Association of Ontario Midwives
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COMPREHENSIVE EVIDENCE SYNTHESIS

UNDERSTANDING THE **SYSTEMIC FACTORS** IMPACTING THE **SUSTAINABILITY OF MIDWIFERY** IN ONTARIO

MAY 2024

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Land Acknowledgement

We acknowledge the land on which the AOM office is located is on the traditional territory of the Mississauga's of the Credit First Nation of the Anishinaabek Nation. It is also part of the Dish with One Spoon covenant. The covenant recognizes the relationship between the Anishinaabek and the Haudenosaunee Confederacy and their agreement to peace and a shared responsibility to care for the land, thus ensuring a life of peace and continued sustenance for the people.

We recognize that practices of health and well-being have been in place on these lands for over ten thousand years and continue to this day. We also recognize the special relationships of Indigenous and non-Indigenous people that have been affirmed through treaties at a nation-to nation level, and the breaches of these treaties by the Crown representing governments of Canada for hundreds of years. We recognize the role of the Association of Ontario Midwives in acknowledging the truth of systemic inequities and resulting health and socioeconomic disparities for Indigenous people and communities and affirm our commitment to reconciliation and responsibility to support Indigenous self-determination. We recognize the inextricable link between sustainability of midwifery and Indigenous sovereignty through dismantling systems of colonial oppression under white supremacist policies and practices.

Thank you

Our deepest thanks to the midwives who make up the Midwifery Sustainability Project's Steering Committee. We are grateful for your insights on the evidence. Your voices are central to the framework underpinning the approach to understanding midwifery sustainability in this synthesis.

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BACKGROUND

Midwives are vital to the world's health workforce and instrumental in meeting the goals and targets set out by the 2030 Agenda for Sustainable Development.[1] Worldwide, midwives provide comprehensive sexual and reproductive health services, playing a critical role in health promotion within families and communities more broadly.[2] While midwives are an essential health profession, gender inequity caused by patriarchal structures results in professional and economic barriers to the integration of midwives in health systems around the world.[3, 4] The recent report, State of the World's Midwifery, by the United Nations Population Fund has drawn attention to the critical shortage of midwives in Canada and globally.[1]

Midwifery was regulated in Ontario in 1994, and the scope of practice is guided by the Midwifery Act. The Act includes an exception clause for Indigenous Midwives ("Aboriginal" is used in the legislation) to recognize the self-determination of Indigenous Midwives who have been serving their communities on Turtle Island for thousands of years and may not choose to be regulated through the College. The province has Canada's largest and most established midwifery workforce, with 1,051 registered midwives reported in 2023 (Figure 1).[5] Midwives in Ontario are experts in primary care for pregnant people and their newborns. Midwives are a part of Ontario's health system, and services are funded by the Ontario Ministry of Health. To ensure accessibility to midwifery care, residents of Ontario who are not covered by the Ontario Health Insurance Plan (OHIP) can still receive midwifery care at no charge.

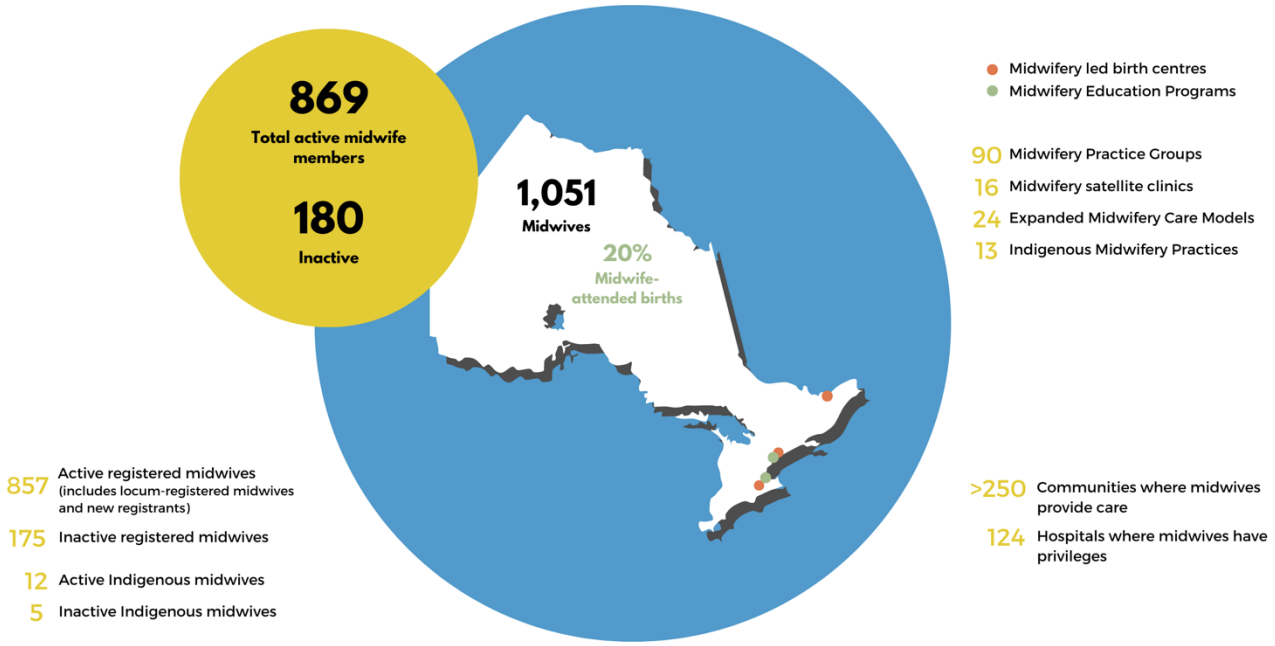
The Association of Ontario Midwives (AOM) is the professional association representing midwives in the province. We are dedicated to advancing the clinical and professional practice of Indigenous/Aboriginal and Registered Midwives in Ontario. We envision midwives leading decolonized and anti-racist reproductive, pregnancy, birth, and newborn care.

The majority of midwives in Ontario work in a community-based 'course of care' model. These midwives are self-employed, working as independent contractors in midwifery practice groups. Payment is through a billable course of care system, and midwives receive compensation, including funding for benefits from the Ministry which funds health and dental benefits, access to parental leave benefits, and contribution to a Group Retirement Savings Plan administered by the AOM Benefits Trust, through community-based transfer payment agencies (TPAs) based on a full course of care (i.e., the period from when a client enters midwifery care through to discharge at six-weeks postpartum). New models for funding were negotiated by the AOM in 2017 in response to demand from midwives and communities for flexibility in funding and models of care, allowing for midwives to work in arrangements that include care outside the originally funded 'course of care' model. In these Expanded Midwifery Care Models (EMCMs), midwives work as employees in Community Health Centres, Family Health Teams and hospitals, serving the needs of the community in a variety of ways. Funding

for Indigenous Midwifery Programs (IMPs) was negotiated in the same contract, supporting Indigenous Midwives working under the exception clause of the Midwifery Act to work in employee models and as independent contractors. The current demand for new models for midwifery practice far outpaces the funding opportunities available for them.

Over the past several years, the AOM has been dedicating resources to gain valuable insights into midwives' variable experiences of wellbeing. We have led research, member surveys, and direct communication with members to learn about their experiences in the profession (e.g., a bullying survey of members and an anti-racism study). Through our work, we have learned that midwives in Ontario are suffering. We have heard from midwives about the combination of inequities within the profession and in the health system, coupled with high rates of burnout made worse by the pandemic and unprecedented rates of disability leaves, a high proportion of which are for mental health concerns. Colonial infrastructures, experiences of racism, discrimination and oppression, bullying, disability, lack of professional recognition and respect, on-call demands, secondary trauma, pay inequity, and inequitable access to power and decision-making are just some examples of the intersecting issues contributing to stress, burnout and attrition across the profession. As illustrated below, the profession sees a higher-than-ever proportion of "inactive" midwives on leave from active practice. This number does not capture the growing number of midwives who have chosen to leave the profession. In 2023, 54 midwives left the profession.

Figure 1. Midwifery in Ontario



Throughout the COVID-19 crisis, midwives have and continue to respond to the sexual and reproductive health needs of populations, enabling safe and effective care across settings (i.e., homes, hospitals, community clinics, and birth centres).[1, 6] However, the pandemic has magnified that even strong health systems are vulnerable, quickly becoming overburdened with the healthcare demands of the crisis. Health professionals have faced an unprecedented burden, which has impacted the supply, distribution, demand, and overall wellness of the health workforce in Canada.[7] While midwives are essential to the health workforce and health systems, burnout and attrition are serious threats to the profession's sustainability. Exploring the systemic factors impacting the health and wellbeing of midwives is key to supporting sustainable midwifery and meeting the sexual and reproductive healthcare needs in communities.

Midwives and researchers have raised questions and concerns about the sustainability of the current state of midwifery in Ontario. In response, we have launched the Midwifery Sustainability Project to understand better and respond to the factors related to midwifery sustainability.

AIMS

The Midwifery Sustainability Project, launched in 2022, is guided by member resolutions, research evidence, and member-generated data. The project's goal is to understand and make recommendations for the association's strategic advocacy regarding the implementation of a series of reforms to the current state of midwifery in Ontario.

We have made the sustainability of midwifery a strategic priority in the Strategic Plan for 2022-2025. Our ultimate aim is to increase the health and wellbeing of midwives and, in turn, the sustainability of the profession while maintaining strong clinical outcomes and high satisfaction experienced by midwifery clients.[8] The Midwifery Sustainability Project will examine systemic factors including, but not limited to, Ontario midwifery funding models, midwifery models of care, health system integration, and systemic inequities and barriers, such as racism, colonialism, ableism, heteronormativity and cisnormativity and gender discrimination, and their impacts on the future of midwives and midwifery.

This comprehensive synthesis report is part of the first phase of the Midwifery Sustainability Project.

A systematic synthesis of the available evidence and an analysis of the research gaps are essential to an evidence-informed approach to addressing midwifery sustainability in Ontario.

Specifically, our comprehensive synthesis was guided by the following research question:

1. What are the systemic factors that impact the sustainability of the profession of midwifery?
    a. In what ways do these systemic factors impact sustainability?
    b. What are the research gaps related to the sustainability of midwifery?

APPROACH

Three sources of evidence informed the findings of the comprehensive synthesis report (Figure 2). First, we used evidence generated by the association through a mix of AOM-led research projects and member-generated data. Second, we turned to the peer-reviewed literature for articles related to the subject of midwifery sustainability. Lastly, we examined the grey literature for relevant reports on aspects of midwifery sustainability or sustainability of health professions more broadly in Ontario.

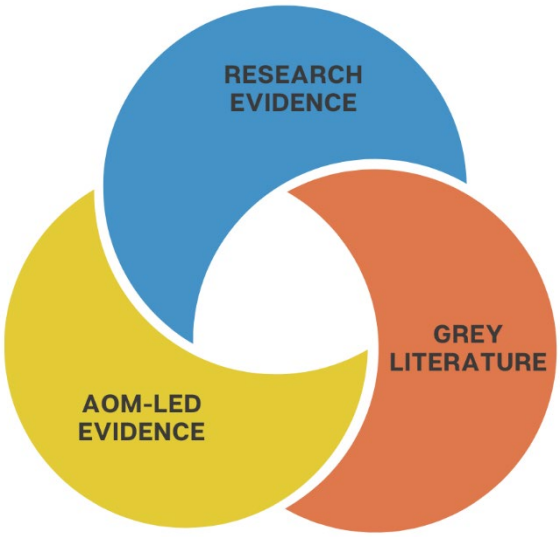


Figure 2. Sources of evidence

Synthesis of the research evidence

On December 13, 2022, we searched the following four bibliographic databases to identify relevant research evidence (systematic reviews and primary studies). An update was completed in April 2024.

1. MEDLINE (U.S. National Library of Medicine's bibliographic database);
2. Cochrane Library (high-quality health evidence database);
3. PsycInfo (psychological science); and
4. Embase (biomedical literature database).

Using the OVID platform, we refined the searches using medical subject headings (MeSH) and keywords based on the following concepts: midwifery AND sustainability, retention, job satisfaction, resilience, professional autonomy, mental health, and burnout. We limited results to the English language and articles published in the last five years. Two reviewers on the synthesis team independently assessed the 452 results from the searches for inclusion. Articles were included if they explored the systemic factors associated with midwifery sustainability.

For each article included in the synthesis, we documented the type of research and the local applicability of the findings. Specifically, we documented the proportion of the included studies within systematic reviews that were conducted in health systems in Canada as an indicator of the findings' local applicability. In the case of single studies, we also documented whether the research was conducted in a health system in Canada. We completed data extraction based on the framework for understanding the systemic factors impacting midwifery sustainability, described below.

Framework for understanding the systemic factors impacting midwifery sustainability

Figure 3 outlines the framework we used to guide our analysis of the evidence related to the systemic factors impacting midwifery sustainability. The framework was initially developed by Mattison et al. in 2017 as part of a series of midwifery-focused health systems research conducted at the global level, as well as the local Ontario context.[4, 9, 10] The research has since expanded to include both a conceptual and applied understanding of the role of midwifery associations in improving sexual and reproductive health and rights, as well as how to strengthen midwifery associations through operational and technical capacity building.[11, 12] The framework is dynamic and continually refined as new evidence emerges from research and policy work.

The framework is layered, and we begin by recognizing the intersection of power and privilege, specifically colonialism, capitalism, and patriarchy, as it cuts across each layer. Systems of oppression intersect in different ways with the concepts presented in the framework. The historical and ongoing impacts of racism and colonialism in Canada are crucial to understanding how these factors influence who gets to be a midwife, as well as which midwives have access to resources and support to help them thrive in their professional roles. Systems of oppression negatively impact the health and wellbeing of midwives.

At the centre of the figure is the midwife and focuses on understanding how to support the health and wellbeing of the midwife in their capacity as a health professional. As a gendered profession, with the majority of midwives identifying as female, the profession is vulnerable to systemic impacts of patriarchal structures and hierarchies of professional and domestic labour associated with "female work". The Sustainable Midwifery Practice Taskforce in British Columbia identified five critical junctures during a midwife's career where burnout and stress are magnified: 1) during midwifery education and training; 2) early career midwifery; 3) early family life and caregiver responsibilities for young children; 4) experiencing a critical incident and potential symptoms of traumatic stress; and 5) aging and experiencing chronic illness and or disability.[13] The image of the path in the framework represents these five precarious phases during an individual midwife's journey in the profession.

Midwifery clients and the care relationship centre on the factors that sustain and satisfy midwives to stay in the profession. These factors can include the impacts of the individual midwife's relationships with their clients, the community factors more broadly that support job satisfaction, as well as the ways in which certain models of care foster mutually beneficial relationships between midwives and clients.

Midwifery care is the next layer, which focuses on integrating midwifery into the range of health system components involved in the provision of quality sexual and reproductive health services, including the models of care in which midwives work, governance, and financial

components. Models of care and working conditions impact midwives, the clients they serve, and the health systems in which they work.

The next layer is understanding the ways in which the professional midwifery association, in this case the AOM, supports the sustainability of the profession. Core activities include, but are not limited to, negotiating and advocating for the effective implementation of agreements with the Ontario Ministry of Health, advocating for the profession in any spaces where midwives are involved in the provision of healthcare services (e.g., primary care policy decisions and public health responses such as COVID-19) and the inclusion and integration of midwives in the health system, supporting midwives in their clinical, inter-and intra-professional practice, and protecting midwives rights to compensation and working conditions that are free from systemic gender and other intersecting forms of discrimination.

The outer layer of the framework includes the main elements that are needed for midwifery to reach its full potential. The elements consist of:

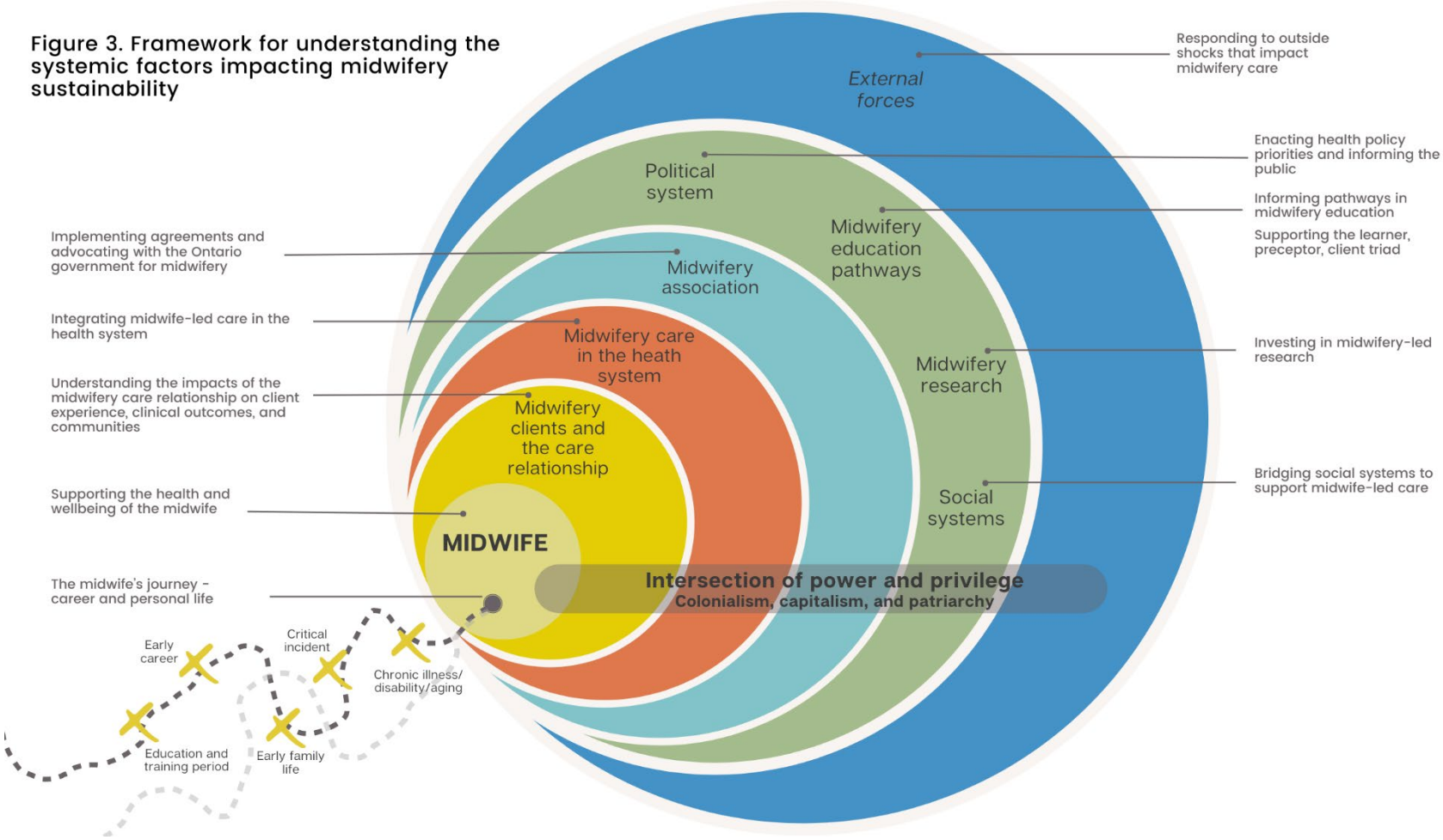
1. ***political system:*** midwifery association's role in enacting relevant health policies and supporting government priority areas, managing the contractual arrangements of midwives, and mobilizing the public to respond to community needs;
2. ***midwifery education pathways*:** recognizing and informing the education pathways in midwifery, which includes the 'what', 'how', 'where', and 'by whom' midwifery is taught, and includes Indigenous midwifery and learning;
3. ***midwifery research*:** investing in midwifery-led research for the advancement of overall population health and supporting midwives in their work; and
4. ***social systems*:** bridging midwifery between health and social systems in ways which recognize that the work of midwives spans systems.

Finally, external forces are shocks outside the issue of midwifery sustainability that can have an unexpected impact, such as economic recession, severe weather events, or war. The COVID-19 pandemic is a perfect example of an external force, which has resulted in unprecedented consequences for health systems and health professionals.

Steering committee consultation

In the spring of 2023, a six-week engagement process took place with the Midwifery Sustainability Project's Steering Committee. The Committee's involvement focused on collaborative engagement in revising and finalizing the *Framework for understanding the systemic factors impacting midwifery sustainability*, reviewing report drafts, and providing critical feedback. The committee generated the recommendations to address midwifery sustainability based on the research evidence and the gap analysis.

Figure 3. Framework for understanding the systemic factors impacting midwifery sustainability



FINDINGS

We present our findings below based on the main elements of the framework for understanding the systemic factors impacting midwifery sustainability. Our findings were informed by 33 relevant peer-reviewed articles from our searches of bibliographic databases, nine AOM-led research projects and member-generated data sources, and six reports found in the grey literature. In each section below, we begin where possible by profiling AOM and Ontario-specific findings, followed by midwifery research conducted in Canada, and then the relevant global literature related to midwifery sustainability.

Intersection of power and privilege

When we interrogated the literature related to midwifery sustainability, we asked ourselves for each included article the following questions to capture the impacts of the intersection of power and privilege:

- Who has access to what?
- Who does what?
- How are values defined?
- Who decides the rules and makes decisions related to midwifery?
- Who is safe?
- How is power negotiated and changed (individual and structural levels)?
- How are midwives differently affected by this representation of the problem?

IMPACTS OF RACISM AND COLONIALISM IN ONTARIO

Midwifery in Ontario has historically been and continues to be dominated by white midwives. Midwifery legislation prioritizes the skills of white women midwives, with privilege embedded in past policies and structures that reinforce systemic barriers for Indigenous, Black, and People of Colour (IBPOC) midwives.[14] Similarly, racism impacts who becomes a midwifery leader, as IBPOC midwives often do not see themselves represented in leadership positions.[14] The 2019 *Experiences of Racism Among Ontario BIPOC Midwives and Students in Midwifery Education and Profession* was the first study to explore the experiences of racism in the profession.[14] The study found that:

- 50% reported experiencing a great deal or considerable amounts of racism from midwives during their education and training;
- 86% reported experiencing racism in their work as a midwife;
- 87% reported witnessing another midwife or midwifery student being a target of racism;

- 61% reported not feeling supported by their practice group when confronted with racism; and
- over 85% of participants agreed or strongly agreed that racism or fear of racism impacts how they communicate, their mental health, and their comfort in working in any community where there are employment opportunities.[14]

The authors of the research recommend actions to raise critical awareness to acknowledge racism in the profession, increase diversity in midwifery through shared values and appreciation for the strengths that diversity brings to midwifery practice while holding accountable those who commit racist acts and preserve racist systems.[14] Interventions include focusing on anti-white supremacy work, improving racial equality through mentorship, and supporting IBPOC midwifery leadership through training and coaching.[14]

Colonial practices dominate midwifery education and training in Ontario, often silencing Indigenous midwifery knowledge and increasing the gap between midwives and the communities they serve. The 2021 forced closure of Laurentian University's School of Midwifery, which was the sole bilingual and northern midwifery education program in Ontario, resulted in midwifery education seats being absorbed by McMaster University and Toronto Metropolitan University, both based in southern Ontario. At this time there are no publicly available plans to reinstate the program in northern Ontario. The loss of the program has had both immediate and longer-term impacts on the sustainability of midwifery in northern and remote communities in Ontario, including the increasing barriers to the provision of culturally safe midwifery services for Indigenous communities and has led to gaps in midwifery care.

IMPACTS OF GENDER ON MIDWIFERY IN ONTARIO

Patriarchal systems oppress midwifery, and the profession faces barriers that are fundamentally rooted in gender inequality. Midwifery is an almost exclusively female profession and is characterized by low status among health professionals, inadequate remuneration, limited professional education and research opportunities, limitations imposed on working to the full scope of practice, professional disempowerment, and lack of voice in decision-making.[3] In Ontario these systemic barriers manifest themselves in the prioritization and valuing of physician-dominated and hospital-based healthcare.[9]

The 2018 landmark legal decision, led by the AOM on behalf of midwives in Ontario to the Human Rights Tribunal of Ontario (HRTO) found a gender pay gap for midwives due to discriminatory actions by the Ministry of Health. The Ontario government opposed the decision through a number of legal mechanisms including the 2020 filing for judicial review in Divisional Court, and the 2021 leave to appeal the decision at the Ontario Court of Appeal.[15] Both the Divisional Court and Ontario Court of Appeal ruled in favour of midwives and upheld the decision of the Human Rights Tribunal of Ontario. The Ontario government has confirmed

that it will not seek to appeal the Ontario Court of Appeal decision to the Supreme Court of Canada, and the original decision and remedial orders remain in place.

This legal win for midwives in Ontario has set a critical precedent for pay equity with far-reaching implications for equity-seeking groups across Canada.[15] The gender pay gap is one example of how patriarchal systems of healthcare spending and compensation-setting oppress midwifery, which is inextricably linked with the sustainability of the profession. We recognize that the legal decision was a vital achievement for the profession and acknowledge that pay equity is only one manifestation of the impacts on gender. The AOM is continuing to advocate for the implementation of the remedial orders, including through the completion of the Human Rights Tribunal of Ontario-ordered Joint Compensation Study, which will evaluate the work of midwives and their physician comparators and provide a tool designed to be used as protection against discriminatory pay in future compensation negotiations.

As part of the remedial orders from the HRTO, the Ministry of Health commissioned a Gender-Based Analysis Plus (GBA+) of compensation policies and practices for independent contractor midwives in Ontario to gain insight into the barriers, gaps or systemic inequities, and to generate actionable recommendations in alignment with the Ontario Human Rights Code. This intersectional approach included stakeholder consultation with those involved in the Ministry of Health's compensation policy and practice development, negotiations, creation, and implementation.[16] There were three main findings of the GBA+. First, power, privilege and oppression dynamics are pervasive in the relationship between midwives and the government.[16] Second, an intersectional gendered lens is missing and as a result not reflected in policies, practices, and decision-making.[16] Lastly, there is a lack of clearly defined compensation priorities in the province's maternal and newborn care sector.[16]

Recommendations to meet the Ontario Human Rights Code are structured by the Organization for Economic Cooperation and Development's (OECD) gender budgeting framework and include:

- ***A strong strategic framework*:** develop a Gender Equality Action Plan for Midwives in Ontario and develop a strategy for the maternal and newborn care section;
- ***Effective tools for implementation*:** develop and apply an intersection gender lens tool for use by the Ministry of Health, adopt gender budgeting practices, and adopt gender impact assessments to evaluate and assess laws, policies, and programs moving forward; and
- ***A supportive enabling environment*:** collect intersectional diversity disaggregated data, increase the accessibility and transparency of compensation policies for midwives; and integrate an intersectional gender lens to the Joint Compensation Study.[16]

Midwife burnout

Burnout emerged across all sources of evidence as the strongest factor impacting the sustainability of midwifery. Our own 2021 Membership Survey results emphasize the magnitude of the problem. Midwives were asked in the survey whether they were considering leaving the profession in the next one to two years or the next three to five years. One hundred and sixty (160) midwives responded that they are considering leaving the profession in the next one to two years (representing 16% of membership), and 155 midwives responded yes to in the next three to five years (representing 15% of membership).

Our survey results align with findings from similar research studies conducted in Canada. One focused on the intention to stay among pre-and post-clinical placement midwifery students, also found that one-third of respondents were seriously considering leaving in the near future.[17] The other study surveyed burnout and intentions to leave the profession among midwives in Western Canada and also reported that one-third of respondents had seriously considered leaving the profession.[18] These rates were even higher in a burnout survey of whether midwives had considered leaving the profession in British Columbia (67%) and Alberta (57%).[19] Table 1 summarizes the key findings from our comprehensive synthesis of the systemic factors impacting midwifery burnout.

Table 1. Summary of key findings of the systemic factors impacting midwifery burnout

Systemic factors impacting midwifery burnout	Key findings from the evidence
Critical junctures during a midwife's career where burnout and stress are magnified	***Midwifery education and training*** • A study of pre-and post-clinical placement midwifery students in Canada found that post-clinical placement students had a significantly lower intention to stay in the profession, which was associated with perceptions at the interface of work and personal life.[17] ***Early career midwifery*** • A high-quality systematic review and one primary study found that early career midwives experienced strain and those with less than 10 years' experience were more likely to leave the profession.[20, 21] • Midwives were more likely to record high levels of stress, depression, anxiety, and burnout if they were aged 40 or below, living with a disability, unable to work off-call, and had less than 10 years' of practice.[22, 23] ***Early family life and caregiver responsibilities*** • Burnout scores were higher among midwives with young children, and those with children under five were particularly vulnerable to burnout.[18] • Two primary studies found diverging results - midwives with children were less likely to burnout[22] and consider leaving the profession.[21] • Family structures, being partnered and/or having children, were not found to be protective against depression, anxiety, stress, or burnout, in a cross-sectional survey of the mental health of midwives in Ontario.[23] • Call schedule was reported as negatively impacting family life, with concerns around having a family and lack of supports for maternity leave.[18] ***Experiencing a critical incident*** • Health professionals who were empathetic and compassionate, and had built emotional connections with their patients were more at risk of being vicariously traumatized by adverse childbirth events.[24] • Midwives reported that their senior colleagues and managers were often more concerned about the legal implications of the adverse childbirth event rather than acknowledging the impacts of the trauma and supporting them.[24] ***Ageing and/or living with a chronic illness or disability*** • Midwives living with a disability and older midwives reported struggling to stay in the profession, because of challenges with meeting the demands of the job, especially night work and being on call.[18] • The physical demands of midwifery were found to be a challenge, resulting in musculoskeletal disorders, which then can lead to reduced job satisfaction.[25]
Mental health	A primary study conducted in Ontario identified a range of factors that have a detrimental impact on midwives' mental health, which included: • funding arrangements and midwifery practice group-based funding arrangements; • caseload midwifery with continuity of care; • toxic 'grind culture' in midwifery to push past health and wellbeing limits to meet job demands; • model of midwifery care in Ontario (uncertainty and unpredictability of on-call intrapartum care), vicarious trauma from attending traumatic births, and emotional labour; • negative inter-and intra-professional relationships, including bullying; and • discrimination in the workplace, including racism, ageism, and homophobia.[26]

Systemic factors impacting midwifery burnout	Key findings from the evidence
Bullying	• A high-quality systematic review found that those who have been bullied in the workplace had lower levels of job satisfaction, higher levels of anxiety and depression, and are more likely to leave their place of work.[27]
Work environment	• Newly qualified midwives were most susceptible to experiencing a mismatch between their beliefs (e.g., client-centred care within a midwifery-led model) with the reality of perinatal care (i.e., medically dominated and focused on institutional priorities).[22]
Models of care	• Burnout in midwives was found to be related to work-related and personal factors rather than client-related factors, and midwives working within a caseload model have a lower incidence of burnout at an individual and group level.[28] • Diverging results were found in a primary study conducted in Ontario, which suggests that midwives working in continuity models experience higher levels of burnout.[26]

Key actions to address the five vulnerable time points in an individual midwife's career, which were identified in the report by the Sustainable Midwifery Practice Taskforce in British Columbia include:

1) ***midwifery education and training*** - implement fewer and longer placements to reduce financial burdens and social isolation and improve psychological safety of learners through transparent and accountable reporting processes;

2) ***early career midwifery*** - support the development and inclusion of midwife leaders across all levels of the health system and support new midwives in their autonomous practice through midwifery association-led programs;

3) ***early family life and caregiver responsibilities*** - regularly assess burnout levels using the Copenhagen Burnout Inventory, and seek necessary supports;

4) ***experiencing a critical incident*** - develop a peer support program following a traumatic critical incident and advocate for paid leave to recover from critical incidents; and

5) ***ageing and/or living with a chronic illness or disability*** – advocate for funding models that do not prioritize volume of births attended and are inclusive of the full range of health services midwives deliver.[13]

These actions generated by the Taskforce illuminate some of the critical supports and interventions needed during these vulnerable time periods and provide specific guidance to consider in the Ontario context. Our report seeks to build on and add to, these recommendations to provide evidence-based guidance for the AOM's Midwifery Sustainability Project.

Midwifery clients and the care relationship

The research evidence identified ways in which the relationship between the midwife and clients acted as a protective factor and supported sustainability. Close relationships with clients[29] and passion for the profession were found to be protective against burnout,[28] and a factor that increased job satisfaction.[25] Similarly, other studies have found that the ability to build relationships with clients coupled with the clear communication of boundaries with clients supported midwives to create better work-life balance.[30] "Partnership," as described in the Canadian midwifery model of care, helps define the relationship.*[31]

A study on rural midwives highlighted how relationships within health organisations, between midwives and other health professionals, and clients and their families were both a joy and a challenge.[32] Relationships were found to be essential to meeting the challenges of rural practice, and the authors highlighted that the importance of time and distance in relationship building needs to be acknowledged, especially among those who have little appreciation of rural and remote contexts.[32] Social capital was a main theme for rural midwives and was characterised by social trust, community solidarity, shared values, and working together for mutual benefit.[32] Rural communities generally exhibit high levels of social capital, which was key to sustainable rural midwifery practice.[32] "Relationships in midwifery have at times been overshadowed by social and economic determinants, for example, the continual emphasis on quantifiable targets, efficiency savings and centralising maternity provision. This is concerning given that midwives in this study reveal how relationships in rural practice need to be given significance and be nurtured for a sense of community solidarity and social trust to develop."[32]

The evidence related to midwifery models of care is covered in detail in the subsequent section. However, we did identify in the research ways in which support for the midwifery model of care, including developing relationships with clients, was associated with job satisfaction.[33] One of the factors that was found to contribute to the job satisfaction and sustainability of practice of midwives working in caseload models was the ability to build relationships with clients.[30] Within free standing midwifery units, positive working relationships had positive effects on midwives' stress levels and general wellbeing, which had a cascade effect on the quality of the service to clients.[34] Fostering a team environment that focused on building both relationships among staff and with clients built a sense of wellbeing for both midwives and clients in a reciprocal and mutually reinforcing capacity.[34]

* "Partnership: Midwives engage in a non-authoritarian and supportive partnership with clients throughout their care. Midwifery recognizes the intimate client-care provider relationship as being integral to the provision of care that is responsive to the unique cultural values, beliefs, needs and life experiences of each client. Research suggests that the nature of the relationship between a client and healthcare provider is one of the most significant determinants of positive outcomes. For Aboriginal communities, the inclusion of extended families and the integration of culturally safe care increases positive health outcomes. Midwifery has grown from and continues to be driven by the voices of women and all people experiencing midwifery care."[29]

Midwifery care in the health system

The next layer in the framework is the integration of midwifery care into the health system. Research has found that health system barriers limit the options available to the midwifery workforce and are most often reflected in siloed work settings, with midwives working in the periphery of the health system, much like what can be found in Ontario.[4] When understanding midwifery care in the health system we look to three core components: 1) the ways in which midwifery care is delivered (i.e., models of care); 2) governance structures for midwifery care (e.g., regulatory structures for midwives); and 3) financial components for how midwifery is financed in the health system and payment mechanisms for midwives).

DELIVERY OF MIDWIFERY CARE

The delivery of client-centered midwifery care includes the range of midwifery models of care, from the originally funded continuity-of-care-based 'course of care' approach with bundled services from early pregnancy through the first 6-8 weeks of the postpartum and newborn period, to the diverse Expanded Midwifery Care Models and Indigenous Midwifery care models found in Ontario, some of which do not include intrapartum care and some which cover sexual and reproductive care outside of pregnancy. Most of the research within this section focused on continuity midwifery models, including intrapartum care, which were found to be protective and associated with lower levels of burnout.[19, 20, 28] Caseload continuity models (versus shift work or episodic care models) were associated with lower rates of burnout, greater autonomy, personal satisfaction, and a greater ability to provide personalized care.[18, 20] Factors contributing to the job satisfaction and sustainability of practice of midwives working in caseload models included the ability to build relationships with clients, control over working arrangements (organisational and practice arrangements), and professional autonomy and identity.[30] However, we note that two studies, one on midwives in Western Canada and another on midwives in Ontario, found that caseload midwifery had higher burnout scores than midwives from other countries who practiced in a similar model.[18, 26]

Ontario has two midwifery-led units: one at Oak Valley Health's Markham Stouffville Hospital, the first of its kind in Canada, and one at Hamilton Health Sciences, which was established in 2022. Both midwifery care units are midwife-led and operate in a physically separate space close to the hospital obstetric unit. At the Oak Valley Health Alongside Midwifery Unit (AMU), the hospitalist midwife acts as a bridge, conducting triage assessments and attending births as a second midwife for community midwives who provide continuity of care through pregnancy, postpartum and intrapartum period.[35] Evaluation research on the unit found that from the perspective of health professionals, the model enhanced interprofessional collaboration, promoted safety, and improved role clarity and collaboration.[35] The role of the hospitalist midwife is to support the safe operation of the unit and enhance its autonomy.[35] Hospital

investments in supporting midwifery manager's leadership skills and knowledge were pivotal to the successful implementation of the unit.[36] At the Midwifery Care Unit at Hamilton Health Sciences, community midwives attend births in an adjacent space to the obstetrical unit but without dedicated hospitalists to provide the bridging role found at the Oak Valley Health AMU.

Alongside midwifery units exist globally, and research conducted in the U.K. found that midwives working in this model valued the environment, approach, and the opportunity to exercise greater clinical judgement.[37] Potential sustainability challenges identified in the study included administrative management, interprofessional tensions, developing appropriate staffing models, midwives' skills and confidence, and information and access for clients.[37]

Research on free-standing midwifery units, such as birth centres, has found positive outcomes that include ownership, autonomy, continuous learning, team spirit, interdependency, mutually supportive relationships (interdependency), enjoying work, and valuing time spent with clients.[34] Sense of ownership and autonomy were key factors that were highly connected to job satisfaction. A lack of hierarchy was noted in this model, in that midwives made decisions together, even where there was a senior midwife on shift.[34] Positive working relationships and enjoyment of the work had positive effects on midwives' stress levels and general wellbeing, which in turn improved the service quality in a reciprocal and mutually reinforcing sense of wellbeing.[34]

In Ontario, there are three midwife-led birth centres, which are free-standing, community-based healthcare facilities.[38] The Tsi Non:we Ionnakeratstha Ona:grahsta', Six Nations Maternal and Child Centre opened in 1996, was the first birth centre in Ontario, and care is provided by Indigenous midwives. The Toronto Birth Centre and the Ottawa Birth and Wellness Centre both opened in 2014. The Toronto Birth Centre is accountable to an Indigenous-led governance structure and focuses on accessible culturally safe birthing services for pregnant people, families, and communities.[39]

Unpublished data collected by the Toronto Birth Centre aligns with the research findings and positive outcomes on free-standing midwifery units outlined above. Important features of the Toronto Birth Centre include:

- midwife-created and group-owned clinical policies that are evidence-informed, align with Toronto midwifery community standards, and are regularly updated by the Midwives' Council;
- purpose-built space and processes designed by Indigenous midwives that reflect how midwives work;
- supportive and inclusive hub for the midwifery community; and

- hosting learners from midwifery and other health professions to teach the ways in which Indigenous and midwifery leadership can shape a birth facility.

Health system barriers to running the Toronto Birth Centre are related to the demands on staff to meet the requirements for operating an Independent Health Facility. Additionally, the current funding agreement limits the options available to the centre to expand the model (e.g., longer stay postpartum for prioritized community clients).

MIDWIFERY GOVERNANCE COMPONENTS

The midwifery governance components range from constitutional governance (e.g., rules and regulations typically made by governments), operational governance (e.g., how individual actors in the health system implement the day-to-day activities such as regulations), and collective governance (e.g., made by close to the ground governing bodies such as midwifery associations and Midwifery Practice Groups). We found limited evidence on midwifery governance components related to sustainability, however, within collective governance, we found one review study that examined midwifery sustainability and job satisfaction in caseload models.[30] Regular practice meetings were viewed as critical to job satisfaction, clinical skills development, and sustainability of practice as they facilitated open communication between midwifery partners and colleagues.[30] The provision of clinical support, social support, continuing professional development, mutual respect, and shared philosophy of midwifery practice increased the development of intra- and inter-professional relationships.[30]

We also identified research evidence relating to operational governance arrangements within alongside midwifery units, which is elaborated on in the *Delivery of Midwifery Care* section. These operational governance arrangements align with hierarchical systems in hospitals.[34] Alongside midwifery units were found to need four key elements in place to support the innovation: finance and service management support, staffing, training, and guidelines, which included eligibility criteria and procedures for managing escalation and transfer.[37]

Autonomy at the practice level was found to be positively or negatively affected by policies and procedures. Formal practice policies, guidelines, and collaborative practice agreements had the power to protect or interfere with the ability of midwives to practice independently.[33] Supportive practice climates sustained and facilitated midwives in their provision of care without unwarranted interference in care plans, consultation, or transfer of care.[33] In routine clinical practice settings, autonomy and respectful work environments impact the ability of midwives to make care decisions for their clients (i.e., without required input or seeking permission from physicians, and support in determining one's own workflow, which can include setting up their own schedule, choosing coworkers, and control over the practice business decisions).[33]

FINANCIAL COMPONENTS FOR MIDWIFERY SERVICES

Financial components for midwifery services refer to considerations around how the health system is financed, midwifery practice funding, and remunerating midwives. Poor remuneration of midwives was cited in multiple studies as a reason to leave the profession.[17, 19, 20, 25] Specifically, midwives found that the pay level was not commensurate with the level of responsibility and stress associated with the job and that poor pay meant they had to work more, which was not sustainable.[19] One study examined the impact of funding arrangements in Ontario on the provision of primary antepartum, intrapartum, and postpartum care services, including considerations related to interprofessional collaboration.[40] The study found that a lack of flexibility within the midwifery 'course of care' funding model coupled with the physician fee-for-service funding model is a barrier to interprofessional collaboration, siloes health professions, and limits innovations to the provision of sexual and reproductive health services within the health system.[40] Two studies examined the financial stressors unique to the caseload model, which included the financial stress of starting a practice, paying other midwives to cover leaves (in order to take time off), financial costs associated with travel to client's homes, and low caseloads during some months.[17, 18] Suggestions to reduce these stressors included better compensation, flexibility for part-time work options, support for sick days/vacation coverage, more pay per course of care, and more off-call career opportunities.[18]

While the research evidence shows that there is an important link between midwifery burnout, low remuneration,[20] and financial reward as a component of job satisfaction,[25] it is not the only explanatory factor to midwifery attrition in Ontario. Despite our significant victory towards midwifery pay equity, midwives' compensation has not yet been rid of gender discrimination. Following the HRTO-ordered 20% compensation increase, our 2021 Membership Survey highlights that one in three midwives are considering leaving the profession in the next five years. These findings suggest that fair and discrimination-free compensation for midwives is one key factor relevant to midwifery sustainability, but other factors, such as flexible work options and supportive work environments, also need to be addressed.

Midwifery association

Midwifery associations play a vital role in supporting the profession. They act as the glue that holds the profession together and are central to integrating it into health systems, supporting enabling environments for midwives.[41] Research has found that to strengthen midwifery, according to the International Confederation of Midwives' three pillars (education, regulation, and association), we need to begin with the association to support the other components.[41] Midwifery associations are key enablers that strengthen the profession across political, health and education pathways.[41] They are the voice of the collective and instrumental in bargaining and implementing agreements.

Locally, the AOM advocates for its members to the Ontario Ministry of Health and in any spaces where midwives are involved in the provision of healthcare services. The AOM plays an important role in securing professional liability insurance for midwives, ensuring adequate coverage for midwives to work to their full scope of practice. The strong relationship between the AOM and the Healthcare Insurance Reciprocal of Canada (HIROC), the provider of insurance to midwives in Ontario (and in many jurisdictions across Canada), provides mutual benefit, with HIROC supporting quality assurance activities through the AOM to promote safe care and midwives demonstrating an excellent safety record, leading to low liability claims.

Membership to the AOM is mandatory for most registered midwives in order to access liability insurance. In provinces where midwives are not obligated to be members of the association, midwifery associations were found to be limited in their advocacy efforts due to a lack of cohesion and information from its membership.[42] The HRTO is an example of leadership by a midwifery association. The AOM led the effort on behalf of midwives in Ontario through collective funding for legal fees from membership, exemplifying an act of member unity for gender pay equity.

We found limited research evidence specific to how midwifery associations can support the profession's sustainability. The Royal College of Midwives' Caring for You is an online hub for maternity care workers and students in the U.K., which includes the Caring for You charter for employers to sign to acknowledge their legal duties to provide safe and healthy working environments. The campaign and charter were in response to research commissioned by the Royal College of Midwives, which found that 67% of the U.K. midwifery workforce reported moderate and above work-related burnout.[22] Researchers of midwifery burnout in Canada argued that their findings of high burnout rates among midwives send a strong message to provincial governments and midwifery organizations to invest in research and programming in order to better understand and address the underlying issues and stressors that lead to attrition.[18]

Strong midwifery associations are catalysts for change, they are essential to and needed in identifying and dismantling colonial and racist policies and practices in midwifery.[14] Contributing to a transformational shift that critically analyzes the ways in which structural and institutionalized racism and other inequities impact, childbearing families, midwifery students, faculty, staff, midwifery associations, midwife regulators, ministries of health, and their policies.[43] At the AOM, we are working towards achieving racial justice, both systemic and interpersonal, in the profession through a process of unlearning, listening, recognizing privilege, and actions toward addressing power imbalances.[44]

Outer context

The outer context consists of the four main factors that are needed to support midwifery sustainability and help the profession reach its full potential and impact.

POLITICAL SYSTEM

The political system includes examining power and process at the political level, responding to changes in government, and understanding the barriers and facilitators related to interest groups (e.g., the Ontario Medical Association and the Ontario Nursing Association). The midwifery association's role is to facilitate the enactment of relevant health policies and support government priority areas through midwifery services. This includes strategic advocacy, developing midwifery leaders, managing the contractual arrangements of midwives, and mobilizing the public to respond to community sexual and reproductive health needs.

Governmental agendas of dominant political parties shape the midwifery workforce's development and the profession's sustainability. As covered in the *Power and Privilege* section of the synthesis, the Government of Ontario opposed the 2018 legal decision of the Human Rights Tribunal of Ontario through several legal mechanisms (2020 filing for judicial review in the Divisional Court and 2021 leave to appeal the decision at the Ontario Court of Appeal).[15] The decision of the Human Rights Tribunal of Ontario is an important example of the political power of the Ministry of Health and its discrimination against midwives. Research on the role and integration of midwifery in Ontario's health system has shown that midwives lack an institutional voice in primary care policy conversations.[9] For example, physician and nurse numbers are the central consideration of health workforce planning in Ontario, and midwives have been excluded from evidence-based health human resources planning in the province[45] despite midwives providing care to 20% of pregnant people in Ontario in 2023.

The GBA+ findings also highlight the absence of an intersectional gender-based lens in policies, practices, and decision-making related to midwifery in Ontario. This results in inequitable compensation of midwives and highlights the urgent need for the development and adoption of gender budgeting practices.[16] Midwives are also omitted from health workforce planning decisions, another symptom of the power and privilege in the health system.[16]

MIDWIFERY EDUCATION PATHWAYS

There are five education pathways to becoming a practicing midwife in Ontario, which include: 1) two four-year Midwifery Education Programs, which offer Bachelor of Health Sciences degrees located at McMaster University and Toronto Metropolitan University; 2) an education program for Indigenous midwifery students offered through the Aboriginal Midwifery Training Program at Tsi Non:we Ionnakeratstha Ona:grahsta', the Maternal and Child Centre on Six

Nations of the Grand River territory; 3) application to the College of Midwives of Ontario as an internationally educated midwife; 4) the accelerated two-year Post-Baccalaureate Program For Health Professionals offered to those with significant relevant experience through the Toronto Metropolitan University; and 5) apprentice programs through Indigenous Midwifery Programs.[46] There are a total of 90 midwifery education seats per year through the Midwifery Education Programs, which receive envelope funding from the Ontario Ministry of Colleges and Universities and the Ministry of Health.

The *Canadian Competencies for Midwives* are the basis for the development of national assessment processes and focus on the knowledge and skills expected of an entry-level midwife in Canada.[47] These competencies are compatible with the College of Midwives of Ontario's Professional Standards and do not replace them.[48] The National Council of Indigenous Midwives' *Indigenous Midwifery Knowledge and Skills: A Framework of Competencies* provides the competency framework as a tool for Indigenous Midwives and midwifery learners.[49]

The 2020 Giinwi Gaashi Maamwiziying Ndaadzikeying event, meaning "How We Used to Be: One Who Assists in Giving Life Together," brought together Indigenous Midwives, AOM, National Council of Indigenous Midwives, education partners, and governments to implement four priority areas: 1) support Indigenous midwifery learning ecosystems; 2) advocate for Indigenous midwifery infrastructure, funding, and systemic change; 3) strengthen the circle of traditional knowledge and support for Indigenous Midwives, birth workers, and students; and 4) expand public awareness of Indigenous midwifery and birth work through networks and communications. This is summarized in the report: An Indigenous Midwifery Action Plan.[50]

While there are numerous midwifery education pathways in the province, the main education pathway exists within university institutions, which is dominated by white culture. Several initiatives are underway to support social justice in the Ontario Midwifery Education Program.[51, 52] We have identified numerous barriers to the sustainability of midwifery education in the evidence. Experiences in midwifery education programs reflect how IBPOC students are valued and respected, setting the tone as future members of the profession. Midwifery students and apprentices have described that midwifery educational climates are places of social exclusion, hostility, overt racism, and racial microaggressions through the unrecognised effects of implicit bias and unacknowledged white privilege.[43, 53, 54]

Midwifery educators require supports and training in equity and diversity in order to provide safe learning environments.[55] The *Equity in Midwifery Education* web resource based out of the U.S. was created to contribute to the development of a representative, diverse workforce through the promotion of equity in midwifery education programs.[43] The tool is aimed at midwifery educators and administrators to support their work in transforming the educational and practice climates, and provides opportunities for interaction with colleagues and trained

facilitators.[43] The authors highlight that the midwifery education system needs to change to reduce the pressure on IBPOC students to just 'survive', which calls on institutional reform at all levels, including faculty, preceptors, and administrators.[43]

As captured in the *Power and Privilege* section, the closure of the program at Laurentian University has centralized midwifery education seats in southern Ontario, excluding learners from northern and remote communities. By locating midwifery education programs in the south of the province, there is an explicit prioritization of the English language and provision of services in urban areas, leaving large geographic areas even more underserved than they already are.

Research is needed that specifically examines why aspiring IBPOC midwives are, or are not, entering the midwifery profession by identifying specific motivators and barriers to entry into the profession, and includes a robust review of the curriculum with a racial equity lens.[14, 56]

We recognize that internationally trained students face unique challenges in entering the midwifery workforce due to positive bias towards midwives trained at Canadian universities.[14]

MIDWIFERY RESEARCH

Capacity-building for research careers among midwives is very limited despite the clear indicators of quality research led by academic midwives and in collaboration with transdisciplinary groups. Midwife researchers are key to the profession's sustainability, as they bring essential knowledge and perspectives and use a diverse range of methodologies to address important gaps in academic studies of midwifery. The most common barriers to midwives entering research are a lack of positions, post-graduate education opportunities in midwifery, funding, and the need to maintain research activity.[43, 57] Most midwives have minimal exposure to research, most often through a research project for their Bachelor of Science during their midwifery education.[18, 43]

We recognize the importance of midwife-led research in advancing sexual and reproductive health agendas. With funding through the Ministry of Health, the AOM offers Mentored Midwifery Research Grants (up to $12,000), Midwifery Project Grants (up to $40,000), and BORN Data Access Research Grants (up to $10,000) to support Ontario-relevant research that improves care for midwifery clients and their families.[58]

One main limitation we encountered during our bibliographic search in four databases of the peer-reviewed literature for this synthesis is the discovery that the Canadian Journal of Midwifery Research and Practice is not indexed in PubMed/MEDLINE. This search engine is the U.S. National Library of Medicine's bibliographic database and the standard for searching for biomedical and life sciences publications. The Canadian Journal of Midwifery Research and Practice is the only national, peer-reviewed midwifery journal, and if it is not being indexed in

bibliographic databases, it means the research that is being done by midwives in the Canadian context is not reaching a wide audience, and likely not meeting its intended impacts.

SOCIAL SYSTEMS

Midwives often act as the connector between health and social systems. In Ontario, this includes providing services to uninsured clients, as midwives are funded to provide care to all residents within their catchment area, regardless of whether the client is covered under the Ontario Health Insurance Plan (OHIP).[59] One research study highlighted the relationship-building that midwives do in their role in the community and public health.[30] "Midwives viewed the relationships they built with women and their families as supporting a wider, public health aspect of educating, informing and supporting women through birth as a normal, holistic and physiological life process."[30] Another study found that a significant motivating factor for midwives was a personal commitment to social and reproductive justice, particularly to improve outcomes among underserved groups.[56] Midwives serve their communities and reduce inter-generational trauma associated with birth through trauma-informed approaches to care.[56]

While we did not identify any research evidence that specifically addressed how midwives' roles in social systems impact the profession's sustainability, we did find publicly available examples of how midwives in Ontario work to respond to their community needs. Within the context of COVID-19, Seventh Generation Midwives Toronto created a home visit vaccination program for Indigenous people, close contacts, and household members.[42] In the summer of 2021, a vaccine clinic pow wow was held by the University of Toronto to support First Nations, Inuit and Métis people with culturally safe services in which Seventh Generation Midwives Toronto participated in vaccine administration.[42]

External forces

External forces are shocks outside the issue of midwifery sustainability that can have unexpected and often significant impacts, leading to major disruptions to the profession. Economic recessions, severe weather events, or war can all impact the delivery of midwifery services in health systems. The COVID-19 pandemic is a perfect example of an external force, which has resulted in unprecedented consequences for health systems and health professionals in Canada and globally. [7, 60] The effects of the pandemic have led to widespread challenges across health systems in Canada, impacting the supply and distribution of health professionals.[7]

Midwives responded as health systems quickly shifted to address the emerging COVID-19-related needs of the population. Midwives in Ontario experienced incredible marginalization among their other health professional colleagues, lacking financial support, recognition as frontline health workers, access to essential personal protective equipment, and difficulties taking time off when exposed to COVID-19.[61] The COVID-19 pandemic magnified biases in healthcare, highlighting the lack of recognition and support for midwifery compared to other health professionals.[61] During the initial waves of the pandemic, when personal protective equipment distribution was limited, many midwives were given fewer supplies than they needed.[61] Often, midwives were left to find and supply their personal protective equipment at their own expense.[61] Midwives were also excluded from financial aid meant to support health professionals in implementing safety measures in their clinics.[61] The Ministry of Health omitted midwives from receiving temporary financial support for frontline and support workers involved in responding to COVID-19.[62]

We also recognize that COVID-19 is not the only external force impacting midwifery. The past few years have witnessed a combination of many external shocks resulting in individual and collective trauma, including but not limited to:

- discoveries of more than 2,000 unmarked graves at former residential schools;
- Black Lives Matter movement in response to historical and continued violence towards Black communities;
- powerful conservative political movements focused on the restriction or removal of reproductive rights;
- anti-Asian acts of racism and violence;
- Tigray war, Russia's war in Ukraine, the Israel-Gaza crisis; and
- geopolitical instability.

GAP ANALYSIS

In the table below, we outline the gaps in evidence using the framework for midwifery sustainability to structure the analysis.

Framework elements	Gaps in evidence
Intersection of power and privilege	• Further evidence is needed to build upon AOM-led research to understand approaches to address racism among IBPOC midwives and students • Evidence is needed to understand the full extent of the impacts (immediate, intermediate, and long-term) of the forced closure of Laurentian University's Midwifery Education Program • Guiding questions include, how has the loss of Laurentian University's Midwifery Education Program impacted the sustainability of midwifery in northern and remote communities in Ontario? How are midwifery students being provided culturally safe midwifery education?
Midwife	• While there is large body of evidence that examines the factors impacting midwifery burnout, many of the solutions place the burden on the midwife rather than addressing system-level issues • Further implementation and evaluation flexible work arrangements, including supportive arrangements for late career midwives and midwives living with disabilities • AOM-led initiatives to address racism, homophobia, and transphobia in midwifery
Midwifery care in the health system	• Implementation research on how to fully address the recommendations from the *GBA+ of Compensation Policies and Practices for Independent Contractor Midwives in Ontario* • Includes Ontario specific data on midwifery models of care and their relationship with job satisfaction, burnout, and attrition, as well as client experience
Midwifery association	• Associations are agents of change and there are opportunities to measure how the AOM is addressing power imbalances in the profession
Outer context Political system	• Understanding impactful mechanisms for midwifery associations to bargain and advocate for midwifery with the government, especially when there is a lack of alignment in priority areas
Midwifery education pathways	• Evidence is needed on how to address the numerous barriers to the sustainability of midwifery education, including pathways to becoming an Indigenous midwife
Midwifery research	• Exploration of research pathways, including how to obtain financial and training supports to enable midwifery research to thrive, where knowledge and learnings exist beyond academic institutions
Social system	• There is no research on how midwives bridge health and social systems
External factors	• Recognition of midwives as essential frontline health workers that respond to health crises

ENABLERS AND BARRIERS

Below, we summarize the factors that emerged from the analysis that act as enablers or barriers to midwifery sustainability.

Framework elements	Enablers to midwifery sustainability	Barriers to midwifery sustainability
Midwife	Stress reduction strategies to avoid burnout include: • part-time work options; • support for sick days and vacation coverage; • increased pay per course of care; • more off-call career opportunities; and • initiatives to reduce bullying and interprofessional conflict[18] Protective factors against burnout: • joy of midwifery practice; • supportive family and midwifery relationships; • social support at home; • relationships with clients; • shared decision making; • like-minded midwifery partners; • managing the unpredictability of being on-call • strong midwifery leaders; • negotiating and maintaining boundaries; • working with learners; • proactive disability supports to sustain wellbeing; and • mental health supports[18, 20, 29, 63] Factors that increase job satisfaction: • support within the team; • good relationships with colleagues; • appreciation and support from superiors; • autonomy; • meaningful work; • interaction with clients; and • supporting physiologic birth[25, 64] • Individual efforts to interrupt and draw attention to racist actions as they occur[14]	Factors that reduce job satisfaction: • heavy workload; • lack of staff and resources; • tension between managing work-life balance; • low remuneration; and • experiencing a musculoskeletal injury[22, 25] Factors related to burnout in midwives: • negative relationships with other midwives and hospital staff; • lack of professional support; • poor organizational culture; • excessive working hours; • struggles with finding work/life balance; • non-caseload or non-continuity models of care; • continuity of care models; • low remuneration; • absence of professional recognition; • living with a disability; • lack of off call work options; • less than 10 years practice experience; and • lack of material resources and personnel[18-20, 22, 23,26, 29, 32] • Bullying within midwifery is a leading workplace stressor and linked to lower levels of job satisfaction, higher levels of anxiety and depression, and attrition[22, 27, 29, 32, 63] • Traumatic experiences and adverse events without adequate support from colleagues and organizations impact midwives' ability to cope and stay in the profession[24, 63] • Culture of self-sacrifice in the profession[21, 63]

Framework elements	Enablers to midwifery sustainability	Barriers to midwifery sustainability
Midwifery clients and the care relationship	• Building relationships with clients and communities[21, 29, 30, 32, 33, 64] • Sufficient resources to spend quality time with clients to both educate and empower them[21]	Emotional demands of working closely in a caring role with clients daily without adequate supports[21]
Midwifery care in the health system	• Professional autonomy[21, 22, 30, 32-34, 63-66] • Practicing full scope midwifery[21, 64] • Collaborative organizational cultures underpinned by teamwork, communication, cooperation, and positive inter- and intra-professional working relationships[21, 24, 32, 34, 63, 64] • Alternative models of midwifery care and flexible practice arrangements[30, 34, 63] • Continuity of care models[64] • Midwifery practice is consistent with the values of midwifery[33] • Respectful and adequate representation of IBPOC midwives[14] • Equity and social justice education and training opportunities[43]	• limits on hospital privileges; • lack of professional recognition; • dominance of the medical model and physician provided care; • hierarchical systems; • bullying from physicians; • high workplace demands; • staffing shortages; • lack of autonomy • inadequate budgets and poor remuneration; • limitations of the midwifery model of care (e.g. being on call) • limits of Ontario's 'course of care' funding model • opportunities for interprofessional collaboration; • siloing of midwifery funding from hospital funding in Ontario; • inadequate education and training • health policies, legislation, and hospital protocols; and • lack of collegial support[17, 21, 22, 24, 30, 32, 40, 63, 65] • Personal expenses and stress of managing clinics in health systems where midwives work as private contractors[29] • Individual and systemic racism as well as microaggressions impacts IBPOC learners and midwives' mental health[14, 43, 63] • Safety concerns due to discrimination (e.g., homophobia and ageism)[63]
Midwifery association	• Strong leadership to identify and deconstruct colonial and racist policies and practices in midwifery[14] • Activities that support the development of midwifery skills and build confidence[34] • Securing sustainable funding sources for the operations of the midwifery association[41] • Raise awareness of the AOM's On Call service[63]	• Midwifery association membership that is voluntary instead of mandatory[41] • Midwifery associations that have weak technical and organizational capacity[41]

Framework elements	Enablers to midwifery sustainability	Barriers to midwifery sustainability
Outer context Political system	• Inclusion of the midwifery association in primary healthcare policy decisions[41] • Government priorities that include sexual and reproductive health and rights[41]	• Systemic issues related to gender, professional, economic, and social disempowerment, which intersect to constrain the progress of the profession[29, 32, 34] • Lack of professional recognition[21, 29] • Absence of intersectional gender-based lens across policies, practices, and decision making related to midwifery in Ontario[16]
Midwifery education pathways	• Providing racially concordant care for community members; • Reducing racial disparities in health; • Personal experiences related to midwife-led care; and • Providing physical and emotionally safe care[56] • Amplify the voices of IBPOC midwifery students[14] • Mentorship programs for IBPOC students to build networks and supports to navigate through systemic racism[14]	• Structural and interpersonal racism; • Feelings of otherness and not belonging within the profession; and • Fnancial constraints (e.g., lack of tuition, scholarships, costs of books and supplies, reduced work hours in order to study, cost of housing, cost of health insurance student had to quit their job)[56]
Midwifery research	• Creating opportunities and pathways for midwives to pursue clinical academic careers will increase professional sustainability through credibility and visibility[57]	• Lack of academic or clinician scientist positions; • Lack of funding opportunities; • Poor integration of academic and clinical roles; • Research output expectations; and • Research opportunities are usually dependent on location[57]
Social system	• Critical analysis of structural and institutionalised racism and other social determinants of health[43]	
External factors	• Recognition of midwives as essential frontline health workers[42]	• Changes implemented to how midwives practice during the pandemic persist, which has both altered and compromised the provision of midwifery care, and also created unsustainable working conditions[60]

LIMITATIONS

The main limitation of the comprehensive evidence synthesis is its methodological approach, which relies on the existing body of research evidence and data. This constraint meant that our evidence synthesis was limited to the available literature, and we were restricted to reporting on the findings that currently exist within the published literature. While we prioritized midwifery research conducted in health systems in Canada, many of the findings originate from outside of Canada, which could limit the generalizability of our conclusions to the Canadian context. We made every effort to provide a thorough and inclusive analysis, prioritizing knowledge generated by the AOM, Canadian studies, and studies conducted in relevant health systems. However, it is essential to acknowledge the inherent limitations imposed by the scope and availability of the existing midwifery research landscape.

RECOMMENDATIONS

Based on what we have learned from the evidence synthesis, the Midwifery Sustainability Project's Steering Committee is hosting the Midwifery Sustainability Roundtable in May 2024 to identify areas of concordance and divergence with the findings in this report in the lived experiences of Ontario midwives.

MIDWIFERY SUSTAINABILITY ROUNDTABLE

The outcome of the Roundtable will be a report that includes a set of recommendations for policy and system change to support the sustainability of midwifery in Ontario. Changes to support sustainability will require cooperation and coordination between the AOM and key stakeholders, including the Ministry of Health, the College of Midwives of Ontario, the Ontario Hospital Association, the Midwifery Education Program, the National Council of Indigenous Midwives, and others. We look forward to working in partnership to forge a healthy and sustainable future for midwives and midwifery.

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