences, reviews of randomized controlled trials, and case studies – to identify all the elements needed by childbearing women, babies and families, wherever they live. Using this evidence, they built a framework to explain what was needed.

External Link

The following content discusses the visual found here: http://www.thelancet.com/cms/attachment/2021722654/2041538459/gr2_lrg.jpg

It was originally published as Figure 2 in: Renfrew MJ,

McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, et al. Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. Lancet. 2014;384(9948):1129–45.

First, the evidence showed that some practices were needed by all childbearing women and babies These are shown in the green boxes at the link above. They include three categories of practices:

- Education, information, health promotion
  This category includes practices that predominantly enable women to make decisions and changes for themselves. Examples might include information about maternal nutrition, family planning services and breastfeeding promotion.

- Assessment, screening, and care planning
  Examples in this category include planning for transfer to other services as needed, screening for sexually-transmitted diseases, diabetes, HIV, pre-eclampsia, assessing labour progress, and mental health problems.

- Promotion of normal processes, prevention of complications
  Examples of practices in this category include prevention of mother-to-child transmission of HIV,

encouraging mobility in labour, clinical, emotional, and psychosocial care during uncomplicated labour and birth, immediate care of the newborn, skin-to-skin contact, and support for breastfeeding

The additional practices needed by women and babies with complications are shown in the orange boxes. These practices are important and can save lives and treat emergencies. The boxes are smaller than the previous ones not because they are less important, but to indicate that if good preventive and supportive care is in place, fewer women and babies should need these services. These additional services include:

- First-line management of complications
  These practices include treatment of infections in pregnancy, anti-D administration in pregnancy for rhesus-negative women, external cephalic version for breech presentation, and basic and emergency obstetric and newborn care such as management of pre-eclampsia, postpartum iron deficiency anaemia, and postpartum haemorrhage.

- Medical, obstetric and neonatal services to manage serious complications
  These practices include elective and emergency caesarean section, blood transfusion, care for women with multiple births and medical complications such as

HIV and diabetes, and services for preterm, small for gestational age, and sick neonates.

There are additional practices needed for clients and babies with complications, which are important and can save lives and treat emergencies, but overall, fewer mothers and babies should need these services.

Next, the evidence showed that all childbearing women and babies – whether or not they have complications – need care to be organized to meet their needs (shown in purple). Maternal and newborn infant services need to be available, accessible, acceptable, and of good quality. (30) They need adequate resources, and for services to be provided by a competent workforce. Services must be integrated into the health system, work effectively across community and hospital services, and there must be continuity of care.

The evidence showed that care is more than what is done; how care is provided is just as important. The next category of the quality framework is about values (shown in blue). Women, babies and families need respectful care, good communication, and care that is tailored to their circumstances and needs – not a 'one size fits all' approach, or an approach that categorizes them into low- or high-risk. Women and families need good communication with the staff caring for them, and the staff must be aware of and understand the local circumstances in which they are living.

The next category is about the philosophy of care (shown in yellow). The evidence shows that women, babies and families need caregivers to work to strengthen their capabilities, not to undermine them by inappropriate interventions, or disempower them by over-medicalizing their care. Care should optimize

women's and babies' own biological, psychological, social and cultural processes and not intervene too soon or unnecessarily.

Finally, the evidence shows that women and babies need care providers who combine clinical competence with interpersonal and cultural competence (shown in grey). Care providers need to work to their full capacity with a division of roles based on need, resources, and competencies. They also need to work in an environment where they themselves are supported within systems of professional education, regulation and employment.

This quality framework allows us to consider the contribution midwifery makes to care. It can be used to illustrate the scope of midwifery. It is clear from this chart that midwifery has vital contributions to make across all the dimensions of quality care, with the exception of the obstetric, neonatal and medical practices needed by women with complications (all except the rightmost orange box). Importantly, this evidence-informed framework demonstrates that women with complications still need midwifery care – it should not be withdrawn from them when medical care is provided. (1)

What Difference does Midwifery Make?

Using the evidence from over 450 **Cochrane Reviews** of effective care, The Lancet Series on Midwifery authors showed that if full scope midwifery is practiced, it can improve over 50 outcomes for women, babies, families and health services. These outcomes include saving lives, reducing harm, improving emotional well-being, mental health, and saving resources, as summarized in Table 3-4.

Table 3-4. Outcomes improved by midwifery (1)

- Maternal and newborn mortality, fewer stillbirths
- Fewer preterm births, low birthweight
- Maternal morbidity reduced (e.g. infections, anaemia, pre-eclampsia, perineal trauma)
- Reduced rate of interventions in labour (e.g. augmentation, cesarean, blood transfusions)
- Improved psycho-social outcomes (e.g. satisfaction with pain relief, lower level of anxiety, reduced incidence of post-partum depression, improved mother-baby interaction)
- Increased birth spacing, contraceptive use
- Increased breastfeeding initiation and duration
- Shorter hospital stays, improved rate of referrals, increased attendance by known midwife

The extensive impact of midwifery has important implications. No matter how a health system is organized, whether mothers and babies are in hospital, in the community, or at home, and whether they have complications or not, all women and all babies need midwifery care to provide information and support, prevent complications, and respond swiftly when complications develop. The Lancet Series on Midwifery summarized the evidence like this;

> These findings support a system-level shift, from fragmented maternal and newborn care focused on identification and treatment of pathology, to skilled care for all, with preventive and supportive care, and treatment of pathology when needed through interdisciplinary teamwork and integration across facility and community settings. Midwifery is pivotal to this approach. (1, p.1130)

Interdisciplinary working is essential to providing high quality care. All the services that women and babies might need must

work together to ensure that they are available, and in a timely manner. Indeed, midwifery not only works to support women and prevent complications, but also provides a central role in helping women to access other services, such as referral for obstetric or neonatal care, mental health services, or community support services (Figure 3-1). In the absence of high quality midwifery care it is likely to be more difficult for women to understand and access the services they need. Midwifery is a fundamentally important component of the interdisciplinary team helping to meet the individual needs of each woman and baby and to access all the services they might need.

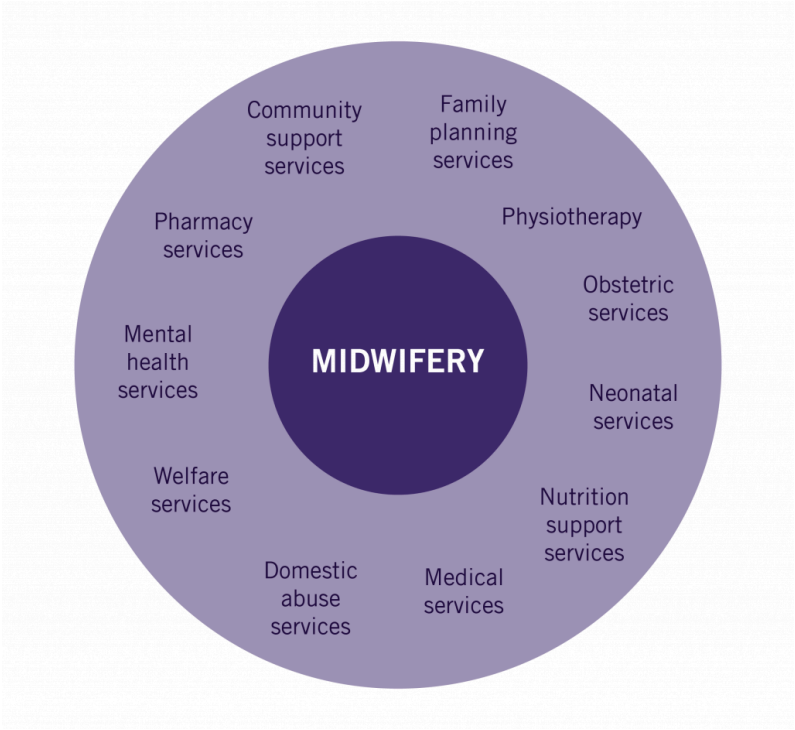

Figure 3-1. Services that women and babies might need

Evidence demonstrates that midwifery – the combination of supportive, preventive, respectful, and compassionate care with swift response when complications arise – has been shown to improve a range of important outcomes; in essence it keeps clients and babies safe, both physically and emotionally. (1)

Why is Midwifery not Universally Available?

The evidence-based framework that we have just reviewed has shown that there is a vital role for midwifery in meeting the needs of women, babies and families wherever they are in the world. So, why is it not universally valued and available to all? History provides some clues to why this is the case.

Health systems across the world developed in different ways and for different reasons. In some countries, there are no midwives and care is provided by a combination of less-skilled workers with doctors to carry out emergency procedures. In others, doctors carry out much of the work of midwives. In some countries, there is strong and universal midwifery care. Each system of care has different outcomes. For example, systems that rely heavily on doctors tend to have higher rates of unnecessary interventions – sometimes referred to as over-medicalization – which can result in avoidable harm to childbearing people and babies, is wasteful of resources and is likely to be unsustainable over the long term.

Another challenge is the disconnect between evidence, policy, and practice. The evidence supporting the positive impact of midwifery is clear, but this is not necessarily reflected in policy decisions at the national or international level. As a consequence, resource decisions and the provision of care correspond to factors other than evidence, and women, babies, and families are deprived of evidence-based solutions.

The root causes of the barriers to midwifery across the world were identified through literature reviews and by asking midwives about their experiences. (31) A summary of the identified interrelated factors appears in Figure 3-2. They found that socio-cultural, professional, and economic barriers combined to provide a hostile environment to midwifery in many countries. Low professional status and a low regard for midwifery resulted in difficult circumstances for midwives, and could lead to burn-out and distress. These factors were themselves set within the context of gender inequality. In many societies, not only were childbearing women subject to the low status accorded to all women but so too were the midwives, the majority of whom were women. This affected their working conditions and their relationships with interdisciplinary colleagues, and adversely affected their ability to provide evidence-based, high quality care.

New evidence about the positive contributions that midwifery can make to survival, health and well-being are prompting action by international agencies to promote midwifery. We are therefore at a crucial point in the evolution of the profession, globally; thoughtful, positive planning and co-ordination are needed to use this opportunity to gain the recognition and resources needed to scale-up the availability of high quality midwifery to make it accessible to all women and children, globally.

Midwifery in the Global Context

Advocating for Midwifery Availability

There are some key developments internationally that are helping

Figure 3-2. Barriers to the provision of quality of care by midwifery personnel

to raise the profile of midwifery, and there is a new, growing awareness of its importance. These developments are about the health of mothers and children, and indeed, about health systems and economic development.

External Links

The following section discusses content found at the following links:

UN Sustainable Development Goals https://sustainabledevelopment.un.org/sdgs

UN Every woman, every child http://www.everywomaneverychild.org

UN Global Strategy for Women's, Children's and Adolescents' Health 2015-2030 http://globalstrategy.everywomaneverychild.org

WHO and UNICEF 2014 Every newborn: an action-plan to end preventable deaths http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf?ua=1

Central to planning at international and country levels over the coming years are the Sustainable Development Goals (SDGs). Agreed by the UN in 2015, these 17 goals will influence strategy and action in all countries until 2030. (32) At first sight, the most relevant goal is Goal 3: ensure healthy lives and promote well-being for all at all ages. But on closer consideration, midwifery can have an impact across most of the other goals: improved nutrition, gender equality and empowering women and girls, reducing inequality, and increasing inclusivity, resilience, and sustainability. These are all goals that midwifery can contribute to achieving.

The growing understanding of the contribution midwifery makes has resulted in a strong movement, internationally, to promote and support midwifery. Organizations such as the World Health Organization, United Nations Population Fund , the **International Confederation of Midwives**, the **White Ribbon Alliance**, and others, are collaborating to build a strong advocacy movement to tackle the barriers to universal provision of high

quality midwifery care and to promote and support midwifery. (33)

This is an exciting time to be in the midwifery profession, as it is now being recognized as an important strategy to combat mortality, keep women and children safe, and contribute to sustaining health systems. It is an important profession, and your work in providing care and in advocating for women, children, and families will contribute to the growing global understanding that midwifery matters for all women and all children, in all countries.

Key Points Summary

- Midwifery is essential, for all women, babies, and families, everywhere.
- Midwives can play a critical role in promoting healthy practices for women and babies, from pre-pregnancy, through pregnancy to the first years of a baby's life, but there are significant political, social, and economic challenges that have, thus far, prevented more widespread availability of high-quality midwifery care.
- This is an important time for midwifery – there are key opportunities including several global developments that promote midwifery , or to which midwifery can positively contribute.

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4. Health Policy Analysis in Midwifery

Cristina Mattison, MSc, PhD(c)

Change in the health care system may be met with a mix of eagerness or resistance by members of the public, health care professionals, governments or other stakeholders. For example, introducing midwifery care into health systems in Canada was a long-awaited and welcome change for many but a change that was resisted by others, and was received differently in various jurisdictions. In each case, changes were effected by new **policies** that were put in place.

In the broadest sense, policy informs action as a result of decision-making through various inputs. Policies are used across settings and institutions. Policies made at governmental levels (e.g. legislation) are the most visible, but policies have a large role in institutions (e.g. hospitals) and organizations (e.g. clinical guidelines or administrative policies from professional associations).

In this chapter we examine how health care policies are defined and look most closely at the processes involved in setting the government's agenda and in formulating new policies. This chapter introduces you to core health policy analytic frameworks, and how they are applied in the context of midwifery. In your role as a health care professional, it is important that you understand how health care policies are made, and are also able to evaluate policies, and potentially, inform **policymaking**.

Policy Cycle

While we often think that policymaking is a straightforward rational process, it can be messy and, most often is not clear-cut. The policy cycle, originally developed by Lasswell (1951), is a helpful lens through which to distinguish various phases of the policy process. (1) The theory is often referred to as the stages model and consists of four main components:

1. Agenda setting
2. Policy formulation
3. Policy implementation
4. Evaluation

This chapter will explore the agenda setting stage in most detail, since knowledge of how to get issues on to the government's agenda is important for health care professionals with interests in informing policy or creating policy change. The other stages will be discussed more briefly.

The development of the policy cycle was central to establishing the field of health policy analysis. The cycle separates the policy

process into distinct components and allows for analyses of individual stages (Figure 4-1). Once a problem is defined , an agenda is set and the process moves to the policy formulation stage. In this phase, policy solutions are presented and evaluated. Solutions that are both technically feasible, and that take into account the arrangement of the health system in which they will be proposed, frequently have greater success in the policy formulation process. An example of such a solution was the introduction of two new birth centres in Ontario, Canada. The reform aligned with the Ministry of Health and Long-Term Care's efforts to move services out of hospitals and into community-based settings. (2) Once a policy has been formulated, it must be implemented. The process of policy implementation can face a number of challenges, and this is particularly the case if the formulated policy does not align with the intended goals, which often results when trying to satisfy multiple, competing interests. The final stage of the cycle is evaluation, which may include a formal evaluation of policy outcomes. Evaluations may be based on outputs, such as number of births, or may assess processes such as a program evaluation of the new birth centres in Ontario. The results of the evaluation could lead to a new or revised policy agenda or new policies, which are also then implemented and evaluated.

Agenda Setting

Agenda setting is the first stage in the policy cycle. The agenda setting framework, as laid out by Kingdon (2011), recognizes the complexity of the public policymaking process and explains in detail the process by which items move from the governmental agenda (i.e. topics that are receiving interest) to the decision agenda (i.e. topics up for active decision). (3) Policymakers face

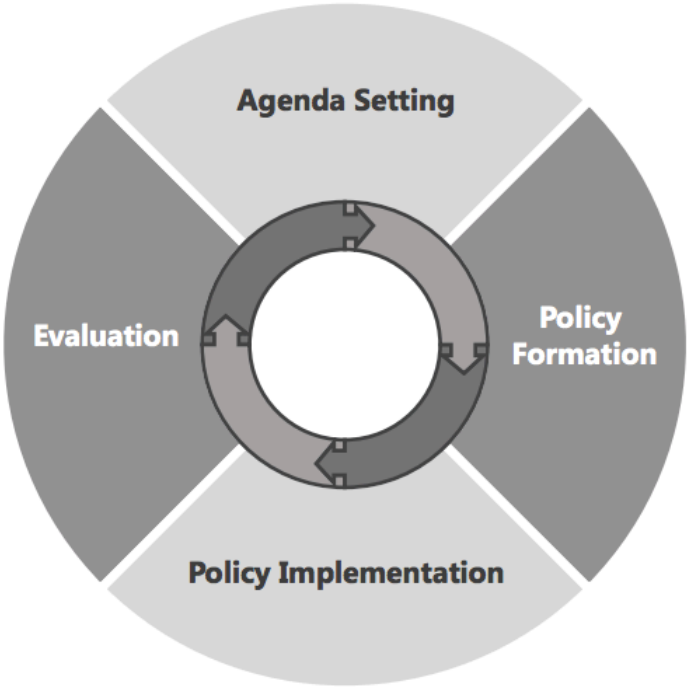

Figure 4-1. The policy cycle.

many time and resource constraints that limit their ability to deal with all the topics. Given all the potential topics that policymakers could pay attention to, the framework explores how and why policy issues either rise or fall away from the government's agenda. The framework consists of three streams: problems, policies and politics (Table 4-1).

Table 4-1. Kingdon's agenda setting framework – the three streams (3,4)

PROBLEM Attention to problems through:	POLICY Generation of policy proposals through:	POLITICS Political events consist of:
Focusing events (crisis or disaster)	Dispersion of ideas in a policy area (a policy proposal circulates and is revised; in the end, some ideas come forward while others do not)	Shifts in national mood (includes changes in the political climate, public opinion and/or social movements)
Change in an indicator (e.g. increasing cesarean rates or the rising cost of healthcare)	Communication / persuasion (items that are more interesting or novel)	Shifts in the balance of organized forces (e.g. interest group pressure campaigns)
Feedback from existing programs (feedback specific to a problem on a program that is not operating or performing as intended)	Feedback from existing programs (feedback specific to policy on a program)	Events within government (e.g. elections, turnover in government, jurisdictional disputes)

Problem Stream

This stream is made up of three components:

1. focusing events, which can be a crisis or a disaster that receives media attention;

2. a change in indicator such as cesarean rates or the rising cost of healthcare; and
3. feedback from existing programs.

Examples of how the midwifery organization can highlight the problems stream to support their aims include:

1. using a focusing event that pertains to scope of practice and is receiving active media coverage to call attention to the problem;
2. using peer-reviewed literature to support that midwives are a cost effective option in low-risk maternity care, linking to a change in indicator; and
3. collecting feedback from a current obstetric program that is not operating as it should and where a midwifery program with the appropriate scope of practice can present a suitable solution.

Policy Stream

This stream consists of diffusion of ideas in a policy area (i.e. natural selection), communication and/or persuasion, and feedback from current programs. These factors can lead to the generation of policy proposals, as those that are technically feasible, fit with dominant values, and are acceptable given future constraints are more likely to be considered. The midwifery organization can align itself with a government's health system reforms, like the example of health system reform in Ontario that

emphasizes client-centred care by moving services out of hospitals into community-based clinics. (5)

External Link

Read the original press release for birth centres in Ontario here: http://news.ontario.ca/mohltc/en/2014/01/midwife-led-birth-centre-opens-in-toronto.html

Politics Stream

This includes changes in national mood and in the balance of organized forces (e.g. interest group pressure campaigns), as well as events within government (e.g. elections). Factors in this stream are more likely to rise higher on the agenda if they are congruent with national mood, have interest group support, lack interest group opposition, and align with the governing party. A midwifery organization can take advantage of the politics stream by having significant public support and strong centralized interest groups, while aligning with the political climate (e.g. values of the dominant political party).

What and who influences the agenda? The governmental agenda is influenced by the problems or politics stream as well as visible participants, while the decision agenda is influenced by a coupling of all three streams into a single package. A policy window is opened by the appearance of a compelling problem, like a focusing or a political event, such as an election. A midwifery organization that wishes to increase the chances of moving an item of midwifery scope of practice legislation onto the decision

agenda may be wise to consider enlisting the help of a policy entrepreneur. This is a person who is capable of, and prepared to, take immediate action to push the issue forward once the window presents itself. Failure to couple the problem, policies and politics streams will result in the policy window closing before progress can be made.

Exploring the agenda setting process is a helpful to understand how items reach the government's agenda and then either rise or fall away from the decision agenda. A last word on agenda setting; discerning what items are on the government's agenda is not always straightforward. Government communications, like budgets, speeches and announcements, are often good indicators. However, neither will give a complete picture as some agenda items will remain relatively hidden from public view at any given time and the media is selective in what it reports.

A fourth 'P' may also need to be considered: Participants, some of whom may be **hidden** and others who are highly **visible.** **Policy entrepreneurs** are a special type of participant in that they can either be a visible or hidden participant and are not restricted to politicians. They also possess certain characteristics: they must have expertise on the issue, hold power in terms of political connections and they must be tenacious. Timing is a critical factor and therefore a policy entrepreneur must not only have the skills, but also the patience to take advantage of a policy opportunity when one presents itself.

Did You Know?

Although academics are generally considered hidden participants, if they make use of the media to discuss their

findings or solutions for an issue, they could be considered visible participants.

Using Kingdon's (2011) multiple stream framework, suppose a midwifery organization wants to change the scope of practice legislation for the profession, it could use the following to influence policymaking (3):

3i Framework

The policy cycle is helpful in identifying and separating the policy process into segments. Complementary to the policy cycle is a theoretical framework, called the 3i framework, which takes account of forces that can shape and influence policies in a complex interplay of institutions, interests and ideas (Figure 4-2). (4) In this framework, institutions include government structures (e.g. federal vs. unitary government), policy legacies (e.g. the role of past policies) and policy networks (e.g. relationships between actors around a policy issue); interests can include a range of actors; and, ideas relate to peoples' beliefs and values. The last element of the framework are external factors and includes releases of major reports (e.g. United Nations Population Fund's 2014 State of the World's Midwifery Report) or political, economic or technological changes.

Did You Know?

There are fourteen health care systems in Canada; there are

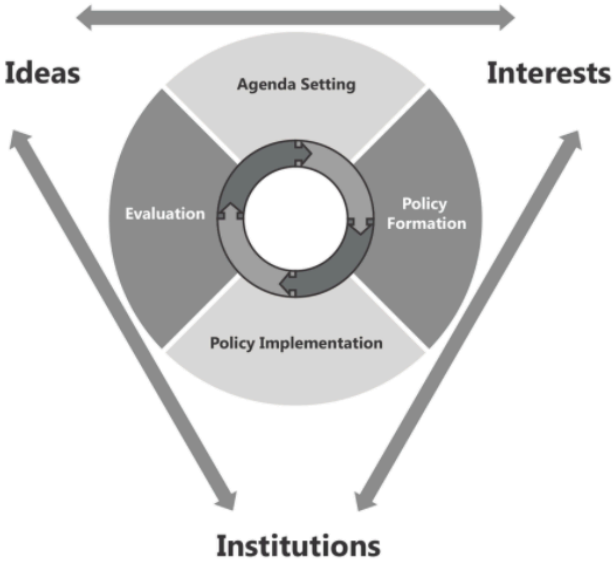

Figure 4-2. The policy cycle and the 3i framework.

ten provincial health systems, three territorial health systems and one federal health system. Each province/territory has responsibility for its own health system. The federal government's arms-length role is less visible, and mostly limited to financial contributions, such as transfer payments, and care for specific populations such as First Nations peoples living on reserve and Inuit, serving members of the Canadian Armed Forces and eligible veterans. (6)

External Link

The United Nations Population Fund's 2014 State of the

World's Midwifery Report can be found here: http://www.unfpa.org/sowmy

Institutions

The 3i framework divides institutions into three categories: government structures, policy legacies and policy networks. The interplay of these components can be studied by competitive analysis to show the importance of the influence institutions have in the political process. (7)

Historical institutionalism is the method most often used for this type of analysis and is grounded on the concepts of **path dependence** and **policy legacies**. (8) These concepts explain how past decisions serve to influence and constrain the decisions or policies that are possible today. (9) The timing and sequencing of events are crucial elements in path dependence, such that seemingly small events may produce large outcomes by setting in motion a particular course of action. (10) We can apply this approach to understand the barriers and facilitators to midwifery legislation that occurred in two Canadian provinces, Ontario and Québec. While these are neighbouring provinces, there have very different midwifery regulations. In Ontario, a window of opportunity was created by the Health Professions Legislation Review (1983), and midwifery-related interest groups were able to take advantage of it in order to formalize the profession. (11) By comparison, institutions constrained the legislative process in Québec since it was the only province to experiment with midwifery practice options, through a pilot project, before

legislation. (12) This example will be used to illustrate the following sections.

Interests

The 3i framework addresses the role of interest groups and the extent to which they influence and impact the policymaking process, examining particular groups of people such as societal interest groups, elected officials, public servants, researchers, and policy entrepreneurs. (4) Some argue that interest groups play a critical role in the political process and are powerful and central to the policy process and outcomes. (13) Continuing with the example of midwifery regulation in Québec, strong interest groups influenced the policy process. Piloting midwifery before legislation was recognized as a compromise to appease significant physician interest group opposition. (14) A broader analysis of health policy shows that separation between interest groups and government policymaking is becoming increasingly difficult. (15) Research on the role of the pharmaceutical industry in health policymaking has shown the significant political power that this interest group can exert, particularly in the United States and the example of human papillomavirus vaccination policies. (15)

Ideas

Traditionally, ideas have been thought to be of lesser influence when compared to institutions or interests. (16) This is because ideas are complex and we know much more about what ideas are than we know about how they work. (17) The 3i framework breaks down ideas into knowledge or beliefs about ‘what is’, values about

'what ought to be' and also combines the two. (4) In the example of the regulatory legislation of midwifery in Canadian provinces, the ideas of feminism provided a strong ideological framework that helped midwifery gain critical support to become regulated in Ontario in 1994. (18)Evolving ideas related to feminism and strong government champions in the Ministry of Health, who acted as the carriers of ideas, helped to move midwifery forward in the province.

External Factors

Interacting with the 3i framework are factors that are external to the policy community yet still have an influence on institutions, interests and ideas. These include events such as the release of major reports (e.g. reports from the Auditor General), media coverage, a disease outbreak (e.g. Zika virus), political (e.g. election), economic (e.g. recession), or technological change (e.g. electronic health records). (4)

Applying the 3i Framework to Midwifery

The 3i framework brings together major political science scholarship to create a useful format to examine policy choices. The framework can be applied to midwifery broadly, such as happened during the process to regulate midwifery in a particular jurisdiction, or to a specific policy issue, such as creating a birth centre. Table 1-2 uses the 3i framework to illustrate the important influences on the decision to implement regulated midwifery in Ontario.

Analyzing institutional factors highlights the importance of the

timing and sequencing of events, and shows how past policy choices, such as capping midwifery education seats, creates legacies that are not only set in motion, but may also limit the scope of future action.

Interest groups, such as midwifery associations, can champion a policy, while interest group opposition can present barriers.

Ideas, particularly values and beliefs, are also influential. In midwifery, women-centred care and feminist ideologies have helped the profession gain critical support. (18,19)

Table 4-2. 3i case study of midwifery in Ontario, Canada (6, 20)

POLICY LEGACIES

British North America Act, 1867

- Fourteen health systems (ten provincial, three territorial, one
- Provinces are responsible for the delivery of health care (with specific populations covered by the federal government)
    - Each province must create regulatory statute(s) and implement midwifery, which accounts for the prese which midwifery legislation does not exist in some j Edward Island and Yukon)

Canada Health Act, 1984

- Five core principles: public administration, comprehensivenes portability, and accessibility
- Private not-for-profit hospitals and private practice physician payment for medically necessary services

Institutions

Midwifery Act, 1991

- Creation of the College of Midwives of Ontario and formal mi programs established at McMaster, Ryerson and Laurentian U
- 1994, midwives secured hospital privileges with the ability to home and hospital settings

Government structures

- Current (2016) Liberal majority government at the provincial the federal level, with no effective veto points
- In the 1980s, the Health Professions Legislation Review was in provincial Conservatives and the subsequent legislation under government

Policy networks

- With the exception of the Ontario Medical Association, po
  specifically midwifery related interest groups in the provin
  policy advocacy roles

Interests	Overview of midwifery related interest groups: • Professional associations (e.g. Association of Ontario Midwive Association of Midwives) • Institution based groups (e.g. Ontario Hospital Association) • Citizen based interest groups (e.g. Consumers Supporting Mid
Ideas	Values • Evolving gender ideologies, particularly feminism, was import emergence of the new midwifery model in Ontario in the 198 Knowledge • Growing body of research evidence supporting the efficacy of
External factors	• The Ministry of Health and Long-Term Care's Action Plan for heavily supports community-based care • The Action Plan for Health Care led to the creation of two nev the province with the aim of offering women greater choice in provider and birth setting

Key Points Summary

- The process through which policies are created is complex.

- As health care professionals, midwives need to have an understanding of health policy analytic frameworks to evaluate health care decisions, and of the concepts needed to inform policymaking.
- Applying the core concepts of health policy making to your own health system provides a deeper understanding of the policies in place as well as the policy options available in your jurisdiction.
- The policy cycle consists of four components: agenda setting, policy formulation, policy implementation, and evaluation.
- Agenda setting explains how issues get on the government's agenda, and examines the factors that cause the issue to either rise up, or fall away from, the decision agenda.
- The 3i framework shows how institutions (e.g. policy legacies) shape the policy options available, while interest groups can help to mobilize (or hinder mobilization) around a policy issue, and that ideas (beliefs and values) of the public and political elites are a key consideration.

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PART II

Midwife as Practitioner

Edited by:
Elaine Carty, MSN, CNM, DSc
Professor Emerita
Midwifery Program
University of British Columbia

5. Midwife as Practitioner

Allison Campbell, MA, BA, BMW, RM and Lesley Page, CBE, PhD, MSc, BA, RM, HFRCM

All those working in maternity care have shared aims: To support health, wellbeing and a positive experience of care around pregnancy, birth and the early weeks of life; to consider long term as well as short term effects of care; to give the best start in life and family integrity; and to contribute to the growth of secure attachments between parent(s) and baby. These aims also include, but are not limited to, the reduction of mortality and morbidity of mother and baby during pregnancy, birth and postpartum, including the morbidity of unnecessary intervention.

The unique role of the midwife is outlined by the International Confederation of Midwives (ICM), emphasizing the importance of (1, p.1):

- Partnership with women to promote self-care and the health of mothers, infants, and families

- Respect for human dignity and for women as persons with full human rights
- Advocacy for women so that their voices are heard
- Cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies
- A focus on health promotion and disease prevention that views pregnancy as a normal life event

Midwives around the world practice to these principles, even while providing care in sometimes challenging settings. We serve diverse populations and women with complex lives, health and social care needs. We face wide economic and social inequalities, as well as variations in care and outcomes between different services and populations. We are becoming more aware of the prevalence of mental illness in the perinatal period, of the level and impacts of domestic abuse and violence against women, of the effects of ethnicity and deprivation on the experience and outcomes of maternity. As globalization increases, we are seeing increasing inequalities the world over, and the highest levels of migration since the Second World War. (2) Many women suffer discrimination, injustice, violence and abuse. Many midwives will care for those who are refugees, those seeking asylum, or undocumented migrants. All of these complexities present a need for care that is highly responsive to different population needs, as well as varying needs of the women and their families. It is central to the midwifery model of care to meet each family where they are

at, and provide the most responsive, reflective care possible within that context.

Reflect

How would the woman's situation and life circumstances differ between: a refugee from Syria, a frightened young mother and partner, and a woman whose pregnancy is not going well?

There are significant variations in the way midwives are trained throughout the world. In many countries, midwives are nurses who have garnered additional training in midwifery while in other places in the world, midwives are self-taught and struggle to acquire basic training. In Canada, there is only one route to becoming a professional midwife. All midwives are educated in a four-year university program. Midwives who have been educated and registered in other countries receive education in the Canadian health care system and the Canadian model prior to writing Canadian registration examinations.

External Link

You can learn more about the midwifery education programs in Canada here: http://cmrc-ccosf.ca/canadian-midwifery-education-programs

There are many similarities and also differences in the way midwifery is actually practiced in different countries and health care systems around the world. In this chapter, we will explore the

midwife as practitioner within the Canadian health care system. We will discuss the midwifery philosophy of care and how it informs midwives' approach to working with individual women, their babies and partners. Then we will look more closely at the midwife's scope of practice, focusing on the five central aspects of the midwifery model of care in Canada: continuity of care, informed decision-making, community-based, choice of birth setting and evidence-informed practice. In the final section, we will discuss some of the unique skills that midwives employ in the provision of care.

Canadian Midwifery Model

Regulated midwifery is very recent in Canada, although midwives have practiced in indigenous communities since the beginning of human life on what is now known as the North American continent. It was not until the late 20th century that midwives organized to set up professional associations, regulatory bodies and educational programs. (For more on this, visit Chapter 8 – Professional Framework for Midwifery Practice in Canada)

In the late 19th C and early 20th C attending births at home was carried out by the Victorian Order of Nurses in cities and Red Cross nurses in northern areas of Canada That role was relinquished to physician assisted hospital birth in part due to physician power but also because midwives at the time were in no position to organize to integrate midwifery in to the system on a permanent basis. (3)

Regulated midwifery began in Ontario in 1993, and currently, most provinces in Canada have health services which provide access to midwifery care, as well as organizations that support full, professionally autonomous midwifery. (4) There are slight

variations in the way midwifery is practiced from province to province, as each provincial health care system is organized slightly differently. However, the midwifery philosophy and model of care are the same across the country, and all midwives in Canada are members, not only of their provincial organizations, but of the Canadian Association of Midwives as well.

External Links

You can learn more about how the Aboriginal Council of Midwives supports and advocates for aboriginal midwives in Canada here: http://aboriginalmidwives.ca/

An overview of midwifery in Canada by the Canadian Association of Midwives can be found here: https://canadianmidwives.org/midwifery-across-canada/

Philosophy of Care

The meaning of the word midwife in English is 'being with the woman.' This has a very specific implication; it means not standing before (the traditional position of the obstetrician) but being beside, on the same level, understanding each other. Midwifery has been described as being a companion on the journey to motherhood, being the professional friend, and being concerned with the making of mothers. This concept of companion, which is embedded in the name itself, is what makes midwives unique practitioners in the health care system.

Traditionally, obstetrics tends to focus on the reduction of risk,

which can lead to and inform an epidemic of fear around pregnancy and childbirth. (5) Midwifery, meanwhile, keeps at its center, the understanding that pregnancy, labour and birth are safe, healthy and normal physiological processes. The College of Midwives of British Columbia describes this as a foundation of the midwifery philosophy of care. (6) It states:

> Midwifery care is concerned with the promotion of women's health. It is centred upon an understanding of women as healthy individuals progressing through the life cycle. It is based on a respect for pregnancy as a state of health and childbirth as a normal physiologic process, and a profound event in a woman's life. (6, p.1)

Midwives place as central, the wellbeing of the woman and her baby, and locate that wellbeing within the woman's individual social context. Framing care in this manner leads us to prioritize creating a positive experience of care, promoting and contributing to the capability of women, forging secure attachments and bonds of love, and enabling joy. It enables midwives to think and see their role as practitioners differently from other health care practitioners within the health care system. The same document goes on to describe that '[f]undamental to midwifery care is the understanding that a woman's caregivers respect and support her so that she may give birth safely with power and dignity.' (6, p.1)

Midwifery care holds a fundamental respect for the personal autonomy and dignity of the woman and her reproductive rights. It centers wellbeing, and moves away from the restrictions of risk-based medicine. While this care-through-relationship approach may appear simple, it is complex and requires a high level of knowledge in a number of fields, including not only health care but also psychology, sociology, counselling and the humanities.

Other aspects of the midwifery philosophy of care are referred to also within the scope and model of care, and will be discussed below.

Scope & Model of Practice

The specific scope of midwifery practice varies by country and jurisdiction, and is discussed in further detail in chapter 3 – Midwifery within the Health Care System. In Canada, midwives specialize in normal pregnancy, intrapartum and postpartum care, from conception to six weeks postpartum. The midwifery scope of practice reflects the internationally recognized scope of midwifery care, as defined by the ICM, which states, in part,

> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. (1, p.1)

While the way midwifery is practiced in Canada varies slightly from province to province, the model of care is the same nationwide. (7,8) Midwives are autonomous, primary care providers. This means that midwives provide care on their own authority. They are the entry-point to the health care system, for

the people they serve. A pregnant woman does not have to also see a doctor, or be referred to midwifery care by a physician. A woman sees their midwife or group of midwives for all pregnancy-related issues, and should also consult with them before seeing a doctor for anything non-pregnancy related. Meanwhile, midwives are able to, and should, consult directly with an appropriate physician, in the event that a woman's care demands knowledge or speciality that is beyond the midwife's scope.

In addition to being primary care providers, midwifery care is shaped by five basic principles: continuity of care (or carer), informed choice, community-based, choice of birth setting and evidence-informed practice. These five principles form the foundation of the midwifery model of care across the country, and together are what make midwifery care unique in the Canadian health care system.

Continuity of Care

A woman's relationship with their pregnancy care providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but a family's experiences with caregivers can empower and comfort, or inflict lasting damage and emotional trauma. (9) The midwifery approach starts in the relationship through which they work with women; a reciprocal partnership: getting to know and trust each other over time. This partnership is made possible by what has come to be known as 'continuity of care', and is arguably the most central aspect of the midwifery model of care in Canada. The Canadian Midwifery Regulators Consortium (CMRC) discusses the importance of continuity of care,

> The Canadian model of care is seen as one of the most progressive in the world. All registered midwives in Canada provide continuity of care so that women and their families have the opportunity to get to know their midwife or midwives well before the baby is born, and have a familiar caregiver with them during labour and birth and for their postpartum care. (10, p.1)

A Cochrane review of continuity of midwifery care, provided by team and caseload midwife, based on 15 trials involving 17,674 women, found benefits in maternal and neonatal health outcomes with the continuity of midwifery care model. (11) When compared to women receiving medical-led or shared care, women at low and higher risk who received continuity of care from a midwife they know during the antenatal and intrapartum period are 24% less likely to experience preterm birth, 19% less likely to lose their baby before 24 weeks gestation, and 16% less likely to lose their baby at any gestation. Women with continuity of care from a midwife were also more likely to have a vaginal birth, and fewer interventions during birth. (12)

External Links

You can read the individual provincial interpretations of the model of care at the links below.

British Columbia: http://cmbc.bc.ca/wp-content/uploads/2015/12/11.05-Midwifery-Model-of-Practice.pdf
Ontario: http://www.cmo.on.ca/wp-content/uploads/2015/07/Continuity-of-Care.pdf
Quebec: http://www.osfq.org/quest-ce-quune-sage-femme/philosophie-et-normes-de-pratiques/?lang=en

External Link

You can read the Cochrane review of the continuity of midwifery here: http://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

In the same review, it was found that women who received continuity of midwifery care were more positive about their overall birth experience, with increased agency and sense of control and less anxiety. (13,12) They also reported greater satisfaction with information, advice, explanation, place and mode of birth, preparation for labour and birth, and choice for pain relief than women who received medical-led or shared care. (13)While the precise mechanisms of continuity are not completely understood, the qualitative research findings suggest these include advocacy, trust, choice, control, and a sense of being heard. (14)

The infographic in Figure 5-1 symbolizes the woman being 'wrapped around' by their midwife who, when necessary, facilitates referral and consultation with other specialist services, and care that is personalized to her needs. This symbolizes the relationship with women which is at the heart of women-centred care. But it will be noted that the woman and her midwife are also 'wrapped around' by a number of other services and different pathways of care. This is not isolated midwifery but midwifery *that connects the* woman with ease to all the resources of well-developed maternity and social care.

The development of relational continuity in midwifery has illustrated the powerful effect of midwives developing a relationship with women over time, while working in systems of

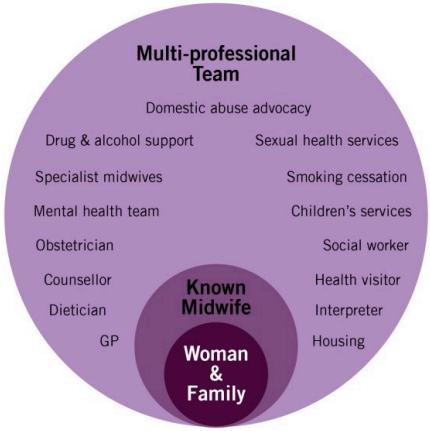

Figure 5-1. Relational continuity – placing woman and family at the center of care to improve communication with a multidisciplinary team

care that are supportive to effective practices, and being integrated in effective health services with ease of consultation, referral and appropriate intervention when necessary.

Informed Choice

Working *in partnership* with means working together to support childbearing women to make decisions about their own care. Midwives recognize the woman as the primary decision-maker for the course of her care. They support the woman's rights to make informed choices, and support thoroughly informed decision-making by 'providing complete, relevant, objective information in a non-authoritarian, supportive manner.' (7, p.4) The College of Midwives of Ontario (8) meanwhile, defines informed choice as a,

'collaborative information exchange between a midwife and her woman that supports woman decision-making.' (p.4)

Informed decision making is a process which involves five steps for conversation and information management (15):

- Finding out what is important to the woman and their family
- Using information from the clinical examination
- Seeking and assessing evidence to inform decisions
- Talking it through
- Reflecting on outcomes feelings and consequences

Often, informed choice decision making does not result from one, time-limited conversation. It may continue over several weeks or months of a pregnancy, and be revisited during several visits with the midwife. The process should therefore be seen as a circle rather than a list. In describing this process with people who are making decisions at the end of life, Gawande (2014) talks about different levels, giving information, providing consumer choices, or interpretive conversations in which much of the care provider's time is spent listening.

In order to do informed choice well, the woman needs to have enough time to fully explore each topic. Midwifery appointments tend to be thirty to forty-five minutes long, for most of the pregnancy. This is for the dual purpose of both supporting relationship-building between the woman, their family, and the midwifery team, and enabling informed choice decision making.

Finally, it is important to recognize that while we profess to offer choice and support women in making decisions, the agenda is ultimately set by the birthing culture in which we live and work, the services available, and the expectations created by those services. The knowledge, values, biases, language and style of the

midwife and other professionals will also influence and inform interactions with the woman, and ultimately, the decisions she makes.

Community-based

Midwives were traditionally community-based, meaning that they were both part of, and understood, the communities and life circumstances of those they served. Community-based services still exist in many countries but have been reduced and limited in many parts of the world. In Canada, most midwives practice out of community-based (rather than hospital-based) clinics. The ability of midwives to practice independently, outside the hospital setting, creates an important conceptual (and political) separation from the medicalized model of care.

Meanwhile midwives in Canada are supported to provide their full scope of care – antenatal, intrapartum and postpartum – in the woman's home, if the woman so chooses, and if the conditions are safe for the woman and the fetus. The midwife's ability to provide care in the home puts the two on more equal footing. The woman is able to receive clinical care in the space she is most comfortable, and the midwife becomes a visitor in that space. This helps to decrease the power imbalance inherent in the traditional health care provider – patient relationship.

Choice of Birth Setting

In Canada, midwives are the only health care providers for whom offering choice of birthplace is an essential aspect of care. In some provinces, physicians have the option to provide homebirth if

they so choose, however in practice very few do so. Meanwhile, where midwifery is regulated, midwives must be willing and able to provide care in any setting, including home or hospital, and in about half the provinces, birth centres, where available. (16) Evidence demonstrates that these are all options which give women and babies who require straightforward care, a safe environment for care and for birth, reducing the risk of unnecessary interventions and ensuring continuity of care. (17)

The ability to provide choice of birth place is key to the midwifery model of care, as it is intrinsically linked to informed choice, and to the principle of providing true woman-centered care, which focuses on the needs and desires of the childbearing woman and her (self-defined) family. Midwives provide information needed for the woman to make an informed choice about the appropriate setting for her, in which to give birth. Because the midwife is able to provide evidence-informed care in any setting, the woman is then free to make that decision based on her own needs and vision for her birth.

The availability of options where midwives may practice fully, be they at home, in birth centres or in midwifery-supportive maternity care units in hospitals, has helped move midwifery and the re-development of midwifery skills and knowledge forward. Systems and protocols for consultation and referral and respectful relationships with other professionals and birth workers are essential components of safety in this regard. The development of the appropriate care pathway, including the provision of different places of birth, is critical to effective midwifery.

Evidence-informed Practice

Finally, midwives are committed to evidence-informed practice.

Evidence-informed practice uses evidence to identify the potential benefits and risks of any clinical decision. This means that that midwives must commit to continually developing and sharing midwifery knowledge. They must attend continuing education opportunities in the field of midwifery and obstetrics, and related topics and must keep their knowledge current about emerging practice guidelines and the research that supports them. You can read more about this in chapter 12 – Midwives Using Research.

Importantly, clinical research, while critical, is only one source of evidence which midwives must be aware of and able to discuss with women. When practice is truly evidence-informed, other factors, including health care resources, the individual clinical state and circumstances, the clinician's own expertise and experience, availability of appropriate resources and the woman's own preferences are also considered. The midwife's clinical expertise ties them all together to inform practice decisions, and in support of informed choice decision making. (18)

Midwives in Canada are autonomous, primary care providers. As health care systems are provincially regulated, there are slight variations in how midwifery is practiced from province to province, however the scope of practice is consistent: normal pregnancy, intrapartum and postpartum care, from conception to six weeks postpartum. Evidence-informed practice, choice of birth setting, community based, informed choice and continuity of care are the five main principles which form the foundation of the Canadian midwifery model of care. Each of these aspects contributes to a unique model of care where childbearing women and their families, their social contexts and preferences for care, are held at the centre. Midwives are called to meet women where they are at, to build trusting relationships, and to provide care that supports normal, physiologic birth with as few interventions as necessary.

The Art & Science of Midwifery Care – Specialised Skills of the Midwife

Working within the midwifery model of care requires several skills and skill sets. As clinicians, many of the midwife's skills overlap with our nursing and physician colleagues. However, the emphasis in our model on relationship building and the provision of informed choice, as well as the midwife's focus on pregnancy and birth as normal physiological processes, demands that midwives take up the role not only of clinicians, but also of educators, companions and promotors of health and well-being. The combination of skills required to fulfil these multiple roles provides a unique bridge between the science of medicine, and the art of individualized care provision. The midwife is called to move between these skill sets with ease and fluidity.

Clinicians

As primary health care providers, it goes without saying that midwives must be proficient in many skills which are related to supporting normal birth and avoiding unnecessary intervention. These include (but are certainly not limited to), an understanding of and ability to support physiological birth, giving information to women and their families, increasing confidence, comfort and mobility in labour, enabling birth in an out of hospital setting, the use of water in labour, avoiding continuous electronic fetal monitoring, assessing carefully to know when intervention is required. (19,20)

Midwives must also understand the importance of knowing how and when to consult, refer, and transfer care, in a timely and efficient manner. In this regard, the ability to develop and maintain good working relationships with interprofessional colleagues, is a critical, though often undervalued skill for midwives, as with all health care providers.

Midwifery practice requires proficiency in a wide range of hands-on clinical skills including those related to assessment, intervention, diagnosis, referral and emergency skills. Importantly, the wisdom and art of midwifery come in the midwife's ability to perform the necessary hands-on skills, *while at the same time* listening, watching, sensing what is happening, reading nonverbal language, and anticipating the needs of the woman and family. In this way, technical skills are woven into intentional conversations, listening, creating a suitable physical environment (e.g. dark and quiet room for labour and birth, or a space that encourages movement). Midwifery weaves these together in a way that respectfully meets the needs and as much as possible, the preferences, of women, babies and families in their individual contexts.

All of these clinical skills are outlined by the CMRC. The Canadian Competencies for Midwives document lists the specific knowledge and skills expected of an entry-level midwife generally in Canada, noting that there may be slight variation in practice form province to province. (21)

Educators

Whether this is forming groups, providing information sessions, or individualized discussions leading to informed choice decision-making, midwives must be able to identify what a childbearing

woman needs to know, translate clinical evidence into accessible language, and support her to make strong, informed decisions. The intention of midwifery is to support the capability of the woman and her family to care for themselves and the baby. Flexible, individualized education is a critical means towards that end. (22)

Companions – 'Being with' Each & Every Woman

As discussed above, midwife means literally, 'being with the woman' – a companion on the journey to through pregnancy, labour and birth, and through the immediate postpartum. 'Being with' implies support, giving and helping the woman understand information, helping lay out the decisions to be made (e.g. induction for postdates labour or place of birth), giving confidence, while also being honest about situations. Underlying all of this is compassion and understanding of the woman's situation and life circumstances. Midwives need to be educated and skilled, but also compassionate and responsive to multiple social contexts.

A focus on the needs of each individual may help illustrate how we might use this midwifery approach in practice. Think about the universal needs of each woman, their baby, the partner or other parent, and family. The woman needs a midwife who understands the profound importance of pregnancy, birth and the early weeks of life. Each woman will have different levels of understanding, as well as different cultural needs, support needs, preferences, desires, hopes, and worries. It is critical that the midwife get to know the woman and her family by listening and responding to them with respect and compassion for their particular life circumstances.

In a way, this reflects what the parents will be required to do: to know, understand and respond sensitively to the needs of their

baby. The midwife may be seen as modelling this interaction in her relationship with the woman. Ideally each person is also supported beyond this relationship. The woman is supported by their family, their community, and health services that support their health, medical, social and psychological needs while providing genuine choices. The midwife, in turn, is supported not only by their family and friends, but also critically by colleagues and systems of care that enable the full scope of practice, and continuous improvement of knowledge, wisdom and skills. It is also far simpler to take this approach when there is continuity of the midwife-woman relationship; although even where care is fragmented some elements may be maintained. The crux of this midwifery approach is to understand that care *mediated through relationship* is fundamental.

Promotors of Health & Wellbeing

Wellbeing includes physical health as well as emotional wellbeing and a sense of security, hope and optimism. Optimal health is the best health for each individual, in their individual context, and given their individual health care needs. What makes this a more complex concept in maternity care is the balance between the woman's health and that of the baby. Holding both of these in mind, not placing the health of one over the other, is critical in considering the appropriateness of interventions to maintain optional health in maternity care. Midwives do this by supporting physiological processes, whenever possible, while keeping in mind the overall context and preferences of each individual woman and case.

Central to midwifery practice is that we recognize the need to support normal human physiology by helping women to have a

normal birth, and supporting them so that they can, if possible, avoid the use of unnecessary interventions (e.g. epidural for pain relief, or the use of artificial oxytocin to induce labour). Meanwhile, if these interventions are needed (or desired), then the midwife's role becomes to support the woman to have the best birth experience possible for them: physiologically, but also emotionally.

Both 'being with' the woman, and pursuing the aim of optimal health and wellbeing require a balance of ensuring women are aware of all the possibilities for care and place of birth, including the evidence supporting each of their options and the risks associated with them. An understanding of the woman's current health status, their values and preferences and life circumstances are critical for optimal health. This demands a unique mix of empathy, compassion, listening, understanding, and availability.

Conclusion

In this chapter, we have summarized the unique approach of midwives and midwifery practice within the Canadian health care system. The midwifery model of care is based on the five key principles of continuity of care, informed choice, community-based, choice of birth setting and evidence-informed practice. This model takes us beyond a medicalized approach to pregnancy, birth and postpartum, towards individualized, humanized care. Midwives are concerned not only with concrete clinical outcomes relating to mortality and morbidity, but also health and wellbeing, maternal capability, secure attachment between mother and baby, and family integrity. Midwives who are educated, skilled and compassionate, who work in effective health services with adequate resources, are critical in the movement towards

humanized, woman-centred care for childbearing families in this country.

Importantly, the midwifery approach represents a new paradigm: we are learning as individuals and as a profession to see, think and practice differently; to move away from childbirth as an illness to be managed and towards a holistic, humanized perspective of the childbearing experience. Humanistic midwifery care requires exquisite communication skills, clinical judgement, diagnosis and decision making, manual skills, and the ability to understand as well as judge the validity of evidence, all while being in partnership with the childbearing woman, keeping her at the centre of care, and promoting optimal health and wellbeing. An ability to move seamlessly between all of the various skill sets, holding each as important as the other, is the art of midwifery practice.

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6. Effective Communication

Terri Rypkema, MEd, RCC

This chapter will discuss the effective interpersonal communication and counselling skills that play a large part midwifery practice: active listening, empathy, problem-solving and the core counselling skills of assessment, goal setting and using motivational tools.

From building a trusting relationship at the first appointment with clients through to the birth and the postpartum visits, midwifes will encounter many situations in which they will need effective communication tools in their repertoire and the skills to utilize them. Midwives will also use these tools with clients' families, colleagues, other professionals, students, and others.

There will be times when the communication is urgent and factual and times when it will be warm and empathic as midwives need to relay everything from good to terrible news. Each time a midwife communicates, they must do so from the position of understanding who their audience is, what they want/need, what information needs to be conveyed, and what role their own

thoughts and emotions play in the communication. It takes a great deal of self-awareness and practice to become an effective communicator.

Values & Self-Awareness in the Midwife-Client Relationship

To be an effective communicator and counsellor the midwife must understand their own values, beliefs and personal characteristics and how these may impact their work with clients. Our values provide guidance for us as individuals; determining what we believe to be right and wrong, and good and bad. They also influence what we deem to be of worth and importance in our lives. Whether we realize it or not, our values inform us in our everyday lives and in the client/counselling and client/midwife relationships.

It is essential that anyone working with people in any kind of counselling capacity be aware of their own values and beliefs, and be self-aware of their emotional, physical and mental response to the client. This means taking time to reflect on your beliefs and assess their effects on your feelings and emotions; that is, checking in with yourself to assess what is happening internally. You may ask yourself: Am I feeling strong emotions as I listen? Do I feel stress or discomfort in my body? Are there words and phrases running through my mind that prevent me from being able to fully attend to what the client is saying? As a midwife, if you are feeling emotionally activated, you can utilize self-regulation tools to manage the activation. Self-regulation tools include slowing down the breath, taking a sip of water, refocussing on the client and, if necessary, asking for a brief break in the meeting.

From this increased self-awareness comes the ability to set and maintain professional and personal boundaries. These boundaries provide emotional safety for both midwives and their clients as they navigate the transformative experience of birth together. Awareness of personal values and beliefs also allow the counsellors to work in a non-judgemental way with clients that have opposing values or refer such clients to an alternative resource more congruent with the client's values. There is no standard that states that a counsellor must ignore their own values and beliefs entirely, but ethical practice requires that you not impose your personal values and beliefs on the person with whom you are counselling.

In most cases, it is not fair to expect midwives to ignore very strongly held values and beliefs in order to serve the needs of clients. There is no shame in acknowledging to oneself that it would be difficult, if not impossible, to work with certain clients because of a fundamental clash over values, beliefs, or consequently, behaviours. Referring the client to another midwife solves the problem while ensuring that the client receives the services they need.

Relationship Building

Along with self-awareness, relationship building will facilitate communication and possible counselling support as the midwife and client work together. This relationship is a professional one, with clear boundaries and expectations, but is still based on warmth and mutual acceptance.

Reflect

What are the differences between personal/professional, physician/midwife, teacher/student relationships?

The essential elements of a helping relationship are listed below. The acronym PANG (positive regard, attending, non-judgement, genuineness) assists in remembering these elements:

Positive Regard

To develop and maintain a healthy clinical relationship, it is important that the midwife be able to maintain a positive manner in the company of the client. They need to portray a belief in the client's strengths and abilities. The midwife also needs to be curious about the client's values and beliefs around **personal power**, birth and family and to acknowledge and accept those beliefs and values as being fundamental to the client's sense of self. (1) If the midwife has a strong sense of their own values and beliefs, it is more likely that they can view their client's beliefs in a positive way.

Reflect

What does positive regard look and feel like for the client? For the midwife? How do you know it is present?

Attending

When engaged in a clinical conversation, midwives have a number of tools at hand to demonstrate that they are engaged with what the client is communicating. Those practices include: orientating the body to the client's face, sitting up in a relaxed and alert manner, making regular eye contact, using continuation sounds, such as "hmmm," and "yes," and nodding the head. These actions indicate interest and engagement in the conversation to the exclusion of all else. Keeping the hands and body fairly still and not toying with a pen or fidgeting in the chair will also communicate active listening. As a result of using these tools, the client should feel heard and know that they are the focus of the conversation for that period of time.

Reflect

What are some of the mannerisms that you may have that could demonstrate inattention? e.g. doodling or fidgeting.

Non-judgement

It is essential that midwives demonstrate an attitude of non-judgement when meeting with clients. This is different from positive regard in that the client may be expressing disturbing material that might cause the midwife to be concerned or to feel 'put off' by the conversation. These feelings usually occur when the client is expressing values or beliefs that contradict those held by the midwife. During those times, the midwife needs to use self-awareness and emotional self-regulation skills to maintain positive regard for the client.

It is critical that the midwife be aware of values and beliefs

that they cannot accept and to be ready to refer the client to another midwife or practice if a non-judgemental stance cannot be maintained. There is nothing wrong with acknowledging that a client's values clash so absolutely with one's own. Attempting to work in that environment is not helpful for either client or midwife.

Genuineness

Genuineness is a fundamental factor in any healthy relationship. It is especially important in a relationship where trust and ongoing communication are critical to ensuring a positive outcome – a healthy birth in the case of midwifery. The midwife can demonstrate genuineness through tone of voice, a warm manner, regular eye contact, and questions that indicate an interest in the client's well-being.

Counselling Skills in Midwifery

While counselling is widely considered to be a treatment format for people with emotional or mental health concerns, most health providers find themselves offering some kind of counselling along with the services within their particular practice. Whether a physician is working with a patient to increase their motivation for losing weight, or a midwife is supporting a family through an adverse birth outcome, the tools they will use are no different from those used by a counsellor supporting a client through, for example, depression. It is, rather, a matter of degree of intervention.

Some of the situations in which a midwife will be called upon to enter into a counselling conversation may include: the client's

concerns about pain management, fear of delivery, a desire to change a habit to enhance their health and the health of the fetus, and so on. It is critical that the midwife have a clear understanding of when they can help the client and when the client should be referred to a mental health professional. Although not an exhaustive list, the following situations require a referral:

- The client is not oriented to time or place or has significant cognitive deficits
- The client is abusing drugs or alcohol
- There is a report or a suspicion of domestic violence
- The client is describing depression or anxiety that appears to be greater than the normal worrying or feeling "blue"
- The client is demonstrating the symptoms of **Post-Traumatic Stress Disorder (PTSD)**

If the midwife is concerned that the client is presenting with symptoms that are confusing or very concerning, they should refer the client to a mental health professional for assessment. Most often, it is best to refer the client to their own family physician who can then make an appropriate referral.

In many cases, when there is no concern about the mental health of the client, the midwife may still want to refer the client and their family to community-based services, such as dietician, multicultural service agencies, or massage therapists.

What is Counselling?

The British Association for Counselling, now the British Association for Counselling and Psychotheraphy, may have been

the first professional association to adopt a definition of professional counselling. In 1986 it published the following definition:

> Counselling is the skilled and principled use of relationship to facilitate self- knowledge, emotional acceptance and growth and the optimal development of personal resources. The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully. Counselling relationships will vary according to need but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict or improving relationships with others. The counsellor's role is to facilitate the clients work in ways that respect the client's values, personal resources and capacity for self-determination. (2)

This definition demonstrates how easily the practice of counselling fits into the practice of midwifery, but as you can see from the definition, there is little if no room for advising clients in the counselling setting. Of course, a midwife will advise the client on the medical aspects of the pregnancy, such as maintaining adequate nutrition or providing lactation support, but they may need to shift the focus to a guidance role when supporting the client to make certain decisions, change concerning behaviours, or to process an emotional concern.

Current models of counselling focus on what is called **person-centred practice**. Interventions are based on each client's goals and draw from each client's internal and external resources,

whenever possible. Working from the client's goals increases their sense of worth and accomplishment and reduces the chance of the client resisting change as they find it difficult to fight against something that they have identified as their desired outcome. Assisting a client to access their own resources allows that client to become more self-sufficient and more likely to generalize their self-knowledge and new skills to future problems.

The Righting Reflex: Avoiding Knowing What's Best

Many people in the care-based professions believe that they know what the client needs. While this is necessary in acute situations, such as a medical emergency, in psycho-social settings, it prevents both the client and the counsellor from thinking outside the box when determining what is best for the client. In their haste to rescue the client from distress, those in care-based professions also risk ignoring the client's needs altogether.

Motivational interviewing theorists call this the **righting reflex**. It comes from a place of caring and a desire to reduce suffering, but it often results in clients feeling misunderstood, over-ruled, and even invisible. It takes significant self-awareness and self-control along with a strong belief in the person-centred model of counselling to avoid getting caught up in the righting reflex.

Søren Kierkegaard captured the need to avoid the righting reflex beautifully in a piece of prose he wrote in 1848.

> If I want to successfully bring a person to a definite goal,
> I must find where he is, and start right there.

> He, who cannot do that, fools himself when he thinks that he can help others.
> To help somebody, I certainly must understand more than he does, but above all understand what he understands.
> If I cannot do that, it is of no help that I am more able than he is and that I know more that he does.
> If I still want to show how much I know, the reason is that I am vain and arrogant, and because I in fact want to be admired by the other rather than help him.
> All true helpfulness begins with humbleness before the person I want to help, and thereby I must realize that to help is not a desire to rule but a wish to serve.
> If I cannot do that, I cannot help anybody. (3)

The midwife must put their feelings and thoughts about what the client ought to do aside and listen carefully to what the client is saying about their thoughts, feelings, and needs. **Reflective listening**, empathy, and careful use of questions are all tools midwives may use to provide guidance and support for their clients. Often, the client will come into their own awareness of what they need to do to solve a problem just by talking it out with another person. This approach is the foundation of person-centred counselling.

Empathy as a Counselling Tool

Once a healthy helping relationship has been developed between the midwife and client, the counselling process can begin. The cornerstone of counselling is empathy. Merriam-Webster defines empathy as:

1. the imaginative projection of a subjective state into an object so that the object appears to be infused with it

2. the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner; also: the capacity for this

It is important to draw a distinction here between empathy and sympathy. Merriam-Webster defines sympathy as:

1. a: an affinity, association, or relationship between persons or things wherein whatever affects one similarly affects the other
b: mutual or parallel susceptibility or a condition brought about by it
c : unity or harmony in action or effect <every part is in complete sympathy with the scheme as a whole — Edwin Benson>

2. a: inclination to think or feel alike: emotional

or intellectual accord <in sympathy with their goals>
b: feeling of loyalty: tendency to favor or support <republican sympathies>

3.

a: the act or capacity of entering into or sharing the feelings or interests of another;
b: the feeling or mental state brought about by such sensitivity <have sympathy for the poor>

4.

the correlation existing between bodies capable of communicating their vibrational energy to one another through some medium

Sympathy tends to remove the boundaries that belong in a professional relationship, allowing the participants to share the experience. However, a sympathetic response to a client is not likely to enable the client to move beyond the immediate feelings toward understanding because the midwife is colluding with client in the emotions the client is feeling. If the client is handing the midwife the tissue box instead of the other way around, it is likely that the midwife is sympathizing with the client and not empathizing. This is not helpful for the client.

An empathic response signals to the client that you understand their experience. For example, saying something like "That must have been very hard for you" invites the client to explore those feelings further and expand upon his or her experience.

Reflect

Why is empathy so important in the helping relationship?

Empathy is typically expressed in counselling sessions using a tool called reflective listening. In a reflective listening interaction, the counsellor/midwife engages the PANG skills, listens carefully to what the client is expressing and verbally reflects back their understanding of what the client is feeling. The client has the option of agreeing with the midwife or correcting them and restating what they are feeling. In either case, it is a successful interaction. If the midwife correctly identifies the feeling, the client feels heard and understood and will likely be open to further exploration of their concerns. If the midwife has misunderstood the client's feelings, the client has the opportunity to correct them. This also enables the client to further clarify their thoughts and feelings.

An example of a reflective listening interaction:

Client	I'm just not sure about having this baby at home. I'm worried that my other children will find it traumatizing.
Midwife	You're not sure if having a home birth is a good idea because your younger children may find the experience traumatic.
Client	Yes, I'm worried that they will find the sights and sounds scary.
Midwife	You are worried that the labour and birth will scare the younger children.

While reflecting back the client's feelings can make the client feel heard and understood, it often doesn't encourage the client

to explore their feelings more deeply or begin the process of problem-solving. There are additional tools the midwife can use to enhance reflective listening interactions and begin to move the client toward finding solutions.

Active Counselling Tools

Paraphrasing

In a counselling conversation, **paraphrasing** the client's statements – not parroting back their feelings using their exact words – gives the client an opportunity to broaden their understanding of their situation. In hearing your interpretation of their feelings, the client has the opportunity to agree with or refute your reflection.

An example of paraphrasing:

Client	I'm just not sure about having this baby at home. I'm worried that my other children will find it traumatizing.
Midwife	You're concerned about having a homebirth because it might frighten your children.
Client	Yes, I'm worried that they will find the sights and sounds scary.
Midwife	You are worried that the challenging process of labour and birth will frighten your younger children.
Client	Yes, and they will be frightened by the strangers in the house, being awakened in the middle of the night, and the big change in their routine. I mean it is a bit scary for me, too, and I'm not sure that I can handle worrying about them as well as myself.
Midwife	You feel uncertain about your decision to have a home birth.

Notice that the client has now begun to talk about her concerns for the birth and not just her concerns about the younger siblings.

Summarizing

After a number of interactions that involve paraphrasing and reflecting back the clients' statements, which helps them to clarify their concerns, the next step is to **summarize** the interactions.

An example of summarizing**:**

Client	I'm just not sure about having this baby at home. I'm worried that my other children will find it traumatizing.
Midwife	You're concerned about having a homebirth because it might frighten your children.
Client	Yes, I'm worried that they will find the sights and sounds scary.
Midwife	You are worried that the challenging process of labour and birth will frighten your younger children.
Client	Yes, and they will be frightened by the strangers in the house, being awakened in the middle of the night, and the big change in their routine. I mean it is a bit scary for me, too, and I'm not sure that I can handle worrying about them as well as myself.
Midwife	So, it sounds like you wanted to have a home birth but you are now re-considering your decision because you have some concerns. You are a little worried about how the labour and birth may affect the younger children and you are concerned about whether or not you can manage their reactions while you are dealing with your labour.

Using effective questions

Questions are helpful in opening an interview, defining problems concretely, encouraging clients to elaborate on issues, establishing goals, and stimulating changes in thinking patterns. However, asking questions in a helping relationship can be a double-edged sword. On one hand, questions can elicit very important information such as occurs during an assessment. On the other hand, asking questions, especially too many questions in a counselling interaction, can cause a client to feel unheard, defensive, and distanced. A midwife must learn to use questions sparingly and thoughtfully as a way to assist the client to explore their emotional concerns.

It is critical that the midwife learn how to manage the timing, content, and purpose of questions in order to preserve the helping relationship with the client. Using questions in a counselling interaction is often where the righting reflex becomes apparent. In order to ask a question, the asker must have a hypothesis about what is happening for the client. The client's answer will then either confirm or deny the hypothesis. If the hypothesis is grounded in what the midwife believes they know about the client's needs, then the questions will naturally reflect that belief. This often leads to the client not being free to explore their own needs and, in some cases being manipulated into doing what the helper believes is best. While anyone working with a client must have some understanding of what the client is presenting and what they may need, the helper must keep an open mind and not ask targeted questions.

Closed Questions and Open Questions

Closed questions and **open questions** are generally the most common types of questions. If a client is asked a closed question, they will likely go with the quickest answer, robbing themselves of the opportunity to contemplate what they truly think and feel about the topic. This automatic answering also decreases the client's opportunity for self-awareness. Closed questions often end in awkward silence because the asker is usually hoping for more so that their hypothesis can be confirmed and the conversation can continue. It is important to remember that most clients won't answer with just a 'yes' or 'no', especially once the helping relationship is formed. However, a carefully crafted open question will garner much more helpful information for the midwife and the client. You know that you have asked a good question when the client sits back and thinks for a while before answering – searching back in their memory or exploring previously unknown thoughts or feelings before answering. An excellent question will often trigger an 'Aha!' moment for the client and lead to a fruitful discussion about the issue. Note the difference between an open and a closed question:

Example of a closed question:

Midwife	Did you use any pain management strategies with your first birth?
Client	No, I didn't.

Turning a closed question into an open question:

Midwife	What kinds of pain management strategies did you use for your first birth?
Client	I used some breathing exercises and my partner massaged my back, but it was still really awful.

Clarifying Questions

There is a third type of question called a **clarification question**. A set of five open questions came out of the **solution-focused therapy model** (4) and have excellent applications in midwifery. These are questions that will help the client to explore their concerns, needs, internal and external resources, and wishes surrounding pregnancy and birth.

1) Exploration Questions

Clients will often report that they have been struggling with a problem for a long time before discussing it with a health care or mental health provider. It is important to use **exploration questions** to determine what kinds of strategies the client used to attempt to solve the problem. This will prevent you from suggesting something that has already been tried and from making the client feel judged for not being successful thus far. Sometimes the client has already discussed the problem with someone and it was not a good experience. It can be very helpful in the building of the therapeutic relationship to avoid making the same mistakes that an earlier professional made with the client.

An example of an exploration question:

Midwife	How has your fear of morning sickness changed since it first began?
Client	Before I got pregnant, I was terrified. I almost didn't want to have children because of it. Now that I am pregnant, I'm still scared, but there is nothing I can do about it now, right?
Midwife	How did this feeling change once you were pregnant?
Client	Well, I guess my fear of being sick became less powerful than my excitement about being a mother.
Midwife	So, you are focusing on the positives of being a mother and not the worry of being sick.

2) Exception Finding Questions

Exception finding questions encourage the client to look at situations where the problem that they are having is not happening. The purpose is two-fold. The client is encouraged by the question to shift away from a 'this problem is always present' to a more reasonable, 'this problem is sometimes not happening' viewpoint. In addition, such questions invite the client to think about why the problem isn't happening when it isn't and to strategize ways to replicate the environment in which the problem doesn't happen, thereby reducing the frequency of the problem. In the following interaction, note how the client is beginning to problem-solve on her own and has come up with two strategies she can use to stay confident and relaxed.

An example of exception-finding questions in midwifery:

Midwife	When do you feel confident about your ability to breastfeed?
Client	I feel pretty confident about it when my mother tells me how wonderful it was to breastfeed.
Midwife	Why aren't you worried then?
Client	Well, I trust my mother. She doesn't lie to me.
Midwife	What is different between when you are worried and when you feel confident?
Client	I feel more relaxed after I have talked with my mom and I believe that I will be successful because she has faith in me.
Midwife	So how can you retain that relaxed and confident feeling when your mother is not with you?
Client	I could maybe write it down? Or remind myself when I start to worry?

3) Scaling Questions

Scaling questions are very useful for talking about the intensity of a physical or emotional feeling. Physical and emotional feelings are notoriously difficult to describe without having some way of setting common ground around the experience. The question can easily be customized to any situation using relevant language. The client presents a **Likert scale** verbally to the client, asking them to describe the intensity of their feeling on a scale of 1-5, or 1-10, assigning a value to each of the numbers.

An example of a scaling question:

Midwife	On a scale of 0-10, with 0 being not anxious at all and 10 being so anxious that you cannot cope, how anxious are you about having a vaginal birth after cesarean for this baby?
Client	Oh, I would say that I am at a 7 or 8. I'm pretty worried about it.

Scaling questions are also useful for having discussions about what would need to happen to change the rating up or down and to explore progress the client has made.

An example, continuing from the conversation above:

Midwife	So, you are at a 7or 8 today. What could happen that would reduce the anxiety to 4 or 5?
Client	Well, you could tell me more about how a vaginal birth after a cesarean works.

4) Coping Questions

Coping questions help the client to become more aware of their inner resources. Often, clients will have coped with a problem for some time before seeking help. However, they frequently don't recognize what skills they have been using to manage. Once the midwife points out that they have these internal skills, the client often becomes more confident in their ability to cope.

An example of a coping question:

Midwife	How did you manage to stay calm during the miscarriage scare early in your pregnancy?
Client	Well, I made sure that I stayed off my feet during those two weeks and I phoned my Mom every day and I asked my sisters to come and make meals and watch my son after school each day.
Midwife	So it sounds like you were very resourceful in terms of asking for help, staying rested, and getting lots of emotional support from your Mom.

5) Relationship Questions

Relationship questions assist the client to look at their own future behaviour without judgement, helping them to set goals. The midwife can ask the client what someone else would notice about them if they made a change in their behaviour.

An example of a relationship question:

Midwife	What would your partner notice about you if you decided that you would no longer listen to the horror stories of birth that your friends insist on telling?
Client	Well, I guess my partner would see that I have stopped worrying and that I was sleeping better and not having bad dreams.

Clearly, questions are a very important part of care provision. Questions, in conjunction with active listening practices enable the midwife and client to move into the process of finding or creating solutions to stated concerns or for the midwife to make appropriate referrals for more specialized care.

Assessment

Assessment is an integral part of the health and counselling professions. It is essential to understanding the client's emotional and physical strengths and needs. The science of assessment can mean asking a lot of questions, which can impede the development of the counselling relationship, but that does not have to be the case. If the midwife is skillful in the art of assessment, which involves using the counselling skills outlined above – relationship building, using effective questions, listening and reflecting, the client will feel the midwife is 'with' them. Assessment takes time

but is the foundation of a trusting and effective communicative client/midwife relationship.

Talking to Clients about Change

Change is difficult for most people and becoming a parent is one of the most challenging changes that a person can make. Many of the changes that occur in the process of becoming a parent are outside the client's control, but many clients also desire to make behavioural changes, such as quitting smoking, eating better, exercising more, or repairing familial relationships. Despite the desire to make these changes, it is often difficult for clients to begin the process and/or follow through.

An effective tool for midwives to talk to clients about change is the **transtheoretical model of behaviour change** (5) developed by James O. Prochaska and Carlo DiClemente. This model describes the five stages through which a client will pass on their way to making a significant change in their life.

External Link

More information about the transtheoretical model of behaviour change can be found at the University of Maryland, Baltimore County website: http://www.umbc.edu/psyc/habits/content/the_model/index.html

Precontemplative Stage

During this first, **precontemplative stage**, the client is unaware that they need to make a change although other people around them may be concerned about their behaviour. Until the client becomes aware of any need for change, the midwife can only provide what is called **passive information**. Ideally, the midwifery clinic/office will have passive information available to clients in the waiting area. Many professionals make use of this passive way of providing clients with information on a variety of issues and concerns that may come up during pregnancy through the use of posters, brochures, websites, and seminars.

Contemplative Stage

Once the client has become aware that they want to make a change in their behaviour, they are deemed to have reached the **contemplative stage**. In this stage, the client has realized that a certain behaviour of theirs has become detrimental in some way or wishes to enhance or add a positive behaviour to increase the likelihood of a healthy pregnancy and birth. During this stage, the midwife becomes an active provider of information, such as referrals to a specialist and/or media with specific information about the concerns. The midwife may share their own expertise depending on the behaviour change the client is wanting to make. It is during this stage that the midwife will make the most use of counselling skills. Asking open questions and helping the client to explore her feelings about making the change naturally leads to the next stage.

Planning Stage

In this stage, the midwife can assist the client to anticipate any obstacles to successfully making a change and generate a plan to eliminate or reduce those obstacles. This is often a very active and practical conversation. For example, the client may anticipate that they are unable to attend a smoking cessation program because they do not speak English well. The midwife may have information about such programs being offered by multicultural agencies in the community.

Active Stage

Generally, the client is doing the hard work of making change in this stage and the midwife takes the role of monitor and, occasionally, coach. Often, the client is accessing a service outside of the midwifery practice, such as smoking cessation, nutrition counselling, or parenting classes, and the midwife's role is just to check in with how the client is doing during normal prenatal check-ups.

Maintenance Stage

In this stage the client learns ways to maintain the changes that they made and, most importantly, to develop a relapse prevention plan. This plan is a critical part of the maintenance stage. The client develops a plan, anticipating the possible ways in which the desired change could be derailed and outlining how derailment threats will be managed if they occur. Most relapses in behaviour change are the result of not planning for times when it becomes

very difficult to maintain the change, such as attending a party where others are smoking, or holidays that include many sugary treats. A good plan for handling these threats makes it much more likely that the client will be able to maintain the desired change.

Despite the client's best efforts, relapse is a very common and normal aspect of making change. It is important for the midwife to reassure the client that change is difficult, that going back to an old and unwanted behaviour doesn't mean starting at the beginning again, and that there is something to be learned from the relapse. Most relapses occur because either something was missed during the planning stage or during the relapse prevention part of the maintenance stage. Either way, the client should be encouraged to look at the early successes in making change and to look at what went wrong so that they can use that information to try again while avoiding the pitfall they encountered the first time.

Sometimes, clients wanting to make a change in their emotional or physical lives have trouble developing and/or maintaining the motivation to make a change. The midwife can play an important role in this situation by using motivational interviewing (6) techniques to assist the client to achieve her goals.

Motivational interviewing strategies are designed to assist the client to look at the difference between what they want (e.g. to be a non-smoker) and what they are now (a smoker). Rather than attempting to convince the client that they should stop smoking the midwife can ask questions that encourage the client to look at why they want to make the change.

An example of a motivational interviewing interaction:

Midwife	In what ways do you think your body will feel different once you have stopped smoking?
Client	I don't know for sure, but I guess I won't feel as breathless and I won't feel sick all the time.
Midwife	It sounds like smoking is making you feel unwell right now and you can see that you will feel better when you stop smoking.
Client	Maybe, but I'm not sure.
Midwife	How did you feel when you smoked your first cigarette of the day today?
Client	Oh! I felt so lightheaded and nauseous. And I worried about what it was doing to the baby.
Midwife	I hear you are concerned for both yourself and the baby when you smoke.
Client	Yes, I am concerned. It wasn't important to me before, but now I have the baby to consider as well. I really shouldn't be doing something that could harm the baby.
Midwife	It sounds like you want to do what is best for you and the baby.

Note that the midwife is not judging the client for her behaviour but is, instead, helping the client to explore her own experience of smoking and the impact it has on her and her baby. This exploration most often leads to development of internal motivation in the client to make a positive change.

Difficult Relationships & Difficult Conversations

There will be times when, despite the midwife's and the client's best efforts at communication, the relationship and/or conversation will be strained. Perhaps the client has trouble building trust or the midwife is being influenced by feelings that

arise if the client reminds them of someone they had a negative experience with in the past. Perhaps their communication styles are so opposite that they just can't connect. There will be times when the midwife must relay difficult information, challenge the client, or manage a difficult conflict with a client's family member or another professional.

The first step in dealing with difficult conversations is to ensure that you feel physically and emotionally grounded. Most people go into what is called the **'fight or flight' mode** when involved in an intense interaction with another person. This makes it very difficult to think and respond clearly and thoughtfully during the conversation.

The fight or flight mode is a basic human instinct that is managed by a small structure in the brain called the **amygdala**. When the amygdala senses some kind of threat, it sends out a chemical signal to the **sympathetic nervous system** to prepare the body to respond to the threat. New research has found that a normal healthy human will do one of five things:

1. Friend (i.e. seek help.)
2. Fight
3. Flee
4. Freeze
5. Flop (When there have been multiple threats with no resolution and the person fails to respond.)

These five responses are thought to be the brain's way of ensuring survival. Of course, a difficult conversation is not a threat to one's survival as such. However, the amygdala does not discriminate very well between types of threat. It will respond to the emotional

threat of a challenging verbal interaction in the same way, albeit with less intensity, as it would to a physical threat.

Once the chemical message is sent out in response to threat the body responds automatically through the sympathetic system. Heart rate and blood pressure will increase, breathing becomes more quick and shallow, and the digestive system will shut down. These changes allow the body to divert needed resources – blood and oxygen – to the arms and legs in order to facilitate the fight, flight, or freeze mode. The person experiences these physical changes in feelings of light-headedness, heaviness in the arms and legs, pounding heartbeat, heavy feeling in the stomach, feeling flushed and hot, and generally agitated.

The chemical messaging and organization of this process is managed primarily by the hormone **cortisol.** Besides managing all the changes in the brain and the body, cortisol also shuts down the **hippocampus**. When a person has been threatened, the brain doesn't 'want' the person to take time to think about what to do to resolve the threat because in the time it takes to think about it, the threat could become fatal. This shutting down of the hippocampus results in people feeling disoriented and incapable of thinking clearly. After a threat, people report that they 'just couldn't think straight', 'felt like they were in a fog', 'couldn't concentrate or cope'. (7) It is this feature of the response to threat that makes communication in an emotionally risky situation so difficult.

There is a way to prevent or stop this cascade of physiological events from happening. In order to turn off the threat response, one must turn on the parasympathetic system. The 'on switch' for the parasympathetic system is deep and slow breathing. Humans have a natural way of doing this that most of us take for granted. If you think back to a time when you saw something that was frightening you may remember that after the threat was gone, you probably took a big deep breath and said blew it out saying

"Whew!" when it was over. People witnessing a near collision often turn to each other, take a deep breath and exclaim, "Wow, did you see that?' while exhaling. (8) This is the body's way of turning on the parasympathetic system to reset the heart rate and breathing rate to normal values.

Reflect

Think back to a time when you were very frightened. (Do not try to think of a time that may trigger a very strong emotional response, such as a traumatic event). Try to remember the first moments after the event.

How did you express your immediate thoughts and feelings?

Do you remember laughing or crying?

How did you interact with the people who may have witnessed the event with you?

Can you think of other times that you felt similar physiological sensations? When angry? Frustrated? Pressured? Rushed?

The midwife can use breath to prepare for a difficult conversation by spending a few minutes privately preparing by taking two deep breaths and letting them out slowly and then breathing on a count of one-two-three-four on the inhale and one-two-three-four on the exhale. This exercise will call in the parasympathetic system, calm the heart, lungs and brain, and bring the hippocampus back 'online'. (9)

During a difficult or challenging conversation, the midwife can manage their breathing, taking a deeper breath when noticing the heartrate increasing and concentrating on keeping the breaths

deep and even. This is a useful tool that midwives can teach to their clients to use to assist them with managing stress, pain, and emotional distress.

In addition to managing the physiological impacts of difficult conversations, the midwife can use a number of strategies and tools to ensure that the conversation is productive. An important tool is ensuring you understand exactly what it is you want to convey. If there is time, think about the goal of the communication. Write down some of the points that need to be made. Make sure that you have any facts that may be relevant at hand. If you are expecting a very difficult conversation, try to rehearse it in your mind. While breathing in a steady manner, visualize the conversation. Imagine yourself being calm and grounded, saying what you need to say and listening to the other person. Often, discomfort and fear about difficult conversations is caused by not knowing what might happen. Having rehearsed the conversation once or twice, the brain will not recognize the real conversation as being novel and will likely keep the body more relaxed and open. (10)

An important tool to use in challenging conversations is to use 'I' messages as opposed to starting sentences off with "You…". For example, "You are wrong". The midwife can begin a conversation with "I am concerned about …" This approach reduces the possibility that the listener will feel defensive and allows them to hear the words being spoken. There is a higher chance of the listener wanting to engage further in the conversation if they are not fighting against the speaker.

An example:

Midwife	I am concerned about the birth plan not being followed as the client had written it. It states that they did not wish to have medications offered, but would ask for them if they felt they were needed.

When providing or receiving feedback, the brain will likely have a similar threat reaction. As with other difficult conversations, it will be important to maintain the breath and keep the hippocampus working well. When the hippocampus is working well, it is possible to hear the feedback, compare it to other similar feedback situations and not be overwhelmed by one's emotions. Good feedback should always include some positive information, some realistic and reasonable information about what went wrong and how it could be done better. Feedback should never be about personal characteristics. It should address specific behaviours that the receiver can change.

Relaying Bad News

There are very specific tools to use when relaying difficult information such as the death of an infant. It is important to remember that many people experience what is called a **flashbulb memory** of the time they received terrible news. It is critical that the midwife be mindful of the language used, the tone of voice, body language, and location for the conversation.

When relaying bad news, it is best to choose a location that is as private as possible, where there are chairs to sit on and is big enough to include family and friends if the circumstances warrant. Ideally, there will be tissues, soft lighting, and the room will be in a quiet place. The midwife should use a calm and soothing voice to relay the information. It is important to state the information clearly and simply while giving plenty of time and emotional space for strong reactions. Initially, there may be expressions of disbelief, rage, blame, tears, or complete silence. There is no hard-and-fast rule about how people will react to emotionally difficult news. The midwife must stay calm, soothing, and be prepared to

answer questions when the client is ready. In most situations, the midwife will just sit and be a witness to the family's grief in the early moments of the meeting until the information is absorbed and initial feelings expressed. After that, there will likely be many questions. It is important to answer questions clearly and simply, as with giving the news initially. If the midwife does not have enough information, they can tell the client that they will get the information as soon as they can and will contact them later. At this time, it is very helpful if the midwife can provide the client and family with information about community supports and any medical information that might be helpful, particularly in dealing with perinatal loss, such as advice and support for the mother on how to manage lactation.

Engaging Partners in the Birth Process

It is important for the midwife to look to the client for direction about who they wish to engage in their pregnancy journey and birth. Typically, the client and intimate partner, family member, or close friend will attend the initial consultation with the midwife. At this time, it is most helpful to discuss what each person's role will be in the process.

The midwife may be asked by the client for advice on who to include in prenatal visits and who could or should attend the birth. This is an excellent opportunity for the midwife to use reflective listening skills and questions to help the client raise awareness about what their needs might be throughout the pregnancy and birth.

An example conversation:

Client	I'm not sure who I want to be there for the birth. Of course I want my partner to be there. My sisters both had our mother there, but I don't know if that is what I want.
Midwife	It sounds like you are sure that you want your partner there for support but you are feeling ambivalent about having your mother there. Let's look at the pros and cons of having her there in the room with you.
Client	Well, if she is in the room with me, I won't be worrying about her hanging around the hospital popping in every few minutes to ask what's going on and she's pretty good at giving back rubs.
Midwife	So she can provide some physical comfort. I'm also hearing that you are concerned that she will be distracting if she isn't allowed to be there and I'm wondering if you are worried that she could be just as distracting in the room with you.
Client	Yes, I'm worried that I'm going to be distracted by her worrying and I won't be able to concentrate on what I have to do. She tends to take up a lot of emotional space. I want a peaceful and calm birth, if I can.
Midwife	Sometimes, parents can hover in a distracting way because they want to be able to help but they don't know what to do. I'm curious about how your sisters handled your mother during their births.
Client	Well, one asked her to bring her homemade broth to sip on during labour and asked Mom for her famous back rubs. The other is the easy-going one and just let Mom do her thing. The thing is, I am more private and introverted than my sisters and I just realised that I don't have to do everything the same way they do. What I really want is for my partner and I to have a quiet and private birth experience. I could ask Mom to be the communications person and my partner can keep her updated by phone. That way, she has a job and feels included and I get the birth that I want.

Occasionally a family member or friend will attempt to engage the midwife in conversation about the client either by phone or email or at some time during the pregnancy and/or birth without her knowledge. One way to deal with this is to invite the client

to provide a list of people with whom the midwife can share information. If someone not on the list attempts to communicate, the midwife is obliged to remind the person that all information about the client is confidential and that the midwife cannot speak about the client without written permission. At that point, the midwife may contact the client to say that they received a request for information and ask for direction.

Further Skill Development

In addition to effective communication skills, counselling skills, and self-awareness, the midwife needs to have specific knowledge of aspects of pregnancy, birth, and family dynamics that can impact the client's life. Important topics to explore are: typical and non-typical family development, pregnancy loss, grief and trauma, mental health and substance abuse, and the resources available for specialized counselling and mental health services. The many psycho-social aspects of birth, including inclusion of birth partners in decision-making, working with other professionals in the birth process, supporting marginalized families also need to be considered. The student midwife is encouraged to take workshops and classes on these topics in order to enhance helping skills with midwifery clients.

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7. Working Across Differences in Midwifery

Nadya Burton, RM, PhD; Andrea Roberston, RM, MA, PhD(c)

This chapter is intended to help midwives think about differences both as a conceptual construct and as the substantive and prompt thought about particular differences between individuals and categorical groupings of people. Midwives need to consider which differences matter, why they matter, and how they may want to think about and attend to them. Here, ideas are introduced to help foster an approach to and an aptitude for attending to differences.

Fundamental Considerations

Health care settings are political spaces that enact and reproduce relations of power. Although often presented as sites of caregiving,

treatment, and cure, they are of course also, 'scenes in which subjects are being created so as to fit into relations of power.' (1–3) The starting points for working across differences are developing a critical consciousness of one's own assumptions, beliefs, values, and biases; an understanding of how one's own perspectives may differ from those of other people; and acknowledging the unearned advantages, privileges, and power that derive from multiple aspects of one's own social position. (4,5)

The practice of working across differences is contextual and varied and does not lend itself to easy answers. The most important skills are openness, a sense of **equity** and justice, critical thinking, good communication, compassion, flexibility, **self-reflexivity**, (6) commitment, and humility. Fostering these, alongside a critical political analysis of power and how it is distributed, will go further than any claim to knowing exactly what to say or do in every situation. Ongoing reading, reflection and dialogue are required, as well as an openness to making mistakes.

Lawrence Shulman (1992), a professor of social work practice, described this learning process: we will make many mistakes along the way – saying things we will later regret, and having to apologize to clients, learning from these mistakes, correcting them, and then making more sophisticated mistakes. (7) It is the effort we put forth and the personal growth that takes place when we reflect upon and learn from our mistakes that are important.

While midwifery is a clinical practice, it is for many, also a practice of **social justice**. (8) Midwifery, like all health care practices, is situated within complex social, cultural, political and economic contexts and can work to alleviate rather than reinforce **inequitable** distribution of power and resources. Many see challenging and destabilizing relationships of power as an integral component towards improving health care experiences. Therefore,

being able to work skilfully and compassionately across differences of power is a core competency for midwives.

Working across differences is not easily learned through facts or through mastering concrete, tangible tasks. Instead, this practice most often involves thinking about attitudes, perspectives, beliefs, and strengthening relational and reflexive capacities. The ideas and concepts presented in this chapter should be talked about with peers and colleagues to gain the benefit of **learning communities**, which are a vital resource for skills development.

Each person encountering this chapter has unique experiences and perspectives. Some people may have grown up in families and communities where they were taught to not see difference as though to notice differences in body size, skin colour or physical abilities is to participate in discriminatory and repressive behaviour. Others may have grown up in environments where differences from majority or dominant cultures could not be ignored, being integral to themselves, their families and their communities. Some people may have grown up thinking a lot about differences between people, and some may not have thought about this idea much at all. Consequently, being attentive to difference will come more naturally to some than to others but being able to recognize and attend to differences strengthens midwives' capacity to work skilfully, thoughtfully and compassionately with clients and colleagues

Differences matter. Differences are meaningful, and can be positively or negatively productive in interactions between midwives and clients. Rather than deny or ignore this, which can be damaging, it is important to acknowledge and engage accountably with differences. Doing so has the potential to foster greater equity and justice. Differences are situated in time and place, and are intricately entwined with and embedded within

relationships of power; and some differences seem to matter more than others.

It is important to remain aware of the assumptions that are sometimes embedded in language and ideas, which may then be unconsciously enacted in the interactions between midwives and clients. Midwives (as health professionals) and clients (as people accessing care) must work together to bring their assumptions into consciousness as much as possible.

Even diversity and social justice frameworks warrant critical reflection. For example, in some cross-cultural competency literature there is an implicit assumption that the health care providers are members of dominant or majority groups, with 'difference' or 'culture' residing in the people accessing care. This binary thinking ignores the diversity that exists among midwives and **reinscribes** an 'us and them' relation between midwives and clients. It is important to attend to the fact that differences reside in everyone.

Reflect

When do you notice difference within yourself? When do you notice differences in another person? What are the effects of locating difference in another rather than in oneself? Consider that we may reinforce the following concepts:

- Those in professional capacities (midwives) are the 'regular' or 'typical' folks who are seeking to work well with 'others'.
- Those seen as being 'regular' (or not embodying

difference) become the implicit yardstick against which difference is measured (9); they become the centre to the 'other's margin. (10)

- We render invisible those of us who are midwives and who are also from communities that are marked as different.

Reflect on your direct or indirect experiences in practice. What examples of assumptions embedded in language do you recall that could depict power or injustice? How have these impacted interpersonal relationships in a positive or negative way? Think about approaches to inclusive language that honour diversity across all members of client/provider relationships.

Once the idea that differences matter to midwifery work has been embraced, then the job is to keep thinking and trying to work competently and compassionately. There is no point of arrival, no moment when the skills have been mastered and when there is no further work to be done. A commitment to social justice requires an ongoing and lifelong practice. Some people may come to the work of equity and social justice with long histories of doing this work in other parts of their lives; some may continue to engage in thinking about working well across differences in their current personal, social, academic, political and working lives. What is most often necessary for learning about this topic is a willingness to engage new ideas, and a comfort with relinquishing or claiming power (depending on one's social location). Testing new approaches, making explicit underlying assumptions, and

revisiting and revising ideas can be vital parts of growth and learning. Examining one's own beliefs and encountering new ideas with an openness to learning may foster shifts in one's thinking, it does not inherently mean giving up one's own closely or strongly held beliefs.

What is Difference?

In some ways, the concept of difference is so **normative** and ubiquitous as to seem benign. However, difference is a fundamental category of analysis and is constantly relied upon. When thinking about distinctions between people and groups, some differences tend to stand out and seem to matter more. Differences that carry more weight or meaning at a particular time and place are dynamic, rather than static truth, reflecting a complex social reality that shifts over time and place. By attending to the differences that matter, midwifery can deliver better care to clients and has the potential to generate more equitable health care practices and to contribute to broader social change.

Some differences are easily visible between people, but do not necessarily carry much weight in certain contexts. For example, some people have short hair and others have long hair, some people wear a lot of jewellery, others wear little or none, some people have blue eyes, others have brown. In many situations, these distinctions are not understood or leveraged as the basis for significant social inequality.

For example, it is not always true that hair length is a benign or insignificant difference between people. There are contexts in which hair length can be enmeshed with experiences of inclusion and exclusion, with identity, and cultural expression, challenge or change. Hair length therefore *is* used as a tool to distinguish

between people. Think, for example, about: hair length and gender presentation, diverse cultural and religious contexts in which hair length or style connotes or defines beauty, power or privilege, and contexts in which length of hair is used to signal an experience such as loss or grief. In these circumstances, hair length might matter a lot.

While it can be helpful to make a general distinction between differences that are or are not meaningful, it can be problematic to draw too firm or rigid a line between these categories. It is important to acknowledge that although limited significance may, at times, be ascribed to a certain difference that significance may change depending on circumstances or experiences.

Some differences *do* carry significant weight in this time and place, and require attention. Differences that midwives need to particularly attend to are those that are entwined with power and the ways in which power is distributed. Skin colour, for example, matters a lot in the current Canadian context; much depends on it. Unearned privilege is granted to those with white skin while Indigenous people and people of colour (individuals and communities) often experience racism and discriminatory behaviour because of the colour of their skin.

In order to consciously and skilfully work well across such differences, midwives need to think about how the realities of the social context of the midwife and client impact on care relationships and processes.

Reflect

Reflect on the following quote about Indigenous nurses and

the health care system in New Zealand from Anderson et al. (2003):

> The supposition that it is the White health professional who subordinates the patient of Color is challenged in an era when societies and health care workforces are increasingly diverse (…) the construct of race is powerfully deployed in healthcare settings to counter traditional nurse-patient roles by subordinating the nurse of Color. Racialized micropolitics of power operate in such a way that power is not held in certain professional positions *per se*, but rather is negotiated in each particular encounter and context, and is mediated by the social signifiers of race, gender, culture, age, and class. (11, p.209)

Consider your clinical experiences. Have you witnessed enactment of power in health care settings? From your observations, how does context influence power and how do race, gender, culture, age and class specifically mediate power?

Although there is no single correct way to approach differences based on skin colour, race or ethnicity, the practice of thinking about, addressing, and being comfortable talking about these differences is an important skill for midwives. For example, for a white midwife working with a client of colour, it may be important to make room for how the client might see them, might interpret their behaviour, and to acknowledge and validate the experiences the client brings to this interaction. Indeed, if a client experiences

an aspect of care as racist, it is important to start from the assumption that the care was/is racist. Recognizing personal experience can be an important entry point for critical analysis of contributing systemic factors.

Openness to constructive criticism and relinquishment of some of the unearned privilege and authority that can come to those with white skin, is important. For example, it may be important that midwives of colour providing care to white clients be supported by colleagues, if required, to rebuke challenges to their authority and expertise in the face of subtle racism, such as a client expressing a lack of confidence in the skills of the midwife, or overt racism, such as not wanting care by particular midwife, based on race. In their study of cultural safety in transcultural nursing practices, Anderson et al., encountered Indigenous nurses that spoke of their experiences of discrimination in caring for white patients who did not want to be cared for by a person of colour. In such cases, the health care professional felt demeaned, disempowered, and culturally unsafe. (11) Good midwifery care is socially just care that seeks to undermine rather than replicate relationships of power, for both midwives and clients.

Noticing and attending to differences is central to working across them. This is in contrast to the perspective that focusing on differences is detrimental to equality and that instead what matters most is our shared humanity. Such an approach assumes that in the end people are far more similar than different, thereby diminishing the significance of differences and how they are experienced, in an effort to look 'past' or 'through' differences to the human being at the core.

One way to critically engage with this approach is to ask, what is the cost of privileging sameness, and of erasing or ignoring differences? While *not* seeing is often intended to express the position that the individual or institution will not discriminate

or judge on the basis of factors, such as skin colour, religion, sexuality, gender identity or ability, the 'not seeing' position can be experienced as uninformed or uncaring, and along a spectrum of micro-aggression to overt discrimination. Choosing not to see can communicate avoidance or discomfort on the part of the person or institution suggesting that such differences do not matter. Refusal to see or acknowledge particular aspects of someone can also be felt as refusal to validate that person's experiences and refusal to embrace the whole person, in their richness and complexity. When people are not respected as whole persons, the opportunity for meaningful and effective health care is compromised.

There is a balance to be struck between the pitfalls of not seeing differences and those of recognizing sociocultural differences. Beagan and Kumas-Tan (2009) state:

> Treating patients as individuals reflects the most common approach to diversity discerned in our study: avoiding discrimination or stereotyping. This is, in fact, the dominant response to diversity in Canada as a whole, and arises from a genuine desire to not treat others badly. In this approach, sociocultural differences are recognized not only as important aspects of both patients and physicians, but also as a basis for discrimination. However, in seeking not to discriminate, physicians aim to neither see sociocultural differences nor apply generalizations at all and inevitably fail to acknowledge generalized social patterns in experiences, life chances, and influences on health. Striving to not notice someone's skin colour is unhelpful when it causes patients to experience racism on a regular basis… In other words, in striving not to notice differences,

> practitioners denied the effects of shared experiences that arose from historical and contemporary power relations – experiences of racism, for example. (12, p.27)

Reflect

When would it be problematic to choose not to see difference, even if well intentioned? Who might be made comfortable or uncomfortable? Consider that it is possible to:

- Miss or ignore parts of people that might be very important to them, leaving people feeling unseen or unrecognized for all of who they are
- Inadvertently discriminate against or hurt others as a result of not seeing something important about them
- Miss the opportunity to acknowledge and appreciate what is different about people
- Impart one's own discomfort with differences, thus making it a difficult topic to raise

One limitation of trying to look past differences is that not everyone shares the same capacity to do so, and often it is connected to where one is socially located, or to what one's identity is. In many parts of Canada, those who are white, for example, might have an easier time saying that skin colour doesn't

matter. They might in fact have never had to consider their own skin colour and how whiteness factors into their own lived experiences; this perception is inseparable from white privilege. People of colour may be more likely to feel that skin colour matters quite a bit. It is less likely that they will be unaware of their skin colour when it is different from the majority, and it is harder to say that skin colour doesn't matter when how one is treated is often connected to skin colour. If someone has experienced discrimination or racism, or people in one's family or community have, they are less likely to be able to say that skin colour doesn't matter. The experience of living in a white normative society is more likely to tell them that skin colour *does* matter.

Midwives must understand, and keep in mind, that ignoring differences or saying they don't matter can be a practice or privilege of those whose identities are seen as the 'norm' in a given social context. Instead of not seeing, midwives are expressly encouraged to attempt to see and understand as much as possible, with openness and a willingness to learn and to be held accountable.

It is important for midwives to create open spaces for differences to be comfortably present, but not to make assumptions about which differences to prioritize in interactions with clients or colleagues. Each person's collection of identities is complex and shifting, and it is important that people be able to determine for themselves which differences are important to them at any given time or relationship. Midwifery clinics strive to be inclusive spaces, wherein differences can be comfortably engaged, without clients being put in the position of having to assert their relevant life experiences either voluntarily or in a compulsory fashion, or having to deny or hide them. Overt symbols of

inclusivity within clinics contribute to the creation of open spaces welcoming diversity.

External Link

There are many guides for creating open spaces online. One such guide, 'Asking the Right Questions' was created by Dalhousie University, and is available here: https://cdn.dal.ca/content/dam/dalhousie/pdf/campuslife/studentservices/healthandwellness/LGBTQ/asking_the_right_questions.pdf

In order to attend to differences well, midwives and other health care providers must make both distinctions and connections between individual experiences (what the experience of the individual is) and group or collective experiences (what a group of people might commonly experience).

Patterns of experience, and systems which support inequitable patterns, are important to identify. So, while an individual (e.g. person of colour, with a disability, from the LGBTQQ+ community) may enjoy a considerable degree of privilege in their life, this does not negate the reality that those groups experience discriminatory behaviours (e.g. racism, ableism, homophobia and heterosexism). This interplay between individual and collective experience of identity demonstrates some of the complex ways that differences are lived out.

Categories can function as a starting place to think about differences. Casting a wide net to include a broad range of differences and to acknowledge the complex ways individual and collective experiences interact and intersect will be helpful.

Differences that may be useful to consider include but are not limited to: skin colour (often socially constructed as 'race'), religion, socio-economic status, age, language, ability/disability, sexual orientation, sexual identity, gender identity, family structure, individual and family status, culture, ethnicity, body size, geographic location, historical location, population membership as Indigenous or settler, citizenship status (citizen, resident, refugee, immigrant, undocumented, Canadian-born), and experiences of trauma.

Reflect

Think about examples of difference. What differences exist beyond those listed in the text? Since lists are inevitably incomplete, how might you find out what is missing or problematic from your viewpoint? What might these variations mean to clients?

Reflect

Think of examples from your own life when it has been useful to use categorical framing for analysis and understanding. When have you revised your categorical awareness and understanding based on something new you learned? When have you found categorical framing was, or could be, frustrating, inadequate or inappropriate?

A limitation of categorical thinking is that it artificially imposes

boundaries on aspects of daily living, and identity factors, such as skin colour, sexuality, socioeconomic status and treats them as discrete and separable. This does not align with a more holistic way of understanding identity and experience in which identity and experience are often with co-dependent and co-constituent and are sometimes contradictory.

Categorical thinking/list making tends to reinforce **binary ways of thinking** about and understanding the world. Identity and experience are far more complex, fluid, nuanced and negotiated. Further, lists tend not to account for the important ways that people resist, succeed, and thrive. They risk simplistically painting communities as static and as victimized, and are not able to account for the nuance, complexity and richness that is part of identity. It is also important to remember that:

> '...social categories such as race, class, gender, sexualities, abilities, citizenship, and Aboriginality among others, operate relationally; these categories do not stand on their own, but rather gain meaning and power by reinforcing and referencing each other.' (13, p.9)

Case Study: History Taking

Diversity & Equity in Midwifery

Framing Concepts

In order to work competently across differences, it is more important that midwives be thoughtful and **reflexive** than to apply to singular strategy. Looking at examples of how differences

have been conceptualized and theorized can help midwives evaluate their own models for understanding their personal participation in health care and in broader social dynamics.

Contemporary approaches to thinking about differences attempt to dispel the notion that there is one central aspect of identity that always comes first or that conditions all other experiences. Rather, current ways of thinking about differences draw on ideas of **intersectionality**, In other words, there is a complex and fluctuating blend of gender, race, ethnicity, age, ability, religion, class, sexuality and more. Intersectionality highlights the complex and multi-faceted aspects of identity impacting how we understand social change. (10) In seeking to provide care that accounts for the full richness of a client's identity, it is important to acknowledge and embrace their complexity.

Often, we are not consciously aware of, nor able to trace, how we have come to have the perspectives we do. Our viewpoint is inextricably linked to the context in which we live. Parents, families, friends, teachers, religious and cultural leaders, legal institutions, media and other parts of the social and cultural landscape inform how each of us conceptualize and make sense of differences. Understanding how these influences shape how we think about difference is an important step towards evaluating if we are satisfied with, or need to change, our perspective. Both knowledge and self-reflexive capacities are enhanced through dialogue with other people, especially those with viewpoints diverse from our own.

Reflect

What is your framework for thinking about differences? Is the way you think about differences helpful in the context of midwifery work? Are there changes or adjustments you want to make, or does the way you think about differences, both conceptually and specifically, work for you?

Reflect

> As an approach to creating knowledge that has its roots in analyses of the lived experiences of women of color (...) intersectional scholarship focuses on how structures of difference combine to create a feminist praxis that is new and distinct from the social, cultural, and artistic forms emphasized in traditional feminist paradigms that focus primarily upon contrasting the experiences of women in society to those of men. Intersectionality is intellectually transformative not only because it centers the experiences of people of color and locates its analysis within systems of ideological, political, institutional, and economic power as they are shaped by historical patterns of race, class, gender, sexuality, nation, ethnicity, and age but also because it provides a platform for uniting different kinds of praxis in the pursuit of social justice:

> analysis, theorizing, education, advocacy, and policy development. (14, p. 157)

Reflect on this statement. Does it change the way you think about feminism? Do you see yourself as a feminist with a role to play in promoting equity and social justice? Can you appreciate how systems and structures in society and history influence the complexity of multiple identities in ways that impact how people experience the world?

Differences that Matter: Relationships of Power

Throughout most of the world, albeit to differing degrees, power and resources are inequitably distributed. Some people tend to have more decision-making power and control and some people tend to have easier access to resources of all kinds, especially those necessary for survival, such as food, shelter, health care, as well as cultural and social resources that are important aspects of a full life. Inequality is not something that simply 'is.' Rather, there are stakeholders who gain from the sustained oppression of certain groups of people. Such oppression may be violent, beyond deprivation of rights and necessities for living, and may extend as far as genocide.

When **social markers** of difference between people are not merely descriptors, but the institutionalized basis on which resources are unevenly distributed, relationships of power are at work. It is important to think about how relationships of power are inevitably a part of working conditions and present in all interactions with clients, families and colleagues. Contemporary

health inequities need to be understood not only within present day distributions of power, but historical ones as well. There are many examples of inter-generational effects of trauma, such as the Holocaust, the residential school system in Canada, and slavery in North America.

Pretending that power relationships are not present, or trying to ignore them is not an effective strategy for addressing or redressing inequality. Being able to identify the impact of power on relationships offers more potential to practice midwifery in ways that support social justice. This is in part because social change usually involves some redistribution of power so that those more privileged relinquish power and those with less privilege gain access to it.

In midwifery, one articulation of redistribution of power is the ideal of non-authoritarian midwife-client relationships, wherein clients are regarded as experts of their own experiences, and primary decision-makers, with midwives sharing knowledge to support informed choice and shared responsibility. The model of midwifery practice seeks to reduce power inequities between the midwife and client. In this way, midwives and clients also challenge conventions of power across the broader health care system. It is worth considering when and how similar intervention strategies can extend beyond those grounded in professional/layperson differences, and when other interventions may be needed to challenge deeper and more complicated inequalities.

Power, Education & Health Care Change

Critical components of revising ideas and changing practices are a willingness to listen to and engage with a broad range of experiences and perspectives, and a willingness to redistribute

power. Within health care educational institutions and practice settings, ideas continue to evolve about how best to train and support learners and professionals to work well with people engaging their services, regardless of interpersonal similarities or differences. Beagan (2003) states:

> A course intended to produce [care providers] able to work effectively across differences of race, culture, gender, sexual orientation, religion, and so on must explicitly address power relations. It must be about racism, not just cultural differences; it must be about homophobia and heterosexism, not just differences in sexuality; it must be about sexism and classism, not just gender differences and the health issues faced by 'the poor.' (15, p.614)

Further, such a course must be focused on helping students develop ways to recognize and challenge their own biases, their own sources of power and privilege.

Case Study: Poverty

Cultural Awareness & Sensitivity

Cultural awareness and sensitivity, cultural competence, and cultural safety are interrelated strategies intended to improve access to healthcare, experiences of healthcare, and ultimately healthcare outcomes. Although their development is not strictly linear, it is useful to notice a pattern of deepening critical assessment, relational accountability, and commitment to equity and justice.

What does it mean for a health care provider to be aware of

and sensitive to diversity? Awareness refers to being cognizant of the differences between self and others and being intentional in action to not discriminate on the basis of difference. This requires acceptance of the idea that all people's lives are shaped significantly by culture.

While some differences may not seem very significant to either party, others may be very important to one or both. It is also possible (sometimes probable) that a midwife will not be well attuned to differences that matter to a client, especially when taking notice relies on comparing others to the self, from the point of view of the self. Education and critical thinking are therefore perceived as essential components of equitable health care.

A common example of cultural awareness (noticing) and sensitivity (caring) is to offer print and electronic materials in the languages spoken by people accessing care, and to offer translation services during in-person, over the phone, or other conversational encounters. Visual cues within the environments, such as wall mounted equity statements and posters reflecting community populations, are also common.

Reflect

Sexuality, childbearing, and family organization, are often socially charged topics. What do you already know and feel about these topics? How did you come to know what you know and to feel what you feel?

Reflect

Have you ever been in a situation in which you felt confident expressing your viewpoint or questions? Have you ever been in a situation in which you felt too vulnerable or threatened in some way to express your views?

Some people feel that to eliminate bias and become more self-aware about one's own social position and the impact this could have on relations with others, what is mostly required is a disposition of curiosity and openness. The logic behind this position is that when someone is open and curious, and is exposed to more ideas and ways of being in the world, they become more flexible in their viewpoints and more accepting of diverse viewpoints. However, accepting that multiple points of view exist does not necessarily require revision of one's own point of view. Relying only on comparison with oneself for noticing differences can be problematic, without critical attention to power and context, oppressive norms can be experienced as natural and acceptable to the people in positions of privilege. In this way, well-intentioned people who perceive themselves as committed to social change and equitable health care can continue to perpetuate oppressive harms.

Curiosity and openness are requisite starting points, but are not enough alone. They must be combined with critical engagement with power and privilege. In acknowledging that people are inescapably, socially embedded in the world, and that differences in access to power exist, it is then possible to recognize when

oppressive power is exercised in both overt and subtle ways. The latter can be more difficult to recognize and therefore to resolve.

Cultural Competency

Being aware that people have different ideas, beliefs and values, and accepting differences, does not require care providers to 'know much' about other people's cultural particularity. This can lead to situations in which people with differences from care providers and institutional norms, are put in the position of having to disclose, explain, and/or defend 'their difference', and may be at risk of being misunderstood, over-ridden, ignored or otherwise harmed. When people have a lot of negative experiences interacting with the health care system, usually in tandem with other systemic oppression, they may become reluctant to share information with care providers, and may withhold information in the interest of self-protection. Conversely, people seeking a health care service are more likely to build trust with and share important information about themselves with care providers if they are not worried about being perceived negatively or treated unfairly. (16,17)

Most care providers want people using health care services to feel entitled to respectful and high quality care that is responsive to their unique needs. Cultural competency through intentional knowledge seeking and acquisition, on the part of care providers is one route to achieve this. It is perceived that acquiring knowledge about cultural specificities will better equip care providers to establish relationships, and gather information and provide services more effectively.

However, cultural competency as a framework has also been subject to critique.

> The dominant response to health disparities within and among populations has been the establishment of cultural competence training, which generally examines cultural sensitivity (focusing on awareness and attitudes), multicultural understanding (focusing on knowledge about particular groups), or cross-cultural interactions (focusing on tools and skills). Yet such approaches have been soundly criticized for encouraging stereotyping; for emphasizing individual attitudes rather than social context and power relations; for overemphasizing knowledge of 'other' minority groups and underemphasizing critical self-reflection; and for entrenching the notion that only those from minority groups have 'culture' or 'diversity,' while the dominant group is 'normal' and therefore not in need of examination. (12, p.23)

Although utilization of the framework is intended to work against bias, it can actually generate bias when care providers rely on it explicitly. (18) People do not experience aspects of their culture discreetly so a framework that includes a checklist approach implies that there are distinct, identifiable and expected criteria that define a culture. The term 'competency' also suggests an end point where culture is understood, predictable and static and positions providers with power and authoritative knowledge rather than recognizing the client as the expert in their experience of culture. (4,18,19)

Reflect

Is there an aspect of cultural diversity that you would like know more about? How would you go about finding out more? How might attending a workshop be useful?

Reflect

Think about something about yourself that could be interpreted by others as tied to cultural specificity. Would you be comfortable with people learning about 'how to care for someone like me' in a workshop format? What would you want people to learn and how would you want this to be learned? What might make this way of learning about differences more or less effective?

Case Study: Culture, Language & Privilege

Cultural Safety

While cultural competence applies to understanding different ethno-cultural group interactions, cultural safety is a term that originated with a strictly Indigenous purpose and context. It recognizes the historical effects of colonization and social structures that disadvantage people. (5) It requires explicit, detailed recognition of the cultural identity of Indigenous people and is unlike **universalism** and **multiculturalism**, where all

cultures are assumed to possess equal and undifferentiated claims on rights and resources in Canada. (19)

Some people perceive cultural safety as continuous from competency, while others see it as a radical departure. (19) Core features include engagement in lifelong learning, practitioner humility, collaboration between care provider and client, critical analysis of systems of power, and explicit commitment to decolonization and redistributions of power. Unlike with cultural competency, in cultural safety, the client is the centre of care and is an expert holder of knowledge.

Cultural safety requires movement beyond being aware of cultural distinctiveness through a checklist approach. It requires development of respect and value, integrating culturally-specific ways of knowing and doing into care. It originated as a conceptual framework in New Zealand in the 1980s through the work of Indigenous Maori Peoples and organizations attempting to address health inequities. (20,21)

Within Canada, cultural safety continues to conceptually evolve and is most strongly advanced in theory and practice, by First Nation, Métis, and Inuit peoples. This Indigenous-led midwifery care includes same-language service and a blending of Western medicine and culturally-specific, traditional medicine and ceremony. These practices in culturally safe health care vary to the extent desired by individual clients and by communities. (22)

Inuit midwives provide care in Inuktitut, an Inuit language, and encourage practice of cultural traditions such as having multiple friends and family attend and witness the birth. (23) Preservation of culture and power over health are embedded within the Inuulitsivik's education model which serves to ensure its sustainability of locally-led and culturally appropriate approaches to care. (24) The power redistribution in this model further extends to the government of the hospital in Puvirnituq, Nunavik, where

an interdisciplinary council receives feedback from the Perinatal Committee, which is led by the team of Inuit midwives. (24)

Increasingly, insights and practices drawn from Indigenous models of cultural safety are being extrapolated to working with diverse populations across Canada. Only the surface of cultural safety has been highlighted here. As cultural safety continues to develop in response to community based needs, practices of harm reduction, trauma informed care, and strengths based care are interwoven as essential to culturally safe care.

Working Across Differences in Practice

In addressing the complex issues surrounding differences it should be remembered that not all strategies will work for all people in all places at all times. Rather, social justice in health care is a process that requires ongoing commitment and engagement. Midwives will need to engage in an ongoing process of gathering multiple strategies. Growth will include mistakes, revision, and expansion. Attentive listening, responsiveness, flexibility and accountability are all valuable skills. Seeing that power influences relationships with both clients and colleagues, and addressing inequities of power, will be another ongoing process for midwives. For midwives to work effectively across differences they need not be members of the communities they serve to provide excellent care. Even when membership is shared to some degree, there is always diversity between people. Both taking direction from communities, and attending to the specific needs of each client as a unique individual, will guide midwives towards respectful and effective care practices.

The following presents introductory skill building strategies that are broadly applicable to goals of social justice.

Working from Within and Alongside

Working *within* one's own community to generate change and garner support for challenging situations, and working *alongside* communities who are seeking to do this work, is social justice work that midwifery must engage.

The practice of working across differences is something that requires support and community. This can be the case when midwives themselves experience racism, homophobia, sexism, classism, etc. In this context, working well across differences is less about learning skills to understand and work with differences, and more about coping with and responding to oppressive behaviours, actions and words from clients or colleagues. A community of informed and action-supporting and/or collaborating colleagues will make this work easier. Both individual midwives and midwifery groups may strive to communicate commitments to equity and social justice in a variety of ways (e.g. posters, participation as midwives in community and activist events, etc.), and they may also choose to prioritize service to populations that have conventionally been under-represented and underserved.

In some situations, midwives will have more privilege than others. Midwives with more privilege must be attentive to the unrelenting nature of anti-oppression work and recognize the added burdens and costs that may fall to peers and clients who experience oppressive attitudes and behaviours.

Every midwife has a role in instigating change. It can be meaningful and effective to work alongside colleagues in pursuit of more equitable and just social relations. This is done by leveraging one's power and privilege to advance the political work of supporting clients and colleagues who belong to groups and

communities subjected to marginalization or discrimination. This working alongside requires investment on the part of the midwives with privilege to become informed, to trust-build, and to relinquish centrality. Midwives who are positioned with privilege must be open to critique and receptive to changing their own behaviours.

Case Study: Intimate Partner Violence

Learning from Mistakes

One aspect of successful working across differences is acceptance of making mistakes. A care provider who thinks they know all they need to know already, or that they are capable of meeting the needs of everyone, is not likely to be open to recognizing mistakes, or revising their practice. A care provider who is afraid of making any mistakes is not likely to work beyond their own comfort zone. Instead, being receptive to the idea of mistakes as inevitable, and a part of learning, is more conducive to social justice work in health care. Feedback from others, self-reflection, taking responsibility for mistakes, and critical exploration of mistakes in relation to power and privilege can contribute to personal and political change. Expecting accolades for recognizing one's mistakes and making change, however, is problematic and can reflect privilege. Humility requires embracing discomfort, and accountability accepting the cost of one's mistakes, alongside a commitment to not repeat them.

Handling mistakes and learning from mistakes is challenging in both the classroom and fields of practice. When recognizing one's own mistakes, it is important to do this type of work without expecting to be comforted, forgiven, or helped by those who have been unintentionally hurt through discriminatory belief or practice. Too often students and professionals who experience the

greatest marginalization are put in the position of both having to enlighten their more privileged peers, and supporting the emotional fallout of their peers, at the expense of themselves.

Generosity also needs to be extended toward the self and others. People should be able to express themselves without fear of being reprimanded for not being 'in the know' about ideas and terminology that have gained currency in particular settings. Revision and growth is more likely to happen when people are genuinely respected, while challenged to think *with and beyond* their prior experiences and comfort zones.

Accepting the inevitability of mistakes also does not mean being complacent about mistake-making. Accountability entails seeking to understand how the mistake came into being in the first place (at both personal and social levels) and how it can be prevented in the future. Too much grief or guilt over making mistakes is ineffectual, and in fact, works to maintain rather than disrupt the status quo. Recognizing, accepting, and taking responsibility for mistakes creates opportunities for crucial learning and capacity building.

Multiple Truths

It is inevitable that midwives will work with clients and colleagues who have different understandings of the world, and these understandings can sometimes be in tension with each other. Acknowledging that diverse and multiple truths will coexist can help midwives work respectfully and sincerely with clients and colleagues, even when midwife-client beliefs and values diverge or conflict. Cultivating a comfort with multiple truths benefits from having clear sense of one's own beliefs and an understanding that validating someone else's truth does not necessitate compromising

one's own. Unlike in clinical situations, where there may sometimes be a 'best' or a 'strongly recommended' way to proceed, the domain of beliefs and practices is plural. A care provider and client do not need to share the same beliefs to create and maintain a positive and effective health care relationship.

The holding of multiple truths does not make all truths equal and does not abdicate individual health care providers from social justice responsibilities. Some 'truths' (personal or social) are inextricable from power and privilege and are sustained through oppression. There will be times when a 'making-room-for-difference' approach will not be enough, and in fact will work *against* rather than *for* equity. For example, if a colleague says something discriminatory about another person, not asserting a difference in belief or attitude can contribute to an unsafe health care environment for many people. Finding ways to indicate a commitment to health and social equity sometimes entails providing care in a context wherein some values and beliefs *do* over-ride others. Accepting and honouring multiple truths does not mean that everything that everyone thinks is fine; it is rather, a generous way of understanding that people's truths will at times collide. Discerning when, how, and with which supports to engage with differences is part of health care and social justice activism.

Partial Knowledge

Midwives are steeped in a world that encourages them to bank facts and be expert knowers. Students are regularly tested and examined on what they know, and people come to midwives for care, in significant part, because of their expert knowledge in the area of childbirth. It is helpful to be aware of this general pressure, and of self-expectation, as it can extend into areas of learning and

care in which dispositions toward completeness, exactness, and 'rightness' do not hold well, and indeed, are detrimental.

In the arena of working across differences, it is not feasible to fully know things beyond the confines of personal experiences and perspectives, and it is difficult work to bring into consciousness aspects of individual experiences and perspectives that inform interpretation. Embracing the partiality of what is and can be known, is crucial. Embracing partiality means that we are accountable and should gain knowledge about, and try to understand, things beyond our own particular location and identity. Acknowledging what is not known can provide an impetus to learn more. In this way, humility can be perceived as a strength. Recognizing and accepting the (at best) partial view that any person can have about another, and pairing this with a willingness to learn more, can help people work well together, without having 'to know everything already.'

Pairing Critical Generosity with Critical Scepticism

Critical thinkers, must draw on both generosity and scepticism. When health care providers find themselves facing things they don't entirely understand, or are not entirely comfortable with, starting with critical generosity can be a good way to keep an open mind to learning and help avoid the quick judgment that can be a first reaction. Starting with the assumption that people are likely acting in ways that make sense to them, or that are consistent with their values, or beginning by erring on the side of generosity, can make it possible to learn about the actions, beliefs or motivations of others, as well as ourselves. Exploratory conversation can be started from a place of seeking understanding, rather than judgment. At the same time, generosity does not need

to be uncritical. It is possible to work towards an understanding of something without agreeing with it or adopting it for oneself. Understanding a client's perspective, as much as possible, is integral to providing informed choice and participating in shared responsibility.

Scepticism is equally important, as it allows for more comprehensive evaluation. As an analytical resource, it is not the same as a negative approach of fault finding. Rather, it is a form of critical thinking that encourages a more robust and dynamic process of consideration.

Both generosity and scepticism are important. The balance of generosity and scepticism may fluctuate from situation to situation, and there may be times when it is necessary to lean more to one side. However, excessive generosity can lead to being unable to identify when a critical response is needed and excessive scepticism can lead to overlooking a lack of experience or unintentional error. Excessive generosity may come from a place of unconscious or even conscious privilege, where overlooking grievous actions sustains status quo relations of power whereas scepticism could reveal and disrupt relations of power potentiating social justice. This critical analysis may be deeply warranted given legacies of colonialism. However, excessive scepticism from suspicion or disparagement due to historical and systemic inequalities can obstruct opportunities for sharing perspectives and broadening understanding.

Lifelong Learning

Midwives and their clients and colleagues are always positioned in multiple ways, connected to and embedded in communities with privilege, and as members of communities subjected to

marginalization and discrimination. Working across differences is a core competency of midwifery work and poses both challenges and possibilities. Striving to do this work skilfully contributes to health equity and social justice more broadly, and in this way, is political.

Each person is at once a unique being, who is socially situated, with knowledge and beliefs that are enabled and constrained by context. This chapter therefore advances the importance of critically examining personal sources for comprehending the world, and the importance of remaining open to multiple possibilities, with the caveat of recognizing that there are limits on how well any person can imagine another person's point of view.

Differences between people exist, and in the context of uneven distributions of power, matter in ways that they otherwise would not. As midwives, it is important to think about how relationships of power are inevitably present in all interactions with clients, families and colleagues. Midwives have a role to play in fighting injustices leveraged on the basis of difference. Fighting injustices is not the same as eradicating differences. Rather, it can be a deliberate appreciation and valuing of differences.

There are many approaches for working across differences and the ones introduced in this chapter will continue to evolve or be challenged or revised over time. Midwifery students and midwives are encouraged to engage in a lifelong commitment to social justice and personal learning. This chapter advances that openness, a sense of equity and justice, critical thinking, good communication, compassion, flexibility, self-reflexivity, commitment, and humility comprise essential components for working well across differences. Fostering these, alongside a critical political analysis of power and how it is distributed, is an excellent place to start.

Key Points Summary

- Midwifery, and all health care, is situated within a complex social, cultural, political and economic context. The differences that you encounter between midwives, other health care practitioners, and clients matter.
- The most important skills for working across differences are openness, a sense of equity, justice, critical thinking, good communication, compassion, flexibility, self-reflexivity, commitment and humility.
- Social and political changes mean that differences can carry more meaning in one place and time than another. The ability to say that 'differences don't matter' is a privilege of those whose who are seen as the 'norm' in their particular social context.
- Adapting a reflexive strategy that is individualized to the situation will be more successful than a one-size-fits-all approach when working across differences. Identities are intersectional, and so midwives also need to acknowledge this complexity when addressing others and when reflecting on their own identity.
- It can be difficult to trace and identify our own differences. Parents, families, friends, teachers, religious and cultural leaders, legal institutions, media and other parts of social and cultural landscapes help to inform how we conceptualize and make sense of ourselves and differences.
- Power is created by an institutionalized basis that

distributes resources unevenly. Relationships of power are inevitable in the workplace and in all interactions with clients, families and colleagues. Contemporary health inequities need to be understood not only within present day distributions of power, but also historical ones as well.

- The model of midwifery practice seeks to reduce power inequities between midwife and client: clients are regarded as experts of their own experiences, and primary decision-makers, with midwives sharing knowledge to support informed choice and shared responsibility.
- Health care providers should practice cultural competency – actively gaining knowledge about cultural specificities. People that have negative experiences with the health care system, and that experience other systemic oppression, often become reluctant to share information with care providers.
- People are more likely to build trust with and share important information about themselves with care providers if they are not worried about being perceived negatively or treated unfairly.
- Cultural safety, which has been advanced by Indigenous peoples in Canada, should also be practiced by Canadian midwives.
- Working alongside those who are marginalized or discriminated against requires investment from those with privilege. Midwives with more power and/or

privilege should recognize the unrelenting burdens that peers and clients may face due to oppressive attitudes and behaviours.

- Becoming informed, building trust, and leveraging privilege to advance the work of others can help in the pursuit of equity.
- A care provider and a client do not need to share the same beliefs to create a positive and effective health care relationship. Understanding your beliefs will help you in acknowledging and respecting the beliefs of others.
- Validating someone else's truth does not mean compromising one's own truth.

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8. The Professional Framework for Midwifery Practice in Canada

Kris Robinson, RM, BScN, MSc

This chapter introduces the core governance mechanisms that form the foundation of regulated midwifery in Canada. It touches on some of the key professional responsibilities associated with being a regulated health profession. Midwives, as health care professionals, must understand both features as they relate to the practice of midwifery in a regulated system. They must also be aware of the regulatory and professional frameworks that form the basis for the practice of midwifery in their jurisdiction and to which they are held accountable. This chapter will present the key elements of this professional framework in Canada as a means to enhance understanding of the responsibilities of midwives as regulated health professionals.

Regulated midwifery is new to the Canadian healthcare system.

However, midwifery is considered to be one of the oldest female professions in the world. (1) History reveals that the practice of midwifery has existed in the land we now know as Canada since recorded history. (1–6) For example, the services of midwives were part of Indigenous communities well before the European settlement of Canada. As well, there are ample historical accounts of settlers bringing midwives with them dating back to the earliest days of settlement. (1,7)

Regulating the Profession of Midwifery

The degree to which midwifery as a profession is organized and regulated within the formal health care system varies widely throughout the world. (8) In Canada, the regulation of professions falls under provincial [territorial] authority for the most part. Section 92 of the Canadian Constitution Act, 1867, assigns to the provinces the authority to make laws in relation to property and civil rights in the province. The Supreme Court of Canada and other courts have interpreted property and civil rights under s. 92 of the Canadian Constitution Act, 1867 to include regulation of professions. (9) A fundamental component of these enabling laws made by provincial and territorial governments is the identification of regulatory authorities/bodies (9) that are responsible for protection of the public through the self-regulation of professions and occupations. (10) For example, the Ontario government's *Regulated Health Professions Act (RHPA)* and associated health profession Acts set out the governing framework for the regulated health professions in Ontario, including midwifery. The *RHPA* is intended to (11):

- Better protect and serve the public interest

- Be a more open and accountable system of self-governance (regulation)
- Provide a more modern framework for the work of health professionals
- Provide consumers with freedom of choice
- Provide mechanisms to improve quality of care

Many argue that the regulation of midwifery and efforts to facilitate the integration of midwifery into health care systems represents a much needed and natural evolution of an ancient role, with inherent advantages for the health of mothers and babies and for midwives.

Those arguing in support of the regulation of midwifery believe that providing a formal framework for the professionalization of midwifery and its subsequent inclusion into the health care system nets distinct advantages, namely:

- Making the services of midwives accessible to a greater number and more diverse client base
- Being able to effect change from within the health care system rather than being on the margins
- Having the services of a midwife be covered by a publicly-funded system
- Achieving a legitimized place in the health care system that will lead to improved health outcomes

The **International Confederation of Midwives** (ICM) provides a clear opinion on the value of regulated midwifery in stating that, 'by raising the status of midwives through regulation the standard of maternity care and the health of mothers and babies will be improved.' (12, p.1) The ICM notes that '[r]egulation is a

mechanism by which the social contract between the midwifery profession and society is expressed.' (p.5)

Others suggest that the efforts to professionalize midwifery represent a potential danger to the essence of midwifery as a uniquely responsive woman-centered model of care. The close relationship that often exists between midwives and their clients is viewed as one of the distinctive features of midwifery and potentially the most vulnerable to erosion within an organized system of care. (1,5,13,14)

Moreover, a move to become an 'elite' profession with a set of standardized clinical skills has the potential to override the caring aspects of midwifery care – the psychosocial aspects of the role, which are regarded, highly. (13) Midwives have been described as guardians of normal birth. The requirement to conform within a medicalized system with its own framework of medically defined standards and requirements is also source of concern to those who have argued against the regulation and professionalization of midwifery. The pressure to conform to bureaucratic requirements, keep up with new technological developments and maintain a place in an increasingly complex medical hierarchy have also been posed as threats that could co-opt the woman-centered model of care that historically midwives have sought to champion. (1)

In contrast, some have argued that many clients do not seek a deeply personal relationship with their midwife at a highly private time in their lives, rather they desire a health professional who is 'competent and who can assist them to have a safe and positive birthing experience.' (3, p.23)

Reflect

In your opinion, what are the advantages and disadvantage of the professionalization of midwifery?

The Shift to Regulated Midwifery in Canada

Globally, midwives have enjoyed a long history of providing maternity care and are well recognized as key to the provision of care to pregnant families. Despite this history, Canada was slow to recognize the practice of midwifery as a legitimate health profession. In fact, until the early nineties, Canada had the unwelcome distinction of being the only developed country in the world that did not officially recognize midwifery. (7) Thanks to the combined efforts of midwives, their supporters, and families who believed in the value of midwifery care within a publically-funded health care system, the majority of Canadian jurisdictions have now recognized the importance of midwifery and have regulated, integrated, and funded the provision of midwifery services.

In 1993, Ontario became the first province to formally regulate the practice of midwifery as a publicly-funded, integrated health service, which can be seen as a turning point in the history of regulated midwifery in Canada. (5) Other jurisdictions followed Ontario's lead (Table 8-1), and steady progress has since been made in the regulation of midwifery as an important component of maternity care in Canada.

Table 8-2. The year formal regulation of midwifery was introduced in Canadian provinces and territories

BC	AB	SK	MB	ON	QU	NS	NL	NB	PE	YT	NT	NU*
1998	1998	2008	2000	1993	1999	2009	2016	2016	n/a	n/a	2005	2011

* Prior to 2011, midwives who were registerable in another Canadian jurisdiction could be employed as midwives by the Nunavut government. 2011 marked the year that midwives could be registered directly by Nunavut under the Midwifery Profession Act.

Yukon: In January 2017 work began on the process to regulate midwifery in the Yukon Territory. This followed a change in government and a clear intent to regulate midwifery.

Newfoundland & Labrador: In April 2016 the Government of Newfoundland & Labrador announced the release of its midwifery regulations and a plan for implementation is underway.

Prince Edward Island: PEI has no provision or formal plans for the regulation of midwives at this time.

Achieving official recognition of midwifery as a health-care profession is regarded as a significant victory for Canadian midwives and supporters of midwifery care. (13) The new-found legitimacy has marked a significant shift in the way that midwifery is now practiced in Canada.

The Regulation of Aboriginal Midwives in Canada

> Historically, Aboriginal communities across Canada have always had midwives. It has only been in the last hundred years that this practice has been taken away from [those] communities. This occurred for a number of reasons, including colonization and changes in the health care system in Canada. As a result of losing

> midwifery, many rural and remote Aboriginal communities are currently required to deliver their babies and access care outside of their communities. Despite these changes, there are still some Aboriginal midwives practicing in a variety of settings across Canada. (15)

Aboriginal midwives who wish to become registered apply to the governing body (College) of their province or territory. There is variation however across provinces and territories as relates to the regulation of Aboriginal midwives. Nunavut, British Columbia, Ontario and Quebec each have legislation that provides an exemption from registration for Aboriginal midwives. Some conditions on these exemptions do exist – in Nunavut and British Columbia, the exemption is only available for midwives who practiced Aboriginal midwifery prior to the coming into force of the *Act*. In Ontario, Aboriginal midwives providing care to persons in Aboriginal communities are exempt from the *RHPA*. The *Ontario Midwifery Act* allows Aboriginal midwives who provide traditional midwife services to use the title 'Aboriginal midwife.' The Quebec 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. (16)

The Legislative Process

In Canada, the administration and delivery of health care services is the responsibility of each province or territory, guided by the provisions of the *Canada Health Act*. Provinces and territories are primarily responsible for regulating health care professions such as the practice of midwifery. (17)

Midwifery legislation can be divided into two parts: a **statute** (sometimes referred to as an 'act') and **regulations**. Each has the force of law but are enacted differently. (18) A midwifery statute is introduced and enacted by a provincial or territorial legislature. The purpose of a statute is to set out the broad principles or rules that govern a particular matter such as the practice of midwifery. Generally, a statute includes a provision that authorizes the development of related regulations.

The purpose of a regulation is to set out the details required to carry out the policy objectives of a statute. For example, a statute may require that all midwives be registered in order to practice. The regulations made under this statute will then describe all the requirements of the registration process.

While not law *per se*, regulating authorities can supplement regulations with enforceable standards that provide further direction regarding midwifery regulations.

Key Features of Midwifery Legislation in Canada

While midwifery statutes may differ slightly among Canadian jurisdictions, they possess many common features critical to the effective regulation of midwifery. These features include

- The identification of midwifery as an autonomous health care profession distinct from other health professions such as medicine or nursing
- The recognition of midwives as primary health-care practitioners. In some cases, a midwife may be the first point of entry for a person seeking maternity care services

- Legal protection regarding who can use the title of midwife. Where the title is protected, only those persons who meet the requirements of midwifery legislation can legally call themselves a midwife
- A defined scope of practice that includes providing maternity care to healthy women and their newborns during pregnancy, labour, birth and up to six weeks postpartum
- The authority to establish procedures for monitoring, enforcing and holding midwives accountable for the legislative requirements of regulated midwifery. This includes the authority to receive and investigate complaints against members, to remove the authority to practice from midwives who are found to be in violation of the standards of practice and finally to establish quality assurance processes that enhance client safety and improve the quality of midwifery care.

In some jurisdictions and locations of practice, a midwife's scope of practice may encompass advanced competencies including management of epidurals, induction and augmentation of labour, and continuing care beyond six weeks postpartum. These latter areas of practice are considered to be advanced competencies that expand the scope of midwifery practice and are of particular importance to the midwife's role in rural and remote areas of Canada where access to primary care practitioners may be limited. After changes to the midwifery regulation in British Columbia, midwives are now able to acquire advanced competencies in acupuncture and to act as surgical first assistants. (19,20) Midwives who assume tasks that go beyond their regulated scope of practice

are required to work in collaboration with other health professionals.

To ensure uniformity and consistency, jurisdictions have collaborated on the development of the ***Canadian Competencies for Midwives***. (21) This process was led by the expertise of the Canadian Midwifery Regulators Council. The *Canadian Competencies for Midwives* provide the basis for both midwifery education programs offered in Canada and for the Canadian Midwifery Registration Examination (CMRE).

Did You Know?

Legislative protection of the title Midwife enables the midwifery regulatory authority to prosecute a person who breaches the legislation by holding themselves out to be a midwife when they are not registered. (12) Prosecution can result in monetary fines, imprisonment and injunctions against further contraventions. (22)(12)

The Role of Regulations

Regulations provide specific instructions regarding how legislation is to be operationalized and enforced and provide the regulatory body with the authority to set and enforce standards of practice. Midwifery regulations include specific authorities and requirements in areas, such as:

- Requirements and processes for registration and maintaining registration

- Standards of practice
- Prescription of medications, procedures and devices
- Screening and diagnostic tests that can be ordered, received, and interpreted
- Minor surgical and invasive procedures that can be performed

Midwifery regulations in Canada are developed and issued by the cabinets of each provincial/territorial government. Regulations are permanent and cannot be revised or changed without government approval, which can be a cumbersome and time-consuming process. As midwifery practice is constantly evolving, it is imperative that regulating authorities have the power to supplement regulations with standards that provide further direction and detail or clarification regarding particular issues that may arise with respect to the implementation of regulated midwifery. While standards are not law per se, they can be enforced by the regulating body. A comprehensive international overview of midwifery regulation is provided by the ICM's *Global Standards for Midwifery Regulation*, 2011. (12)

External Link

ICM *Global Standards for Midwifery Regulation* (2011) can be found here:
http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/GLOBAL%20STANDARDS%20FOR%20MIDWIFERY%20REGULATION%20

Midwifery as a Self-regulating Profession

In Canada, midwifery is a **self-regulated** profession in which implementation and enforcement of midwifery legislation is delegated to a professional body referred to as a *College of Midwives*. Such colleges are governed by members of the profession and may include government-appointed public members. Some midwifery regulatory authorities have made public representation a requirement for all college committees. (23)

The primary purpose of any regulatory authority is to protect public safety and well-being. As a self-regulating profession, it is midwives who have the responsibility to ensure that midwifery legislation is rigorously and effectively enforced. Self-regulation (as opposed to government or third party regulation) is often seen as an appropriate mechanism for protecting public safety due to the specific knowledge and skills held by the members of that profession.

In addition to its legislative responsibilities, a regulatory college may also be responsible for developing and enforcing a *Code of Ethics*, supplementary standards of practice, and policies or guidelines on issues related to midwifery practice.

Additional issues governed by the college include:

- Setting standards regarding who may enter the profession
- Setting requirements for members to remain in the profession
- Setting standards or expectations of practice that are

intended to protect the public by ensuring care provided is safe and of a high quality
- Creating processes for holding midwives accountable to the standards of practice
- Determining how members may be disciplined or removed from practice

While there is consistency in the regulatory framework across all jurisdictions, every midwife must be familiar with the specific standards to which they will be held accountable. Each local college/regulatory authority outlines standards and guidelines for midwifery practice in their jurisdiction on their website.

Fundamental Features of Midwifery Self-regulating Authorities

Codes of Ethics

Each regulatory authority must develop a **code of ethics**, which are intended to outline the values and principles that its members use as reference points to guide their practice. Broadly speaking, a code of ethics provides a moral context for midwifery practice by describing the values and principles that guide the ethical orientation and behavior of midwives in all aspects of their practice. A code of ethics can provide a foundation for decision-making in difficult situations.

Standards of Practice, Policies and Guidelines

Professional standards of practice describe behaviors and practice expectations that midwives must demonstrate in all aspects of their work including clinical practice, education, administration and research. The standards determine how midwifery practice is assessed and the expectation of practice. Standards of practice provide an important guide for midwives in their practice, thereby supporting consistency in practice and ensure accountability of midwives to their regulatory body and to the public. They allow a greater understanding of role of the midwife by the public by providing an open and clear description of the expectations of care they should expect to receive from midwives as well as standards of professional conduct and accountability for midwives.

Standards of practice should be evidence-based and encompass all aspects of midwifery including specific areas of practice, inter-professional relationships, communication and professional responsibilities. (25–27) They can be loosely grouped into three areas of purpose, and may relate to very specific but different areas of practice (Table 8-2).

Table 8-2. Three areas of purpose for midwifery standards of practice

PURPOSE	AREA OF PRACTICE	EXAMPLE
Broad	Ethics/ principle	*Standard on Informed Choice,* College of Midwives of Manitoba http://www.midwives.mb.ca/policies_and_standards/standard-on-informed-choice.pdf
Directional	Day-to-day duties	*Standard on Nitrous Oxide-Oxygen Blend*, College of Midwives of Ontario http://www.cmo.on.ca/wp-content/uploads/2015/07/15.Nitrous-Oxide-Oxygen-Blends.pdf
Clinical	Models of practice	*Indications for Discussion, Consultation and Transfer of Care*, College of Midwives of British Columbia http://cmbc.bc.ca/wp-content/uploads/2016/12/Indications-for-Discussion-Consultation-and-Transfer-of-Care.pdf

Continuing Competence

Regulating authorities establish requirements for **continuing competence** regarding midwifery skills (e.g. being up-to-date in procedures for neonatal resuscitation, cardiopulmonary resuscitation, emergency skills, electronic fetal monitoring, etc.)

There is an expectation that each midwife to make efforts to ensure that their practice is evidence-based, which entails a commitment to remaining up-to-date on research and changing aspects of clinical practice. Those skills that are considered to be advanced skills will require additional training as well as periodic renewal of competency.

Regulatory Authority vs. Professional Association

The profession of midwifery in Canada is supported by two distinct bodies, each with its own purpose – the regulatory body and the professional association. As the previous section described, the role of the regulatory body is to regulate the practice of midwifery in the interest of protect public safety. In contrast, the role of the professional association is to serve the interests of the profession. Table 8-3 outlines other key features of each body.

Table 8-3. Distinguishing features of regulatory authorities and professional as

REGULATORY AUTHORITIES

- Protect the public interest
- Enforce legislative requirements
- Set criteria for registration
- Provide guidance to members by developing codes of ethics/conduct, standar practice, policies, and guidelines
- Investigate complaints about members and take appropriate disciplinary acti
- Maintain a public register with information about registered individuals

In all jurisdictions where midwifery is regulated, registration with the regulatory authority is mandatory as this provides midwives the authority to practice. It has been noted that there are exemptions for Aboriginal midwives in some jurisdictions. However, membership with the professional association may not be required. As noted above, in some provinces/territories the professional association has the responsibility of negotiating

contracts and other aspects of remuneration while in other jurisdictions where midwives are funded via an employment model they are often represented through unions that negotiate on their behalf.

Professionalism in Midwifery

As members of a self-regulating profession, midwives are expected to maintain professional accountability to themselves, to clients in their care, to colleagues, and to their profession. These expectations of midwives are often defined in the *Standards of Practice*, the *Code of Ethics* and the *Code of Conduct* of their regulatory body, and in the case of students in their *Student Handbook* or *Program Guidelines*.

Professionalism could be described as set of practices intended to ensure midwives are respectful, thoughtful care providers, who demonstrate ethical behaviour in all aspects of their practice. The principles of professionalism should underpin the application of all aspects of midwifery practice. Some examples of professionalism are outlined in Table 8-4.

Table 8-4. Examples of professionalism in midwifery practice

- Working collaboratively with colleagues, both intra- and inter-professionally
- Demonstrating respect for the rights and feelings of others
- Recognizing cultural competence is a central aspect of professional behaviour
- Not engaging in any professional activity that would negatively affect the honour, dignity of the midwifery profession
- Adhering to the regulations and policies of their regulatory body, workplace, or educational program
- Supporting the learning process for themselves and others
- Maintaining confidentiality

External Link

The Canadian Medical Protective Association's *Good Practices Guide – Professionalism* can be found here: https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/professionalism/Professionalism_in_practice/being_professional-e.html

Professional Boundaries in Midwifery Practice

The close therapeutic relationship that can develop between midwives and their clients can be a strength of the model of midwifery care. The relationship is one based on mutual trust. Midwifery care can be described as partnership where clients

bring knowledge of themselves and their bodies and the midwife brings their knowledge and skill regarding pregnancy and birth. (28, p.2) Maintaining professional boundaries with the right balance of trust and intimacy is important to fostering effective client-midwife relationships (Table 8-5) where the needs of clients are paramount and midwives are able to maintain appropriate boundaries within the therapeutic relationship.

Table 8-5. Key points for maintaining effective professional boundaries

- Understand that there is an inherent power differential in midwifery clien
- Seek to establish clear boundaries with appropriate role expectations at th
- Strive to create a safe and respectful environment that is focused on the n
- Avoid or limit self-disclosure
- Communicate clearly
- Avoid giving or receiving significant gifts
- Be aware that any physical contact, outside that which is required to prov
- Develop self-awareness of what constitutes blurring of boundaries and be clients, their partners or families
- Seek advice when concerned that a therapeutic relationship could be com
- Be familiar with the *Code of Conduct* and *Code of Ethics* as set by your reg

Midwifery and Social Media

Midwives and midwifery students must clearly understand social media use and misuse. There are potential benefits and pitfalls associated with use of social media in its many forms as a method of interacting, networking and as a communication tool. However, as a highly accessible virtual public space it has the potential to facilitate even unintentional breaches of client privacy and confidentially. Two aspects to consider when using social media in midwifery practice are:

Client Confidentiality

Midwives have a responsibility to maintain the confidentially of all clients' personal health information in accordance with federal and provincial laws, and the policies and standards set by their regulatory body and workplace (midwifery practice or employer). These laws and policies assure clients that their personal health information cannot be used in any manner without their written permission and their privacy is maintained at all times. This applies to written information (even where client identifiers and details have been removed or altered), photographs and other descriptions of events and/or persons. The legal implications of breaches of confidentiality should be understood along with the knowledge that all means of electronic communication/ information can be retrieved and could be used in a court of law. One notable exception is when child abuse is suspected: it is the midwife's duty to report such cases to appropriate authorities.

Professional Integrity

Midwives have an ethical responsibility to avoid engaging in any activity that could undermine their own professional integrity and reputation as well as the honour, dignity and credibility of the profession. Therefore, good judgment should be used by midwives when using social media in their personal life.

External Link

To better understand the implications of social media for health care professionals visit the following decision:

http://www.srna.org/images/stories/RN_Competence/Comp_Assurance_Hearings/SRNA_Discipline_Decision_Strom_Redacted_Oct_27_2016.pdf

External Links

Midwifery regulatory bodies and related organizations often produce their own guidelines and policies for social media use. Examples include:

Nursing and Midwifery Board of Australia: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Policies/Social-media-policy.aspx

College of Midwives of British Columbia: http://cmbc.bc.ca/wp-content/uploads/2015/12/16.06-Guideline-for-Participating-in-Social-Media.pdf

College of Midwives of Ontario: http://www.cmo.on.ca/professional-conduct/client-relations/midwives-using-social-media/

Midwives Information and Resource Service (MIDIRS, under the National Childbirth Trust): https://www.midirs.org/midwives-and-social-media/

International and National Midwifery Leadership

The focus of this chapter has been on Canadian midwifery, and the specifics of regulation. There is a wealth of information on regulation and standards from which midwives may draw, both internationally, and nationally.

The International Confederation of Midwives (ICM)

The ICM is an accredited non-governmental organization agency that provides leadership in maternity services, globally, and represents and supports midwifery professional associations worldwide. The ICM currently has 121 midwifery associations, which represent 108 countries in every continent of the world. Its current membership exceeds 400,000 midwives. The ICM has a clear vision and mission for maternity care and midwifery worldwide (Table 8-6).

Table 8-6. ICM vision and mission (29)

VISION	MISSION
ICM envisions a world where every childbearing woman has access to a midwife's care for herself and her newborn.	To strengthen m promoting auto women and in k women, and the

The ICM Foundational Pillars

The ICM has identified three foundational pillars – education, regulation, and strong member associations – through which it works to strengthen midwifery worldwide. In the area of education and regulation the ICM, through the work of its standing committees, has developed a number of core documents relating to regulations and standards for midwifery. The use of global standards, competencies, tools and their guidelines ensures that midwives in all countries have effective education, regulation and strong associations. These documents guide midwives associations and their governments to review and improve on the education and regulation of midwives and midwifery, and enable

countries to review their midwifery curricula for the production and retention of a quality midwifery workforce. They include:

- ICM *Global Standards for Midwifery Education* (2013) http://internationalmidwives.org/assets/uploads/documents/CoreDocuments/ICM%20Standards%20Guidelines_ammended2013.pdf
- *Essential Competencies for Basic Midwifery Practice* (2013) http://internationalmidwives.org/what-we-do/education-coredocuments/essential-competencies-basic-midwifery-practice/
- ICM *Global Standards for Midwifery Regulation* (2011) http://internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/GLOBAL%20STANDARDS%20FOR%20MIDWIFERY%20REGULATI
- Midwifery Regulation Implementation Toolkit (2014) http://internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/ICM_Toolkit_ENG.pdf
- ICM *Position Statements* (2008 – 2017) http://internationalmidwives.org/who-we-are/policy-and-practice/icm-position-statements-general/

The full list of the ICM core documents can be found on the ICM website. In addition to its core documents, the ICM has developed a wide range of position statements, which describe its beliefs and principles and provide guidance for its members. The position statements cover a wide range of topics including those

that relate to maternal and newborn health as well as other social and economic issues.

Every three years the ICM sets out a strategic direction, which directs its activities for the triennium following. Each triennium the ICM holds an international congress in a member country. The purpose of the congress is to bring together midwives globally to meet and conduct global business and hold scientific and professional meetings. An additional stated aim is to celebrate midwifery as a profession in all its global diversity.

External Link

Visit the International Confederation of Midwives website here: www.internationalmidwives.org

Canadian Association of Midwives (CAM)

CAM is the national organization representing midwives and the profession of midwifery in Canada. CAM is a member of the ICM. Its mission statement includes a commitment to provide leadership and advocacy for midwifery as a regulated, publically-funded profession. CAM provides leadership in providing a midwifery perspective on issues of national health policy in maternal and child health. All provincial and territorial midwifery associations are eligible to be members of CAM and currently have membership on the CAM board of directors. Individual midwives who are members in good standing of their local midwifery association are eligible for full membership of CAM. Membership is also open to midwifery students.

The objectives and activities of CAM are supported by its mission statement, values and beliefs. The goals and activities of CAM are described in a five-year strategic direction developed by the CAM Board. CAM also has developed a number of position statements that relate to issues of midwifery practice in addition to areas of social and economic interest.

Another important contribution of CAM to Canadian midwifery is the establishment of the *Canadian Journal of Midwifery Research & Practice*. As the official journal of CAM, it is Canada's only national, peer-reviewed midwifery journal. (30)

Each year CAM hosts a national meeting and conference in a member province/territory. Like the ICM Congress, the goal of this national meeting is to provide an important forum for the organization to conduct its national business, to provide an important opportunity for networking amongst midwives and to provide a conference program that covers important areas of midwifery practice, education, and research.

External Link

Visit the Canadian Association of Midwives website here: www.canadianmidwives.org

Canadian Midwifery Regulators Council (CMRC)

The CMRC was formed in 2000 and is comprised of all the provincial and territorial midwifery regulatory authorities in Canada. It was originally created in order to develop a national process that would facilitate the recognition and mobility of

midwife registration across jurisdictions thereby facilitating mobility of the midwifery workforce throughout Canada. The CMRC's mandate has evolved over the years to include a number of other aspects to support protection of the public interest in its member jurisdictions, including setting and maintaining high national standards of midwifery practice and developing common administrative processes between the colleges and regulatory bodies.

A contribution of the CMRC has been development of the *Canadian Midwifery Competencies*. This document outlines the knowledge and skills expected of an entry-level midwife in Canada. They were developed in a collaborative effort involving all the provinces and territories, and they maintain consistency of practice across the country. In addition, the CMRE is based on the *Canadian Midwifery Competencies* and is administered by the CMRC. The CMRC has produced a number of important position statements including:

- CMRC Diversity Statement (2011)
  http://cmrc-ccosf.ca/sites/default/files/pdf/CMRC_Diversity_Statement_Final_2011.pdf
- CMRC Ethical Recruiting Statement (2011)
  http://cmrc-ccosf.ca/sites/default/files/pdf/CMRC_Ethical_Recruiting_Statement_Final_2011.pdf
- CMRC Position Statement on the Use of Gender Inclusive Language (2016)
  http://cmrc-ccosf.ca/sites/default/files/pdf/Gender%20Inclusivity%20Statement%20FINAL%20EN%20April%202016
- CMRC Position Statement on the Protected Title of "Midwife" (2016)

http://cmrc-ccosf.ca/sites/default/files/pdf/Use%20of%20Protected%20Title%20of%20Midwife%20Statement%20

Since 2009, a representative of the CMRC has been a member of the ICM Regulation Standing Committee (representing the Americas) and participated in the development of the ICM's *Global Standards for Regulation.*

External Link

Visit the Canadian Midwifery Regulators Council website here: http://www.cmrc-ccosf.ca

National Aboriginal Council of Canada (NACM)

Midwives have always formed a part of Aboriginal communities in Canada but the practice of Aboriginal midwives in their local communities has changed over time and is emerging as an important feature of maternity care in those communities. (2) The National Aboriginal Council of Canada (NACM) was formed in 2008 in response to a need to support the development of midwifery in Aboriginal communities and to provide support for Aboriginal midwives. Its vision is "Aboriginal midwives working in every Aboriginal Community". The mission of NACM includes advocating for the restoration of midwifery education, the provision of midwifery services and the choice of birthplace for all Aboriginal communities consistent with the U.N. *Declaration on the Rights of Indigenous Peoples.* NACM functions as an umbrella organization within the Canadian Association of Midwives and its

membership includes midwives from across Canada representing First Nations, Inuit and Métis midwives.

External Link

Visit the National Aboriginal Council of Midwives website here: http://www.aboriginalmidwives.ca/

Key Points

- The organization and regulation of midwifery varies throughout the world. In some countries, it is regulated by health profession acts and regulatory bodies (colleges). The ICM values this means of regulation as a way to improve the standards of maternity care.
- In Canada, regulation of midwifery began in the 1990s when midwifery care in Ontario was integrated into the funded health services. Regulation of midwifery and Aboriginal midwifery in Canada varies by province/territory, but generally identify midwives as autonomous health care professionals with a defined scope of practice that includes providing maternity care to healthy clients and newborns up to six weeks postpartum.
- In Canada, midwifery is a self-regulating profession, which means that members of the profession are responsible for ensuring that midwifery legislation is

enforced, effectively. Regulatory bodies, often called colleges, develop codes of ethics, standards of practice, and policies for midwifery.

- Practicing midwives must understand the codes of ethics, and maintain professional integrity and boundaries. There may be several standards to which a midwife is held accountable. These include the standards identified by their college/regulatory authority, their employer/practice, and any applicable national laws on health information confidentiality.
- The ICM is an accredited non-governmental organization that provides leadership and standards for midwifery for 108 member countries.

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PART III

Midwife as Educator

Edited by:
Michelle Butler, PhD, MSc, BSc, RM, RN
Executive Dean
Faculty of Science and Health
Dublin City University

9. Health Education & Promotion

Mary Nolan, PhD MA BA RGN

This chapter provides a brief overview of the history of antenatal education for labour and birth. It considers the wider remit of parent education in the 21st century and discusses the principles of adult education with particular reference to leading effective groups for mothers, fathers and **co-parents** both in the antenatal and postnatal periods. Examples of many activities that midwives might employ to achieve important learning outcomes are given.

Role of the Midwife in Transition to Parenthood Education

The transition to parenthood period, from pregnancy to the first months of a new baby's life, is an excellent time to promote the physical and mental health of the whole family because new parents have a particular openness to change at this stage of

their lives. (1) Pregnancy and early parenthood offer a **teachable moment** in which people are exceptionally open to reflecting on their lives and aspirations, and prepared to make changes in order to be the best parent they can for their new baby. Midwives are uniquely placed to harness this energy for change of mothers- and fathers-to-be. Every encounter with a pregnant or new mother, or with a person who will be a key figure in the life of the new baby, is an opportunity for health education and for supporting their motivation to be 'good enough' for their babies.

Midwife-led transition to parenthood groups can be used to:

- Help parents-to-be to understand what happens in labour and birth
- Promote normal birth by increasing understanding of the benefits that normal birth confers on mother and baby
- Prepare parents to maximize the woman's own resources for coping with the intensity of labour
- Boost parents' knowledge and confidence to make their own choices in labour
- Increase parents' knowledge of what new babies need in order to thrive
- Help parents devise personal strategies for achieving physical and mental wellbeing across the transition to parenthood
- Provide the opportunity to reflect on what kind of parent they'd like to be
- Enable parents to anticipate and prepare for some of the challenges that having a baby will present

- Help them to make friends who will support them after their babies are born

Key Figures in the History of Antenatal Education

In primitive communities (and in some communities today), girls learn(ed) the business of giving birth by observing and supporting their own mothers and relatives in labour. From an early age, they were primary carers for babies and infants in their families and villages. This meant that they came to maturity with an already well-developed set of skills for early parenting.

In the 20th century, in industrialized nations, birth began to move out of homes and into medical facilities, and traditional community structures began to disintegrate. This created the need for formal antenatal education to enable women and their partners to gain confidence and acquire skills for birth and parenthood. The agenda for antenatal education in the 20th century was determined by a number of key medical figures who made it their lives' work to try to understand why human labour was so painful and what method of coping was best to help ease the pain. These pioneers of antenatal education include: Dick-Read, Lamaze and Bradley.

Grantly Dick-Read

In his ground-breaking book, "Childbirth Without Fear" (2), Grantly Dick-Read (1890-1959) tells the story of how he attended the labour of an unsupported young woman in the East End of London (UK) who laboured without apparent distress and gave birth easily to her first child. The woman explained that she had not expected labour to be painful and Dick-Read deduced from

this that it is culturally-induced fear of birth that leads to so many women having difficult labour experiences. Dick-Read proposed that fear of childbirth led to muscular tension which increased pain, thereby creating even greater fear (Figure 9-1).

Figure 9-1. Dick-Read's Fear, Tension, Pain cycle (2)

His solution was to *educate* women about birth. By increasing their knowledge of what happens during labour, Dick-Read felt that women's fear would be reduced. (2) In addition, he wanted to help women learn relaxation skills to use in labour so that they would be less tense and therefore, experience less pain and fear. He recommended that women should learn to recognise how their muscles feel when they are tensed and when relaxed, and described an activity that is often used in antenatal classes to the present day. This is an extract from his book:

Instruction is given in a quiet voice, slowly and clearly:

"Take a deep breath through an open mouth; curl up the toes and tense the muscles of one leg…(short pause)…release the breath slowly and relax the whole limb. Compare in your own mind the feelings of tension and relaxation."

This exercise is repeated, followed by the other leg. The instruction is then extended to other groups of muscles allowing them to become alternately tense and relaxed. And so one works through the whole body, recognising the sensation of tension in a muscle and its absence in relaxation. (2, p.501)

Did You Know?

There are many non-physiological reasons that may contribute to the pain clients experience in labour. Nowadays, people often do not have any experience with labour prior to their own labouring, and anxiety about labour pain may lower their pain threshold. (3) Depending on the location of the birth and medical interventions used, labouring clients may be unable to adjust their birthing position, which may make managing pain difficult. In addition, media portrayal of birth is often sensational, depicting emergency situations rather than showing the normality of labour.

Fernand Lamaze

Fernand Lamaze (1891-1957), a French obstetrician, is associated

with the **psychoprophylactic** method of childbirth preparation. Psychoprophylaxis was developed in the USSR in the 1930s and '40s as a method of managing labour without the use of pharmacological pain relief. Soviet obstetricians believed that pain in labour came from the mind rather than the body and that conscious relaxation, accompanied by controlled breathing, could alter women's perception of pain (4) What might today be considered a viewpoint that is both patriarchal and flawed reflected the new interest in conditioned responses and behaviourism arising out of the work of Pavlov in Russia in the 1890s and Watson in the USA in the 1920s.

Lamaze visited the USSR to observe women using psychoprophylaxis for labour and birth and was inspired to introduce the method in France where it soon became popular. By the end of the 1950s, psychoprophylaxis was known across Europe, in the US, the Middle East, North Africa and Latin America. In 1956, Lamaze published his book, 'Qu'est-ce que l'accouchement sans douleur? ('What is childbirth without pain?') (5) with an English translation appearing in 1958 under the title, 'Painless Childbirth.' (6) His classes included training in muscular relaxation and patterned breathing. Lamaze was also innovative in explaining medical terms in language that women could understand , enabling them to communicate more easily with maternity professionals.

Did You Know?

The theoretical base for psychoprophylaxis drew on the work of Ivan Pavlov, the Russian Nobel Prize winner, who demonstrated conditioned and non-conditioned responses to stimuli.

Did You Know?

There was great rivalry between Dick-Read and Lamaze. In 'Painless Childbirth', Lamaze scorns Dick-Read for not knowing enough about the workings of the human brain. Dick-Read was hostile to psychoprophylaxis because of its links with the Soviet system, which he detested, and also because he felt that his own work was not sufficiently acknowledged by Lamaze.

Robert Bradley

Robert Bradley (1917-1998) was influenced in his thinking by his upbringing on a farm where he regularly observed animals giving birth. He came to believe that, like animals, women could also give birth without drugs or distress. (Bradley's belief that animals do not feel pain when birthing is questionable.) He challenged the then popular use of 'twilight sleep' for labour whereby women were confined to beds with high sides and so heavily sedated that they were unaware of the birth of their babies. Instead, Bradley developed a method of childbirth preparation that helped women draw on their own resources for managing the intensity of contractions. He taught abdominal breathing and deep relaxation and created birth environments which were quiet, dark and private. Bradley felt strongly that if a father had been shown how to support the mother in labour, he could make a significant contribution to her experiencing a straightforward vaginal birth. He therefore provided extensive education for fathers in his book

'Husband-Coached Childbirth' (7) In The Bradley Method, couples were, and are, taught different relaxation techniques that are practised throughout pregnancy so that mothers develop a conditioned relaxation response to their partner's voice and touch.

Influential Childbirth Educators

Sheila Kitzinger

Sheila Kitzinger (1929-2015) was an English childbirth educator whose training in anthropology gave her insights into the different ways in which women the world over think about and approach labour and birth. A tireless advocate for natural childbirth, she rejected the didactic methods of antenatal education that were customary in the 1960s and '70s, preferring to provide antenatal sessions that offered women the chance to explore their fears and hopes around birth. 'The Experience of Childbirth' (1962) presented a pioneering account of the emotional and sexual dimensions of birth, and 'The Good Birth Guide' (1979) supported women to take control of birth at a time when medical intervention in labour was increasing. (8,9)

Andrea Robertson

A great friend of Kitzinger's and a significant figure in the development of training for childbirth educators was the Australian birth activist, Andrea Robertson (1948-2015). As a practitioner, she supported the **informed choice agenda** by discussing with women and their partners a range of choices that they could make during labour, offering them alternatives

to the interventions associated with the medical model of birth. She established a Graduate Diploma in Childbirth Education in Australia for health professionals who were keen to develop antenatal education services but whose initial training did not include preparation for facilitating groups of adult learners.

Did You Know?

Other influential childbirth educators include Marjorie Karmel (introduced the Lamaze method to the USA), Elizabeth Bing (co-founder of Lamaze International), Elizabeth Shearer (wrote and taught about having a vaginal birth after caesarean) and Penny Simkin (teaches about support in labour especially for women who have experienced a previous traumatic birth); Janet Balaskas (founder of the Active Birth Movement in the UK), and Jean Sutton (introduced the idea of 'optimal foetal positioning' – how a woman can assist her baby to assume the best position for a straightforward birth.

Contemporary Transition to Parenthood Education

The pioneer theorists and practitioners of antenatal education focused on preparing women and their partners for labour and birth. However, antenatal education has been reshaped and considerably extended in recent years so that it is now a curriculum for parenting education rather than just birth education. This is in response to the huge advances made by neuroscience in our understanding of early brain development,

coupled with new insights from psychology into how social and emotional development are shaped by early relationships.

Stress & Relaxation

In recent decades, researchers in different countries began to realize that maternal stress in pregnancy impacted every aspect of the unborn baby's development. Chronic stress could influence gestational age at birth, birthweight (10) fetal brain development (11) and the baby's and young child's physical, emotional and cognitive wellbeing (12) Stressful experiences in uterine and early life, and **insensitive parenting** could lead to a lifetime of adverse health and poor relationships. (13,14)

The first 1000 days (from conception to two years) appear to be crucial in determining the way in which stress is managed throughout life. Stress experienced in the womb, (mediated by maternal levels of adrenalin) and in the first years of life, appear to set children's **hypothalamic-pituitary-adrenal axis** (HPA axis) thereby influencing their capacity for learning, and their capacity for learning, and their ability to regulate their emotions, handle frustration, and manage relationships in later years.

The midwife has an important opportunity in transition to parenthood groups, and during individual encounters, to help parents-to-be understand how stress affects them and thereby impacts on their babies and children, and to help them learn relaxation skills. Relaxation practice and discussion of the impact of stress on parenting are now central to parent education programs. (15) Relaxation is presented as important in pregnancy, as a strategy for coping with the intensity of labour and thereby increasing the likelihood of a normal birth, and as a means of managing parenting stress. A relaxation script for use with

pregnant women and their birth companions can be found in the Appendix ('A script for practising relaxation').

Normal Birth

There is newly emerging understanding of the importance of vaginal birth in giving the baby the best possible start in life. Evidence now suggests that:

1. The stress of labour is important for the release of **prolactin**, which contributes to the baby's lung maturation (16)
2. Elective cesarean may be a risk factor for childhood obesity (17)
3. The use of **synthetic oxytocin**, such as Pitocin or Syntocinon®, during labour is responsible for decreasing breastfeeding rates (18)

There is a growing body of evidence on the importance of vaginal birth in seeding the **microbiome** of the baby, that is in facilitating the colonization of the gut with diverse bacteria acquired while the baby travels through the birth canal and comes into contact with bacteria in the mother's vagina and fecal matter from her anus. (19)

Research has also found that in general, women feel more satisfied with a vaginal birth than a surgical one. (20) This is important because the relationship between the mother and baby is affected by the mother's feelings about her labour. (21)

If the findings of research continue to indicate that cesarean birth is detrimental to human health, antenatal preparation for labour and birth will become increasingly critical in supporting

clients and their birth companions to maximize their emotional and physical resources to achieve an uncomplicated vaginal birth.

Mental Health

Much is now known about depression during pregnancy as well as after the birth. What was once referred to as postpartum depression is in fact often a continuation of depression that started during pregnancy or is related to a previous history of depression . (22) Recognising and treating perinatal depression is a public health concern because it strongly impacts the relationship between the mother and baby which in turn scaffolds the new baby's emotional and social development. (23) The contemporary agenda for transition to parenthood education therefore focuses on promoting the mental health of mothers across the transition to parenthood. There is also a need to consider the partner's or co-parent's mental health as the evidence is growing that if they are suffering from psychological impairment, this adversely affects the mother's well-being and is linked to **harsh parenting** of their infants. (24, 25)

The Couple Relationship

The changes in roles, routines and responsibilities that mark the transition to parenthood can threaten the stability of even well-established couples. Couple conflict has been implicated in the development of emotional and behavioural problems in young children. (26) Transition to parenthood education provides an opportunity to help couples examine their relationship, understand how it might be affected by the arrival of their baby, recognize triggers for conflict, and develop strategies for quarrelling positively.

Sensitive Parenting

Early positive relationships form the basis of the child's future wellbeing:

> When we have secure attachment to loving others, we are granted a lifelong gift. When attachment processes are impaired, the diverse manifestations of psychic pain within the higher mental apparatus can lead to chronic feelings of distress throughout life. This distress often encumbers the way in which we can relate to others. (26, p. 345)

In every encounter with a pregnant or new mother, their partner, and their family, the midwife has a wonderful opportunity to promote sensitive, responsive parenting that helps the baby to become securely attached. Securely attached children are confident to explore the world as they grow up and demonstrate better understanding of others' emotions, thereby enhancing their ability to form successful relationships. (28)

Did You Know?

Attachment theory was first developed by John Bowlby (1907-1990) who was a British child psychiatrist and psychoanalyst. He worked with children with severe emotional and behavioural difficulties and this led him to propose the critical importance of early relationship experiences with key carers – parents, family members – for the later development of children's personality.

Social Support

Many clients expecting their first baby may find themselves without a network of support once they leave work or because they live far from their extended family. Therefore, the traditional support and guidance provided by grandparents may not be easily accessible. Friendships made during parent education sessions support new parents' mental health and enhance their self-efficacy as they give and gain reassurance that their babies are developing normally and that their parenting is satisfactory. By facilitating group formation, midwives can provide participants with a network to support them through the transition to parenthood. (15)

Developing a Transition to Parenthood Education Program

Pregnancy is an ideal time to explore the kind of birth that parents want to have and to help them acquire information and skills that will enable them to make and implement their own choices in labour. It is an opportunity to explain the importance of normal birth and to counter some of the common myths that parents are exposed to such as that cesarean birth has no adverse consequences for the baby and that formula milk is just as nutritious as breastmilk. It is also an opportunity to explore with parents what kind of parent they want to be; to increase their understanding of how babies develop self-esteem and resilience, and to explain how babies' sense of who they are is shaped by the way in which the key people in their life respond (or don't respond) to them (Table 9-1). Topics, such as bonding and

attachment, baby cues, how babies communicate, how babies learn about themselves, language development, why babies cry and how to play with a baby, are now as central to the transition to parenthood education agenda as traditional topics, such as getting ready for labour and birth, bathing a baby, nappy changing, minor illnesses, feeding and safe sleeping (Table 9-2).

Table 9-1. Characteristics of effective transitioning to parenting education (29)

- — Responsive to the needs of both parents
- — Participative
- — Covers the entire transition to parenthood, not solely labour and birth
- — Includes the emotional dimensions of parenthood
- — Encourages social support
- — Provides practical advice on early childcare
- Provides culturally-sensitive information to different participants

Table 9-2. Topics for a transition to parenthood program

	What hopes and fears do I/we have for the baby?
	What factors affect the baby's development in the womb?
Stress & relaxation	How will I/we recognize and manage my/our stress and the baby's?
	What relaxation strategies can I/we use for pregnancy, labour and parenting?
	Where will the baby be born? How does labour start? What happens during labour and what will it be like? How do birth hormones work? Who do I/we want to be with me during labour?
	How can I cope with pain?
	What can I do to help as the birth companion? Who will support me?
Normal birth	What will happen if the baby needs some help to be born? What is involved in induction, forceps, vacuum, cesarean? Do I/we have a choice?
	How might I/we feel?
	How will I/we feel when the baby is born? What is birth like for the baby? What does the baby need once born? What happens if there's a problem with the baby?
	How do I/we keep ourselves feeling positive in my/our everyday life?
Mental health	How are everyday activities affected by the arrival of the baby? What things might make me/us unhappy after the birth of the baby? How can I/we recognize the signs of depression? What help is available?

Couple relationship	What kind of parent(s) do I/we want to be? How did my/our own parent(s) parent? How do we want to bring up the baby? How will we divide the household chores after the baby is born? How will we manage my/our household budget? How will we agree leisure arrangements? How do we settle arguments? What are good ways of managing conflict? How will our sex life be affected?
Sensitive parenting	What are the specific baby care skills I/we need to learn? What does the baby need to grow into a confident, inquisitive, happy toddler? How can I/we play/interact with the baby? Why do babies cry? How should I/we respond to the baby when the baby cries? How can I/we build a close relationship with the baby whether breastfeeding or bottle feeding? How will I/we know if the baby is unwell?
Social support	What support do I/we need to be a contented parent?

Did You Know?

A recent study has noted that there is 'no compelling evidence to suggest that a single educational programme or delivery format (is) effective at a universal level'. (30, p. 118) In order to engage parents, it is vital to identify what they want to learn about and when, rather than present an agenda drawn up by the facilitator and delivered without reference to the particular needs or interests of the group members.

Reflect

What topics are covered in antenatal sessions/parenting groups at the place where you work?

Developing a Theory of Change

It is important when devising a transition to parenthood education program to be clear about the outcomes you hope to achieve and how you expect the program to achieve them. You need to have a **theory of change** or a **logic model** that summarizes the topics you cover in your sessions, makes clear how the parents will engage in the program and how what they do will lead to the desired outcomes. Table 9-3 provides an example of such a theory of change.

Table 9-3. Theory of change linking topics, activities and outcomes of a tran

CORE TOPICS	WHAT PARTICIPANTS DO
How lifestyle factors, including stress, affect the unborn baby	Receive and share information about diet Practise relaxation techniques
Labour and birth	Receive and share information about nor Practise skills for communicating with he of contractions
Babies' physical, social, emotional and cognitive development	Receive and share information about bab
Mindfulness/reflection	Group leader models reflection Parents have opportunities to develop mi
The couple relationship	Group leader models good listening Parents practise listening and conflict res
Mental health	Parents have multiple opportunities to ta
Stress management skills	Parents discuss their hopes and fears, ide everyday use
Where to go for help and information	Parents receive and share information ab them

While not every parent-to-be will feel comfortable attending a transition to parenthood group, many derive great benefit from being with people going through the same major life change as themselves. Research suggests that while parents value the factual knowledge and skills that they acquire in transition to parenthood sessions, they also value very highly the friendship of other group members (Table 9-4). (32)

Table 9-4. Parent-perceived benefits of parent education

PERCEIVED BENEFITS	LEADING TO INCREASED	LEADING TO DECREASED
• Gaining knowledge, skills and understanding • Feeling of being accepted by other parents (a boost for positive mental health) • Support from other parents	• Sense of control • Ability to cope • Empathy with their children	• Feelings of guilt • Social isolation

Universal Transition to Parenthood Education vs. Targeted Education

The aim of all education and services offered to parents as they make the transition to parenthood is to promote a healthy pregnancy and normal birth, prevent maternal physical and mental illness, support healthy lifestyles and sensitive parenting, and to reduce families' need for services by building the capacity of parents and communities to ensure the wellbeing of children. Parent education has been defined as 'a process that involves the expansion of insights, understanding, and attitudes and the

acquisition of knowledge and skills about the development of both parents and their children and the relationships between them'. (32, p. 18) In this endeavour, both universal and **targeted services** have value (Table 9-5). All families should receive support to help them improve their health and wellbeing, and there should be additional support for those who need extra help or who are most at risk.

Table 9-5. Advantages of universal and targeted transition to parenthood education

UNIVERSAL	TARGETED
• EQuitable and reaches all families • Avoids stigmatisation • Is more likely to reach everyone who needs help, given that it's not always possible to recognize families who are at risk • Can help to build social capital and community cohesion	• Focuses resources on those with most needs (and therefore has the greatest potential to make a difference to families' wellbeing) • Offers more in-depth support than would be possible in a universal program • Reaches those who may not be able to access or fully benefit from a universal service because of language difficulties, poverty, transport difficulties, health problems, etc

The Essential Elements of Leading Transition to Parenthood Sessions

Adopting a Strengths-based Approach

Adults, even if they are very young, always come to transition

to parenthood sessions knowing something that is relevant to being a parent. They have all had multiple life-experiences that have shaped their ideas about parenting and what their baby will need. Some will have had a nurturing childhood and enjoyed the positive regard of their parents. Although these individuals have models of responsive parenting to draw on, this does not mean that parent education is wasted on them. Everyone needs time to think about the responsibilities they are undertaking, to voice their worries and receive reassurance and guidance if wanted and needed, and to build up a support network that will help them cope with the challenging early days, months and years of new parenthood.

Some people attending the sessions will not have had a childhood that set them up to be a sensitive parent. They may have experienced neglect; emotional, sexual or physical abuse; or inconsistent parenting that has left them anxious and uncertain about how best to parent their baby. Some may be suffering the disadvantages of poverty and/or ill-health; others who are at risk will not manifest any obvious need. Therefore, it is important to ensure that your approaches to facilitating transition to parenthood groups value everyone's contribution and empower each person to recognize and build on their particular strengths.

Parent Education Activity – Recognizing and Valuing People's Strengths as Parents

Avoiding Information Overload

There is little evidence that giving people information changes their behaviour. Change happens when people are motivated to change either because they recognize that their behaviour is having adverse effects on themselves or their loved ones, or

because there is a financial or social inducement to change. Information is nonetheless important. However, it is not sufficient to just provide the information to the group members; they must be helped to understand the ways in which the information is relevant to their personal situation. Adults are pragmatic learners; they learn on a need-to-know basis. If the information you are giving them is deemed irrelevant, or not relevant at this particular point in their journey to parenthood, they are less likely to retain it. 'The amount of correctly recalled information is closely related to the subjective importance of the material.' (33, p. 220)

Many anxious educators talk too much and as a consequence they overwhelm their groups with facts, forgetting that people need little information but a great deal of emotional preparation in order to become confident and fulfilled parents. Additionally, *giving* information is less effective than *sharing* it, so it is important to invite participants to say what they already know about a particular topic and then give information that builds on what they have shared.

Parent Education Activity – Building on what Group Members Already Know: A Model for Information Sharing

Keeping groups small

Many, if not most, parents-to-be attend transition to parenthood programs in order to make friends, as well as to learn skills and acquire information that will help them meet the challenges of early parenthood. (15) The opportunity to make friends will be very much affected by the size of the group and the skills of the facilitator. A lecture delivered in a formal setting to a large group will not help those attending to get to know each other. The group has to be small enough to encourage participation and active

learning. Anecdotal evidence from parent educators suggests that a group of between 8 and 16 people works best. However, many adults will not have the confidence to share their ideas even in a group of this size. The facilitator can therefore split the group into smaller groups of four to six and this will enable people who would be intimidated from speaking in the bigger group to take part in discussions and make friends.

Single sex small group work enables participants to share their thoughts and feelings that some would not share so readily, or at all, in a mixed group. A study on gender-specific group discussions found that when men are in an all-male group, they interrupt each other with supportive comments. (35) These supportive comments decrease as the number of female members in the group increases. (35) If there are same-sex couples in the group, the facilitator may decide not to do single sex small group work but this decision will depend on their knowledge of the group and what will work well for everyone in it.

The most important small group in transition to parenthood education consists of the childbearing client and their supporting partner. Transition to parenthood education provides participants with the opportunity to talk to the key people in their lives about the personal issues that will affect them deeply when they become a parent. For example, it seems that a major source of dispute between parents in the early weeks and months of a new baby's life is quarrelling over who does what – how the daily chores and essential baby care tasks should be most efficiently and fairly shared out. In transition to parenthood sessions, midwives can give participants time to think about this together.

Parent Education Activity – Who Does What?

Providing Diverse Learning Opportunities

Everyone has a different way of learning; of receiving, sorting, processing, interacting with and applying information and skills. Everyone has a different way of understanding their feelings and opinions. The way in which you, as the group facilitator, learn most effectively, won't necessarily be the way in which group members like to learn.

To ensure that everyone has a chance to learn in their preferred way(s), the facilitator needs to provide a variety of learning opportunities. Some people will find it most helpful to talk about their own experiences and listen to those of their peers. Others will find that visual aids, such as pictures and video clips, enhance their learning. Others again will enjoy kinetic or **embodied learning**, e.g. for coping with labour contractions or bathing a baby. Most learners will do best when classes include opportunities for multimodal learning.

Visual Learning

A well-chosen picture is likely to give rise to a series of relevant questions that group members would not have thought of without the visual stimulus. Pictures are particularly helpful to visual learners and the discussion that pictures often generate will be enjoyed by auditory learners. Modern technology facilitates opportunities for parent educators to provide lots of visual learning opportunities although it is important not to overuse or rely on PowerPoint® or YouTube™ clips, at the risk of alienating learners whose primary form of engagement is auditory or kinetic.

When selecting video clips, for example of birth or babies interacting with their parents, it is important to be mindful that the clip will impact each parent differently, and differently from

the way that it impacts you as the facilitator. Some clips may enable understanding in one area while subverting key messages you are trying to get across in another . For example, a video clip showing the passage of the baby through the pelvis may contradict the work you are doing with the group around practising upright positions for labour and birth if the video shows the mother in a supine position. It is essential that you have the appropriate permissions from the intellectual property rights holder when using picture or video information.

Parent Education Activity – Helping Group Members Think about Support in Labour and the Physical Environment

Auditory Learning

In contrast to visual learners, auditory learners do best when they are able to hear information and then discuss it.

You can provide good learning opportunities for auditory learners by facilitating discussions, either in the whole group or in small groups. Many people will be too shy to contribute their ideas in a large group, even one that comprises only eight or ten people, and feel more confident to talk in a smaller group with just a few others. You can also enhance learning opportunities for auditory learners by providing verbal recaps.

Parent Education Activity – What Kind of Parent Do I Want to Be?

Kinetic Learning

The brain uses in excess of 20% of the body's energy. (36) It also requires water, rest and protein to function efficiently. When

a person sits down, their heart rate slows and the amount of oxygen that gets to their brain decreases by as much as 15%. (36) While parents sit in the group, their brains are therefore becoming increasingly inefficient. Simply standing up and moving around can increase the amount of oxygen getting to the brain, and so improve learning. (36) Movement is especially appreciated by kinetic learners.

There are many opportunities for kinetic learners in transition to parenthood sessions. Learning how to change a diaper or bath a baby requires practice. Just as it is impossible to learn to ride a bike by watching another person ride one, the only way to acquire any skills is to try them out and then keep practising! There is a long history in midwifery-led parent education of, for example, showing parents how to bath a baby by standing at the front of the group and demonstrating with a doll (or a baby). This was helpful to a point, but no new parent came away from this demonstration feeling confident about bathing their baby!

Parenting Education Activity – Bathing the Baby

Parenting Education Activity – Breathing through Contractions

Parenting Education Activity – A Script for Practising Relaxation

Using Role Play

Many educators are nervous of role play, and parents-to-be may also be reluctant to participate. However, handled sensitively – without ever mentioning the words 'role play' – it can be an immensely effective means of enhancing learning and understanding.

Parenting Education Activity – Cesarean Mock-Up

Ensuring a Satisfactory Pace of Learning

Most adults have a fairly short concentration span of about ten minutes. (37) Regular changes of activity will help to keep their attention so that they are learning for as much of the time as possible. People pay particular attention to the beginning and ending of a learning experience. (37) The first ten minutes of the session is a period of high concentration. Ice breaker activities that achieve the double goal of helping group participants get to know each other, and of covering a key issue, make the best use of this critical opening phase.

Parent Education Activity – Building Mental Health by Helping the Group Develop a Supportive Network (How to use Ice Breakers)

Similarly, to maximize on the opportunity provided by increased attention at the end of a session, the facilitator can offer a review of the topics that have been covered, and/or invite group members to share a 'take-home message'. This will help group members retain key messages and ideas.

Parent Education Activity – Ensuring that New Learning is Retained so that it can be Drawn upon when Group Members Need It (Recap)

Since helping group members to build a supportive social network is one of the key aims of transition to parenthood education, it's important to have a break during the session so that people can socialize over a cup of tea and/or light snacks. The educator should facilitate introductions between group members who are shy or uninterested in engaging with other group members.

Using Digital Tools

The majority of transition to parenthood education attendees today are what the American education consultant, Marc Prensky, describes as 'digital natives', i.e. people familiar from birth with learning through digital media. (38) There is a wealth of material on the web that can, with the appropriate intellectual property permissions, be used in transition to parenthood sessions to enable parents to learn in a way with which they are very comfortable.

Some useful videos are described below with a brief account of the keypoints which midwives and group participants could discuss.

Mother Talking to Her Baby

External Link

The following section discusses the video found here: https://www.youtube.com/watch?v=WdLKpxktJB4

This video shows a mother lying on her side in bed talking to her very young baby who is lying next to her. The mother uses **motherese** and eye contact to engage with her baby. She 'talks' to her baby and then allows her to respond. When the baby pauses, the mother takes up the conversation. The baby is able to maintain excellent eye-contact and sustain the conversation for long periods. Occasionally, the baby turns away. This is her way of controlling the level of stimulation she is receiving. The mother in this clip is always respectful of her baby's need for a pause. When the baby has had a rest, she returns to the conversation and

the mother takes up her cue to continue. This is an example of a mother and baby who are perfectly attuned to each other.

This mother is helping her baby to develop emotionally as well as cognitively. As the baby watches her mother's face (she is lying close to the mother so can see her clearly – babies are very short-sighted) she is learning not only about how to hold a conversation, but she is also linking what the mother is saying to the expressions on her face and to the tone of her voice. She is therefore having a lesson in human emotions as well as in human communication. Because the mother respects her baby and gives her baby space to express herself, the baby learns that she has a place in the world, and that her ideas are worthy of attention. This will enable her to grow into a healthy toddler who can assert herself, but also knows that other people have a part to play in her life as well.

The fact that this clip shows an interaction between a mother who is speaking a language with which group participants will probably not be familiar helps them to identify the characteristics of the exchange between mother and baby, focusing on *how* the mother/baby dyad communicate rather than on *what* they are saying.

The Importance of Reading to Babies

Storytime routines benefit even the youngest children, helping them to build vocabulary and communication skills critical for school readiness (39) It is never too soon to start reading to a baby. The primary aim of reading to a tiny baby is not to teach them to read; rather, reading is an opportunity for the parent to hold their baby close, thereby stimulating the release of oxytocin, which is the hormone of social bonding, thereby enhancing parent-child relationships; to have a conversation with their baby, and to help

the baby develop a sense of 'story' and of sequence – beginnings, middles and ending – all of which lay the groundwork for the infant mind to acquire early language and literacy skills.

The best books for babies and very young children are picture books that enable a story to be told but offer the flexibility to link images and ideas to the baby's environment. The speed with which babies and toddlers come to understand how a book 'works' is amazing. They quickly learn about page turning, naming objects in pictures and appreciating that books have a start and a finish.

External Link

The following discusses the video found here: https://www.youtube.com/embed/FJUxDt93X5s?feature=player_detailpage

The baby in this video is just able to sit up (probably about seven or eight months old), yet she is able to mimic the rhythms of the story she has probably been read many times; she concentrates on the page and signals that she has reached 'the end' of the story by turning to the adult in the room for acknowledgement. This baby has already developed an enjoyment of books and of 'reading' that will stand her in good stead when the moment comes for her to learn to read in some years' time.

The 'Still Face' Experiment

External Link

The following section discusses the video found here: https://www.youtube.com/watch?v=apzXGEbZht0

This video clip shows the famous 'still face' experiment devised by Professor Edward Tronick at the University of Massachusetts in the 1970s. A mother is invited to interact with her baby who sits opposite her in a high chair. After a few moments during which the baby is fully engaged, the mother is asked to turn away and then return to look at her baby with a totally blank face. The baby is immediately taken aback and puzzled. As the mother continues to be non-responsive, the baby tries increasingly desperately to attract her attention and get her to re-engage in their playtime. The baby's vivacity quickly turns to wariness and finally, she starts to flail her arms and legs and cry, looking away from the mother and withdrawing from engagement with her.

This clip illustrates firstly, a positive interaction between a mother and her baby, with each clearly enjoying the other's company. After the mother adopts the 'still face', the clip shows how diverse the methods are which the baby uses to try to get her to re-engage. Having a relationship with the key adult in her life is vital for her wellbeing and she strives to ensure the continuity of that relationship. At the end of the clip, the baby demonstrates the kind of behaviour that infants who have not received sensitive, responsive parenting will manifest – withdrawing, crying (but ultimately becoming silent) losing motor control and sending out stress signals.

How Babies Take the Lead in Shaping Encounters with Others

External Link

The following section discusses the video found here: https://www.youtube.com/watch?v=N9oxmRT2YWw

This is a very funny clip that shows a young baby's response to a new experience – his mother energetically blowing her nose close to him. The baby demonstrates alarm, but doesn't cry, suggesting that he has a secure relationship with his mother and knows that she is to be trusted even when she does frightening things. When the mother blows her nose again, the gap between her action and the baby laughing is much shorter than the first time, indicating that the baby has learned that this behaviour is not threatening. Soon the baby is leaning forward in his chair, watching the mother intently, clearly encouraging her to 'play the game' again and the mother willingly responds to his cues although her nose is becoming rather dry! Encouraged by her baby's evident enjoyment, she talks to him, thereby adding a new element to the interaction between them. At the end of the clip, the baby startles again in response to the mother's action, momentarily losing control of his arms and flailing, but very quickly recovers and laughs joyously. This baby understands that laughter is a positive form of human communication and can be used to encourage further interaction.

Text Messaging

There is a body of evidence, drawn primarily from smoking

cessation studies and HIV research, to suggest that the use of texting to transmit key information may be very effective in promoting healthy lifestyles and improving outcomes for patients with various conditions. (40–43) It would seem reasonable to assume that text messages could also be used to reiterate important information shared during transition to parenthood sessions and support and encourage people in their aim to be sensitive parents.

In British Columbia, a telephone text-messaging service called SmartMom (44) has been developed to deliver prenatal education. SmartMom texts users three messages each gestational week, providing evidence-based information. Messages are consistent with current professional guidelines and peer reviewed prenatal education curricula, and have been designed to facilitate clients' access to knowledge and local resources, to understand prenatal assessments, and to promote behaviour change to support healthy pregnancy and delivery.

External Link

Learn more about the SmartMom text messaging program here: https://www.smartmomcanada.ca/index.aspx

In order for messages to be effective, the research to date suggests that they should be:

1. Empathetic – Acknowledging that behaviour change is difficult and encouraging clients to do the best they can (for instance, with regards to quitting smoking)

rather than threatening them with adverse outcomes if they don't. (45)

2. Personal – Tailored to the individual needs and interests of the user

3. Motivational – e.g. "Keep going, you can do it!"

4. Goal-setting – Goal-specific and time-limited.

5. Regular (reliable) – Erratic use of messaging doesn't have the impact that regular messaging, such as once a week, has on maintaining motivation and knowledge levels.

Parenthood Education for Non-Childbearing Partners

Early editions of Myles' Textbook for Midwives, known for decades the world over as 'the midwives' bible' presumed that antenatal classes would be attended by pregnant women only. In the 1964 edition of her book, chapter 41 is entitled 'Mothercraft Teaching by Midwives' and is 73 pages long.(46) Towards the end, there is a single paragraph headed 'A Word to the Expectant Father'. Fathers are assumed not to be participants in antenatal education even though Myles observes that 'during this century (the 20th) men have been taking an increasing interest in the subject of child-bearing and rearing' (p727). Myles also assumes that all women attending 'mothercraft' sessions are married and that a family consists of mother, father and child(ren).

The situation is, of course, very different today when a variety of family structures are socially accepted and babies may not be being born into traditional nuclear families. Same-sex couples are now seeking transition to parenthood education as are couples

where one partner is an experienced parent and the other is becoming a parent for the first time. Individuals and couples who are going to adopt a baby come to sessions; young mothers may come with their own mother; men may come who are not the biological father of the unborn baby. Pregnant women may attend with a female or male friend who is going to be their birth companion.

The challenge and excitement for the facilitator of leading such varied groups is to ensure that everyone is made welcome; everyone has the opportunity to acquire the information and skills they are seeking, and to share their particular feelings about becoming a parent or co-parent.

Including Fathers

Today, there is far greater understanding of the powerful influence exercised by fathers over a range of outcomes for their children. Researchers have identified the significant role that fathers play in determining the success of breastfeeding (47,48) and have recommended that efforts be made to ensure that fathers are well educated about infant feeding, and general healthcare issues related to babies and infants. (49) Paternal disengagement from their babies is predictive of early social problems in children, while fathers playing with their infants correlates with a reduction in behavioural problems in boys and emotional difficulties in girls. (50)

Given the evidence that fathers can play an important part in the healthy development of their infant, it is important that midwives offer them specific support across the transition to parenthood. Men need to develop their identity as fathers as soon as possible and find a positive role for themselves in the new family. (51) Engaging with father during pregnancy and providing

education about early child development and babycare skills ensures that 'paternal caregiving patterns that develop during infancy persist and influence the way in which fathers interact with their children over time.' (52)

Including Non-birth Mothers

All members of the LGBTQ2 community should feel welcome at transition to parenthood sessions, and facilitators need to ensure that teaching and learning activities always include non-birthing parents.

Facilitators may become very anxious about not using the 'correct' language to refer to people's relationships and thereby causing offence. At a time when LGBTQ2 parents are struggling to gain recognition and there is not enough research on their needs in parenting education, the issue of language naturally assumes a particular sensitivity. Yet even parents who identify as gay recognise that they, too, can still make mistakes with language. The authors of a very recent book entitled 'Pride and Joy: A Guide for Lesbian, Gay, Bisexual and Trans Parents' (53) write in a section headed 'A word about words':

> We recognize that both 'LGBT' and 'straight' cover a huge variety of different family shapes and self-definitions…We are also aware that language is powerful, and for times where our language inadvertently denies experiences or leaves a reader feeling silenced, we apologize unreservedly. (p11)

Remember that whatever group members' gender, sexuality, partnership or parenting status, they are attending the transition

to parenthood sessions to try to become the best parents they can, and to learn from the facilitator and from the other group members. Provided the facilitator is kind, respectful, an excellent listener, and a skilful group leader, there will be few, if any, parents who complain should s/he use an 'incorrect' title, word, or phrase.

Evaluating Transition to Parenthood Programs

One basic indicator of the success of a transition to parenthood program is the number of parents-to-be attending each week. If the number remains steady from the first session to the last, and people who can't attend contact the facilitator to say why they can't come and express regret, this is an excellent indication that the sessions are being enjoyed by the parents. And there is little learning without enjoyment! One aspect of the facilitator's public health role is to enthuse the parents-to be with a desire to learn more. Some of those attending sessions will have had unhappy experiences at school and may have become disenchanted with education, associating it with feelings of inadequacy or humiliation. If the facilitator can provide a truly engaging and relevant experience of education, this may play a part in encouraging parents-to-be to continue to learn as they raise their children, which may in turn transmit a love of learning to their children.

As a facilitator, you need to be observing your group closely to gage how effective the session seems to be in enabling learning. Indications that group members are learning include:

- Making links between information being shared in this session and information from previous sessions, thereby

demonstrating that they are expanding their knowledge-base and applying it
- Asking insightful and challenging questions that demonstrate understanding of the ideas and concepts being explored
- Able to demonstrate practical skills without support
- Making statements indicating a shift in their values or motivations (e.g. 'I used to think that … but now I see that ….')
- Arranging to meet outside the session (i.e. taking an interest in each other's lives and building social networks)

While it is satisfying to have an indication that the people who attended the session enjoyed it, this is not sufficient; there must be a more robust evaluation to gauge how much the group members have learned. Learning happens in three domains:

- Cognitive: This is about acquiring accurate factual information, understanding it and being able to apply it to one's personal circumstances.
- Affective: This means becoming more aware of one's own ideas, prejudices and feelings, with the result that one's attitudes and behaviours change.
- Motor: This is about learning skills that require bodily actions and expressive movements.

Learning Outcomes

Each session should be designed with learning outcomes in mind and the content designed to achieve the desired outcome (Table 9-6).

Table 9-6. Examples of learning outcomes

By the end of this transition to parenthood session, participants will be able to.....	Describe what they can do to help t
	Bath a baby (motor)
	Explain the terms: cervix, show, ut
	Talk about how they feel household
	Understand their options for labour
	Hold a baby of less than three mont

Reflect

Look at the agenda for any transition to parenthood or antenatal education session you have observed and decide what the learning outcomes might have been. Do you feel they were achieved? What evidence do you have that they were or were not?

Once the group members have left, you should go through each of your intended learning outcomes and ask yourself whether they were achieved during the session. This is a rigorous process, requiring evidence from the session that learning took place. If the outcome of your evaluation indicates that one or more learning outcomes were not achieved, your agenda for the next session should include further opportunities to achieve those outcomes.

The impact of a transition to parenthood program can be further evaluated by arranging a reunion for the people who attended it some weeks after their babies have been born and ask them what impact the program has had on their experience of labour, birth and early parenting, including which components were relevant and which were not. Such a reunion is also an opportunity for the new parents to debrief their labours, swap stories, see each other's babies, and renew friendships made during the program.

Reflection

Given that transition to parenthood education offers a profound opportunity to make a difference to the lives of babies and children by promoting sensitive, responsive parenting, the facilitator has a responsibility to reflect on every session. Gibbs' reflective cycle (Figure 9-2) can be used to explore individual incidents occurring during a transition to parenthood session, or to reflect on the session as a whole.

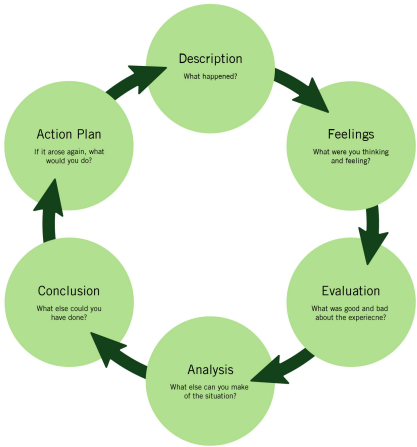

Figure 9-2. Gibb's reflective cycle

Reflection – Transition to Parenting Session

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10. Approaches to Midwifery Education

Jayne Marshall, PFHEA, PhD, MA, PGCEA, ADM, RM, RGN

This chapter will outline the standards informing the development of midwifery education programs internationally and the methods used to assess the knowledge, skills and attitudes of the future midwife. In addition, a range of learning activities and teaching methods will be explored to demonstrate that the individual needs of students should always be at the heart of midwifery education.

Standards for Midwifery Education

The International Confederation of Midwives (ICM) developed the *Global Standards for Midwifery Education* (1) in 2010 to strengthen midwifery worldwide by preparing fully qualified midwives to

provide childbearing clients, their babies and families with high quality, evidence-based health care. However, these standards represent the minimum expected from a quality midwifery program with emphasis on competency-based education rather than academic degrees, as detailed in the *Essential Competencies for Basic Midwifery Practice* (2) that were initially developed in 2002.

All midwifery education programs should comply with the standards for pre-registration midwifery education endorsed by the recognized professional regulatory body of the country in which the program is undertaken. The national regulatory body should be guided by the international definition of the midwife (Table 10-1).

Table 10-1. International definition of the midwife

A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the International Confederation of Midwives' (ICM) *Essential Competencies for Basic Midwifery Practice* and the framework of the ICM *Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery. (3)

The Mission and Philosophy of Midwifery Education Programs

It is essential when designing a midwifery education program to first have consensus from all those facilitating the program on the mission and philosophy of the program. These declarations will shape not only what is taught but also how it is taught. The mission statement should represent the program in one or two sentences and address points such as:

- Purpose: Why does the program exist?
- Core values: How will this program be implemented?
- Integrity and passion: Why is this program important to society?
- Specificity: What is the level of academic award/degree offered?

The statement should also reflect the mission of the educational institution Table 10-2.

Table 10-2. Example mission statement for a midwifery education program

The purpose of this Bachelor of Midwifery program is to prepare a safe, competent and confident graduate midwife who is able to positively contribute to the health of childbearing women and their families within this country/locality. Our program embraces the diversity and equity of students and works to provide accessible education, which is culturally sensitive. We foster critical thinking in the academic setting that will extend into the practice setting and forms the basis for sound professional practice. Our faculty engage in active clinical practice, leading edge research, and professional leadership.

Purpose	…to prepare a safe, competent and confident graduate midwife
Core values	Our program embraces the diversity and equity of students and works to provide accessible education, which is culturally sensitive. We foster critical thinking in the academic setting that will extend into the practice setting and forms the basis for sound professional practice.
Integrity and passion	…to positively contribute to the health of childbearing women and their families
Specificity	…Bachelor of Midwifery…
Educational institutional values	Our program embraces the diversity and equity of students and works to provide accessible education, which is culturally sensitive. Our faculty engage in active clinical practice, leading edge research, and professional leadership.

Reflect

Does your university have a clear mission statement for its midwifery education program? Do you think it adequately reflects the appropriate points? Create your own mission statement considering the questions above.

The World Health Organization (WHO) outlines that the philosophy of midwifery education should recognize that individuals are unique and should promote equal rights, regardless of sex, race, religion, age and nationality. (4) The training should embrace the whole of a client's life continuum rather than focusing specifically on pregnancy, birth, and the postnatal and neonatal periods. Training should also specifically address the circumstances of the country in which the family resides, including the particular public health challenges. Ultimately, midwifery education should be client- and family-centred to promote safe childbearing and birth, with the midwifery student being adequately prepared to deliver health services in a full variety of settings, including the local community, ensuring they have some understanding of the realities of the lives of childbearing clients.

The education of the future midwife should focus on meeting the holistic needs (psychological, emotional, physical, social and spiritual) of the client in a sensitive and competent manner, acting as their advocate and working in partnership with the client and their family to promote a safe and satisfying experience of childbearing and the transition to parenthood. The program should prepare students to be quick thinking and caring midwives, possessing a sound knowledge base and competent clinical skills, by using student-centred learning methods that develop critical thinking, analytical and problem-solving skills. Students should be encouraged to reflect on their practice and to take responsibility for their own learning so they develop into life-long learners capable of recognizing their own needs for continuing professional development.

Reflect

Does your university have a clear philosophy that shapes its midwifery education provision? How does this compare with the WHO's philosophy?

Construct a statement that reflects your personal philosophy of what midwifery education should consist of. You may wish to consider the following questions:

- How do adults learn?
- How can learning be facilitated for adults?
- What elements should be considered best practice in midwifery?

Curriculum Design: Competency-based

Models for curriculum design for midwifery education have been prepared by the ICM within a series of four resource documents and are conceptually framed by the ICM *Definition of the Midwife*, the ICM P*hilosophy and Model of Care* (5) and the ICM *International Code of Ethics*. (6) Furthermore, the curriculum outlines adhere to the ICM *Global Standards for Midwifery Education* and include all the ICM E*ssential Competencies for* ***Basic*** *Midwifery Practice Education*. The curriculum outlines and the suggested content organization are based on the principles of adult learning and are competency-based in their design, and teaching and learning strategies. The curriculum model should be

independent of the design of midwifery education programs within a country's educational system, that is whether the program is direct entry, as part of a nursing program, or following completion of nurse training.

Midwifery educators have the responsibility to ensure that the curriculum content aligns with, but does not exceed the regulatory authority for midwifery practice in the country, however this may include some knowledge and skills that the ICM would identify as additional. A midwifery curriculum must also include teaching, learning and assessment activities that facilitate the acquisition and demonstration of the required midwifery competencies, as well as their associated knowledge skills and behaviours/attitudes (KSB/A) for commencing midwifery practice in a dynamic, complex and multicultural context. Although curriculum development may appear linear and is expected to follow a logical progression, it could also be described as a spiral process, building on knowledge and skills gained from one year to the next.

Setting Learning Outcomes & Objectives

Learning outcomes specify the intended endpoint of a period of engagement in specified learning activities. They are written in the future tense and should clearly indicate the nature and/or level of learning required to achieve them. They should be achievable and assessable, use language that student midwives can easily understand, and avoid any ambiguity or over-complexity. They should relate to explicit statements of achievement and always contain verbs. Objectives should be SMART: Specific, Measurable, Achievable, Realistic and Timely.

Individual outcomes should relate to one of the three domains in the taxonomy described by Bloom (1956) (7):

- **Cognitive**
- **Psychomotor**
- **Affective**

When describing outcomes, it is usual to begin with a stem phrase, such as: 'At the end of this session, the student midwife will be able to…' A verb is then used to state specifically what the student midwife will be able to do (e.g. '…demonstrate…' or '… describe…') in relation to the relevant domain described by Bloom (1956) (in terms of knowledge, skills or attitudes) followed by a clear statement of the topic of interest (e.g. '…the anatomy of the breast'). (7)

Cognitive Domain (Knowledge Outcomes)

As shown in Table 10-3, there are six major categories of cognitive processes. (7) At the bottom of the diagram are the simplest processes, and at the top the most complex. The expectation is that the simplest categories should be mastered before moving onto the more complex ones: taking the learner on the journey from a novice to an expert. (8)

Table 10-3. Bloom's Taxonomy of Learning (1956) (7)

	COGNITIVE PROCESS	LEVEL OF SKILL
Higher Order Thinking Skills	Evaluation	
	Synthesis	Expert
	Analysis	
	Application	Trainee
Lower Order Thinking Skills	Comprehension	
	Knowledge	Novice

Anderson *et al.*, (2001) revisited the cognitive domain and modified it; referring to verbs rather than noun forms as well as rearranging the higher order cognitive skills as shown in Table 10-4. (9) The revised taxonomy reflects a more active form of thinking.

Table 10-4. Revised taxonomy of learning from Anderson *et al.*, (2001) (9)

	COGNITIVE PROCESS	LEVEL OF SKILL
Higher Order Thinking Skills	Creating	
	Evaluating	Expert
	Analysing	
	Applying	Trainee
Lower Order Thinking Skills	Understanding	
	Remembering	Novice

Table 10-5 lists the elements and a brief description of the cognitive domain and also provides some useful verbs that can be used to map the learning outcome on to the relevant level. An example of a knowledge-based objective, at the level of comprehension, might be: 'At the end of this session, the student

midwife will be able to discuss the physiological changes that occur in pregnancy and their significance to the assessment of maternal and fetal wellbeing.'

Table 10-5. A comparison of Bloom's original taxonomy of learning and Anderson et al.'s revised taxonomy of learning (7,9) Grey boxes indicate the shift in Anderson *et al.*'s taxonomy where 'creating' and 'evaluating' are flipped.

	BLOOM'S TAXONOMY	ANDERSON *et al.*'s TAXONOMY	DESCRIPTION	USEFUL VERBS FOR OUTCOME-LEVEL STATEMENTS
	Evaluation	Creating	Ability to judge X for a purpose	Judge, appraise, evaluate, compare, assess
Higher Order Thinking Skills	Synthesis	Evaluating	Arranging and assembling elements into a whole	Design, organize, formulate, propose, create, summarize
	Analysis	Analysing	Breaking down components to clarify	Distinguish, analyse, identify compare, contrast
	Application	Applying	Using the rules and principles	Apply, use, demonstrate, illustrate, practise
Lower Order Thinking Skills	Comprehension	Understanding	Grasping the meaning but not extending it beyond the present situation	Describe, explain, discuss, recognize, interpret
	Knowledge	Remembering	Recall of information previously presented	Define, list, name, recall, record, describe

To achieve a learning outcome, a range of teaching and learning

methods might be utilized such as an initial lecture, followed by a group seminar or tutorial, reflection on practice or case scenarios. The students will then apply their knowledge and reflect on their clinical experiences, and then an assessment can be made as to the extent they understand the subject matter. Using the knowledge objective example above, the corresponding assessment would relate to how well the student understands the chronology of changes that occur in pregnancy and their significance to midwifery practice when undertaking antenatal examinations with pregnant women.

Psychomotor Domain (Skills Outcomes)

Bloom (1956) suggested that skills outcomes should be written in terms of competence which are ascribed to five levels as shown in Table 10-6. (7) An example of a skills-based outcome at the competency level of imitation would be: 'At the end of this session/placement, the student midwife will be able to listen to the fetal heart using a Pinard stethoscope.'

Table 10-6. Bloom's (1956) five levels of psychomotor competence

	COMPETENCE LEVEL	DESCRIPTION
Higher Order Competence	Naturalization	Completes skilfull tasks competently and automatically
	Articulation	Combines one or more skills in sequence with harmony and consistency
	Precision	Reproduces skill with accuracy and proportion
Lower Order Competence	Manipulation	Performs skill from instruction
	Imitation	Observes skill and tries to reproduce it

Teaching and learning methods for this domain includes the student acquiring some background knowledge (in this case anatomy and physiology related to pregnancy and the range of equipment required) but for students to perform this skill accurately, they need to practise. This may be on models or, on the childbearing client, with supervision and feedback from their lecturers, mentors and the client. Assessment of competence involves a number of observations, not simply asking the student to describe what they would do. As students develop their knowledge and skills, a subsequent skills-based outcome at the level of articulation may be as follows: 'At the end of the session/placement, the student midwife will be able to safely undertake an antenatal examination of the pregnant client and accurately document and report the findings to others.'

Affective Domain (Attitudinal Outcomes)

Attitudinal outcomes are often seen as the most difficult to write because they describe patterns of observable behaviour. Bloom (1956) called this the affective domain which also has five levels as shown in Table 10-7. (7) An example at this domain at the level of responding might be: 'At the end of this session, the student midwife will be able to demonstrate awareness of the importance of respecting cultural differences when undertaking an antenatal examination on a pregnant client.' This learning outcome focuses on student midwives being able to show that they have understood and can respond to different cultural issues with which childbearing clients may present.

Table 10-7. Bloom's five levels of attitudinal competence (7)

	LEVEL	DESCRIPTION
Higher Order Competence	Characterizing	Behaviour consistent with a value system
	Organizing	Shows commitment to a set of values by behaviour
	Valuing	Displays behaviour consistent with a single belief without coercion
	Responding	Complies with expectations in response to stimuli
Lower Order Competence	Receiving	Aware of external stimuli, e.g. listening

Reflect

Using Tables 10-3, 10-6 and 10-7, as a guide, develop two

learning outcomes for each of the three domains (cognitive, psychomotor, and affective) of Bloom's (1956) Taxonomy. Remember that the level at which you write the outcomes will be determined by the stage at which you are at in your midwifery education program.

Learning Styles & Teaching Methods

The midwifery educator must recognize that each student midwife may prefer a different **learning style** and teaching method to acquire and develop their knowledge and skills. As such, the techniques used to deliver theory and practice should be tailored accordingly. Each learning style should be incorporated into the curriculum activities so that every student is able to learn effectively and be successful in their studies.

Learning Styles

Employing a variety of teaching methods and styles will enable individuals to learn more effectively such that they are able to remember more of what they learn and apply it. The seven learning styles are outlined in Table 10-8. There is no correct mix of learning style nor is a style fixed. An individual may develop ability in less dominant styles and/or further enhance dominant styles that they already use effectively.

Table 10-8. The seven learning styles

LEARNING STYLE (also known as)	DESCRIPTION
Visual (spatial)	You prefer using pictures, pictures a spatial understanding and depend o midwife educationalist's non-verba such as body language to help with understanding. Usually visual learn the front of the classroom and also descriptive notes over the material presented.
Aural (auditory-musical)	You prefer using sound and music a discover information through listen interpreting information by the me pitch, emphasis and speed. Usually learners gain knowledge through re out loud and may not have a full understanding of information that i The temporal lobes of the brain con content with the right temporal lob focussing on music.
Physical (kinesthetic)	You prefer using your body, hands a of touch, learning best with an activ 'hands-on' approach. Physical learn favour interaction with the physica and may have difficulty staying on remaining focussed. The cerebellum and the motor corte back of the frontal lobe) deal with t majority of our physical movement
Verbal (linguistic)	You prefer using words in both spe writing. The temporal and frontal lobes man particular style.

Logical (mathematical)	You prefer using logic, reasonin systems. The parietal lobes, particularly t control our logical thinking.
Social (interpersonal)	You prefer to learn in groups or people. The frontal and temporal lobes l of our social activity. The limbic influences both the social and so and affects our emotions, moods behaviour.
Solitary (intrapersonal)	You prefer to work alone and us The frontal and parietal lobes as limbic system affect this style.

It is vital that each student is aware of their own preferred learning style and the characteristics of this style so they can acquire the constantly changing and increasing amount of information. When students take responsibility for their own learning they attribute meaning to the process of learning, becoming increasingly more satisfied with the environment in which they interact. Analyzing one's own learning style in terms of personal strengths and weaknesses is beneficial for the student. It assists them in becoming a more focussed and attentive learner that should ultimately lead to educational success. Educators therefore should be mindful in matching teaching strategies to the students' unique learning styles in order to increase motivation and efficiency to enable all students to grow as learners.

Teaching Methods

Once content has been created, specific learning activities and teaching methods, which are consistent with the learning outcomes and required content, must be identified. The teaching methods chosen also need to reflect each of the learning domains: cognitive, psychomotor and affective. Having an appreciation of the focus of the teaching will enable selection of the most appropriate method(s) to facilitate student learning. A summary of different teaching methods is included below Table 10-9.

Table 10-9. Summary of teaching methods

FOCUS	METHOD	DESCRIPTION
Lecturer/ Teacher (transmitting learning)	Direct instruction	Lecturer determines what is important for student to learnStudent is expected to remember or replicateDeep understanding and recombining of information are minimal Emphasis on acquiring information or procedural skills Limited synthesis of new understanding
	Skills, drills and practise	Emphasis is to provide a strong link to the information to improve remembering it or, on repetition to focus on developing skill Serves to impart information
	Lecture	Limited intellectual exchange between student and lecturer Significant amount of information can be conveyed to large group in short amount of time Can be more effective when lecturer includes discussion with participants
Dialogue between Lecturer/ Teacher and Student	Question and answer	Requires reflection from student and understanding of core content to enable a two-way exchange between partiesCan help with both recall and acquisition of informationStimulates thought and encourages divergent thinking Lecturer can assist with formatting and reformatting learner's ideas without diminishing the value of their original ideas

	Discussion	Differs from question and answer method as lecturer and student exchange ideas on an equal footingLecturer aims to develop a greater depth of thinking and foster the manipulation of information for solving problemsMore of a debate of different points of view rather than exchanging ideas
	Mental modelling	Reflects an individual's internal, personalized, contextual understanding of how something worksEnhances student ability to direct their own learning by modelling the use of cognitive processes in the solving of some problemFormed either through direct or shared experience of what the individual believes to be related content, services or systems
Student (discovery learning)	Discovery learning	An inquiry-based, constructivist learning theory where student is expected to draw on past and existing knowledge to discover facts, relationships and new understandings to enhance their learning (10)Student may explore and manipulate objects, ponder questions or perform experimentsPromotes increased recall of concepts and knowledge
	Role play	Involves participants taking on a particular role in a given situation and with a scenario and explanation of the characters, playing out the roles in the safe environment of a classroom before embarking in the real worldRequires adequate briefing beforehand and debriefing afterwards by the lecturer otherwise it will be of little useShould only be used with consensus of the group, with no one being coerced into participating against their will

Simulation	An extended role play that has structure and rulesStudents are expected to make definite decisions and/or define an end product
	Involves the use of prior knowledge and the discovery of new knowledge, and also expects the student to generate the question to be answered.
Inquiry-based learning and problem-based learning	Students define their own learning outcome and undergo independent/self-directed study before returning to the group to discuss and refine their knowledge. Motivates and deepens autonomous learning Teacher takes on role of facilitator, to channel inquisitiveness, provides structure and support
e-learning	Electronic learning using a computer/internet to deliver part or all of a courseEncapsulates a wide range of learning tools such as virtual learning hubs, online simulation, games for learning, learning blogs, ebooks, etc.
Blended learning	A combination of all the methods discussed above to optimise learning and develop lifelong learners of all their students
The flipped classroom	An instructional strategy that reverses the traditional learning environment by delivering content often online, outside of the classroom, then moves activities, including those that may have been considered 'homework' into the classroom.A type of blended learning

Reflect

Consider the teaching methods listed in Table 10-9 and provide an example of a typical learning experience from your midwifery education program that would address each of these methods.

Assessment Methods

The curriculum's **assessment** strategy should include a range of methods and tools that accommodate the student midwife's acquisition of knowledge, psychomotor skills, professional behaviours/attitudes and critical thinking that leads to appropriate decision making. As a result, the student midwife will be expected to undertake both theoretical and clinical assessments that should not only comply with the standards required by the professional regulatory body of the country in which the program is undertaken for entry to the professional register, but also the academic regulations of the higher education institution facilitating the program. Whatever method is chosen to assess the student midwife's knowledge, skills and attitudes, the assessment tool should be both **valid** and **reliable**.

Formative Assessment

The goal of **formative assessments** is to promote learning and gather constructive feedback that can be used by the teacher and

student midwife to guide improvements in the ongoing teaching and learning context either in written or clinical work. These types of assessments are an integral part of effective teaching and do not contribute to an overall module/final program grade.

Summative Assessment

The goal of **summative assessments** is to measure the student midwife's level of success or competence that has been obtained at the end of a module/clinical component or program. This type of assessment uses a standard or benchmark to compare the student's level of attainment.

Assessment Tools

An assessment tool can be used for different assessment methods. Examples of assessment tools include written essays, written examinations, case studies, oral examination, oral or poster presentations, Objective Structured Clinical Examination (OSCE), and portfolios. It is helpful for the assessment strategy to be continuous to encourage the student midwife to maintain their learning throughout the program rather than postponing their studying for an end of year examination.

Giving Effective Feedback

Providing feedback to student midwives is an essential part of their education and training program as it helps them to maximize their potential at different stages of the learning process, raises

their awareness of their strengths and areas for improvement and identifies actions to be taken to improve performance. Feedback can be directive, which informs the student of the aspects of performance that require correction, or facilitative, which assists the student to develop their practice.

The feedback can be written, verbal or numerical depending on the type of assessment undertaken. The detail given should be specific to the task but constructive to enable the student to make connections to related tasks or contexts. It can be **informal** or **formal** in nature. Good feedback is part of the overall dialogue or interaction between lecturer and student midwife and not simply a one-way communication. Providing structured, formal feedback can help reinforce, modify and improve behaviours. However, if feedback is not given or received in a safe and constructive way, it can also have negative, unintended consequences. Although feedback tends to be about observed performance, good feedback is forward-facing (feeding forward) and helps the student midwife to reflect on their performance and identify new goals, improvements or actions. If students do not receive feedback they may assume their performance is of a satisfactory standard and there are no areas they need to improve upon. Students value feedback especially when it is provided by credible individuals who they respect as a role model or for their specific knowledge or clinical competence. Grounding feedback within an overall approach that emphasizes ongoing reflective practice will assist the student midwife to develop the capacity to critically evaluate their own and other's performance, to self-monitor and move toward professional autonomy.

Reflect

Consider feedback you have received as a student. From these experiences, identify the specific elements that have constituted good feedback and those where it could have been further improved.

Key Points Summary

- It is vital to the health and wellbeing of childbearing clients, their babies and families that all midwives are educated and trained to the ICM Global Standards for Midwifery Education as a minimum.
- Each midwifery education program should be based on an overarching mission statement and philosophy that reflects its core values and that all stakeholders subscribe to.
- Midwifery educators should acknowledge the different learning styles of each student midwife and ensure that a variety of teaching methods and assessment tools are included in the curriculum to accommodate their individual needs.
- It is essential that both midwifery educators and clinical-based midwifery mentors provide timely feedback and feed forward to support the ongoing growth and development of each student midwife.

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11. The Academic Midwife: Scholar, Educator, Researcher

Michelle Butler, PhD, RM, RN

This chapter focuses on the midwife as both a **scholar** and an **academic**. There are some shared assumptions about being an academic. These include academic freedom, the community of scholars, scrutiny of accepted wisdom, truth seeking, collegial governance, individual autonomy, and service to society through the production of knowledge, the transmission of culture, and education of the young. (1, p.76) These are the terms upon which the midwifery academic enters and contributes to the academy, and they provide a social mandate and a bias for exploration, discovery, independence, and service. They also highlight the obligation of the midwifery scholar to contribute both to the midwifery agenda and to the wider academic agenda. This chapter will explore the:

1. Development of midwifery as a specialist branch of study
2. Role of the midwifery scholar and academic in the development of midwifery knowledge
3. Role of the midwifery academic in the academy

In pursuing these three themes, this chapter traces the developing concept of midwifery scholarship over recent decades and considers how this development has helped to shape midwifery as a profession, as a philosophy, and as a paradigm. It builds on the discussion in other chapters that explored educational aspects of the midwifery role (Chapter 10) and the midwife as educator (see Chapter 9), and shifts the focus to the midwife as researcher and knowledge broker, and the scientific and philosophical contribution of midwives to the academy and the wider policy and research agenda.

The Professionalization Agenda

Midwifery is as old as time itself, but its formal professionalization through regulatory recognition and status as a professional discipline varies from country to country. In some jurisdictions, (e.g. England, Netherlands), midwifery has been recognized as a distinct discipline and practice has been fully regulated for well over 100 years. In other countries (e.g. Canada, USA) regulation has only begun to be put in place in the late 20th century. In many countries, with and without regulation, lines remain blurred between the roles of midwives, family doctors, obstetricians, nurses, community health workers, and traditional birth attendants. (2)

Recent research has linked rapid and sustained improvements in maternal and newborn mortality and the quality of maternity care with the development of formal midwifery training, as well as motivated and respected licensed midwives who are integrated into the health system. (3) This finding emphasizes the need for robust education programs to prepare midwives for their role. In countries where midwifery practice has been established for some time, there has been a distinct movement towards professionalizing midwifery. This movement advocates for the recognition of midwifery as a distinct profession, as opposed to a **discipline**, and is heralded the proliferation of direct-entry education programs (without requiring entrants to be already qualified as nurses), the development of midwifery academic pathways including graduate entry to the profession, and the development of a midwifery research agenda. This movement is about reclaiming midwifery – regaining professional autonomy lost through domination of the profession by the medical and nursing professions – and gaining greater professional autonomy over practice as well as over the organization of work; all of which will enable midwives to provide women greater choice and control over their care. Sandall suggests 'midwives are claiming a discrete sphere of knowledge and expertise, legitimated by a desire for a more equal partnership with women in an area where medical care has been criticized.' (3, p.206)

In 2016, the International Confederation of Midwives (ICM) identified the three pillars of a strong midwifery profession as:

1. Education to provide a highly competent, qualified workforce
2. Regulation of the activities of the professionals
3. Organization of the members in a strong association

To be recognized as a profession, any profession must:

> 1. Define its role and how it relates to other professions
> 2. Take responsibility for a prescribed body of knowledge – a substantive field of specialist knowledge, which professionals command and apply (5)
> 3. Own the professional knowledge that creates and explains 'the official accepted 'facts' about the social and physical world that form our consciousness' (5, p.44)
> 4. Regulate its membership, acting to uphold the profession's reputation and standing, and protecting it from imposters

These four elements are considered to the hallmarks of being a profession. For midwifery, they infer a place for the midwife scholar within the academy as the custodian of midwifery as a particular branch of study, excelling at pursuits involving reading, thinking and studying midwifery, developing curricula, delivering higher learning relating to midwifery, and developing the midwifery knowledge base through research.

It can be argued that professionalization can be both enabling and controlling: enabling development of the role of the midwife as an autonomous practitioner with a specific remit; controlling: protecting the public from substandard practice It is also argued that midwifery is both an art and a science. The art of midwifery refers to the attitudes and actions based on recognition of the intrinsic dignity of the human person, compassionate concern for the human person, and the creative use of the science of midwifery in service to women and babies. The science of midwifery relates to having an organized body of midwifery knowledge developed through scientific research and logical analysis. (7)

Did You Know?

Robbie Davis-Floyd is a medical and cultural anthropologist and Senior Research Fellow at the University of Texas, Austin. She is an acclaimed expert on childbirth and midwifery with a special interest in birth and training of obstetricians and midwives. She highlights the importance of the science of midwifery in her concept of the 'post-modern midwife' as one who is 'scientifically informed' and can draw from both the biomedical system and her 'own folk system,' knowing the limitations of both. (7, p.707)

You can read more about her work here: http://www.davis-floyd.com/

Boyer's Model of Scholarship

Reflecting this dyad of art and science, Boyer's (1997) model of scholarship identifies four types of scholarship, which if applied to midwifery move beyond teaching and research to a broader role involving the synthesis, integration and application of midwifery science. (9) Boyer's model examines the scholarship of discovery, of integration, of application, and of teaching, and is used here to frame the discussion of midwifery scholarship.

The Scholarship of Discovery

Discovery most closely relates to the research role. A commitment

to use robust methods to systematically follow an investigation to wherever it may lead contributes to knowledge development and furthers the intellectual climate of the academy.

In understanding the knowledge underpinnings of midwifery practice, it is vital to distinguish between 'unsubstantiated prejudice and reliable knowledge.' (10) It is research evidence that informs midwifery practice, expanding knowledge about appropriate practices to make childbearing safe and fulfilling and allowing continuous improvement to be made in the provision of skilled, sensitive care for women and babies. (11) For educators, conducting research is important to remaining current in teaching and clinical practice and in contributing to the body of professional knowledge. Participating in research and disseminating research results strengthens the midwifery profession and ensures the use of up-to-date curricula and teaching methods. (12) Luyben (2009) suggests the aim of midwifery research is to create a body of knowledge that underpins and improves midwifery practice and maternity care. Further, she advocates that achieving this aim involves maintaining focus on woman-centred care; the effectiveness and quality of maternity care; the multiple aspects (physiological, social and psychological) of the childbearing process and the impact of maternity care on these; the options available to women for maternity care; evidence-based practice and standards for maternity care; and developing a vision and sound basis for midwifery practice. (13) The ICM, in both its International Code of Ethics for Midwives (14) and in its position statement on the Role of Midwives in Research (15), emphasizes the importance of midwives employing up-to-date evidence in their practice to ensure safe birthing practices in all environments and cultures, and midwives being responsible for developing midwifery knowledge in order to improve the health of women and their

babies. The ICM proposes that midwives should have a role in developing and sharing midwifery knowledge through various processes including peer review and research.

Reflect

How can midwives in clinical practice help advance the scholarly study of midwifery?

Across countries, midwives have only been conducting research in the last 30 years. Until as recently as the second half of the 20th Century, in most circumstances, midwifery knowledge was passed down from midwife to midwife and little was documented or recorded as written knowledge. As a result, midwifery knowledge was based largely on tradition, intuition, authority and research generated within other disciplines. (13) Dr. Ans Luyben traces the development of midwifery research beginning with a statement by the World Health Organization (WHO 1987) that midwives should study the work of midwives and together with scientists, develop a body of explicit midwifery knowledge and raise a group of midwifery researchers. She traces the emergence of midwifery researchers in the USA, who focused largely on the effective provision of midwifery care, to midwives in the UK using research to challenge the issues they faced every day in practice, and later influencing and supporting midwives in other European countries to become research active. She also examines the ways in which the role of the midwife as researcher has been supported across countries, including the introduction of midwife researcher positions and the development of national professional guidelines reinforcing research as a part of the role of the midwife.

In the UK, up until the 1980s most of the research in relation to

maternity care was conducted by obstetricians and dominated by the medical model of care. Research conducted by social scientists such as Sheila Kitzinger, Ann Oakley, and Marjorie Tew in the 1970s however, provided the foundation for the broad base of midwifery research today by shifting the focus to women's and parents' experiences of birth, becoming a mother, and challenging assumptions about the safety of birth in non-hospital settings (Clark, 2000). This was followed by early studies by midwives that challenged routine midwifery practices such as perineal shaving and enemas (Romney, 1980 and Romney and Gordon, 1981), the liberal use of episiotomy (Sleep, 1984).

Did You Know?

In the UK until the 1980s, most of the research in relation to maternity care was conducted by obstetricians and was dominated by the medical model of care. In contrast, research conducted in the 1970s by social scientists, such as Sheila Kitzinger, Ann Oakley, and Marjorie Tew, provided the foundation for the broad base of today's midwifery research by shifting the focus to women's and parents' experiences of birth, becoming a mother/parent, and challenging assumptions about the safety of birth in non-hospital settings. (10,16) This was followed by early studies by midwives that challenged what were at the time routine midwifery practices such as perineal shaving (17) and enemas (18) and the liberal use of episiotomy. (19)

Traditionally, midwives became involved in research and sought research training on an ad hoc basis (13) and the only graduate

programs (masters and doctoral programs) available to midwives were in the sciences, social sciences, nursing or management domains. However, over the last 20 years and beginning in the UK and Europe, there has been an encouraging growth of graduate programs specifically aimed at midwives. The value of these programs exists not only in their focus on issues of particular relevance to midwifery and its professionalization, but also in their ability to draw in candidates with considerable experience and understanding of the field. Training midwives in research methodology and in evaluating research evidence enables midwives with academic training to question and make conclusions about the strengths and weaknesses of clinical practices in obstetrics. (20) Addressing issues through research and international debate helps to consolidate an international community of midwifery scholars. The development of a midwifery research agenda and the legitimization of research as a part of the midwife's role brings areas that most in need of research into focus in order to build research capacity. Further development is required to ensure midwives are included: in clinical scholar programs, such as those that are already available to other healthcare professionals through for example the Health Research Board in Ireland, or the Canadian Institutes of Health Research in Canada; in research training positions (e.g. PhD studentships) in grant funding programs; and as in midwifery scholars in early career research training (e.g. post-doctoral) programs.

A notable development that occurred first in the UK was institutional support and the positive impact it had on the growth of maternity care and midwifery research. Clark identifies the establishment of the National Perinatal Epidemiology Unit (NPEU) in Oxford in 1978 as being instrumental in developing research and research capacity in midwifery in the UK. (10) The NPEU

was responsible for the establishment of the national Midwifery Research Initiative (MRI) in 1988. Led by Mary Renfrew, it was the first major grant funded midwifery research program to be headed by a midwife. Through close collaborations with clinical colleagues and maternity service users, the provision of support for novice researchers, dispersion of expertise, and generation of networks within the maternity care system, the MRI was instrumental in establishing a solid foundation for midwifery research. During the 1980s the NPEU supported midwives undertaking research, while the MRI offered a more visible focus for midwives thinking about undertaking research. (10)

Did You Know?

Mary Renfrew is presently Professor of Mother and Infant Health in the University of Dundee, where she is also Director of the Mother and Infant Research Unit. An early pioneer of the role of midwife as scholar, Mary has worked internationally universities and hospitals in Oxford, Leeds and York, UK and Alberta, Canada. In 1996, she founded the multidisciplinary Mother and Infant Research Unit (MIRU) at the University of Dundee, with the aim to improve the health and care of childbearing, women, their babies and families, addressing inequalities in health. The research conducted at MIRU has informed policy and practice in infant feeding and maternity care, both nationally and internationally. Renfrew is the author of our Chapter 3: Midwifery Matters.

Acknowledging that although not all midwives can or should be researchers, Lavender identifies a number of ways in which all

midwives can and should be involved in strengthening midwifery knowledge and practice. (21) These include:

- Providing support for midwives to audit their own practice and contributing to audits of their own organizations
- Accessing and making sense of the evidence and using it appropriately in their practice
- Challenging practice and guidelines when the evidence is weak
- Considering the strength of the evidence when advocating for women who express a preference for alternative practice options
- Providing a midwifery perspective on the priorities for research
- Engaging in local and national research networks
- Being thoughtful users of evidence

Midwifery academics can and should support midwives to engage in this way and should assist midwives interested in doing research to navigate the roadblocks involved, such as getting access to scarce funding, identifying collaborators, accessing sites, recruiting participants, and having appropriate research capacity. (22)

The Scholarship of Integration

Integration gives meaning to isolated facts and puts them in perspective. This is done by interpreting findings, drawing together one's own research and that of other researchers, and

bringing new insight to original research. According to Boyer it is 'through this 'connectedness' that research ultimately is made authentic.' (9, p.19) Integration is sometimes referred to as synthesizing. It can be argued that Boyer's scholarship of integration needs to be extended to include how scholars provide leadership and strategic direction, collective reflection and critique, and in the case of midwifery promote the midwifery agenda through publication and scholarly writing. Mander refers to the three 'R's of midwifery scholarship – each of which is founded on requirement that midwifery scholars are also engaged in clinical practice. 1) Research – clinical practice enables the academic midwife to stay involved with grass roots clinical activity and ideas. (2) (w)Riting – clinical practice triggers ideas for publication, particularly around topics that need to be discussed but are too early for research. 3) Reality – universities are criticized for being 'ivory towers', but practice enables the academic midwife to keep her feet well and truly on the ground. (23)

Much of the research that informs the midwifery curriculum and midwifery has been conducted by other disciplines and may lack the scope and particular midwifery focus that it could have if midwives were involved in the research. Luyben (2009) suggests research conducted by midwives has a particular focus on midwives' ways of working and in particular aims to improve midwifery practice. She cites Cluett and Bluff's observation that one of midwifery research's strength is the rich diversity of research methods, and suggests that this diversity allows midwifery researchers to go beyond medical questions to several other aspects of midwifery practice. (13)

Lavender (2010) exposes the lack of evidence available to support midwives, to inform maternity policy, and to support women to make decisions. Further, she suggests that many policy

decisions are based on expert opinion rather than research evidence, due to the absence of research evidence. Lavender asserts that midwives do not generally appreciate this this lack of evidence. (21)

In addition, midwives tend to use **social research methods** rather than large-scale **randomized control trials** or **population-based studies**. While social research methods answer the types of research questions that midwives are concerned with, other stakeholders or policy-makers may not value such approaches as sources of evidence for practice. McVane Phipps (2010) suggests that large population-based studies are not suitable to answer questions about pregnancy and birth, as they are not congruent with a humanistic midwifery paradigm that places the pregnant woman at the centre of care, and the midwife working with the woman to make choices that are relevant to her own circumstances and belief system, the notion of not providing interventions in practice. Lavender (2010) suggests the parameters for what is considered to be evidence (empirical studies drawing on positivist research methods) may be difficult or pose ethical challenges to implement in midwifery contexts and may not adequately capture the social context of midwifery phenomena.

Did You Know?

There are three paradigms of health care, each of which casts influence on childbirth from their differing ways of defining the body and its relationship to the mind.

The three models are: the technocratic, which considers the mind and body to be separate and views the body as a machine; the humanistic model, which emphasizes a connection between the mind and body and views the body as

> an organism; and the holistic model, which insists the body, mind, and spirit are one and views the body as an energy field that interacts with other energy fields. (24)

Studies of this type often do not provide insight into the experiences of individuals and the humanistic perspective, or may prove to be challenging from an ethical or logistics perspective, but population-based or trial studies are generally accepted as the most valid approaches to determining population needs and outcomes, or the effectiveness of interventions. Rather than leaving these types of research to others, midwives need to engage in all types of research to answer the range of questions that are relevant to midwifery. In doing so, midwives will capture the midwifery perspective, particularly when it comes to interpreting the findings. For example, two recent studies in North America examined birth outcomes for planned out-of-hospital births in comparison to planned hospital births. One study conducted by Dr. Eileen Hutton and colleagues in Ontario (25) concluded that planned home birth attended by midwives in a jurisdiction where home birth is well-integrated into the health care system was not associated with a difference in serious adverse neonatal outcomes and was associated with fewer intrapartum interventions. These findings suggest planned homebirth is as safe as planned hospital birth. A similar study conducted by Jonathan Snowden and colleagues in Oregon (26) concluded that planned out-of-hospital birth was associated with higher perinatal mortality. Taken at face value, these findings suggest home birth is not as safe as hospital birth. However, if the findings are examined in more detail, issues arise that explain the difference in findings and that bring a more accurate interpretation of the safety of home birth provided by

midwives who are properly integrated into the system. (27) On examining the findings, Hutton found that compared to the Ontario home birth population, the Oregon study included women birthing at home who should have been considered high risk, who had lower transfer rates to hospital during labour and who used a variety of regulated and non-regulated care providers for home care. She concluded that care providers in Oregon were likely not well integrated into the health care system, meaning they may not have had access to referral and other supports for women in labour. This example highlights the need for midwives to undertake their own research. If midwives are not involved in doing research, they cannot be sure that others are asking the right questions or coming to midwifery-sensitive conclusions that will provide the best information for care of clients.

In Canada, basic research training is included in the undergraduate midwifery curriculum, to ensure that graduating midwives can use research methods to identify the needs and preferences of their clients, and evaluate their own practice in terms of its effectiveness and how well it meets the client's needs. Chapter 13: Midwife as Researcher, written by Hutton, contains more information about the importance of research in midwifery.

External Link

In 2016, Eileen Hutton was the second annual Elaine Carty Visiting Scholar at the University of British Columbia, and gave a public lecture which can be opened from the following link: http://midwifery.ubc.ca/2016/03/01/2016-dr-eileen-hutton/

The Scholarship of Application

Academia serves the interest of the wider community by applying knowledge to problems and to individuals and institutions, and to using problems to define the agenda for scholarly investigation. This can be interpreted as midwifery research promoting and supporting evidence-informed practice and also as ensuring research is clinically relevant.

The concept of evidence-*informed* practice is a more recent iteration of evidence-based practice (see Chapter 12: Evidence-informed Midwifery for more), and recognizes the importance of professional judgement, individual and contextual factors, experiential knowledge combined with research-based evidence for effective and individualized practice. It also recognizes that very often in medicine generally, evidence is lacking. McVane Phipps emphasizes the need to consider all forms of knowledge, stating that rigid adherence to research as the only method to develop midwifery knowledge 'discredits the vast store of wisdom passed down through all the ages of human existence that enabled women to give birth safely.' (28, p.87) She suggests the true function of midwifery research is to verify or discredit beliefs about the benefits of intuitive and experiential knowledge and to question the ritualistic use of interventions that appear to interfere with the natural processes of pregnancy, labour and birth. Spiby and Munro recommend that midwives engage further and contribute to the guideline development process to bring the midwifery perspective to their development and to challenge guidelines that are not fit for purpose. (29)

Did You Know?

Midwifery organizations are increasingly involved in producing guidelines for practice. For example, since 1999 in Ontario, Canada, the Association of Ontario Midwives has produced evidence-based clinical practice guidelines (often shortened to CPGs). The value of having midwifery specific guidelines are that they are written to reflect midwifery values such as informed client choice and they can address topics that may be less relevant to other health care providers (and therefore less likely to exist) such as care of clients choosing out of hospital birth. The CPGs are available online here: http://www.aom.on.ca/print/Health_Care_Professionals/Clinical_Practice_Guidelines/Default.aspx

Spiby and Munro point out a potential challenge to autonomy and clinical decision-making as a result of the evidence-based movement. (29) One the one hand, the rapid growth in the development of evidence-based clinical guidelines and practice standards by organizations such as the National Institute for Health and Clinical Excellence (NICE) in the UK, use methods that synthesize the evidence to a level that would be impossible for most practitioners. While these pre-synthesized resources facilitate discussion between midwives and clients, Spiby and Munro suggest this approach could relegate midwives to a passive role of following pre-set guidelines, and at the risk of losing some of the critical skills that are honed through the stages of the evidence-informed cycle (formulating research questions, searching for and appraising the evidence to inform clinical

practice, utilization, and evaluation). (29) Taking a passive role may lead midwives to have a less critical approach to practice in general and impact on the practice of individuals in areas that would benefit from empirical enquiry. They also claim that clients will continue to seek out evidence despite the availability of guidelines or where guidelines do not yet exist, and further, that regardless of the availability of guidelines, midwives should still be able to discuss the evidence with their clients from the context of their situation and needs.

Lavender draws attention to the growing consumer engagement with evidence in maternity care settings in the UK, largely driven by midwifery client's dissatisfaction with the care provided and their awareness that interventions are being used without adequate evaluation and without taking their views and experiences of clients into account. (21) A similar pattern has been seen in other countries and it can be argued that comparable consumer involvement and lobbying was critical to the establishment of midwifery in British Columbia, Ontario and other provinces in Canada. Interest of clients in the evidence raises the imperative for midwives to be capable of discussing both the evidence and its resulting recommendations with their clients. An ability to discuss the evidence is a crucial aspect of the informed choice pillar of the midwifery model of care in Canada. The midwifery academic can contribute to evidence-informed midwifery practice both by promoting and disseminating the evidence for practice, helping to interpret and apply the evidence, and by generating evidence to contribute to the body of midwifery of knowledge.

There is a need for midwifery scholars and academics to promote evidence-informed practice and to build capacity amongst students and midwives to evaluate research, so that they have the skills to understand, interpret and apply new knowledge.

Simply knowing the evidence is not a guarantee that midwives will adopt an evidence-informed approach to practice. Lavender draws attention to significant variations in how midwives use evidence in practice, with some but not all variations emanating from lack of knowledge of the evidence. (21) Some midwives may choose not to depart from traditional approaches to practice despite evidence to support a departure, or be reluctant to use the evidence in practice unless pressured to do so by peers or organizational protocols. They may also use the evidence only when it justifies their actions or supports their personal beliefs or purposes, or not adopt evidence-based practice because of contrary, negative personal experiences. The academic midwife has an active role to play in both knowledge creation and knowledge translation thus ensuring that clients have access to the best available and balanced information on which to base their care.

Supporting Clinically Relevant Research

A second aspect of the scholarship of application relates to identifying priorities for research based on problems or issues arising from clinical practice. Academic midwifery departments may feel under pressure to pursue broad scope, large scale, grant-funded projects rather than smaller, narrow scope studies that more closely align with specific issues midwives see regularly in practice, or with the humanistic or holistic approaches to practice. (28) However, whether research is conducted on a large scale or in local small-scale studies, the results it generates must have an impact and be relevant to those who will use the findings. In planning studies midwifery scholars and academics must therefore

work closely with midwives in practice and consult with clients when generating strategic research priorities.

Reflect

Think of three midwifery interventions that you commonly see used in labour.

1. What do you know about the effectiveness of these interventions? What, if any, alternatives are there to these interventions? What does the evidence say regarding the intervention and it's alternatives?
2. What do the guidelines say about these interventions? How are they supported or not supported by evidence?
3. What type of evidence is available? How adequate is the evidence? Are there any gaps in the evidence?

The Scholarship of Teaching

The scholarship of teaching includes educating and enticing future scholars. In his discussion of this aspect, Boyer emphasizes the importance of the educator having extensive knowledge, creating a common ground of intellectual commitment, stimulating active learning, encouraging students to be critical, creative thinkers and life-long learners, and educators also being learners. (9) Educators

must do more than simply transmit knowledge; they must be part of transforming and extending it as well.

To use evidence to inform practice, midwives must be able to access that evidence, make sense of it through effective critique and interpretation of findings, and reconcile evidence with the knowledge they have gleaned from their own experiences. (21) As noted earlier, Lavender (21) found significant variations in how midwives use evidence in practice, with some but not all of the variation emanating from lack of knowledge about the evidence. Lavender observed that even when they have the knowledge, midwives may:

- Choose not to depart from the traditional approaches to practice despite the evidence to the contrary
- Be reluctant to use the evidence in practice unless they are pressured to do so by their peers or organizational protocols
- Use the evidence only when it justifies their actions or supports their own personal beliefs or purposes
- Not adopt evidence-based practice because of contrary negative personal experiences

Therefore, having the skills to interpret and apply the evidence and knowledge of the evidence is not a guarantee that midwives will adopt an evidence-informed approach to practice. This suggests an important role for the midwifery scholar in promoting evidence-informed midwifery as a leader and change agent – beyond individual student cohorts.

Midwifery academics must support midwives to develop the knowledge and skills to become thoughtful users of research findings, beginning in the undergraduate curriculum, where

students must be introduced early to the importance of evidence-informed practice and learn the skills to find and interpret evidence. The curriculum should follow through by building skills in knowledge acquisition, focused on the latest evidence and enabling students to become midwives who can provide evidence based information for clients, can choose the appropriate, evidence-informed course of action for each client as an individual, and who can also appreciate where the evidence is lacking. (21) In Canada, basic research training is included in the undergraduate midwifery curriculum, aimed at ensuring graduating midwives can use research methods to identify the needs and preferences of their clients, and to evaluate the effectiveness of their own practice and how well it meets the needs of each client.

In Canada, the majority of midwifery academics are active in clinical practice, which is considered vital to maintain their clinical credibility. In addition, emphasis is placed on midwifery academics ensuring that their teaching is informed by their own research and the two are interdependent, that is, teaching emerges as a result of one's own and others' research and questions that arise from teaching and practice feed into and stimulate their research. The challenge is to not neglect the crucial role that clinical practice plays in the life of the academic midwife. (23)

Midwifery Scholarly Work

The recent publication of the Lancet series on midwifery is an example of midwifery scholars working collaboratively to set the agenda for quality maternity care and to begin a discussion about the contribution of midwifery to improving perinatal outcomes. (3) Another example is the remarkable publication by midwifery

scholars in Canada, *Reconceiving Midwifery*, stimulated national and international discussion about the status of midwifery in Canada, the achievements made to date and the remaining challenges. (30) It traces the history and politics involved in the establishment of midwifery in Canada, the development of midwifery education, and access to midwifery, including unregulated midwifery, before defining the challenges and opportunities remaining for midwifery in Canada. Similar publications and position pieces by scholars such as, Bourgeault's *Push! The Struggle for Midwifery in Ontario* (31), the Atlantic Centre of Excellence for Women's Health Prairie Women's Health Centre of Excellence's *Proceedings from the Midwifery Way Forum* (32), added to the debate that generated some shared understandings about the priorities for midwifery in Canada.

Midwifery scholars must challenge the practice of midwifery, ensure that the values of midwifery are not lost over time, and support midwives to embrace the principles of midwifery. Citing examples such as, antenatal diagnostic tests, the systematic use of electronic fetal monitoring on admission and during labour, the use of the term *low risk*, restriction of food in labour, Mead suggests midwives have been guilty of offering clients many practices and technologies without sound evidence, and 'even when evidence demonstrated that the argument put forward was potentially flawed.' (33, p.140) Mead suggests that midwives struggle to uphold the principles enshrined in midwifery of woman-centred care and that midwives are the guardians of normal birth and submits that these principles are introduced from the beginning on midwifery education programs but before very long, students realize 'the gap between the theory and practice, and the common adoption of practices that are not based on evidence and not recommended by international authorities.' (33, p.141) This suggests midwife educators and scholars have an

important role in interrogating midwifery practice with students and practising midwives.

Within the wider academy, the midwifery scholar represents midwifery and promulgates midwifery priorities. Midwifery scholars provide the expert view on normal pregnancy and birth, which they use to influence thinking amongst other disciplines and amongst policy makers. They draw on the evidence, or generate evidence where none exists, to demonstrate value of midwifery care for women, their families and society. They identify emerging midwifery concerns and generate insight into the experiences of those concerned. They synthesize the required literature to illustrate the current state of knowledge and thinking across countries on issues of importance. They provide periodic reflections on the current state of midwifery and maternity care, and make recommendations for next steps.

Future Directions for Midwifery Scholarship

Midwifery is a relatively new academic discipline and as such midwives are commonly new to research. Although the number of midwives conducting research is increasing, midwifery research capacity remains uneven both within and between countries, with some areas and/or countries having considerable capacity and others very little. European initiatives, such as the EU COST (Cooperation in Science and Technology) and European Research Framework programs (currently FP8), promote collaboration between partners in different countries and across professional disciplines, thereby helping to share expertise and generate greater coherence in the focus of research. The foundation of these initiatives is collaboration, cooperation and networking.

There has been substantial growth in midwifery research

networks and networking in recent years. Luyben advocates that it is almost impossible to carry out research without a supporting network with access to experts for counselling, as well as statistical and computer support. (13) Networking and conferencing are ways in which midwifery researchers share their results, seek feedback on their work and generate further collaborations.

Recognizing the value of collaborative networks and emphasizing the importance of research as 'the foundation of midwifery's Three Pillars and ongoing education and research as the lifeblood of any vibrant profession,' (p.1) the ICM established the Research Standing Committee (RSC) and the Research Advisory Network (RAN). (34) The RSC provides strategic leadership in relation to research and together with the RAN aims to provide member associations across countries with up-to-date information on all aspects of midwifery practice, education and service. The RAN comprises members from many countries and aims to facilitate research collaboration among members and provide expertise and advice to the ICM and the RSC on research issues. The RSC recently conducted an international survey (using the RAN) to identify global midwifery research priorities. (35)

Midwifery scholars can look to the international community research agenda through the initiative of the ICM. To encourage involvement of all midwives, not just those presently in the research community, the ICM established a midwifery discussion list 'to provide an open forum for discussion on issues relating to research on midwifery and reproductive health…to create an international network of people who are eager to share information (e.g. workshops, seminars, conferences and new research) and to promote links, collaborative working, joint problem-solving and mutual support.' (36, p.1)

Research networks may also take the form of communities of

practice. For example, the British Columbia Midwifery Network, which launched in October 2014, is a collaborative initiative aimed at linking midwifery academics, midwives, students and researchers across British Columbia who are working in the area of midwifery and perinatal care, in order to build research capacity and a program of research around clinically relevant areas. (37) The initiative aims to support midwives to engage with research and to support them in that process.

Challenges for the Midwife as Scholar/Academic

This chapter has emphasized the importance of midwifery scholarship and the integration of midwifery scholars to the academy. However, attracting midwives from clinical practice to full-time academic positions has proved difficult. In the UK, Mander has proposed that, due to the nature of midwifery as a practice-based discipline, there is often a mutual lack of understanding by midwives about the nature of the academic role and by academics of the midwifery role. This is in part believed to be because each party may have limited experience of the other. (23) However, in some jurisdictions like Canada, midwifery academics are expected to be active in clinical practice and, very often, midwives in full-time clinical practice are involved as clinical educators or as part-time or sessional instructors in midwifery education programs. The Canadian scenario poses its own set of challenges in terms of workload and reconciling scheduled teaching duties with 24/7 on-call commitments. Nonetheless, the Canadian context does not include the concern found in other countries regarding the clinical credibility of midwifery educators (38) or the *theory-practice gap*. (39) For the midwifery academic, meeting the requirements of a full-time

academic appointment and the clinical requirements to remain on the midwifery register includes can be a challenging.

Academic appointments may not be attractive to midwives due to the use of short-term contracts, salaries for academic and research positions that are not commensurate with clinical positions, or the academic appointment and promotion process that is traditionally aimed at recent graduates rather than professionals with commitments who are already well established on a career track.

Summary

This chapter explored the role of the midwifery scholar and academic and makes the case for the pivotal role of scholarship to the development of midwifery and its recognition as a profession. Four types of scholarship were identified that relate to: doing research, integrating research, supporting and promoting the application of research (evidence) to practice, and teaching. While acknowledging that midwifery is relatively young as an academic discipline and as such has relied heavily on research produced by scholars from other disciplines, this chapter presented the importance of shifting midwifery scholarship to centre-stage to capture midwifery nuances, to ask the types of questions that midwives would ask, and to use study methods that capture the essence of midwifery. This chapter called on midwives to be more involved as scholars and academics, to lead on all aspects of midwifery scholarship, and to focus research on issues that can make a difference to midwifery practice, clients and society. Finally, this chapter highlighted the potential for the midwifery scholar/academic to promote the interests of midwifery and of

clients and their families within the academy and amongst policy makers through scholarly debate and publication.

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PART IV

Midwife as Researcher

Edited by:
Eileen K. Hutton, BSc, MSc, PhD
Assistant Dean & Professor
Midwifery Education Program
McMaster University

12. Midwives Using Research: Evidence-based Practice & Evidence-Informed Midwifery

Vicki van Wagner, RM, PhD

The chapter will review definitions of evidence-based practice (EBP) and, specifically, will explore how evidence-informed midwifery defines itself. The intertwined histories of midwifery and EBP are explored to show the meaning and importance of EBP to midwifery practice and policy.

Introduction

It might seem obvious to the current generation of midwives and

other health care providers that practice should be informed by evidence as this is now an accepted approach to health care. When the concept of evidence-based medicine (EBM) was introduced in the early 1990s however, this idea was harkened as a '**paradigm shift**' (1, p.1) and even a "revolutionary movement." (2) The concept of EBM evolved to EBP to be inclusive of not only other health care professions but also other professional disciplines. The need to use evidence as the basis for decision-making has become an expected, if challenging, approach to practice and policy-making in all areas.

Midwifery, particularly midwifery in Canada, has a unique relationship to EBP, and a history that provides insights into both our profession and the ongoing evolution of the application of evidence to maternity care. (3) EBP offers much to midwives and health care practice, but it is important to understand the potential limitations and unexpected effects of a naïve application of EBP. For example, in Ontario, Canada midwives have generated an integrated approach to EBP through midwifery **clinical practice guidelines** (CPGs) and other evidence-based resources for midwives and clients that combine a rigorous look at evidence with a values-based approach to the application of evidence. (4)

What is EBP?

EBP is commonly defined as a commitment to base health care on the best available scientific evidence. The term EBM was first used in an article in the *Journal of the American Medical Association* (*JAMA*) in 1992, and it had evolved from previous labels including, research-based practice. (5) EBP is used interchangeably with evidence-based health care and has generated labels specific to particular health professions such as evidence-based midwifery,

nursing, physiotherapy. The concept is also now applied outside healthcare professions, such as evidence-based social work and teaching; and evidence-based policy and evidence-based management.

EBP uses well-defined criteria to evaluate the quality of clinical research, creating a **hierarchy of evidence** (Table 12-1). The most scientific and therefore highest quality research is generally considered to be the **randomized controlled trial** (RCT). RCTs may be blinded, such that study participants and/or health care providers and/or those evaluating the results do not know which participants received which intervention. Blinded RCTs are frequently referred to as single-, double- or triple-blind, despite these terms having been found to be used and interpreted inconsistently. (6,7) The present guidelines state that reports of blinded RCT should include explanation of who was blinded after assignment to interventions and how. (8)

Table 12-1. Hierarchies of Evidence, after Sacket et. al (9).

1. a) Systemic reviews of RCTs
   b) Individual RCTs with narrow confidence interval
2. a) Systematic reviews of cohort studies
   b) Individual cohort studies and low-quality RCTs
3. a) Systematic reviews of case-control studies
   b) Case-controlled studies
4. Case series poor-quality cohort and case-control studies
5. Expert opinion

In clinical research, such as maternity care research, blinding of the participants and health care providers is often not possible as both the care provider and patient know the nature of the treatment being applied or not applied, such as would be the

case if the intervention involves, e.g. physical therapy. However, participants should still, if at all possible, be randomly assigned to their groups and it is 'still desirable and often possible to blind the assessor or obtain an objective source of data for evaluation of outcomes.' (10) In maternity care, both childbearing clients and care providers involved in trials are commonly aware of the treatments, but patients are randomized in allocation to their group to either receive or not receive the treatment. The randomization process that distinguishes the evidence from RCTs from cohort or case-control studies and outcomes research, as it reduces **systematic bias**. What is now the Canadian Task Force on Preventive Health Care (CTFPHC) developed a system for grading the level and quality of research evidence in 1979 (revised in 2003 (11,12)), which was used in the first EBP 'how-to' guide in 2000. (13) This system established the RCT at the top of the research hierarchy and evolved to **systematic review** or **meta-analysis** being preferred to single RCTs.

A sense of the rationale for these hierarchies of evidence is contained in the following quote from the 2004 *Centre for Health Evidence User's Guide* (5):

> Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision-making, and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician, including efficient literature-searching, and the application of formal rules of evidence in evaluating the clinical literature. (p.2420)

EBP claims to be both **epistemological** and clinical, as it proposes optimal ways to develop knowledge and asserts that information

obtained from high-quality scientific research is the foundation for effective clinical practice. (14) Some advocates of EBP argue strongly that the use of scientific research is superior to the use of other forms of knowledge, such as individual clinical experience, physiologic principles, expert opinion and understanding of patient, professional, or social values. (1,5,15,16) Hierarchies of evidence place expert opinion and individual case reports at the lowest level of quality. Others argue that scientific evidence must be part of a decision making process that integrates all of these forms of knowledge. (15) Rather than shifting away from expertise and expert opinion, the shift towards EBP is a shift towards a new kind of expertise , that of critically appraising relevant evidence and applying it to clinical practice. (17)

Practitioners engage in EBP in a series of steps. EBP demands that clinicians learn first to find, then analyze and finally to apply evidence in appropriate situations. Over time many tools for EBP have evolved, such as systematic reviews and CPGs, which can make EBP easier. Midwifery professional organizations often create their own CPGs, but midwives will often also use reviews and other evidence-based tools from other professions, such as obstetrics, pediatrics, family practice and nursing, to inform their practice.

Advocates in the early nineties posed EBP as a central paradigm shift for clinical care providers, promising not only a more systematic and scientific approach to clinical practice but also a challenge to practices based on tradition, professional opinion and authority. (1,5) Since that time, the concept that quality scientific evidence is fundamental to health care has been universally accepted, while at the same time debate about how to best produce, evaluate and apply evidence continues. Good evidence is now argued to be essential to both care providers and the recipients of care. (14,18,19)

Medical, midwifery, and nursing education have enthusiastically adopted EBP. In 2003, the journal, *Evidence-Based Midwifery*, began publication and there are now also many scholarly texts to guide evidence-based midwifery. (20,21) Linked with not only health care practice but also with education and with institutions that produce or support research, EBP is deeply entwined with research funding decisions and academic career paths (see Midwife as Researcher chapter). EBP has now become so ubiquitous, some worry that "evidence-based everything", dilutes the meaning of the term. (22)

Did You Know?

An article published in the *Journal of Advanced Nursing* in 2002 charted the number of times EBP and its variants were used in the titles of articles or in abstracts published in the professional literature since it was first used in 1992. (23) Over its first decade EBP spawned not only thousands of articles, but many texts, several international journals and research institutions. (24)

External Link

The journal *Evidence Based Midwifery* from the Royal College of Midwives is available here: https://www.rcm.org.uk/access-evidence-based-midwifery-journal

The Intertwined Histories of EBP & Midwifery

Some of the early advocates for better scientific evidence were childbirth activists and feminist women's health scholars. (25) Lack of scientific evidence for numerous routine obstetric practices was the basis for many critiques of the medical management of childbirth. These critiques helped shape both the development of the EBP paradigm and the development of midwifery in Canada. Early calls for EBP used examples of the wide variations in obstetric practice to make the case that an evidence-based approach was needed across medical professions. The differences in rates of induction and episiotomy in different hospitals in the same region and different regions in the same country were proof that a more scientific approach was needed. Welsh physician, Archie Cochrane (1909-1988), after whom the Cochrane Database of Systematic Reviews is named, is widely considered to be the founder of EBP in the UK. In 1979, Cochrane named obstetrics as one of the least evidence-based of the fields of medicine, but this was soon to change. (3)

External Link

The Cochrane Database of Systematic Review is available here: http://www.cochrane.org/

An enthusiastic and influential group of physicians, epidemiologists and teachers at McMaster University formed the Evidence-Based Medicine Working Group (EBMWG) in 1992. McMaster's history as an innovative medical school, one that was willing to experiment with new approaches to clinical care and student admission and teaching, positioned it to be one of the

birth places of the new EBP paradigm. Members included internal medicine specialists Gordon Guyatt, David Sackett and obstetrician Murray Enkin, all of whom were destined to become influential leaders of EBM, internationally. McMaster was also one of the Canadian leaders in family-centred maternity care. (26)

Murray Enkin (Figure 12-1) is a key figure in both the evidence and childbirth movements. As a family doctor in Saskatchewan he attended births, including those of his own children, in an environment he describes as low tech. From his earliest days as a medical student Enkin had a great respect for women during childbirth and for the process of natural birth. When the EBMWG formed, he already had a long history in working to humanize childbirth and had been frustrated by a lack of interest in family-centred approaches by other physicians and institutions. In the decades from the 1990s onwards, Enkin would emerge as an important champion of many reforms to maternity care including the legal recognition and acceptance of midwifery in Canada and for a fuller role for midwives in all jurisdictions. (3)

Enkin was a co-author of the first textbook of EBP in maternity care, *Effective Care in Pregnancy and Childbirth* (*ECPC*) (27), a large, two volume compilation of the best evidence from both clinical and social science perspectives. ECPC is remarkable in a number of ways, first in that it modelled the integration of inter-professional and inter-disciplinary perspectives (Figure 12-2). It modelled a democratization of health care practice that many EBP advocates hoped for, including as reviewers, consumer advocates, sociologists, anthropologists and basic scientists as well as family doctors, obstetricians and pediatricians. The authors also created an accessible paperback version, first published in 1989, for both professionals and the public called the *Guide to Effective Care in Pregnancy and Childbirth*. (27) Complied and disseminated prior to

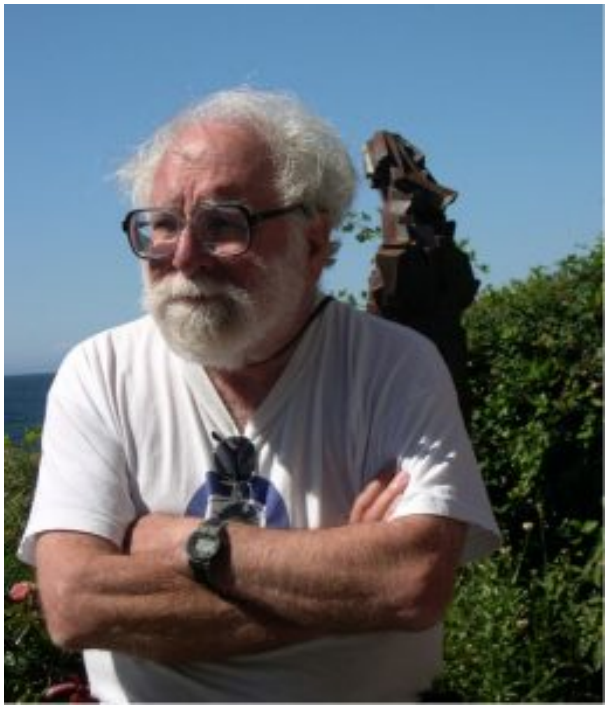

Figure 12-1. Murray Enkin, photo by Michael Klein.

wide access to the internet, ECPC was a remarkable achievement and marked a new era in maternity care.

One powerful and controversial tool contained in ECPC was the summary list of practices that were beneficial, unknown or likely to be harmful. It also listed practices that did not have a strong enough evidence base to either encourage or discourage but which needed more evidence. The authors claimed there was evidence to encourage many practices that supported midwifery care, like one-to-one care in labour; intermittent auscultation of the fetal heart and mobility in labour; choice of birth place and care provider. Practices that they claimed should be abandoned

Figure 12-2. Multiple editions of ECPC have been released. Photo by the author.

included routine shaving; electronic fetal monitoring; arbitrary limits on the length of labour; episiotomy and separation of mother and baby. Childbirth reform movements had long expressed concern about the overuse of many of these procedures. (25,29–32) The lists in ECPC created a holistic vision of what a normal birth might look like (and what it might not). It also gave clear guidance when common interventions lacked an evidence-base (28):

> First. . . the only justification for practices that restrict a woman's autonomy, her freedom of choice and her access to her baby, would be clear evidence that these restrictive practices do more good than harm; and second, … any interference with the natural process

> of pregnancy and childbirth should also be shown to do more good than harm. We believe that the onus of proof rests on those who advocate any intervention that interferes with either of these principles. (p.389)

Many of the first champions of EBP in maternity care appear to have assumed that the systematic interpretation of scientific evidence would support a 'family-centred' or 'woman-centered' approach to childbirth that respected rather than pathologized the physiology of birth. (28,33) Midwife, Jilly Rosser, is one of the founders of Midwifery Information and Research Service, an evidence-based service for midwives in the UK. She spoke for many midwives in calling ECPC "a bible for midwives." ECPC was popular with midwives, not only because it provided so much information to base practice on, but also because of the strong support it gave for normal birth. (34) Midwifery Professor and first Director of Midwifery Education at McMaster Karyn Kaufman described the reception of the midwifery community to ECPC by saying, "it felt like science was on our side." (3) EBP seemed to support change, normal birth, choice and control, key demands of childbirth movements internationally. For Canadian midwives, not yet legally recognized in the early nineties, the EBP movement supported the central aspects of the model of care they were advocating for: continuity of care, choice of birth place and physiologic birth.

As the decade progressed EBP was swept forward by the information technology revolution and has transformed into the massive enterprise we know today. Some would say that from its origins as a new paradigm it has transformed not only into an institution but also an industry. (3) As the popularity and authority of EBP grew so did debate about it.

The Evidence Debates

In the first decades of EBP there has been a flurry of debate about its claim to be the new paradigm for health care. Some claimed that medicine has always based its work on research and that there was nothing really new about it. Others turned EBP's own argument against it stating that there is no evidence for EBP. Some authors pushed against its growing authority worrying that it had become impossible to be against anything that claimed to be based on evidence, thus silencing the rebuttal and debate that is an important part of the scientific process. Advocates claimed that EBP breaks down hierarchies both within and between professions as well a with users of care and that it promotes dialogue. (5) Skeptics warned that despite good intentions on the part of the early EBP advocates, that the use of evidence for fiscal restraint and rationing of care rather than for good patient care would be worrisome (35), while others argued that allocation of limited funding should be based on evidence. (36) Another critique focused on the fact that EBP seemed to provide one right answer and to be a grand narrative that seemed reductionist and positivist. (15) This appeared to be out of step with postmodernist scholarship at a time when many disciplines were rejecting modernist notions and emphasizing concepts like partiality, **situatedness**, hybridity, ecology, and complexity. (3) EBP has also generated terms with more nuanced meaning such as evidence-informed practice (37), and labels with counter meanings such as practice-based evidence (38), or person-based evidence, (39) which reflect some of the debates about EBP.

These debates led evidence experts to clarify and defend EBP, to define what evidence is and what it is not (40) and to soften the hierarchy to be more inclusive of patient preference and other knowledge such as skill and judgement.

What EBP Can & Can't Do

Despite the debates, the hopes and expectations for EBP in maternity care were high. As noted above, some hoped that EBP would help humanize childbirth and counted on it to bring change and choice. (3) Others hoped that if practice was based on best evidence it would bring clarity and take some of the uncertainty out of clinical practice. However, although scientific evidence can determine which test or treatment may work best over a population it does not eliminate the need for clinician skills, judgment and decision-making on the scale of individuals. One of the early goals was to eliminate the need to rely on expert opinion, yet EBP has increasingly demanded a new kind of expertise. Clinicians are now required to provide guidance through the lens of both scientific evidence and judgement based on experience. Advocates embraced the idea that EBP challenges authoritarian approaches to health care and demands life-long reflective practice from all practitioners. Despite these hopes, some worried that strong pressures in the system would lead to the use of evidence to support a pre-existing belief or practice. (3)

The law and ethics of health care demand that people are informed about and participate in decisions about their care. ECPC concisely states that the goal of scientific evaluation of health care is to determine the "most effective means to achieve" the objectives of care, but cannot set the objectives. (28) EBP does not eliminate the need to need to explore goals and objectives, client values and preferences to inform how evidence is applied to individuals. ECPC challenges the health care system to look at goals and objectives at an institutional level and for the system as a whole.

It is increasingly clear that some important questions cannot be addressed with RCTs and that the hierarchy of evidence does not apply to all questions about childbirth. (41,42) Pregnancy and birth are complex phenomena with many interdependent factors that may confound results of RCTs when results are applied in a real life setting. (41,42) As the evidence movement has matured, the value of different kinds of knowledge to answer many questions in maternity care has become clear, including observational studies, findings based on the analysis of large data sets, practice audits, and qualitative research and mixed methods approaches.

Many hoped that evidence would settle the debates about appropriate rates of intervention in childbirth. After more than two decades of EBP variations in rates of induction and cesarean remain problematic all over the world. The application of evidence sometimes leads to unexpected effects, such as the recommendation for induction of labour between 41-42 weeks appearing to increase the rate of induction prior to 41 weeks. (43) Both the research process itself and the application of the evidence it provides involve interpretation. It is clear that personal beliefs and values and institutional norms can influence how evidence is interpreted. Some evidence is taken up very readily and other evidence seems almost impossible to implement widely. An example is intermittent auscultation of the fetal heart (IA) in a low risk pregnancy. Despite national obstetric guidelines (44) advocating IA for low risk pregnancy, high rates of routine electronic fetal heart rate monitoring are difficult to change. (3) Many factors far beyond evidence have an impact on how and if evidence is applied. (3) Societies in the developed world seem to have a tendency to default towards technology, and evidence that advocates for more technology seems to be taken up more easily than evidence that advocates less technology. (3) Workplace demands for efficiency and staffing pressures can influence what

evidence is applied and what evidence is not. Evidence that provides multiple interpretations should facilitate client choices, however health systems commonly aim to standardize rather than individualize care and implement singular understandings and routine practice rather than client choice. Clearly, the debates about EBP will continue to evolve and change.

External Link

The Society of Obstetricians and Gynaecologists of Canada obstetric guidelines can be found here: http://sogc.org/wp-content/uploads/2013/01/gui197CPG0709r.pdf

Evidence-Informed Midwifery

Midwives around the world enthusiastically support EBP and there is extensive literature and many resources to support evidence-based midwifery. Most midwifery education programs are built around enabling students to acquire and use the skills required for EBP, such as how to search the research literature and how to critically appraise research articles. Many midwifery education programs are designed to expose students to both science and social science knowledge and expect them to use both to inform practice.

Many midwives feel most comfortable using the label, evidence-informed midwifery. The term integrates the concept of informed choice and EBP. It acknowledges the need for midwives to explore the values and preferences of their clients. It fits well with the midwifery philosophy in which clients are the primary decision

makers, working in partnership with midwives to determine the best course of care. The term also acknowledges that midwifery decisions will include contextual factors. The midwifery model of care is an ideal model for what could be called the integrative approach to EBP, one that uses clinical research evidence as one of the many sources of knowledge that are essential to consider in assisting clients to make decisions.

For Normal Birth

Much midwifery work on EBP looks at the evidence through the lens of normal birth. Many midwifery researchers actively focus their research on topics relevant to normal birth, including how to preserve as much normalcy as possible even in complex situations. There are many evidence-based tools produced by midwives to support normal birth such as the Royal College of Midwives' Campaign for Normal Birth in the UK and the American College of Nurse Midwives' Normal Birth: Pearls in your pocket or the Wales Normal Birth Pathway. Midwifery research supporting the safety of out of hospital birth has been integrated into national guidelines in the UK (45) through the advocacy of midwives working on inter-professional guidelines committees.

External Links

Information on the Royal College of Midwives' Campaign for Normal Birth in the UK can be found here: http://www.rcmnormalbirth.org.uk/

The American College of Nurse Midwives' presentation of Normal Birth: Pearls in your Pocket can be found here:

http://www.midwife.org/Evidence-Based-Practice-Pearls-of-Midwifery

Documents related to the Wales National Birth Pathway can be found here: http://www.wales.nhs.uk/sites3/page.cfm?orgid=327&pid=5786

For Advocacy

Many midwives find EBP a powerful tool for advocacy and actively use evidence both in day-to-day practice and in policy making at every level from practice to institution to broad health system forums. Midwives have described carrying a file of important studies, reviews and CPGs with them, so that if other care providers questioned the care they were providing they could produce the evidence and have a more informed discussion with their colleagues. (3) International work studying the implementation of evidence-based midwifery reveals that midwives often face barriers in the hospital setting, including particularly lack of autonomy. (46) Some jurisdictions have created midwifery staff positions (47) and research networks (48), to promote and support EBP. Research in New Zealand shows higher rates of EBP at home births than hospital births even when the same midwives have been in attendance, which may support the case that autonomous midwifery practice is an ideal setting for EBP. (49)

For Evaluation

Midwives also contribute to evidence-informed midwifery by critically appraising research done by others. The midwifery model supports spending enough time with clients to explore multiple interpretations of the evidence. Much of the important RCT evidence about childbirth that has emerged over the past two decades, for example from RCTs about post-term pregnancy or pre-labour rupture of membranes at term, is open to multiple interpretations and approaches, with risks and benefits to either a decision to intervene or take an expectant management approach. The differences in outcomes between alternate approaches may be similar or small; therefore, the importance of discussion and choice rather than routine care is heightened. The midwifery model, with its commitment to informing clients of risks, benefits and alternatives and exploring the client's goals and values, is ideal for exploring multiple options rather than one right way.

Midwifery professional associations, such as the Association of Ontario Midwives (AOM), have produced an impressive set of CPGs formed through a values based approach. These values include providing guidance to midwives hoping to support normal birth and informed choice. They prioritize areas of practice where midwifery interpretations of the evidence differ from current medical guidelines and look at multiple rather than singular interpretations of evidence. They create companion resources and cell phone apps for clients to use. The following example is of a recommendation from a midwifery CPG on post-term pregnancy. Note that it integrates information, critical appraisal, choice and support for normal birth, and uses the evidence grading system of the CTFPHC (4):

> Inform clients that the absolute risk of perinatal death

> from 40+0 weeks to 41+0 weeks to 42+0 weeks' gestational age changes from 2.72/1000 to 1.18/1000 to 5.23/1000; currently available research is not of high quality and has not established an optimal time for induction. Therefore, women with uncomplicated postdates pregnancies should be offered full support in choices that will allow them to enter spontaneous labour. A policy of expectant management to 42+0 weeks following an informed choice discussion is the most appropriate strategy for women who wish to maximize their chance of normal birth. (p. 19)

External Link

The full Clinical Practice Guideline No. 10: Management of the Uncomplicated Pregnancy beyond 41+0 Weeks' Gestation is available here: http://www.aom.on.ca/files/Health_Care_Professionals/Clinical_Practice_Guidelines/CPG_beyond_41_FINAL.pdf

Clinical Applications

What would an evidence-informed midwifery practice look like? It would mean that as a midwife you listen to the clients and families you work with and find out what is important to them. You continually update your knowledge of the evidence. To do this you use relevant guidelines such as the AOM, Society of Obstetricians and Gynaecologists of Canada (SOGC), or National

Institute for Health and Care Excellence (NICE) guidelines and other evidence-based resources. You know how to search the web to find high-quality systematic reviews and use the Cochrane database. You get alerts to your preferred journals to keep abreast of new findings. In clinical practice you ask yourself key questions, including:

- What is the clinical situation and the specific findings for this client?
- What does your client say? What do other family members think? What is important to them?
- What is the evidence? How is it relevant to the general clinical situation? To the individual?
- What does your experience tell you?
- How can you best communicate the risks, benefits and the alternatives?

You use evidence to inform and support choice and actively give permission for reasonable alternatives. You develop your skills of critical appraisal and clinical reasoning and you become a skilled advocate for your clients and the profession, using evidence. By actively interpreting evidence to support normal birth you help lower rates of intervention in your practice settings. You let evidence challenge you and your worldview. You try to be open about your biases and engage in open dialogue about philosophies of birth and childbirth care. You respect evidence but know there is more to good practice than good evidence.

Conclusion

Midwives have an enthusiastic and critically aware engagement with EBP. Midwives have an ideal model of practice to implement evidence-informed care, with the benefits of autonomy and continuity of care. A commitment to EBP and participating in the creation of evidence-based tools provides an important common ground for midwives and other health professionals. Internationally, midwives recognize that evidence is an essential part of providing good care. Midwives contribute to the development of EBP by advocating for evidence-based approaches to care in their practice settings and at higher policy levels. While midwives want to contribute to the research, which creates better evidence and want to use evidence to inform their practice, they recognize that evidence alone cannot determine individual values and objectives of care. Midwives can and are playing a valuable role in the scholarship of EBP and in the integration of evidence with client choices and values.

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13. Midwife as Researcher

Eileen K. Hutton, BSc, MSc, PhD

The generation of knowledge is a defining characteristic of professions. As in other health care fields, midwifery research helps to describe the profession and provides evidence for its activities. (1) This chapter provides a historical context for midwives as researchers, describes the research process, and provides a rationale for midwives to undertake research. A description of the role for midwives as they generate profession-specific knowledge is provided.

History of Midwives in Research

Midwives have a long history of generating new information and of communicating this information to enhance the quality of care provided by their colleagues. As clinicians, midwives are natural researchers; they ask questions about the care that they provide, critique clinical observations, and shape practice based on these

findings. Today we describe this activity as **reflective practice**, and going far into midwifery history we have examples of midwives who undertook this same activity and contributed to the knowledge base of the profession.

Catharina Schrader (1693-1746)

A Flemish midwife who cared for over 4,000 women and newborns and carefully documented her the care she provided (Figure 13-1). Her records show that over her many years of practice she prepared summaries of best management so others might benefit from her observations.

Did You Know?

Catharina Schrader's notes were published in a memoir titled 'Memoryboeck van de Vrouwens. Het notitieboek van een Friese vroedvrouw 1693-1745'. Her notes were meant to serve as a financial record, patient registry and a guide to future midwifes. The notes were translated into English in a book titled 'Mother and child were saved. The memoirs (1693-1740) of the Frisian midwife Catharina Schrader.'

Angélique Marguerite Le Boursier du Coudray (1712-1794)

In 1759, after practicing midwifery for ten years in Paris, King Louis XV named Mme du Coudray (Figure 13-2) as, the King's Midwife. She was well paid to travel the country and provide what we would now call continuing education to both urban and

Figure 13-1. Catherina Schrader, drawn by J Folkema in 1714. Public domain photo. *https://en.wikipedia.org/wiki/File:Catharina_Cramer.jpg*

rural midwives. She authored a textbook for use by midwives, and invented and developed teaching manikins (Figure 13-3), which revolutionized midwifery education. It is reported that by 1780 two-thirds of all French midwives had studied with Mme du Coudray. The teaching tools and approaches that she developed

speak to both her role as an educator, and demonstrate her early role in **knowledge translation**.

Figure 13-2. Angelique du Coudray, 1833. Public domain photo. *https://en.wikipedia.org/wiki/File:Ang%C3%A9lique_du_Courdray.jpg*

Did You Know?

Many of Mme Du Coudray's obstetrical teaching manikins can still be seen in the Musée Flaubert et d'histoire de la médecine in Rouen, France.

Figure 13-3. Mme du Coudray's teaching manikin, now in the Museum of Man in Paris, France. Photo by Ji-Elle.
https://fr.m.wikipedia.org/wiki/Fichier:Machine_de_Madame_du_Coudray-Mus%C3%A9e_de_l'Homme.jpg

The life-like teaching models were made of leather and in very many ways are similar to the torsos in use now that are made of plastic. The models were easily transported and could demonstrate the basic manoeuvres of normal birth, as well as manoeuvres involved when complications associated with variations in position are encountered such as occipital posterior, or breech presentations. Approved by the French Academy of Surgeons in 1758, her models are confirmed to be the first approved teaching model for simulated learning in obstetrics.

External Link

To learn more about Mme du Coudray, visit:
http://www.cjmrp.com/articles/volume-9-2010/educating-midwives-with-the-world-s-first-simulator-madame-du-coudray-s-eighteenth-century-mannequin

Ethel Margaret Burnside (1877-1953)

Midwife Burnside was the first woman to be appointed as chief health visitor in the county of Hertfordshire, on the northern border of London, UK. Concerns had been raised about the general health of children in the country, and Burnside established a standardized record to be used for childbirth, newborn and early child hood care. These records included birth weight, method of feeding and records of each child's ongoing weight, illnesses and general development for the first year of life. Her team of midwives and nurses used these standardized forms at all of their clinical visits and the data was subsequently transcribed into ledgers at the county office. This system was in place from 1922 until 1948 and provided a wealth of information that was later used to link birth outcomes and early childhood experiences to adult outcomes and provide the basis for David Barker's Hypothesis, which is now referred to as the **Developmental Origins of Health and Disease** or the DOHaD theory.

External Link

To read more about the DOHaD Theory, visit:

https://dohadsoc.org/wp-content/uploads/2015/11/DOHaD-Society-Manifesto-Nov-17-2015.pdf

Midwives & Research

Midwives, like all health professionals, have come to appreciate the role of research in informing best practice. Much of the information used by midwives to guide clinical practice can be garnered from research findings of other professions, such as nursing, and medicine – particularly obstetrics and neonatology. So, one might question whether specific midwifery research is needed and further, whether it should be midwives who conduct the research.There are, of course, many reasons that midwives should be involved in primary research, three of the fundamental reasons include:

- Midwives ask questions that are of unique importance and relevance to improving care to women and infants during pregnancy and childbirth
- Other health providers may not ask the questions to which midwives need answers
- Midwives have a professional responsibility to generate knowledge relevant to their specialty

Two additional reasons for midwives to be involved in generating knowledge relate to the nature of midwifery. The first reason relates to the magnitude of effect that can result from an absence of knowing. Internationally, pregnancy and childbirth are considered normal, physiologic functions and most women giving

birth are considered to be at low risk of associated complications and are thus under the care of midwives; therefore, if midwives get something in their care wrong, it has the potential to affect large numbers in the birthing population. For example, for many years clamping of the newborn umbilical cord immediately following birth was encouraged as part of a **postpartum hemorrhage** prevention strategy. Early in the 21st century adequate research emerged to suggest that this action was detrimental to newborns, affecting them for as long as six months following birth. Midwives played an important role in generating this research: Judith Mercer, a midwifery scientist in Boston led the earliest research on delayed cord clamping involving very preterm infants. The results of her work has changed practice for these very vulnerable infants. Eileen K. Hutton, a Canadian midwifery researcher published the first systematic review of delayed cord clamping in the full term infant. (2) Diane Farrar, a British midwifery researcher, studied the transfusion effect of delaying cord clamping by weighing infants immediately following birth. (3) These works contribute to the changed and changing guidelines. The strategy of clamping the umbilical cord within seconds of birth had been used for years without any testing and has impacted generations of infants.

Reflective Practice Question

Why do you believe we need midwifery research? Why do you think it is important that midwives conduct research?

External Link

Judith Mercer discusses how observation from practice can lead to research in the following interview:
https://www.scienceandsensibility.org/p/bl/et/blogid=2&blogaid=99

The second reason for midwives to undertake research has more to do with the evolution of obstetrical practices over the last century, many of which have become 'usual care' without research evidence of their benefit, and perhaps more concerning, no evidence on their potential harm. For example, **electronic fetal heart monitoring** (EFM) was first developed in the 1970s and introduced to routine care with the hope that it would identify fetuses who were experiencing difficulty during labour. At the time, there was no research to demonstrate its effectiveness in screening for at risk fetuses among low risk labouring women. It is still used in many settings today, yet no studies since have been able to show if or how EFM improves outcomes for these neonates. (4) However, EFM is associated with higher rates of intervention, including increased rates of cesarean birth. (4) Even in the absence of evidence of benefits, and strong evidence that, routinely used, EFM is harmful, it is very difficult to change practice.

Did You Know?

Women and infants have been exposed to many practices in

maternity care that have had both short and long term detrimental effects. As late as the 1970s, because birth was treated as a surgical event, all women routinely received an enema in labour to cleanse the birthing site. Women were placed in stirrups and were covered in sterile drapes to maintain a sterile area around the birth canal. Women also routinely received an episiotomy in order to ease the birth of the infant across the perineum. This was meant to prevent uncontrolled damage to the perineum as it was thought that a surgical incision would heal better than a ragged tear . Preparing the surgical site for the episiotomy meant that the perineal area had to be shaved in early labour, and further cleansing of the birthing site involved swabbing the perineum and vaginal cavity with cleansing agents such as povidone-iodine (trade names: betadine®, or proviodine™ and others). All of these activities likely changed the normal flora that the infants were exposed to during the birthing process. We are just now beginning to understand how this flora might be important to the life-long health of the infant. (5)

Midwifery-specific research helps shape the profession and makes it responsive to the current needs of society. Although some might argue that midwifery has been slower than many other professions to undertake research, in the last number of years considerable headway has been made. Some very influential research papers have been shaping contemporary midwifery. For example, the **Cochrane review** (6) reporting that continuity of midwifery care models improved outcomes for women and babies provided a powerful basis to support the reintroduction of a model of care that in many jurisdictions had all but disappeared.

Research papers on homebirth from the UK, the Netherlands and Canada have provided solid evidence that has altered national guidelines to state that care providers should, 'explain to both **multiparous** and **nulliparous** women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth.' (7) These are important research papers because they have helped to ensure that women and families who want to choose a birth at home have this option available to them. In addition to enhancing care and broadening care options for women, midwifery lead research influences the way the profession is perceived. The role of positive research outcomes helps maintain the credibility of the profession of midwifery in a way that should not be underestimated.

The Lancet Series on Midwifery published in 2014 enhanced the understanding and credibility of midwifery as a profession. The series reported on a major research initiative undertaken by world leaders in midwifery research to develop a research framework.

Their project also outlines priority research areas for midwifery globally and describes how investing in midwives will enhance quality of care in the areas of reproductive, maternal, newborn and child health.

External Link

The Lancet Series on Midwifery can be found here: http://www.thelancet.com/series/midwifery

The Research Process

The research process has been widely described in the literature and may vary somewhat depending on the field of study. In general, it refers to a systematic approach to collecting information, sometimes called data, which is then analyzed to answer a question of interest. The research process is briefly described below.

In health sciences, questions are very often a narrow, clinical questions such as, 'When is the best time to place the umbilical cord clamp on a healthy term infant following birth?' Other questions of interest to clinicians may be broader types of research questions such as, 'How does interprofessional education during training affect working relationships among midwives and obstetricians?' or 'What do pregnant women understand about weight gain in pregnancy?' In the research process the development of the initial question is a very important step in the process, and it is then refined following a careful review of the

literature so that the question can be framed in terms of what is already known about the subject.

Once the question is formed and refined the most appropriate research method to answer the question must be determined. For example, a researcher might choose a randomized controlled trial to test a particular approach or an intervention in comparison to what is in current practice. Sometimes random assignment of an intervention is not possible, feasible or even ethical. In such cases, a cohort study design is an alternative approach that might be considered. In the case of determining opinions or beliefs about a topic qualitative methods may be appropriate. Once the method is settled upon, the study design is written up into a study protocol that will inform all the details of how the study will be carried out.

The next step is to collect data to answer the study question. This might involve recruiting and interviewing participants or administering questionnaires, for example. Another potential data source is data collected as part of population databases, like the Better Outcomes Registry & Network (BORN) database to which Ontario midwives contribute. To ensure accuracy of the data the dataset is cleaned and prepared by undertaking logic checks such as date of birth follows date of entry to care. The cleaned dataset can then be used for analysis and the results interpreted.

The final step in the research process is knowledge translation whereby new information is disseminated, usually in the form of a scientific manuscript, ideally published in a **peer reviewed**, or refereed journal. Information is also often shared at scientific conferences to research peers, and at conferences for practitioners when there is direct clinical application of the findings.

External Link

Visit the BORN website here: https://www.bornontario.ca/

Funding Research & Researchers

Obtaining grant funding is typically a highly completive process and in many respects shapes and limits the research that is undertaken. Thus, **grantsmanship** is an important skill to master for any midwife entering the research arena as a primary researcher. Much time is spent on applying for grants, many of which are not successful in the grant competition process. For midwives with academic positions, or other positions focusing on research, maintaining an up-to-date academic curriculum vitae

(CV) is essential. The CV is the credential used to move through the promotions process, but most importantly it is the document that provides reviewers of research grant proposals with information needed to evaluate research capacity – the ability to undertake the research being proposed to ensure the project under consideration for funding in is likely to be done, and done well. Research grant reviewers consider the researcher's:

- Educational background
- Awards of distinction received during academic training or research career
- Number and type of grants previously received
- Number of peer reviewed publications including those resulting from grants
- Number of first authored papers
- Publications by the quality of journal where the work is published
- Number of times the publications has been cited
- Presentations – peer reviewed, keynote invitational, oral, poster
- Presentation awards received
- Number of graduate students that have been supervised, awards those students obtained

Contributing to Research

Research has become increasingly sophisticated and typically requires specific expertise and outside funding to undertake.

Nonetheless, there are a variety of ways in which all midwives can contribute to scientific research endeavours.

Practitioners

Midwives practitioners are experts in the provision of maternal child care and have a major role to play as part of the research team. Research questions often arise from day-to-day practice, and although a midwife may not lead a research project, communicating an important question and working collaboratively on the development of a project to answer it can make a significant contribution to increasing knowledge in the field. During the development phase of a research protocol midwives can provide insight to ensure that the study design is suited to answer the research question being asked. They are best able to determine if the proposed methods for things, such as recruitment and implementation of the study protocol, are feasible in the practice setting. Midwives are also the primary route through which clients are recruited from the practice setting.

Many research questions can be answered using **population databases**. Midwifery databases have been used to answer very specific questions such as to determine the outcomes of planned home birth. The quality of the research in these cases depends entirely on the quality of data input at the midwifery practice level; thus midwives have a critical role in deriving these data. At the time of entry of data into population data sets, it may be difficult to justify the value of time spent on the activity, however, studies that have resulted from using these data have been essential in informing, maintaining, and enhancing choice for women regarding matters such as place of birth. (8,9)

External Link

An example of a data base study can be found here: http://pediatrics.aappublications.org/content/pediatrics/early/2014/09/17/peds.2014-1146.full.pdf

Mme du Coudray, who was introduced earlier in this chapter demonstrated that she understood the value of what we now call KT when she travelled widely with her teaching models to upgrade practitioners level of clinical knowledge. The role of KT is being increasingly recognized as an critical component of successful research. It has become a standard that research proposals include endorsements or partnerships with **knowledge users**. It is also increasingly common to have interprofessional research teams. Midwives can participate in research projects led by midwife researchers or by researchers from other professions or disciplines, contributing a midwifery perspective to every aspect of the research. Once new knowledge is gained, it will be of little or no use if practitioners do not use it. By working with their professional associations to develop clinical practice guidelines, or in their own practices to prepare practice protocols, midwives can contribute to knowledge translation. Midwives should also participate in presenting new information to colleagues and learners, for example at **hospital rounds**.

Research Team Members

When midwives generate a research question, they may play a key role as either a principal **investigator**, **co-investigator**, or a **co-applicant** on research project. Sometimes midwives have

particular expertise that they bring to the research question being asked, and may be invited to participate on a project on that basis. Alternatively, midwives with additional research training may wish to work in the capacity of salaried research assistants or coordinators. Research projects often require research assistants or research coordinators to help to manage the undertaking, and these positions can be funded by research grants. In some settings, such as Australia and the UK, staff midwifery research positions are available in hospitals or other organizations involved with health care. The role of the midwife researcher in these positions varies, but may include assisting with external research projects, initiating and running the daily operations of research projects, and knowledge translation for midwives and other interprofessional members of the obstetrical care teams.

Clinician Scientist

Clinician scientist is the term frequently used to describe those who both lead research endeavours and provide health care. The term 'scientist' is inclusive and refers not only those who are doing basic science, but to those doing epidemiological work, or using qualitative approaches; it includes social scientists, bio-scientists, and many others.

The division of time spent by clinician scientists in research and in clinical practice will depend on the funding arrangement that supports their salary. Typically, a clinician scientist focuses on health research or basic research as it applies to a medical field. However, such a scientist could have training in other specialties, such as sociology or anthropology, and make contributions to knowledge of care provision. Clinician scientists typically understand research questions relevant to clinical practice, and

can play a role in transferring findings from research bench-to-bedside, closing this breach with effective knowledge translation. Their contribution to the profession is key in ensuring generation of the knowledge needed for best clinical practice. Opportunities for midwifery clinical scientists are more common in the UK and Australia than in Canada at this time where such opportunities are rare. Professions such as medicine have well identified pathways to become a clinician scientist– in Canada, for example, there are two routes:

- The Royal College of Physicians and Surgeons approved doctor of medicine (MD)/ doctor of philosophy (PhD) degree program where the undergraduate MD and PhD programs are combined
- The Clinician Investigator Program where PhD studies are undertaken concurrent with the postgraduate medical education (residency). (10)

Usually a clinician scientist is prepared for research at the doctoral level in their area of specialty. A qualified midwife might have additional training in **health economics**, or in **clinical epidemiology**, or in **bioethics**, for example. Their research might specialize in studying clinical interventions (e.g. use of sterile water injections for pain management using methods such as randomized controlled trials) or using population databases to answer questions about health care utilization (e.g. comparing home and hospital birth outcomes). They may also use qualitative methods to explore a particular health topic (e.g. the needs of obese pregnant women or the experience of uninsured immigrant women seeking maternity care).

In the academic setting and within the research milieu, the expectation is that a researcher will build a 'body of research'.

This means that the research undertaken by a particular researcher will, over time, contribute to a growing understanding of a particular topic. That is, each small study builds to try to understand a particular phenomenon or problem of interest. In specialties like midwifery, this expectation that researchers build a 'program of research', such that researchers develop expertise in particular areas and build on the work in their area of study over their careers. This body of research is considered when research contributions are being evaluated for funding purposes or for tenure and promotion within the academic setting, so it is important that researchers understand the expectations of the system in order to increase the likelihood of career success.

Building Research Capacity

Challenges

Despite the examples of early midwife researchers given at the beginning of this chapter, in most settings, midwifery research has not developed alongside clinical practice. Evidence derived from research has become the expected underpinning for contemporary clinical practice, thus imposing on the profession a sense of urgency to generate knowledge. Research takes time to arrive at answers and the incongruence of a need for knowledge and the time required for knowledge generation can cause frustration.

Research is expensive to undertake and can be seen as using scarce resources without immediate benefit. (10) Lack of infrastructure support for midwifery researchers – including access to financial support during advanced research training; balancing research with other career demands; and absence of

research infrastructure for funding, publications and presentation of findings is also common. Perhaps as a result of these factors, development of research capacity is a challenge faced by the midwifery profession in many jurisdictions. (11) As a result, Canada currently has midwives who may do some research as part of academic work with teaching and practice but few who commit significant time to the research process as career research scientists. The profession needs to develop strategies to enhance the opportunities for growth of research generally, and particularly to address the shortage of midwifery clinician scientists.

Strategies

The role of a good mentor in the success of a researcher cannot be underestimated. The requirement for good mentoring begins in the early stages of acquiring additional research skills. Making careful choices around the educational program that is selected for

advanced degrees, with particular attention to the choice and role of supervisors during this process will pay off. Characteristics of a good mentor include one who will (12):

- Provide support in securing resources needed
- Provide opportunities to enhance learning, develop skills and gain experience
- Provide advice without expectations
- Protect the mentee in transiting academic pathways – either as learner or as new researcher

Relative to other professions, midwifery has proportionately fewer research scientists, and those entering the realm of research may find that they need to look outside of the midwifery profession for mentors. Although this might be viewed as a limitation, it can also be a potential strength. A mentor who is an expert researcher outside of midwifery may in fact be able to provide excellent, and unbiased mentoring.

Conclusion

Professions like midwifery often prioritize clinical practice as their core business to the extent that the needs of researchers are ignored. However, it is incumbent upon the profession to create midwifery specific knowledge, resulting in a professional obligation to support researchers undertaking this needed work. In order to continue to provide the best possible care to clients and their infants, the profession needs researchers who will think critically and creatively and undertake high quality research, in order to make meaningful changes to practice through the generation of new knowledge. Midwifery scientists have an essential contribution to make to the sustainability of the profession and it is contingent upon individual midwives, professional associations, regulatory agencies and funding bodies to support this important activity.

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Glossary

TERM	DEFINITION
Academic	Someone whose interests lie in the theory and concepts of academy of higher learning.
Affective domain	Development of feelings, attitudes, motivations, and values
Amygdala	A brain structure responsible for autonomic responses asso our emotions.
Assessment	A systematic process/procedure for collecting qualitative a performance against specified outcomes or competencies.
Avatar birth	An icon or figure that represents the user in a virtual space the virtual environment through the actions of the avatar. S can experience a birth as the labourer or support partner.
Basic	The knowledge and skills that would be expected of all mid
Binary ways of thinking	Classifying things using only two distinct, opposing catego (classifying gender strictly as either woman/man), or gay/s
Bioethics	The study of ethical and moral implications of health care p
Birth asphyxia	The result of a lack of oxygen to the baby before, during or products (acids) building up in the cells where they cause t
Birth attendant	An accredited health professional that is trained in the skil immediate postnatal period. (1)
Canadian Association of Midwives	Canada's national organization for midwives and midwife
Canadian Competencies for Midwives	A document that outlines the knowledge and skills that all to be able practice.
Clarification question	Questions that may sound like open questions but actually something or misunderstood something.
Clinical epidemiology	Epidemiology is the study of the distribution and determin and the application of this study to the control of health pr methods of epidemiology to problems arising from clinical

Clinical practice guidelines (CPGs)	Systematically developed recommendations for care in
Clinician scientist	Someone who has both a health professional degree an their work.
Closed question	Questions that can be answered by either a "yes" or "no
Co-applicant	A member of the research team, usually named on the such as analysis skills or access to the patient populatio
Co-investigator	Shares many of the responsibilities of the named Princi the steering committee – or management team.
Code of ethics	A set of practices that outline the values of a profession character of the profession. Members of the profession
Cognitive domain	Thinking/knowledge and development of intellectual sk procedural patterns and concepts that serve in the deve
Contemplative stage	A stage found in the Trans Theoretical Model of Chang change in their behaviour.
Continuing competence	The ongoing enhancement, integration and application to practice safely and ethically in a profession.
Co-parent	Any person who shares equally in the care of the child.
Cochrane review	Summarize primary research findings and are internati
Coping question	Questions about how the client has coped with the prob
Cortisol	A steroid hormone produced by the adrenal gland. Regu immunosuppressant. When under stress, blood levels o especially when used as a medication.
Culture	Beliefs, values, and behaviours that are shared and lear setting. Culture can also be transmitted or learned throu
Discipline	An area of study.

Discrimination	Unjust or prejudicial actions or decisions that treat a perso gender, race, age, or disability.
Electronic fetal heart monitoring (EFM)	A monitoring device used to graph fetal heart activity for t labour. During labour the heart rate is reported in conjunct
Embodied learning	A method of teaching where a learner uses their body's se
Episiotomy	A surgical incision of the perineum.
Epistemological	A philosophical term for the study and theory of knowledg
Equity	The absence of unfair and avoidable or remediable differen process and a goal. It involves the recognition of difference people differently in order to achieve equality.
Ethnicity	Groups with common national or cultural characteristics a traditions, values, or beliefs. Ethnicity may be dynamic, cha environment.
Exception finding questions	Questions that enhance existing and past successes
Exploration questions	Questions that explore the client's previous attempts to sol
Fight or Flight mode	A common reaction in people who are facing a sudden and to fight off the danger or to run away from the danger.
First Nations	In Canada, also known as Status and non-Status Indians. In in Canada and 617 First Nation communities across the cou Aboriginal languages.
Flashbulb memory	A highly detailed, vivid 'snapshot' of the moment in which
Formal communication	Part of a formative or summative written assessment or cli
Formative assessment	A range of formal and informal assessment procedures, inc learning process in order to modify teaching and learning a

Grantsmanship	The art of obtaining grants-in-aid of research; the skill o
Harsh parenting	A maladaptive behaviour that is characterized by or ma directed at the child. (25)
Health economics	The study of how scarce resources are allocated among maintenance, and improvement of health, including the and benefits, and health itself are distributed among ind
Health inequity	Inequalities in health that stem from some form of discr
Hidden participant	Specialists such as academics, interest groups, civil serv relevant to the issue and may suggest solutions or alter
Hierarchy of evidence	Systems which guide the evaluation of evidence used in evidence considered to be most reliable and scientific at
Hippocampus	An organ in the temporal lobes of the brain that holds c automatically, e.g. riding a bicycle, reading, managing m senses, such as smell and sound, with certain memories
Historical institutionalism	A social science method that uses a comparative approa institutions to find sequences of social, political, econon case studies.
Hospital rounds	A type of medical education where topics of clinical rel midwives, obstetricians, family physicians and their lea the presentation of a particular patient, and often the pa typically research findings or clinical management that
Hypothalamus-pituitary-adrenal axis	The interactions between the hypothalamus, pituitary g system that controls reactions to stress. This system als energy usage.
Indigenous People	Similar in meaning to Aboriginal Peoples, Native Peopl its Decade of the World's Indigenous People. Indigenou Aboriginal people internationally.
Inequitable	Unfair and avoidable differences in key indicators amon
Informal communication	In day-to-day encounters with lecturer/mentor; peers a
Informed-choice agenda	Providing information to clients so that they can make over their own care.

Insensitive parenting	A failure to respond to the child's needs appropriately; e.g. handling or not expressing affection.
Intersectionality	The notion that differences are not additive, but the interac effect.
International Confederation of Midwives	A non-governmental organization that represents and pron also establishes global standards and competencies for mid
Inuit	Aboriginal people largely inhabiting the northern regions o people in Canada, the majority living in 53 communities in Nunatsiavut (Labrador) Nunavik (Quebec); Nunavut; and In of these four Inuit groups has settled land claims that toget
Investigator	Also known as the Principal investigator (PI) – the lead res through a university.
Knowledge translation	The activity involved in moving knowledge or findings der
Knowledge users	An individual or group of individuals who will use researcl
Learning communities	A group of learners that are eager to share their knowledge done by meeting in person or online to discuss and collabo
Learning style	Ways in which an individual learns (e.g. visual learner, kina learning styles, although one learning style may be domina different situations.
Likert scale	A scale measuring the degree to which people agree or disa
Logic model	A tool to evaluate the effectiveness of a programme both du
Meta-analysis	A method which combines data from multiple studies to dr
Métis	Aboriginal people who trace their descent to mixed First N who identified in the 2011 National Household Survey, alm

Microbiome	The microorganisms that populate the body or a part of
Mindfulness	Paying attention to the present moment – to your own parenting, mindfulness involves paying attention to the
Motherese	The way in which mothers (and adults in general) talk t song tone, simple sentence construction and repetition.
Motivational interviewing	Using specific questions to tap into the client's intrinsic reluctance or ambivalence to change, set clear goals, an style of counselling to engage a client who wants to ma making a change.
Multiculturalism	Equal respect for all cultures.
Multiparous	Someone who has previously given birth.
Normative	Creating, establishing, or conforming to, a standard. In that something that does not match can be deemed 'abn
Nulliparous	Not yet having delivered a child. Nulliparous clients ma never had a pregnancy of any outcome.
Open questions	Questions that invite the answerer to open up or explor you…" and "How did you…".
Paradigm shift	A total and complete change in the way things are done revolutionary change that completely replaces the old w
Paraphrasing	Rewording the client's statement using your own words
Passive information	Information that is available for the client to access on t
Path dependence	Describes how the decision options one faces for any gi even though past circumstances may no longer be relev to a process. May be phrased in common parlance as, 'h
Peer reviewed	A journal that includes only papers that have undergon field.

Person-centred practice	A method of counselling that places the client in the driver counsellor is expected to observe and understand the client most importantly, their strengths and resources. This obser helping relationship through the use of PANG skills.
Personal power	Influence over others, the source of which resides in the pe
Phocomelia	Congenital malformation of the limbs, but may include the
Policies	Rules, principles, or guidelines that are adopted to help ach
Policy entrepreneurs	A highly influential participant that invests much of their c self-serving items, and have the ability to push items highe
Policy legacies	Policy legacies refer to the lasting effects of decisions. Past
Policymaking	The formulation or creation of policies.
Population-based study	Examines outcomes in a population that shares a common representative, or include all, of the defined population.
Population databases	A dataset that includes standardized information collected report on incidence and prevalence of outcomes or conditio the population. They can provide estimates for survival out of new interventions. These data sets can also inform chang
Post-traumatic stress disorder (PTSD)	A mental illness that often results from exposure to trauma serious injury to one's own person, or others. It may also b Common symptoms include flashbacks to the traumatic ev detachment.
Postpartum hemorrhage	Blood loss exceeding the normal amount. For vaginal birth
Praxis	Practice, as distinguished from theory. In this context, the c
Precontemplative stage	A stage found in the Trans Theoretical Model of Change. T change in their behaviour.
Professionalism	An essential set of attitudes and behaviours expected throu

Prolactin	A hormone produced by the pituitary gland that enable
Psychomotor domain	Manual tasks that require development of coordination develop precision, accuracy and efficiency.
Psychoprophylaxis	A method of preparing women to labour without pharm physical conditioning, and breathing exercises.
Race	A socially constructed category of identity based on ph ideology that places humans in a hierarchy of social val
Randomized controlled trial (RCT)	A trial design which aims to minimize bias. Participants receive the intervention/treatment or the 'control group The outcomes of the groups are then compared.
Reflective functioning	The capacity to understand behaviour in light of a perso
Reflective listening	Developed by Carl Rogers, this communication strategy back to the speaker in order to confirm that it has been centred approach to counselling.
Reflective practice	Critically evaluating the care that you are providing an
Reflexive	A qualitative research term that contributes to trustwor bias.
Regulations	A form of law that describes how an act will be implem and any penalties).
Reinscribes	Re-establish a particular context.
Relationship questions	The care-provider asks the client what a friend, partner, thinking, or behaviour.
Reliable	The degree to which an assessment tool produces stable
Representation	A portrayal or depiction of something (a person or expe
Righting reflex	The tendency to advise clients about the right path for g noncommittal about change, this approach often just re

Sage-femme	'Wise woman' in the French language, and the French Can
Scaling questions	Questions that allow the client to describe the problem qua
Scepticism	A method of suspended judgment and systematic doubt.
Scholar	A specialist in their area of study; one who studies in a spe
Self-reflexivity	The ability to reflect and consider who one is in relation to
Self-regulated	A profession or occupational group that is able to set the st set by the government.
Situatedness	Meaning and/or identity that is dependent on the specifics etc.).
Social justice	Fair and equal distribution of wealth, opportunities, and pr tax laws, labour laws, sexism, ableism, racism, ageism, hom
Social markers	Individual attributes such as race, class, nationality and ger
Social research methods	Involve both qualitative and quantitative approaches to ans such as political science, sociology, media studies, program
Solution-focused therapy model	A goal-oriented approach that assumes that all clients knov that life and take steps toward it. Counselling then focuses
Statute	An act or law passed by a legislature or parliament.
Summarize	Pulling related statements together into a cohesive stateme
Summative assessment	An evaluation of student learning, skill acquisition and aca period.
Sympathetic nervous system	A part of the nervous system that serves to accelerate the h sympathetic nervous system and the parasympathetic nerv
Synthetic oxytocin	Used in obstetrics to induce or accelerate labour. Pitocin an oxytocin.
Systematic bias	Systematic error in research when sampling or testing enco

Systematic review	A structured literature review that identifies, selects an quality systematic review identifies all potentially relev based on the quality of the research. It presents a summ the limitations of the evidence.
Targeted services	Parent education programs for mothers and fathers wh such as addiction, domestic violence, poverty or crimin
Teachable moment	A time or period in people's lives – often a period of tra particular topic or acquire particular skills
Theory of change	Makes explicit how the program activities will lead to t
Transtheoretical model of behavioural changes	Also known as the 'stages of change', this method of co work through the six stages of change: precontemplatio termination.
Universalism	The idea that the same ethics apply to all people of all c
Validity	The extent to which an assessment accurately measures
Visible participant	Heads of state and other individuals occupying highly v issues, solutions, or viewpoints.
White Ribbon Alliance	An international non-profit that campaigns for and pro safe and healthy environments.

Activities for Transition to Parenthood Sessions

Mary Nolan, PhD MA BA RGN

The following are examples of activities that might be used in transition to parenthood sessions to build group members' capacity to have the labour they want to have and to be the best parents or co-parents they can be. All the activities are underpinned by the recognition that adult learners are not 'blank slates'; they have had many experiences in their lives, and acquired a great deal of information, that can be transferred to the new experience of becoming a parent or co-parent for the first time, or for a subsequent time.

Recognizing and Valuing People's Strengths as Parents

Aim: To give group members confidence that they already have skills and qualities that will help them when they become parents/co-parents.

Learning Outcomes: Having participated in this activity, group members will be able to:

- Acknowledge their strengths as individuals and as parents or co-parents
- Describe the qualities of a 'good' parent
- Identify what babies need in order to thrive physically, socially and emotionally

Activity: Ask each person in the group to say (to the group or the person next to them), or to write down, something they feel they are good at in life or a positive quality that they have. Give examples to guide the process e.g. 'I'm an organized person'; 'I have a good sense of fun'.

Participants' ideas may include:

- Good at managing on very little money
- Good at my job
- Good at helping my friends when they're having problems
- Good at planning events
- Love meeting new people
- Like learning
- Easy to be with
- Have lots of experience
  because I'm part of a lar
- Always do what I say I'l
- Have lots of energy

Ask the group how these skills and qualities will help them as a parent. This should start a discussion on what makes a good parent and what babies really need to be happy and healthy.

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Building on what Group Members Already Know: A Model for Information Sharing

The following is an example of how to elicit and build on what the group members already know about a particular topic. Imagine that the topic for the transition to parenthood session today is labour. The midwife starts by drawing out what group members have been told about labour by friends and family members. S/he then validates the experiences that have been shared and emphasizes key learning, namely that it's quite normal to be

uncertain about whether labour has started. S/he adds a little more information to what has already been shared and moves on to exploring group members' anticipated feelings about the start of labour. After allowing some time for discussion, s/he moves the group on to consider when they would want to go to hospital or the birth centre. This is always a key concern of the people who are going to be supporting the mothers during labour. S/he then offers a few minutes for the pregnant woman and whoever has come with her to the session to share their private views on when is best to go to hospital. Finally, the midwife signposts group members to further information if they want it.

So the model is:

- Draw out what group members already know on the topic.
- Validate correct information and acknowledge every experience of labour that has been shared (nobody's experiences are 'wrong' although they may be unusual).
- Add more information if needed (remembering that adult learners want information on a 'need to know' basis and do not want to be overloaded with facts).
- Facilitate discussion of feelings.
- Ask key questions (and wait for answers; avoid providing them yourself).
- Provide an opportunity for private discussion between the pregnant woman and her companion.

Aims: To strengthen the pregnant women's and their birth companions' belief in women's innate understanding of labour and birth and to enhance communication between the pregnant woman and her birth companion.

Learning Outcomes: Having participated in this activity, group members will be able to:

- Describe the signs of labour
- Understand that early labour may be a period of uncertainty for the pregnant woman and her companion
- State when they anticipate going into hospital/attending the birth centre/calling the midwife (if they are having a home birth)

Example: The discussion might run like this:

Midwife	What have your friends told you about how labour starts? Or what has your mother told you happened when you were born?
Group member #1	My friend said they weren't really sure whether this was 'it'; that it just felt like period pains.
Group member #2	My sister was having contractions for hours and hours but the midwife wouldn't admit her to the hospital.
Group member #3	I think my mother said her waters broke and she had a bloody show?
Midwife	Well, everything you've mentioned is right. And especially the comment about not being sure whether labour's begun; that's a very common experience. Often the mother has mild pains low in her tummy or in her back at the start of labour and these can last a long time, although some people go into strong labour very quickly. And, yes, some women have a show and for some, the start of labour is their waters breaking.How will you feel when you think that labour has started?
	Encourage class discussion
Midwife	And when do you want to go to the birth centre? As early as possible or as late as possible?
	Encourage class discussion
Midwife	Just take two minutes now to share your feelings with your companion about when to go to the birth centre or hospital. It will be helpful to understand how you each feel when the big day actually comes.

Small group work in couples (i.e. the pregnant woman and whoever has come with her to the session)

Midwife	Thank you. There's lots more information on the internet about how labour starts. I've got a list of reliable websites that I'll give you at the end of the session. Let's move on now to what happens later on in labour.

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Who Does What?

Aim: To strengthen the relationship of the two people who are going to look after the baby by anticipating sources of conflict following the birth

Learning Outcomes: Having participated in this activity, each couple will be able to decide how they will manage household and baby care tasks after the baby is born

Activity: Give each pregnant woman a pack of cards which includes three header cards:

- I will do this
- You will do this
- We will both do this

On the other cards are pictures of everyday activities such as doing the washing up, shopping, cleaning the bathroom, changing the baby, feeding the baby, playing with the baby, paying bills, etc. The pregnant woman and companion are then invited to place each activity card under one of the three header cards.

There is no right or wrong way of sorting the cards. The value of the activity lies in the discussion that the pregnant woman has with their non-pregnant partner or companion about managing their lives after the baby is born.

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Helping Group Members Think about Support in Labour and the Physical Environment

The following is an activity that will appeal to group members who are strongly visual learners. This doesn't mean that the activity won't also appeal to other group members who might be primarily auditory or kinetic learners. Everyone can and does learn visually, and as long as you are providing a range of activities, you will be catering for everyone in your group.

Aim: To support the pregnant women and their birth companions to make decisions about the environment of labour and what kind of support the women want and their companions can provide

Learning Outcomes: Having participated in this activity, group members will be able to:

- Describe the physical environment of the labour room in a hospital or birth centre, and strategies for making it as comfortable and relaxing as possible for the labouring woman and her birth companion
- Identify a range of positions, upright and reclining, which a labouring woman might find helpful and which will make her labour as efficient as possible
- Identify the kind of support that birth companions might offer

Activity: Lay out a series of realistic pictures of labour that

include the labourer and birth companions. Ask the group to discuss their responses to each picture. Use prompts to get people talking:

- What strikes you about this picture?
- Have you thought about labouring in this position?
- How is this mother being supported?
- How could the labourer and companion make themselves comfortable in this room? What comfort items could they bring from home or ask the midwife to get for them?

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What Kind of Parent do I Want to Be?

Aim: To promote sensitive parenting

Learning Outcomes: Having participated in this activity, group members will be able to:

- Identify parental behaviours that enable babies and young children to flourish physically, socially and emotionally
- Identify parental behaviours that might undermine very young children's trust and self-esteem
- Identify the everyday stresses that parents face, such as tiredness, that can contribute to insensitive behaviour towards their babies and small children
- List sources of support for parents, such as family members and friends, health and social care

professionals, parent and baby groups, infant feeding groups, postnatal exercise sessions etc.

Activity: If the group is large, split it into smaller groups of about four people. Ask each group to share examples of when they have seen parents behaving well, that is, demonstrating what the group members each consider to be excellent parenting. If the group includes someone who is confident to write, ask them to write down the group's ideas.

After about five minutes, ask the groups to discuss examples of when they have seen insensitive parenting.

Then ask the small groups to reform as a single group and invite them to share their ideas about what constitutes sensitive parenting and what kind of parenting might be harmful to babies and small children. Discuss why parents might sometimes not be the great parents they would like to be. You could lead the discussion towards addressing the stresses that new parents face and where they can find support.

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Bathing the Baby

Aims: To build the confidence of parents-to-be that they will be able to care for their baby. To develop an appreciation that providing physical care to a baby is also an opportunity for interaction with the infant.

Learning Outcomes: Having participated in this activity, group members will be able to:

- Undress, safely bath and dress a baby

- Identify items of baby equipment commonly sold in shops that are not suitable for use with babies
- Understand the importance of talking to their baby

Activity: If possible, provide every couple in the group with a doll dressed in a diaper, vest and snap onesie and with towels and cotton wool balls. You need the same.

Start by laying out items that are often used when bathing and changing babies such as baby soap, baby shampoo, talcum powder, ear buds (cotton swabs e.g. Q-tips®), bath support, nappy/diaper cream, etc. Ask the group which items they think are essential when bathing a baby. Without making anyone feel foolish, explain that none of these is essential and some can be harmful, such as talcum powder and ear buds , and offer to show the group how to bath a baby safely and effectively.

Demonstrate how to undress, bath and re-dress a baby. Invite all the group members to work alongside you so that as you do something, they are copying you. Encourage questions. Emphasize how important it is to talk to the baby as s/he is being bathed as this is a wonderful time for interaction.

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Breathing through Contractions

Aim: To boost group members' confidence that they have resources for coping with the intensity of contractions.

Learning Outcomes: Having participated in this activity, group members will be able to:

- Use their breathing to control stress and remain as relaxed as possible during contractions
- Understand how to support a labouring woman to breathe well during contractions
- Appreciate how long a mid first-stage contraction might be

Activity: If possible, have a candle available to light. Then demonstrate taking a calm in-breath and breathing out gently through the mouth so as to make the candle flame flicker. Invite group members to close their eyes and practise similar breathing with a slow intake of breath and gentle out breath through the mouth. Ask them to keep the candle flame in mind and to imagine making it flicker but not extinguishing it as they breathe out.

Ask group members how this felt.

Then invite them to practise again, and on this occasion, time 40 seconds (or 30 or 60) to give them an idea of what breathing in this way through an average length contraction (mid first stage) might be like.

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A Script for Practising Relaxation

Aim: To nurture a healthy pregnancy

Learning Outcomes: Having participated in this activity, group members will be able to:

- Understand how their bodies feel when their muscles are tense and when they are relaxed

- Practise relaxation as a pregnancy and parenting strategy for maintaining physical and mental health

Example: The following script for practising relaxation in a transition to parenthood class appears courtesy of the author from her own publication (cited below). Note the deliberate use of both 'he' and 'she' in this script.

> Shut your eyes if you want to. I am looking down and not watching any of you. I won't look up until the end of the session. If you don't want to close your eyes, that's fine. If your eyes start to feel heavy at any point, let them gently close.
>
> Become aware of your own breathing. The in-breath and the out-breath. Your breathing is rhythmical. If your attention wanders away from your breathing, bring it gently back to your in-breath and your out-breath.
>
> Now, every time you breathe out, imagine that your breath is carrying away all your tension.
>
> Think about your legs and as you breathe out, let your legs feel heavy, your feet firmly in contact with the ground, and your thighs rolled slightly apart.
>
> Think about your tummy. There's no need to hold it in tightly. As you breathe out, feel your tummy relaxing.
>
> Think about your hands and arms. So much tension can accumulate in your hands. As you breathe out, let your fingers become gently curled; even your thumbs are slightly curved, and your elbows are resting against your body.
>
> Think about your shoulders. As you breathe out, let your shoulders sink downwards, so that they feel loose and easy.

And finally, think about your face. You have lots of muscles that work your face but now, as you breathe out, let the expression on your face slip away so that your forehead is smooth, your jaw loose and your mouth perhaps slightly open.

Spend a moment appreciating how your body feels when it is truly at ease. If any part feels tense, use your out breath to cleanse the tension, letting it slip away as you breathe out.

Now you have time to think about your unborn baby. Your baby is warm inside the mother. He or she is hearing sounds which have become very familiar – mother's heartbeat; mother's and father's voices; perhaps the voices of other family members who have been around during the pregnancy; the sound of blood flowing through the placenta.

Your baby is cuddled by the walls of the womb – when he stretches out his arms, he feels the soft contours of his mother's body. When he is born, he will be surprised by the space around him and will be soothed by being held close to you.

Your baby is fed on demand while she is inside. Her food is brought to her and all the waste products are taken effortlessly away. She will be in a very strange new world when she's born and has to ask for food and tell you when she's uncomfortable. Feeding her and changing her will soothe her.

Your baby is uniquely your special child. He knows the two of you and has a relationship with you that no-one else can have in quite the same way.

When he is born, he will be content when you offer him the warmth and the holding that he has experienced

in the womb, and when he hears the sounds that he has become familiar with inside his mother. So hold him close to your heart, talk to him, and keep him close to you.

Enjoy a few moments now with your baby……..

Become aware once more of your breathing: the in-breath and the long out-breath. Count through three cycles and then open your eyes and come back into the room.

Nolan, M. Education for calm pregnancy. International Journal of Birth and Parent Education. 2015 2(4):5

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Cesarean Mock-up

Aim: To protect the mental health of clients who need a cesarean, and of their companions, by enabling them to anticipate the physical environment of the theatre and the emotions they might feel

Learning Outcomes: Having participated in this activity, group members will be able to:

- Understand the range of feelings that mothers and their birth companions might experience if the baby needs to be born by cesarean
- Identify the medical and para-medical staff who will be present at a caesarean operation
- Describe the environment of the theatre and the cesarean procedure

- Anticipate their feelings (whether the mother or the birth companion) before and during the operation
- Describe how a baby born by caesarean can be welcomed into the world
- List the support a mother who has given birth by caesarean might need when she returns home

Activity: Introduce the activity by explaining that some babies will need help to be born and that surgery has a part to play in keeping birth safe. Ask the group if they would like to learn what happens during a cesarean.

Invite one of the pregnant group members to spend five minutes sitting with her feet up, to role play being the client undergoing the cesarean. We suggest using a different name for the client during this role play – this prevents the volunteer from feeling that by assuming the role of someone having a cesarean, they will have one themself. (REF)

Ask the group who will be present in the theatre with the client. As group members name members of the surgical team (e.g. the surgeon; theatre nurse; scrub nurse; operating department practitioner; student; paediatrician) invite them to take up their position around the client.

Draw attention to the number of people present for the operation. Ask the client playing the patient and the person playing her partner how this might make them feel.

Then talk through the operation, inviting the group to consider:

- What they might see, hear, smell in theatre
- How long it will be until the baby is born
- What happens to the baby at birth
- How the baby can be welcomed into the world

- How long it takes to stitch the mother's wound etc.

At the end of the activity, start a discussion about how people might feel if their baby needed to be born by cesarean. (Relieved? Disappointed? A failure?) Ask them to think about what support a client who has given birth by cesarean might need when she comes home.

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Building Mental Health by Helping the Group Develop a Supportive Network (How to use Ice Breakers)

Aim: To build social networks among group participants and enable them to consider their own attitudes and ideas in the light of those of other people.

Learning Outcome: Having participated in this activity, group members will:

- Know some of the people in the group better

And will be able to do at least one of the following:

- Describe several easy-to-prepare healthy snacks for themselves
- List Parent and Baby groups that they could attend for support
- Identify characteristics of a 'good parent'

- Acknowledge some of their worries about becoming a parent

Activity: Split the group into smaller groups. Ask the small groups to remind each other of their names. Then give each one a slip of paper with a question or discussion topic, such as:

- Can you think of a healthy meal you could prepare in ten minutes while your baby is having a nap?
- Do you know of any parent and baby groups close to where you live?
- What do you think makes a good parent?
- What one thing worries you most about becoming a parent?

You may choose to ask each group to share their ideas, or it may seem better to let the discussions remain private and not share them in the large group. Be guided by how much time you have and whether it would be helpful for group members to share their ideas.

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Ensuring that New Learning is Retained so that it can be Drawn Upon When Group Members Need it: Recap

Aim: To consolidate the learning that has been achieved during the session, thereby making it more likely that it will be remembered when needed.

Learning Outcome: Having participated in this activity, group members will be able to:

- Identify key learning that they have achieved, whether facts, skills or ideas, that will influence their birth and parenting

Activity: Ask group members to close their eyes for a moment and to take a couple of deep breaths to calm the mind and body. Very briefly, list the topics that have been covered during the session. Ask group members to identify something they've learned. Then ask everyone to open their eyes and invite each person to share what they've learned.

(This activity will tell you a lot about the learning that has taken place during the session. Listen carefully for what group members have remembered and appear to have found relevant and useful, but also note the topics that were covered during the session which no-one mentions. You might want to think again about these topics and how you are facilitating them to ensure that the intended learning outcomes are being achieved.)

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Reflection – Transition to Parenthood Session

There are all kinds of formal ways of evaluating a transition to parenthood session. You might ask group members to fill in a questionnaire at the end of each session, or at the end of the programme. You might follow them up after their babies have been born and find out whether the transition to parenthood

programme was helpful to them during labour and in the first weeks of their new baby's life.

You also need to take a few moments after each session to question yourself about the effectiveness of the session. The following questions provide a framework for constructive reflection.

What happened during the session?	**What were you thinking and feeling during the session?**
• What did you and the parents do during the session? • Did you do most of the talking, or did the group members? • Was there plenty of movement? • Was there a range of learning opportunities to appeal to group members with different learning styles?	• Did you feel confident throughout? Or nervous? Or even frightened? • Were you affected by parents' stories and/or emotions? • Were you able to remain in the moment and immerse yourself in each activity/discussion, or were you constantly thinking ahead to what you would say or do next?

What was good and bad about the session?

Good	Not so good
• Parents were involved throughout the session. • They interacted with you and with each other. • Their body language and comments suggested that they were enjoying the session.	• You did most of the talking and the group members did not contribute much. • It was hard to get them involved in activities. • Group members' body language and comments suggested that they were bored and disengaged. • The session over-ran and there was no time for a break in the middle.

What sense can you make of the good and not so good aspects of the session?

- Was it a *good* session because you were well prepared? Because you had a colleague to support you? Because the parents were attending a second session and already knew each other a little?
- Was it a *poor* session because you weren't properly prepared? Because you didn't understand the agenda for the session? Because you arrived late? Because it was a new group of parents? Because you gave too much information and didn't explore the group members' ideas and feelings? Because the topics covered didn't seem to be of interest and relevance to the group members?

What could you do to ensure that the next session is more

effective in terms of helping group members engage and learn about becoming a parent?

- Be better prepared?
- Be clear about what you want the group to learn, to discuss and to practise?
- Allow more time for ice breakers to help people get to know each other?
- Avoid standing all the time, but sit down and be part of the group?
- Invite more contributions from the group members?
- Use more small group work to help shy people share their ideas?
- Identify the key points you want to make on each topic to avoid information overload?
- Facilitate practical skills work with more confidence?
- Manage the timing of the session better so that group members can have a mid-way break and still finish the session on time?

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Jenna Robertson, MA, RM

Case Study: History Taking

You are meeting Edie for her history and physical appointment. She arrives to the appointment alone. She is a 32 year-old G1P0 and she presents as a cisgender, femme woman. The first section of the Ontario Perinatal Record asks for information about the pregnant person's partner.

Question 1

How can you greet Edie and ask her questions about her partner in a way that is in inclusive of 2SLGBTQI folks and also acknowledges that not every pregnant person has a partner?

"Hi Edie, welcome to our clinic. I'm going to be asking you a lot of questions today as we go through your history. Can I start by asking if you have a partner in this pregnancy?"

By asking "do you have a partner" instead of "what is your partner's name," the midwife is leaving space for clients who are un-partnered during pregnancy.

Edie answers that yes she has a partner.

Question 2

How do you ask questions about Edie's partner without making any assumptions about the partner's gender?

"What is their name?" Using they/their pronouns to ask about

a client's partner until the client has identified the gender of their partner allows space for the client to name their partner's gender without asking direct questions. Once the client names their partner, the midwife can refer to the partner by name only, avoiding pronouns until the client names the partner's gender.

Example Dialogue	
Midwife	What is your partner's name?
Edie	Viviane
Midwife	And what does Viviane do for work?
Edie	She is a teacher.
Midwife	And how old is she?
Edie	She's 34.
Midwife	And is Viviane your only partner at this time?

Once the client names her partner's gender the midwife can mirror the language the client is using to refer to her partner. Asking follow-up questions about other partners can start to open the conversation toward sexual orientation and also avoids assumptions that pregnant people are monogamous and acknowledges the existence of poly relationships.

Sexual Orientation: The new version of the Ontario Perinatal Record (OPR) has space to ask about sexual orientation. Learning about a client's sexual orientation is important in addition to gaining information about the client's current partner. Many queer or bi women present in pregnancy in relationships with cis men. Without careful history taking their queer identity may be erased during their time in midwifery care. This erasure may lead to feelings of anxiety or depression. Midwives should avoid the

assumption that clients are heterosexual, even when they present to care in heterosexual relationships. Questions like "is Viviane your only sexual partner at this time?" and follow-up questions about sexual history like, "Do you know what the term 'sexual orientation' means?" "Can you tell me about how you identify your sexual orientation?" "Can you tell me if you have had sexual relationships with men, women, or both?" can help the midwife to establish an accurate sexual history. Note that many people will identify as straight when asked even if they have had/are having same-sex relationships, so asking varied questions, and asking specifically about sexual history and not just sexual orientation is important.

Gender Identity: Unfortunately neither the new nor the old OPR has space for noting the gender identity of clients or their partner(s). However, midwives can be attentive to using gender-neutral language, mimicking the language and pronouns used by clients and their partners, and asking direct questions about gender identity. Midwives should avoid the assumption that midwifery clients and their partners are cisgender.

Question 3

How can you ask questions about how the pregnancy was conceived without making any assumptions about the origin of the gametes?

Questions like: "Did you use any fertility treatments to conceive this pregnancy," can get the conversation started for 2SLGBTQI clients and for straight clients alike, but if no fertility treatments were used then the midwife will need to keep asking open-ended questions in order to elicit a complete history.

Example Dialogue

Midwife	Did you use any fertility treatments to conceive this pregnancy?
Edie	No, well…doctors weren't involved.
Midwife	Can you tell me more about that?
Edie	Well we just inseminated at home.
Midwife	Using donor sperm?
Edie	No, my partner had sperm saved from before her transition.
Midwife	I see. And so just to clarify so that I ask the right questions about family history, this pregnancy involves your egg and Vivane's sperm?
Edia	That's correct.
Midwife	Ok, thanks for taking the time to explain. Since I'm going to be asking some questions about family history, it's important for me to know those details so that I can ask the right questions and get accurate information to help me in caring for your family. Is there anything else you would like me to know right now related to family history before we continue?

External Link

Families are coming to midwifery clinics in all kinds of shapes and sizes. Midwives in Ontario should be familiar with the Bill 137, also known as "Cy & Ruby's Law": http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=3554

Midwives should avoid assumptions about the gender of the people sitting in their clinic rooms and even avoid assumptions

about which partner is the pregnant client. A couple may present as a straight, cis appearing couple, but the couple may include a trans man who is the pregnant client and not his cis, female partner. History taking that uses inclusive, open-ended language benefits all clients (cis & trans, queer and straight) because an open-ended approach to history taking leaves space for all clients to honestly share their stories so that as care providers, midwives get the most complete and most accurate information and also begin to build trust with clients from the first clinical encounter.

Case Study: Intimate Partner Violence

Rebecca Plett, PhD

Sarah is having her first baby. She's in her early 20s, and recently married: her parents and in-laws spent a lot of money on a lavish church wedding and honeymoon. On her wedding day, Sarah paused on her way into the church, her arm linked in her father's, feeling a dread in her gut that she was making the wrong decision in marrying this man but currently saw no way out; few narratives had shown her a life other than marriage to a man and children.

Several years earlier, after high school, Sarah got a job at a factory. There she noticed a young man paying particular attention to her, someone known around the factory as a nice guy, and she decided to go on a date with him, not having had any previous romantic encounters. The date started off well, and after dinner and a movie, he offered to drive her home. Instead of taking her straight there, however, he took Sarah to a secluded area and demanded she have sex with him. When she said no, he did anyway, forcibly. After a derogatory comment about her loss of virginity, he dropped her off at her parent's home. Feeling overwhelmingly ashamed and shocked, Sarah took a bath and contemplated taking a bottle of pills. The next day, she told her mother what happened, and her mother, fearing her daughter be labelled as promiscuous, urged that Sarah marry him and make the best of the situation.

Caring deeply about her family's approval, Sarah got married despite a sense of dread. She became pregnant shortly after her wedding, and her husband also began hitting her around this

time. Feeling an overwhelming instinct to protect her child, Sarah did everything in her power to placate her husband, including enabling his drinking to the point he would pass out and would no longer be a threat. Throughout her pregnancy, her husband became increasingly violent, though he avoided causing visible evidence, and became obsessed with the possibility that this wasn't his child, and that Sarah had cheated on him.

Of course, you don't know any of this when you meet Sarah for the first time. What you do notice is that she has a slight bruise around her wrist, and her husband hasn't come to any appointments: a fact that Sarah defends with vigour. You begin to suspect she might not be safe, and are also concerned for what may transpire when the baby comes.

Question 1

What are some of your options in seeing Sarah through her pregnancy and labour with care?

a) During one of your appointments, you could confront Sarah directly and tell her she needs to leave her husband.

b) You could call the police, or the local child-and-family services (at this point, there are no children involved).

c) You could build trust with Sarah for a few appointments by supporting her and being positive about her.

d) Be indirect in offering resources and support services

While you may feel a sense of urgency in assuring Sarah and her child's safety, answers a) and b) have the potential to make matters worse for her. Here are a few things to keep in mind when

caring for a client who appears to be in a situation of partner violence:

1. Clients with abusive partners may experience the most abuse during the pregnancy and postpartum periods (Moore 1999);
Expectant fatherhood can arouse feelings of fear and insecurity in the father-to-be about his own role in parenting, especially if he faced abuse from his own father. These feelings can manifest through control and abuse of partners. In Sarah's case, her husband was abused by his father.
2. Often, abusive partners maintain control through emotional and psychological violence, making it less visible.
Sarah's husband, for instance, has repeated told her she is "ruined" for any other man, and that he is the only one who will "put up" with her. Because of this, Sarah feels the unbearable tension of being afraid of leaving, and ashamed that she stays.
3. Direct confrontation – saying "you need to leave right now," for instance – can potentially increase danger.
Sometimes criticism of abusive partners can lead to the client becoming defensive of their partner and their situation, particularly if the direction makes them feel ashamed of staying in a situation they know is dangerous, but can't yet leave.
4. Depending on the situation, some abusers exert

control by requiring their partners to report every interaction with every person they encounter.

For instance, after a midwifery appointment, the client may feel they need to report what was discussed, and if the midwife recommended leaving, this may lead to anger by the abusive partner that puts the client in significant danger. In addition, further controls may be put on the client (like not being able to go out at all), narrowing their scope of support.

5. Leaving a violent relationship is not simple, and a safety plan needs to be in place before someone may decide leaving is better than staying (Macy et al. 2009).

These plans can include securing a safe place to go, like a relative's house or shelter; keeping important documents in a hidden location; memorizing emergency numbers, and assuring financial security. Sarah's husband controls their bank accounts, but she has been reserving small amounts of cash when he asks her to take out money for his trips to the bar.

6. Violence often leads to chronic health problems, which can impede the ability of carry out a safety plan. (Macy et al. 2009)

During pregnancy, the development of chronic conditions due to physical violence increases stress, creates delays in seeking care, and can lead to poor nutrition, and substance abuse to cope (Moore 1999).

7. Those in situations of violence are not passive victims, but are often weighing their options carefully:

Sarah, for example, knows she shouldn't be 'letting' this happen to her, but is anxious about her ability to care for a new baby on her own, her financial well-being if she leaves, and her family's insistence that divorce is a sin. These may seem to be trivial, but for Sarah, these are her very real struggles, and it is because of this that many prefer the term survivor over victim.

Question 2

What can you do as a midwife?

1. Screening for violence should be universal; that is, all clients can be given information on resources and safety – this also needs to be done apart from partner
2. Providing information for leaving an abusive relationship (how to develop a safety plan, signs of violence, expectations of what a healthy relationship looks like, and resources available (like shelters, financial and legal aid)) can be done anonymously through posters in offices, bathrooms, exam rooms, and brochures given directly. Even providing 'safety cards' throughout the clinic that are discreet and carry useful information about resources.
3. When leaving a violent situation, many clients need the support of a variety of services. Midwives can foster a sense of community practice and advocacy by

familiarizing themselves with the services available – counselling, legal and financial aid, medical services beyond birth care, housing, etc.

4. Ultimately, those in violent situations need support in a non-judgemental setting: you should be there to offer a relationship built on trust and support, to build the client up and emphasize the positive aspects of what they are doing in relation to their pregnancy, birth, and care of their infant. In this way, you can say in a context of trust, "when you're ready, here are some resources and supports that you can access in order to help you leave."

Lauren Wallace, PhD

Case Study: Poverty

You are meeting Abena, a 28-year-old Muslim newcomer to Hamilton for her second appointment; she is 4 months pregnant. By reading her intake form, you find out that she arrived alone from West Africa three months ago to start her undergraduate degree at McMaster University. Abena plans to stay in Canada for the duration of her degree while raising her child. She has secured subsidized housing and Ontario Works.

At her first appointment, Abena expressed that she was feeling positive about the pregnancy. When you ask her how things have been going lately, she is visibly distraught and describes how she has been feeling lonely. She is also stressed about the energy it will take to raise her baby in Canada as a full-time student without family and without much financial support.

Question 1

You want Abena to feel that you empathize with her situation. How can you express empathy for Abena's feelings of loneliness and financial stress and establish rapport having never experienced her exact economic or social situation?

1. **"That's so horrible. I can't imagine how you feel. I am sorry you're in this situation"**
2. **"It sounds like you are in a difficult place. Can**

you help me understand what you would need in order to feel more supported?"

3. **"At least you and the baby are healthy"**

4. **"Well you don't need to worry because there are lots of resources available in Hamilton for mothers who are in difficult financial and family situations. I can connect you with a newcomers group at the North Hamilton Community Health Centre and a program for subsidized daycare since you may not have anyone to take care of the baby once you are back in school. There is also Essential Aid who can provide you with used clothing."**

5. **Both B and D are good responses.**

Answer: 2

Clients experiencing low income often tend to seek healthcare later in pregnancy and attend fewer visits than women of median and high income. One reason for this care-seeking pattern is clients' experiences of shame in their interactions with healthcare professionals. One of the determinants of a client's engagement with the health system is a healthcare professional's attitude and willingness to genuinely listen and express empathy and compassion. (1)

It might seem like a good idea to express that you are sorry for the situation (response #1), however, this is confusing empathy with sympathy. Expressions of empathy are driven by the shared connection of being human and may help clients to move away from feeling shame and further isolation. On the other hand, sympathy can actually exacerbate the feeling of shame and reinforce the differences between healthcare practitioner and

client rather than promoting their connection. Inherent in sympathy is the sentiment "I don't understand your situation, but things look pretty bleak."

"At least" (response #3) is usually not a good lead in for empathetic responses since rather than expressing an understanding of the client's feelings, it shuts down the conversation with the sentiment that things are not as bad as described.

Response #2 is the best response because it conveys that the midwife is listening to the client's perspective and is open to assist. At first glance, it may also seem like a good idea to immediately describe the resources available in Hamilton for pregnant newcomers experiencing low income (response #4 and #5). However, responding with a list of resources immediately may be overwhelming for Abena. This response is also based on the assumption that Abena wants these types of assistance. Response #2, which is more open-ended, allows you to take time to get to know Abena, her unique situation and approach to mothering, whether she wants assistance, and if so, the types of support that she would prefer.

Example Dialogue	
Midwife	It sounds like you are in a difficult place. Can you help me understand what you would need in order to feel more supported?
Abena	Well I want my baby to grow up in a Muslim community but so far, I have not been able to connect with a mosque where there are other people from West Africa. I have been going to one mosque but the people there are mostly from the Middle East.
Midwife	I see. Ok, I know of a mosque downtown where another one of my African clients and her family attends. I could find out the name of the place if you are interested.
Abena	Ok. Thank-you. I would like to know more about that place.
Midwife	Alright I will give you a call when I find out. You also mentioned that you are feeling worried about money. Is there anything that would help you feel less stressed?
Abena	I don't know what I will do when I give birth and I have to attend class. My neighbour Grace says that she will be able to watch the baby sometimes but I hear that daycare is very expensive in Canada.
Midwife	It is true that daycare is very expensive. There is actually a government program that mothers can apply to which allows them to pay a much lower amount for daycare.
Abena	Oh. I would be interested to find out more about how I can pay less.
Midwife	Ok. I can give you the website where you can find out more. There is an application form and mothers who want to enter the program have to apply in advance. If you decide you want to apply I am willing to help you with the application form.
Abena	Thank-you.

It is important for midwives to understand that the primary factors that shape health are not medical treatments or 'lifestyle choices' but rather the conditions in which people live and work – the

social determinants of health. (2) In addition to having clinical knowledge and expertise, midwives should be aware of the social determinants of health and the resources available in community to their clients. The midwife in the dialogue above uses open-ended questions and responses to explore Abena's situation without making assumptions about the resources that they need or want. This dialogue is client-centered and promotes autonomy since the Abena is treated as the expert on her social and economic situation and needs.

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Case Study: Culture, Language & Privilege

Lauren Wallace, PhD

Part 1

Amaani is a 29-year-old Muslim Somalian newcomer to Hamilton who is planning to have a home birth. Amaani does not speak fluent English so you have arranged for a professional interpreter to assist at your visits. After the second visit, Amaani speaks to her daughter who is eleven years old. Amaani's daughter tells you that her mother does not like the interpreter that you have chosen because she thinks that she is untrustworthy and is providing you incorrect information. She is dissatisfied and has suggested that her daughter interpret instead. You notice that Amaani's daughter seems very intelligent and think she might be up to the task.

Question 1

Should you proceed by agreeing with Amaani? Why or why not? What are the things you should consider in formulating your response?

Accuracy is important when using interpreters. Family or friends of the client who are untrained interpreters may omit important information or may not be able to speak English confidently or fluently enough to translate the information at the required level needed for informed consent. Children and adolescents, in particular, may not be aware of all relevant information or terms.

When family or friends, rather than professional interpreters, are used, client confidentiality cannot be guaranteed. Family and friends may also be biased in the delivery of medical information to a loved one; for instance, they may avoid relaying some information in order to avoid interpersonal conflicts.

Furthermore, communicating sensitive health information can be a stressful experience for children and adolescents, especially where there is a negotiation or debate within the family about a health decision and the child is forced to play the role of broker between a health professional and family member. For this reason, the use of children, adolescents or other family members is not recommended.

Unfortunately, in some locations, professional interpretation may not be available due to a lack of accessibility, funding limitations, or other practical issues. In these cases, telephone interpretation is often available . When professional interpretation is not possible, arranging for the client to bring a relative or friend to the appointment is the next best option. However, using untrained interpreters, especially older children is riskier, and midwives need to be aware of and advise clients of the potential pitfalls. (1)

Part 2

As her pregnancy progresses you want to understand Amaani's preferences for attendants at her birth.

Question 2

Which of the following options is the best way to discuss birth preferences using cultural humility?

1. **"I know that most Somali women in our city prefer not to have any men present at the birth. Which female relatives are you planning to have attend?"**
2. **"It is your decision to determine the people that will observe and help you at your birth. Who are you planning to have present at your birth? For example, some women prefer to have only female friends and family members present. Others like their husbands and other male family members to attend as well."**
3. **It is best to not ask specific questions about birth attendants in order to avoid making assumptions and acting on cultural stereotypes.**

Answer: #2

This represents an approach that identifies more closely with cultural humility. Some health care providers, as in response #3, aim to take a neutral approach to avoid stereotyping. They are concerned that if they notice a patient's race, culture or class they will be enacting prejudice. However, in seeking to treat clients only as individuals this leads them to become 'colour blind' or 'culture blind,' hindering recognition of the ways in which sociocultural processes influence clients' experiences of health, health care and access to care. (3)

On the other hand, some health care providers, as in response #1, take an approach more aligned with cultural competence, the understanding that cultural knowledge and belief systems can be studied and mastered. (4) The problem with this approach is that it does not recognize that cultural knowledge is dynamic.

While there is a need to consider the role of cultural beliefs in understanding experiences of health and access to healthcare, there is a need to consider how cultural practices and beliefs may be adopted and uniquely adapted by different individuals, families and communities. Generalizations may be necessary for the purposes of illustration, however, they should not be interpreted as a representation of characteristics applicable to all members of a specific community or cultural group.

Rather than focusing on learning about each culture to master each culture's belief systems, or taking a culture-blind approach, cultural humility is a reflexive approach that recognizes generalized cultural patterns in a specific locality while seeking to partner with clients to understand their unique characteristics and experiences. Cultural humility also incorporates a lifelong commitment to self-evaluation and self-critique and is a political stance that aims to redress power imbalances between health care practitioners and clients and their communities. (3, 4) Response #2 asks open-ended questions about birth attendants and recognizes the potential importance of the gender of attendants for Somalis without making assumptions about Amaani's preferences. While it is true that in Somalia, men do not customarily accompany their wives during labour, studies with Somali communities in North America suggest that some women prefer their husbands to accompany them in labour. (2)

Part 3

Amaani is planning a hospital delivery and has requested that aside from her husband, only women should be present for the birth. A week before the due date, you get a panicked call from Grace, Amaani's neighbour, who says that baby is coming quickly

and that she and Amaani are still at home. You are at another birth, so call EMS and the second attending midwife. When you arrive, the paramedics are already there but they missed the birth; Amanni delivered her baby lying on her living room floor. The baby is vigorous at birth and Amaani's vital signs are normal. Next, you deliver the placenta and everything is going fine. You tell Amaani it is alright if she stays at home for a few hours because there is no reason to go to the hospital. Amaani says that she would prefer to go to the hospital and be monitored there.

Amaani's husband requests that the paramedics, who are both male, leave, but they remain in the room.

Question 3

How do address your client's request?

As Amaani's midwife, you should explain to the paramedics that your client is a Muslim woman and that privacy is needed while Amaani is cleaned up and dressed in clean clothes. The paramedics may be reluctant, but they should exit to wait in the hall.

One of the dilemmas that midwives face is how best to work as allies with clients who are less privileged in order to promote client-centered care and health equity. In this situation, Amaani is disadvantaged by the fact that she does not speak English, and her husband is disadvantaged by the fact that he is not a health professional. The fact that the paramedics are also credentialed as health care professionals and are the midwife's colleagues put her in a good position to advocate for Amanni. Midwives should be aware of their unearned privileges and the principles of allyship. The Anti-Oppression Network, in collaboration with PeerNetBC and Stephanie Nixon, describe how being an ally involves 'an active, consistent, and arduous practice of unlearning and re-

evaluating, in which a person of privilege seeks to operate in solidarity with a marginalized group of people.' (5)

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