Midwife Teresa Bandrowska (seen here with client Jennifer Poitras) says her role at the Ottawa Birth and Wellness Centre enables her to use her midwifery skills in a broader way.
In addition to clinical work, teaching and policy, research is another important facet of the midwifery career spectrum.

As a followup to the fall 2014 issue of *Ontario Midwife*, here is a sample of some of the research work currently underway in midwifery:

**Elizabeth Allemang** is the lead researcher on a project that recently received a grant from the Ministry of Training, Colleges and Universities to develop a package of three learning modules for midwifery students. Along with co-researchers Patricia McNiven and Liz Darling, Allemang will develop the modules to address three key fundamentals in clinical learning: primary midwifery care management; care planning and clinical decision making; and collaboration and consultation.

**Andrea Robertson** is currently completing her PhD, which focuses on women who have had children apprehended by child protective services at the time of birth, their experiences and, secondarily, improving the provision of care during this time. Robertson’s research focuses largely on exploring issues of ethics, autonomy, trust and marginalization of pregnancy in relation to teaching and learning midwifery.

**Karline Wilson-Mitchell’s** research work looks at the wellbeing of new parents and families both at home and abroad. Resilience is one theme of her work. For the twinning program between the Canadian Association of Midwives and the Tanzanian Registered Midwives Association, Wilson-Mitchell has been collaborating on work related to adolescent pregnancy and resilience. She will also be studying and developing strategies and interventions to promote resilience in adolescent mothers and maternal-newborn caregivers in the Americas as a member of a multidisciplinary team. As part of a research group from the Ryerson Centre for Immigration and Settlement (RCIS) that is looking at how change affects newcomer families, Wilson-Mitchell has co-authored a paper with Robertson that will soon to be published on the RCIS website titled *Intergenerational violence: focus on post-migration context in Canada*.

---

### Midwives and Family Health Team collaborate

The Thorncliffe Pregnancy Clinic opened in early February. The clinic is a collaboration between the Midwives Clinic of East York-Don Mills and the South East Toronto Family Health Team. It aims to bring coordinated and culturally sensitive care to Thorncliffe Park, one of Toronto’s fastest-growing, but greatly under-serviced areas.
Midwifery career spectrum: a range of phases and capacities

by Juana Berinstein, director of policy and communications

Welcome to our first issue dedicated to the midwifery career spectrum. Our goal for this issue was to showcase both midwives working in different phases of their midwifery careers and in different capacities within their careers.

This work has been prompted, in part, by a series of focus groups that the AOM conducted recently among midwives in their first five years of midwifery practice and among midwives who consider themselves to be “late career.” Both groups articulated a number of rewards and challenges around being a midwife at each end of the career spectrum, including struggles such as being on call 24/7. But there is uniqueness, too, that distinguishes newer midwives from those in their third decade of service. Find out more on pages 6 and 7.

Credit for prompting this issue must also be given to the Work Life Balance Task Force, which has also worked to shed light on the challenges midwives face at different points in their careers. In our story on page 4, chair Isabelle Milot talks about the need for work-life balance and midwife Manavi Handa discusses the challenges she faced in particular when getting a cancer diagnosis that threw her world into chaos.

This issue also includes engaging stories about leadership, and midwives who have expanded the limits of what a midwife can be. Our leadership roundtable on page 8 features three midwifery leaders who found themselves at the forefront of three different settings: international midwifery, Aboriginal midwifery in Canada, and at the local hospital level. You’ll learn more about midwives who are pushing the boundaries of just what a midwifery career means: our profile of Stephanie Crouch on page 5 highlights just some of the ways midwifery skills can be mobilized in unexpected ways that serve the needs of a given community.

Ultimately, at the heart of many of these stories are some fundamental tensions: what will Ontario midwifery look like in five, 10, 20 years? Our hope is that this issue will be an important part of an ongoing conversation among midwives, clients and supporters. Let us know what you think—join the discussion at regional meetings and the annual general meeting or email me at juana.berinstein@aom.on.ca

Sincerely,

Juana
Balancing act

Birth doesn’t happen on schedule. When you’re working in a client-centred profession like midwifery, unpredictable working hours come with the territory. But how do you manage the demanding call schedules oriented toward being available to clients 24/7 while raising young children or caring for aging parents?

According to the 2013 AOM Benefits Trust member survey, 52% of midwife respondents have a partner and dependent children who live with them and 11% are single with dependent children. Half of respondents are the primary income earner for their household and a third are the sole income earner.

midwife Isabelle Milot, chair of the AOM Work Life Balance Task Force, which was formed following a member-led effort to improve work-life balance for midwives.

The task force is looking at both long-term work, such as funding models, as well as short-term work that can help midwives now. One such initiative included posting sample call schedules on the AOM website so that midwives can learn from each other and find new ways of making call schedules work for them.

For some midwives, finding work-life balance has meant some burdens fall to their partners and family supports. For example, finding childcare that fits midwives’ needs can be a particular family challenge. Midwife Rachel Dennis found that by not being able to inform her partner—who does contract and general labour work—of any regular, consistent work hours, he is challenged in planning his own work schedule.

“If I need him home all of a sudden because I have to attend a birth, he has to tell his clients he either can’t work or the deadline has to be pushed back,” Dennis says. “Because of that, he doesn’t get that many contracts.”

For other midwives, meeting personal challenges like illness has meant adjusting their schedules around their needs.

In 2008, while working a full caseload, teaching as a sessional lecturer at the Ryerson midwifery education program and chairing the AOM diversity work group, Toronto midwife Manavi Handa was diagnosed with breast cancer.

She took a year off for cancer treatment—which continued for 18 months in total. When she returned to work, she jumped right back in to full-time practice. Ultimately, though, she hit a wall—and had to “redefine what normal means.”

Handa took an additional year off to reevaluate her needs. It took a few tries to figure out what would work for her, but Handa has now settled on a new routine. In addition to her work volunteering for the west end Uninsured Walk-in Clinic, Handa teaches as part of the Ryerson faculty. Part of the year, she sees clients and does clinic as part of a shared-call team where she is on-call one out of two weeks. When teaching, she is not on call.

Handa says she has come to embrace the need to say “no” and encourages others to reevaluate their needs too.

The Work Life Balance Task Force is developing a tip sheet on alternative practice arrangements. It will be launched following a webinar on May 27. To register for this and other webinars visit bit.ly/AOMwebinars

“The whole issue of balance affects everyone in one way or another. It’s a common denominator for all midwives regardless of where they are at in their career,” says midwife Isabelle Milot, chair of the AOM Work Life Balance Task Force, which was formed following a member-led effort to improve work-life balance for midwives.

The task force is looking at both long-term work, such as funding models, as well as short-term work that can help midwives now. One such initiative included posting sample call schedules on the AOM website so that midwives can learn from each other and find new ways of making call schedules work for them.

For some midwives, finding work-life balance has meant some burdens fall to their partners and family supports. For example, finding childcare that fits midwives’ needs can be a particular family challenge. Midwife Rachel Dennis found that by not being able to inform her partner—who does contract and general labour work—of any regular, consistent work hours, he is challenged in planning his own work schedule.

“If I need him home all of a sudden because I have to attend a birth, he has to tell his clients he either can’t work or the deadline has to be pushed back,” Dennis says. “Because of that, he doesn’t get that many contracts.”

For other midwives, meeting personal challenges like illness has meant adjusting their schedules around their needs.

In 2008, while working a full caseload, teaching as a sessional lecturer at the Ryerson midwifery education program and chairing the AOM diversity work group, Toronto midwife Manavi Handa was diagnosed with breast cancer.

She took a year off for cancer treatment—which continued for 18 months in total. When she returned to work, she jumped right back in to full-time practice. Ultimately, though, she hit a wall—and had to “redefine what normal means.”

Handa took an additional year off to reevaluate her needs. It took a few tries to figure out what would work for her, but Handa has now settled on a new routine. In addition to her work volunteering for the west end Uninsured Walk-in Clinic, Handa teaches as part of the Ryerson faculty. Part of the year, she sees clients and does clinic as part of a shared-call team where she is on-call one out of two weeks. When teaching, she is not on call.

Handa says she has come to embrace the need to say “no” and encourages others to reevaluate their needs too.

The Work Life Balance Task Force is developing a tip sheet on alternative practice arrangements. It will be launched following a webinar on May 27. To register for this and other webinars visit bit.ly/AOMwebinars

“"The whole issue of balance affects everyone in one way or another. It’s a common denominator for all midwives regardless of where they are at in their career,” says midwife Isabelle Milot, chair of the AOM Work Life Balance Task Force, which was formed following a member-led effort to improve work-life balance for midwives.

The task force is looking at both long-term work, such as funding models, as well as short-term work that can help midwives now. One such initiative included posting sample call schedules on the AOM website so that midwives can learn from each other and find new ways of making call schedules work for them.

For some midwives, finding work-life balance has meant some burdens fall to their partners and family supports. For example, finding childcare that fits midwives’ needs can be a particular family challenge. Midwife Rachel Dennis found that by not being able to inform her partner—who does contract and general labour work—of any regular, consistent work hours, he is challenged in planning his own work schedule.

“If I need him home all of a sudden because I have to attend a birth, he has to tell his clients he either can’t work or the deadline has to be pushed back,” Dennis says. “Because of that, he doesn’t get that many contracts.”

For other midwives, meeting personal challenges like illness has meant adjusting their schedules around their needs.

In 2008, while working a full caseload, teaching as a sessional lecturer at the Ryerson midwifery education program and chairing the AOM diversity work group, Toronto midwife Manavi Handa was diagnosed with breast cancer.

She took a year off for cancer treatment—which continued for 18 months in total. When she returned to work, she jumped right back in to full-time practice. Ultimately, though, she hit a wall—and had to “redefine what normal means.”

Handa took an additional year off to reevaluate her needs. It took a few tries to figure out what would work for her, but Handa has now settled on a new routine. In addition to her work volunteering for the west end Uninsured Walk-in Clinic, Handa teaches as part of the Ryerson faculty. Part of the year, she sees clients and does clinic as part of a shared-call team where she is on-call one out of two weeks. When teaching, she is not on call.

Handa says she has come to embrace the need to say “no” and encourages others to reevaluate their needs too.

The Work Life Balance Task Force is developing a tip sheet on alternative practice arrangements. It will be launched following a webinar on May 27. To register for this and other webinars visit bit.ly/AOMwebinars

“"The whole issue of balance affects everyone in one way or another. It’s a common denominator for all midwives regardless of where they are at in their career,” says midwife Isabelle Milot, chair of the AOM Work Life Balance Task Force, which was formed following a member-led effort to improve work-life balance for midwives.

The task force is looking at both long-term work, such as funding models, as well as short-term work that can help midwives now. One such initiative included posting sample call schedules on the AOM website so that midwives can learn from each other and find new ways of making call schedules work for them.

For some midwives, finding work-life balance has meant some burdens fall to their partners and family supports. For example, finding childcare that fits midwives’ needs can be a particular family challenge. Midwife Rachel Dennis found that by not being able to inform her partner—who does contract and general labour work—of any regular, consistent work hours, he is challenged in planning his own work schedule.

“If I need him home all of a sudden because I have to attend a birth, he has to tell his clients he either can’t work or the deadline has to be pushed back,” Dennis says. “Because of that, he doesn’t get that many contracts.”

For other midwives, meeting personal challenges like illness has meant adjusting their schedules around their needs.

In 2008, while working a full caseload, teaching as a sessional lecturer at the Ryerson midwifery education program and chairing the AOM diversity work group, Toronto midwife Manavi Handa was diagnosed with breast cancer.

She took a year off for cancer treatment—which continued for 18 months in total. When she returned to work, she jumped right back in to full-time practice. Ultimately, though, she hit a wall—and had to “redefine what normal means.”

Handa took an additional year off to reevaluate her needs. It took a few tries to figure out what would work for her, but Handa has now settled on a new routine. In addition to her work volunteering for the west end Uninsured Walk-in Clinic, Handa teaches as part of the Ryerson faculty. Part of the year, she sees clients and does clinic as part of a shared-call team where she is on-call one out of two weeks. When teaching, she is not on call.

Handa says she has come to embrace the need to say “no” and encourages others to reevaluate their needs too.
Although Stephanie Crouch is not providing midwifery services, she’s still bringing the principles and benefits of midwifery to a whole new group of women in her community.

Currently working for an OB/GYN, Crouch provides some postpartum and well-woman care, while also running a pessary clinic for senior patients. Pessaries are used to treat incontinence and uterine prolapse for women in their childbearing years and beyond. Though quite different from midwifery, Crouch finds her work at the clinic infinitely gratifying.

Running appointments that allow time for discussion, getting to understand the patients’ concerns and forming relationships all benefit the women who come under Crouch’s care. Being fitted for a pessary can be physically uncomfortable, not to mention embarrassing for some patients, Crouch says. But getting to know her patients and taking a midwifery approach helps.

“[Women] feel comfortable coming to see me even if the procedure itself isn’t the most pleasant thing. I feel really good about that part of what I’m doing,” says Crouch.

Crouch is one of only a handful of midwives who work in a college-approved alternate practice arrangement (APA), outside of the traditional model and scope of midwifery. APAs require approval from the College of Midwives of Ontario and must serve the needs of the community. For example, Toronto midwife Jay MacGillivray has a CMO-approved APA that exempts her from providing home birth services because her HIV-positive clients give birth only in hospital.

Crouch began looking for new ways to practice several years ago when her partner fell ill and the demands of on-call work, paired with caring for her partner and small children, became too difficult to manage.

She heard a local doctor was seeking help with the pessary clinic, and things quickly fell into place. obstetrician Kim Rogers thought Crouch’s hands-on midwifery skills made her an ideal candidate for the position, while Crouch was looking for work that would allow her to continue to use her midwifery skills and training.

“So it was fortuitous that Dr. Rogers was looking and I was looking,” Crouch says.

Crouch’s arrangement required the coordination of a few key pieces, including insurance coverage.

“The AOM looked at what Stephanie wanted to do in the community, and we saw the gap that this work would fill. We were happy to work with HIROC to facilitate the right kind of insurance that would meet her needs,” says Bobbi Soderstrom, insurance and claims advisor, at the AOM.

She also needed the support of the CMO. “It was great of the college to be open to this. If they had not, I would not have come back to midwifery,” Crouch says.

While the arrangement has helped Crouch’s personal situation, it also meets an important need in the community, she says.

Wait-list times to see Dr. Rogers were sitting at two years before Crouch took over running much of the pessary clinic. With Crouch now dedicated to seeing those patients, women are receiving care faster from both the physician – whose time is freed up to address those on the wait list – and by Crouch, who can more easily fit in last-minute appointments. Crouch acknowledges that only being able to perform delegated acts under Dr. Rogers’s authority has been a challenging element of her new work arrangement. But the independence she’s gained in running the pessary clinic has provided a lot of satisfaction.

Crouch says she misses delivering babies and does see a time when she can come back to providing full midwifery care, if the right arrangement became available and if she could continue to work with the pessary clinic.
Challenges and rewards in the first five years

Though there are now more than 700 midwives providing care in Ontario, four out of 10 women who seek midwifery care cannot access it. Meeting the demand for care is difficult, particularly in communities where growth in the number of midwives is stymied by a lack of hospital privileges or by late-year budget approvals. For newer midwives trying to meet that demand by finding permanent work, barriers to obtaining hospital privileges can be especially frustrating.

Following her final year as a student, Jill Parsons secured a new registrant position at the Midwives Collective of Toronto. Though the practice was able to contract two new registrants, the number of general registrant positions was restricted because of the cap on births the practice faces at Mount Sinai Hospital.

It’s something Parsons has heard a lot of from other new midwives—the challenge of finding work.

“We’re hearing stories now of general registrants who are struggling to find jobs or are on short-term contracts or locums but don’t have stable positions,” she says.

Although the number of midwives is growing, many hospitals either cap the number of midwives who can have privileges at the hospital or the total number of births midwives can attend—both of which severely limit a practice’s ability to bring on new midwives.

Tammy Roberts—who graduated from the MEP in 2011 and has been running her own practice, North Channel Midwifery, since 2013—has also heard from classmates about challenges finding work. But, having gone through the process of setting up her own practice, Roberts thinks greater focus needs to be placed on preparing for the transition from student to full-time midwife, Roberts notes. “Every transition is difficult, but if you’re prepared, at least you go into it with eyes open.”

For Zuzana Betkova, who also graduated from the MEP in 2011, working in an under-resourced and high-needs area has brought both the greatest challenges and rewards to her work as a locum midwife.

Having previously worked in a downtown Toronto practice, Betkova recently spent four months working in Attawapiskat on locum for Neepeeshowan Midwives. Her next stop will be a locum in Nunavik.

Going from an urban practice to a community that requires lengthy approvals for ultrasound requests and clients to travel outside of the community for such tests has taught valuable lessons, Betkova says. “I love my job in Toronto, but taking a break and seeing what else is out there in terms of midwifery has been good and made me fully appreciate midwifery and what it can actually do for women in different contexts,” she says.

The experience has made her wonder how midwives can better serve communities and what changes to the model would allow for the provision of even better health care. For example, in rural and remote areas, where public health resources are scarce, following clients beyond six weeks postpartum would allow greater continuity of care and improved health, Betkova suggests.

Regardless of whatever challenges their roles have presented them with, all three of these midwives have noted some of the most helpful resources throughout their transition into being a general registrant has been the help and advice from colleagues.

“I lucked out to be in a practice that is very conscious of their role in mentoring new registrant midwives and it was always made clear at any time if I was ever worried about something who it was I should contact and…that there would be no grumbling,” Parsons says.

The support Roberts received, not only from her hospital CEO, but also from local physicians and especially from fellow midwives, was invaluable when setting up her own practice.

In the end, the challenges and hard work have resulted in a growing practice—the best reward for Roberts.

“When you work in a smaller place, those are the rewards: seeing the babies as they get older, seeing how quickly the practice is growing and all by word of mouth.”

“Every transition is difficult, but if you’re prepared, at least you go into it with eyes open.”

Tammy Roberts, RM
Midwife Kerstin Helén would like to work until she’s 65 years old. But 23 years into the profession, at age 54, she’s already finding that the irregular hours that can go hand in hand with midwifery are starting to take a toll.

“When I was younger, I could go home and sleep six hours in the daytime, but now I can only sleep two hours at the most,” says Helén, who carries a full case load at Barrie Midwives.

As a single mother, Helén hasn’t been able to build up enough RRSPs to fund her retirement. She says she exercises regularly and eats healthily so she’ll be able to work long enough to save the money she will need to support herself in retirement, but she worries that this won’t be possible.

“I joke with my kids and say ‘feed me when I’m older’, but it’s a real worry when you don’t have enough money,” says Helén.

Helén says that in Sweden, where she began her midwifery career, the midwifery model offers late career midwives options that are not possible under the current Ontario model. Swedish midwives can choose to work in labour and delivery or to provide only prenatal or postpartum care. Midwives also work in gynecology and provide well-woman care, and insert IUDs and prescribe oral contraceptives. Specially-trained midwives perform obstetrical ultrasounds.

Helén has explored a number of career options within midwifery, hoping to reduce her case load to half-time. She’s an auditor for the College of Midwives of Ontario, is one of the AOM’s ESW instructors and also teaches the SOGC’s ALARM (Advances in Labour and Risk Management) Program. But these part-time roles haven’t generated enough income to enable Helén to reduce her caseload, so she continues to work full-time at Barrie Midwives.

In response, at the AOM’s annual general meeting in 2013, she and Sarilyn Zimmerman brought forward a resolution asking the AOM to “ensure that senior midwives continue to contribute to the profession by developing work strategies and options that are sustainable.” Currently, 158 registered midwives in the province are aged 50 and older. Some of them participated in three focus groups held by the AOM last fall for late career midwives.

“I think there’s a great space for an experienced midwife to help newer midwives set up practices or to be a consultant for practice management or clinical care. Younger midwives can benefit from that wealth of experience,” says Helén.

Options like these have been brought to the negotiations table the AOM shared with government. Most recently, the AOM brought proposals to government for the creation of Clinical Midwifery Specialist roles – where a highly experienced midwife could provide targeted training and support in a particular community or around a particular issue. However, ministry officials have not accepted this proposal, so it’s been back to the drawing board. As Helen points out, “Midwives in late career have different specialties and interests that could be harnessed.” Indeed, the contributions of midwives in late career must be valued so that the profession doesn’t lose out on the unique insight and experience they bring.
At the helm

Over the course of a midwife’s career, there can be many opportunities to grab—or create—a leadership role. So Ontario Midwife talked to a panel of three midwives with provincial, national and international leadership experience to discuss what it takes to be a leader.

What made you interested in seeking a leadership role or to be in that position?

Remi: One of the expectations for us as members of that [first] graduating class was that we would take on opportunities more broadly in the midwifery professional world, beyond our clinical roles. Whether that was taking on responsibilities within the AOM or the college or beyond, there was an expectation that we wouldn’t “just” be midwives—we were to become ambassadors for the profession.

Bridget: I tended to get involved where I saw there was something I could offer or where I wanted to know more about the working of the organization or where I felt that, by getting involved, I could contribute to improvements to women’s health. Attending an ICM council meeting in the Philippines as AOM president exposed me to midwifery at the international level, and I became totally passionately engaged in the politics of it all.

Kerry: Initially, I was involved as a member of NACM. I had resisted a leadership role. I wanted to focus on midwifery clinical work with women and communities. But there weren’t very many Aboriginal midwives graduating and practicing, so I felt the need to improve maternal and newborn care in Indigenous communities.

I was influenced by mentors who really encouraged me to take a leadership role. Mentors like, for example, Carole Couchie, who was the first Aboriginal woman to graduate from the midwifery education program in Ontario, and Katsi Cook, who is an Indigenous midwife and traditional elder.

What are the greatest rewards that came with your leadership roles?

Remi: There’s this idea that—and Bridget, I credit this to you—you know you’ve been successful when you bump into a client six years down the road, and the client doesn’t remember you, because the care you provided as a midwife was about them, not about you. Leadership is like that: you create something that outlasts you.

Kerry: It’s fulfilling to see the impact of our work on the community, to see the rebirth of Aboriginal midwifery, and to see young Aboriginal women who want to be midwives. As Indigenous people, we need midwives to work in our communities. We need midwives in all the places we live—in cities and in the north. As leaders, we need to keep inspiring people to become midwives so we can generate midwives for our communities.

What are/were the greatest challenges?

Kerry: Being on call and trying to juggle meetings and my clinical responsibilities—but I think that’s true of any midwife. It can be challenging to take the time off call to attend meetings with MPs in Ottawa, for example. I could not have done it without the support of my practice. Sometimes that’s challenging, because all midwives have their own needs and demands that we are trying to balance.

Remi: A lot of the rewards that come from being a leader are deferred. It’s not like you do...
something and immediately there’s a standing ovation for the work you’ve done, because part of what you’re trying to do as a midwifery leader is change the way we approach women’s health and the way health systems respond to women’s health. It’s a long-term project.

Bridget: The role of the leader is to manifest the direction and vision that has been given by your members. Leading a fledgling profession takes immense courage and stamina. You need the courage to knock on the doors of politicians and policy makers and take your seat at the tables that impact maternal and newborn health. It can be extremely lonely being in the leadership position as well. One is constantly strategizing and deciding how and when to take opportunities. As much as you are working with a team, they’re looking to you to take the next step to move the organization further along. The image I have is that leadership is like turning a wheel. It was turning before you and will continue to turn after, but the role of the leader is to make sure that wheel keeps turning, that the organization is constantly achieving its goals.

When I was president of the ICM, it was a challenge to come back to practice and into my daily life. While flying home over the Atlantic, my role changed. I morphed from being an international leader working with the WHO and international agencies to mother, wife, clinic member and teacher. I landed into the midst of everybody else’s busy lives and carried on. I often felt like I was living two separate lives!

How do midwives pursue leadership along the career spectrum and in various parts of the health care system?

Remi: The notion that leadership opportunities for midwives are limited, in terms of formal already existing roles — that might be true. But I don’t think that that’s a reason not to pursue leadership opportunities. Part of being a leader is the recognition that, rather than sitting and waiting for somebody to say here’s a job or a role or title you can apply for, that you seek out those leadership opportunities and you create roles where roles don’t exist.

Bridget: I agree. As midwives, we need a profound vision for our future. We need to see ourselves contributing broadly to the health of women and families. We need to be vocal about the social determinants of health and their impact on maternal and newborn well being.

Our scope of practice should not be seen as limiting our participation within the larger framework of community health or the health-care system. We should be identifying places where our knowledge can help improve the lives of women and children. We should be encouraging and supporting each other to become leaders.

Kerry: I would echo that. It’s important to mentor each other and to support new midwives coming into our profession. We must nurture students and get them involved. This is what I want to tell midwives who think they can’t take on a leadership role because they don’t have the skills or experience: don’t hesitate. Just get involved, start small, join a committee. These skills and experiences come. It was no different for us. That’s how we evolved into becoming leaders.

This discussion has been edited and condensed. For the full version visit ontariomidwives.ca/newsletter

“We should be encouraging and supporting each other to become leaders.”

“It’s really important to include mentorship as a part of leadership and to support the new ones coming up—nurturing those students and getting them involved.”
“One of the reasons I became a midwife was to change the way people view birth. I wanted families to have safe and satisfying experiences. At the OBWC, I have the opportunity to do that in a broad, interprofessional way.”

Teresa Bandrowska, RM and lead midwife
Ottawa Birth and Wellness Centre

Birth centres provide new role for midwives

There’s a sort of poetry to Teresa Bandrowska and Genevieve Gagnon splitting the clinical lead role at the Ottawa Birth and Wellness Centre (OBWC). Once preceptor and student, the two now work closely together to balance the demands of clinical work with the administrative duties of running a birth centre.

They represent the two ends of the midwifery career spectrum: Gagnon is entering a phase of her life where family and childbearing may take a more prominent position. Bandrowska is nearing retirement and finds on-call work physically challenging, but still wants to be a midwife. Splitting the role provides them both with that balance they seek—while still being able to serve clients in the community.

Their partnership with the Champlain Newborn Maternal Regional Program has increased interprofessional education between midwives, nurses, physicians and paramedics, says Bandrowska. Non-midwifery clients get exposed to midwifery care and midwives when they come in to access the wellness programs. It’s something that’s been incredibly satisfying, Bandrowska says, to continue to use her midwifery skills but in a new, broader way.

“One of the reasons I became a midwife was to make changes to the way people view birth. I wanted families to have safe and satisfying experiences. At the OBWC, I have the opportunity to do that in a broad, interprofessional way,” she says.

The opening of the birth centres in both Ottawa and Toronto not only promotes normal birth and expands options for out-of-hospital birth, but also created an opportunity for midwives to function in a new role.

Each centre treats the role slightly differently based on its own needs, but at both, midwives have been able to inform and lead the provision of out-of-hospital maternal and newborn care.

At the Toronto Birth Centre, midwife Sara Booth takes the helm as clinical lead, overseeing pieces that ensure quality care, such as credentialing, implementing clinical policies and programs, and recruiting birth centre aides and front-line staff. Booth has been able to build on her existing midwifery knowledge while developing even more skills. “It’s been a wonderful challenge, and a great learning curve,” says Booth.

Gagnon agrees.

“You’re naive to some of the complexity of running an organization when you’re not in it,” she says. The leadership role at OBWC has provided “a better understanding of what hospitals or large organizations have to deal with… Why certain decisions have to be made.”
When Faith Pegahmagabow attended her daughter’s labour more than 20 years ago to provide support, she was struck by a feeling of having her hands tied—unsure what to do, unable to help.

She was also struck by a feeling that the more things change, the more they stay the same. Though she was able to attend her daughter’s labour (unlike her husband, who had not been allowed to attend when Faith gave birth to their daughter) “there was no advancement in terms of birthing. I wanted her to be comfortable in her birthing; they wanted her in bed, and I’m thinking, ‘There’s got to be a better way than this’.”

Until the early 1990s, Pegahmagabow didn’t know what a midwife was. Ten years later, she was part of the first class enrolled through the Aboriginal Midwifery Training Program at Six Nations.

Her daughter’s birth experience, combined with attending a presentation by some midwives from Six Nations, sparked Pegahmagabow’s interest in birth and midwifery—and ultimately set her on her path to becoming a midwife herself.

Originally intending to work as a midwife with a possible clinic in her own home, life threw a few bumps in the road. After finishing the midwifery program, Pegahmagabow returned to her community in Parry Sound, only to find she’d lost her home in a fire, dashing her dreams of providing birthing services in her home to her community.

As the only midwife in the area, Pegahmagabow struggled with the idea of working in isolation. Instead, she worked as a community health worker and used her midwifery skills when she could.

“I would provide prenatal support to moms who were interested—using my knowledge to give women information.”

Pegahmagabow now gets to put her training and skills as a midwife to use as a second attendant working with midwife Judy Rogers whose new practice, Midwives of Georgian Bay opened in Parry Sound in 2014.

Prior to the practice opening, Rogers had been in the community to put out “feelers,” Pegahmagabow says, and gave a presentation at a local high school. Pegahmagabow’s niece, who worked at the school, invited her to attend, which led to the two midwives meeting.

Pegahmagabow’s role involves attending home births with Rogers, assisting with set up and throughout labour, and taking over baby monitoring once labour is over.

“Being a second attendant fits my lifestyle right now,” says Pegahmagabow, who is now raising three of her grandchildren aged 10, eight and six years.

Though in her early sixties, Pegahmagabow’s future holds many possibilities, including providing primary care as a midwife, given the recent funding commitment for Aboriginal midwives made by the Ministry of Health and Long-Term Care in the contract ratified by midwives on Dec. 23, 2014.

“I would like to reintroduce traditional home birthing back into our Anishinabek communities, as well as the use of traditional medicines used in a woman’s childbearing life,” she says. “I would like to be able to practice, to rebuild my home and to offer women a place to birth with me as their midwife.”
AOM Annual Conference and AGM
MIDWIFERY transforming health

May 4-6, 2015
Delta Toronto East

PRE-CONFERENCE WORKSHOPS
Monday May 4

Maya Chacaby: Aboriginal Cultural Competency

The Pen is Mighty: Writing practice protocols workshop

Free for members!

Register by April 20
and you could win a Medela™ Pump in Style Breastpump

visit aom.on.ca