A Case Study of the Implementation of Regulated Midwifery in Manitoba

By

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Abstract

In 2000, midwifery was regulated in the Canadian province of Manitoba. Since the inception of the midwifery program, little formal research has analyzed the utilization of regulated midwifery services. Currently, many women are denied access to midwifery care due to the shortage of midwives in Manitoba. The specific objectives of this mixed-methods case study were to describe the utilization of midwifery health care services in Manitoba from 2001/02 to 2009/10 and to explore factors influencing the implementation and utilization of regulated midwifery services in Manitoba. The study was guided by the Behavioral Model of Health Services Use (Andersen, 1995). Data collection and analysis were an iterative process between documents, interviews, and administrative data. The quantitative analysis used the population-based administrative data housed at the Manitoba Centre for Health Policy to study the utilization of midwifery care. There was modest growth in the overall rate of midwifery-attended births, as well as in the number of midwives over the 10-year time period. Twenty-four key informants were purposefully selected to participate in semi-structured interviews for the qualitative component. Interviews were audio-taped, transcribed verbatim and analyzed using content analysis. Three main topic areas were identified: barriers, facilitators, and future strategies/recommendations. Themes arising under barriers included conflict and power; lack of an educational program; perceptions of the profession, and a precarious profession. Issues of gender underpinned some of these barriers. Constituent influence was a prominent facilitator of the profession. Future strategies for sustaining the midwifery profession focused on ensuring avenues for registration and education, improving management strategies and accountability frameworks, enhancing the work

environment, and evaluating the model of practice and employment. Results of the document analysis supported the themes arising from the interviews. In spite of scientific evidence that supports the midwifery model of care, there remains an inherent struggle to justify the profession and ensure its widespread implementation in Manitoba. The findings have implications for maternal child health professionals working on collaborative efforts to facilitate access to midwifery services for women. This study adds to the growing body of literature related to midwifery in Canada.

Key words: midwifery, implementation, policy, Behavioral Model of Health Services Use, feminism, Manitoba, Canada

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I dedicate this research project to midwives all over the world, in particular in Manitoba, where the details of the long arduous hours go unrecognized, yet their exemplary work is one of the reasons midwifery exists in the Manitoba and the fight for women's choice is still alive.

Disclaimer

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Chapter I: Introduction

This chapter will provide a brief background of how cultural beliefs in society related to technology have impacted childbearing practices. A description of the demographics of Manitoba will be given to provide a context to the setting of this study. This chapter will then address the problem and describe the purpose of the proposed study. It will also address specific issues that have impacted the growth of the midwifery profession in Manitoba, and provide a brief synopsis of these issues in the context of the past and current status of the profession. Finally, salient points will be discussed regarding the significance of the study.

Background

The advancement and use of technology is critical in modern day medicine for the management of disease. However, the inappropriate use of technology in childbirth can impede normal processes of birth (Burst, 1983). As a result, women may be deprived of autonomy and self-directedness in their choices for what they deem important to their health. Often the intent of birth interventions is to hasten and control the birthing process. The rationale behind the control over the birth process is to improve birth outcomes for mothers and babies (World Health Organization [WHO], 1996).

In the past few decades, birth has become more institutionalized because of increased interventions such as the augmentation or induction of labor, episiotomies, epidurals, and cesarean sections. Technology has enhanced the capacity of health care providers all over the world to intervene during the intrapartum period (WHO, 1996). Support of those normal processes is easily compromised when technology is believed to be superior in achieving an optimal birth outcome (Cragin & Kennedy, 2006).

The practice of routine birth interventions has failed to acknowledge the WHO's guidelines on the care of women giving birth (Eide, Nilsen, & Rasmussen, 2009). The WHO's (1996) guidelines define "normal birth" as:

> Spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition. (pp. 3-4)

In addition to this definition, the WHO (1996) states that there should be no interference with the natural process of birth without a valid reason. The caregiver's role in the context of childbirth is summarized as supportive, observational, assessing and intervening if necessary, and referring if problems arise.

The definition of the caregiver's role given by the WHO (1996) aligns with the midwifery model of care. While practices differ among midwifery providers, the global midwifery model views pregnancy as normal (Rooks, 1999). Midwives are experts in "protecting, supporting, and enhancing the normal physiology of labor, delivery, and breastfeeding" (Rooks, 1999, p. 370). One noteworthy difference in the midwifery model is that the "possibility of complications" does not preclude honoring the values of women's choices for their maternity care experience (Rooks, 1999, p. 370).

In a Delphi Study used to examine exemplary midwifery care, Kennedy (2000) identified the following as essential elements of midwifery care: "supporting normalcy of pregnancy and birth, vigilance and attention to detail and respecting the uniqueness of women" (p. 4). Further, the most significant difference that transpired was the "art of

doing ‘nothing’ well” (p. 4). For at least seventy years, the science of competent midwifery care has been documented in research (Kennedy, 2000).

Multiple factors have an impact on the outcomes of birth. Factors such as provider type and client and system characteristics all contribute to the variances of birth outcomes analyzed in the literature. Recent and past evidence demonstrate favorable maternal/fetal outcomes related to midwifery and support for out-of-hospital births. For example, the Birthplace in England Collaborative Group (2011) found no difference in perinatal mortality and intrapartum neonatal morbidities between birth settings (obstetric, home, and freestanding midwifery units). Midwifery is also associated with lower rates of intervention. One study showed women in the midwife group had lower rates of episiotomy, 3rd or 4th degree tears in the midwifery group. Cesarean section in both multiparous and nulliparous groups was also lower compared to those receiving care from the medical group (Fraser, Hatem-Asmar, Krauss, Maillard, Bréart, & Blais, 2000). Furthermore, midwifery care has been associated with satisfaction with care (O’Brien, Chalmers, Heaman, Darling, & Herbert, 2011; Overgaard, Fenger-Grøn, & Sandall, 2012; Sutcliffe, Caird, Kavanagh, Rees, Oliver, Dickson, & Thomas, 2012).

Description of Setting

Manitoba is a mid-western Canadian province with a population of just over one million people. The majority of the population resides in the urban areas (72%), whereas the vast rural areas are sparsely populated (28%) (Statistics Canada, 2011). Winnipeg is the capital city and is the most densely populated metropolitan area (730,018) in Manitoba. Health services are publicly funded and administered through the five newly amalgamated Regional Health Authorities (RHAs) (Manitoba Centre for Health Policy

[MCHP], 2010). According to the 2011 census, people from North American Aboriginal origins (First Nations, Inuit, and Métis) accounted for 17% of the population in Manitoba. Other diverse ethnic groups include people from European origins (71%) and Asian origins (10%) (Statistics Canada, 2013). In 2007/08, 15,391 births were reported in Manitoba, and there was a slight increase in 2010/11 to 15,943 births (Statistics Canada, 2012). Between 2007/08 and 2008/09, 40.7% of the pregnant women in Manitoba received prenatal care from an obstetrician/gynecologist and 35.5% from a family physician. The majority of pregnant women received delivery care from an obstetrician/gynecologist (73.4%). During this same time period, midwives attended 4.6% of the births in Manitoba and 4.5% of women received prenatal care from a midwife (Heaman, Kingston, Helewa, Brownell, Derksen, Bogdanovic, McGowan, & Bailly, 2012).

Statement of the Problem

In spite of scientific evidence that supports the midwifery model of care, there remains an inherent struggle to justify and sustain the profession globally. In 1997, the *Midwifery and Consequential Amendments Act* was passed. In 1998, the Midwifery Implementation Group (MIC), was mandated to develop; integration strategies of midwifery into the regional health care system; a payment model for the midwives; and a plan for midwifery education with emphasis on the Northern and Aboriginal communities (Manitoba Health, 1998, p.4). Midwifery was regulated in Manitoba in 2000. However, since that time, key components of the original implementation plan have not met projected targets for the number of midwives and midwifery-attended births. It was projected that 140 midwives would need to be integrated into the Regional Health

Authorities by the year 2005 in order to meet the goal of the anticipated birth rate of 14% (Manitoba Health, 1998). By 2005, there were only 30 practicing midwives in the province (Manitoba Health, 2005). As of 2010, based on the College of Midwives of Manitoba registries, the status was 38 practicing midwives, 15 non-practicing midwives, and 11 student midwives (Manitoba). The 38 practicing midwives fell drastically short of the projected need of 140 midwives by 2005. Moreover, various endeavors initiated in the province, such as the educational programs, have yet to increase the number of midwives to the projected target. The shortage of midwives directly impacts women's access to maternity care. In 2011, seventy percent of the women who requested midwifery care in the Winnipeg Regional Health Authority were declined such care due to the full caseloads of the midwives (J. Erikson, personal communication, September 1, 2011).

Furthermore, the lack of graduates from existing educational programs and lack of funded positions have contributed to a shortage of midwives. As a result, regulated midwifery in Manitoba has not been fully implemented. Other than anecdotal information regarding the shortage of midwives in Manitoba, no critical analysis has been done to explore factors that have influenced the implementation and utilization of regulated midwifery services since the legislation was enacted.

To date, minimal documented information exists about Manitoba midwifery. Studies have looked at the educational background of lay and nurse midwives, the implementation of midwifery in Manitoba, and stakeholder perceptions of midwifery integration (Kreiner, 2005, 2009; Maltby, 1992; Olson & Couchie, 2013; Scurfield, 2002). Maltby (1992) examined the characteristics of the educational background of lay

and nurse midwives in the province prior to legislation. Scurfield (2002) analyzed the factors that impacted midwifery legislation such as processes, negotiations, and policy. Findings in Kreiner's (2005) study revealed the importance of successful provincial midwifery education programs as critical to the sustainability of the profession. Another finding from her study was that the integration of Aboriginal midwifery into regulated midwifery was feasible. A more recent study looked at barriers and challenges of midwifery practice in one remote First Nations community in Manitoba (Olson & Couchie, 2013). One finding from this study highlighted how the policy of evacuation was not congruent with the Millennium Development Goal of having a skilled birth attendant at every birth. This study validates the importance of the midwifery role to bring birth back to the Aboriginal communities. The following table provides a brief synopsis of the targeted goals of the original implementation plan of midwifery in Manitoba in comparison to the status of midwifery as of 2011.

Table 1

Comparison of Projected Targeted Goals of the Implementation Plan to 2011 Status

Goals from original implementation plan: Integration into regional health care system, increase access to primary care for women, target priority populations: adolescent (<20), Aboriginal, immigrant, socially isolated, poor, other (Manitoba Health, 1998).

Birthrate	Status as of 2011
Midwifery-attended births were to be at 14% of provincial births within 2.5 years of implementation	Midwifery-attended births (2009/10 data) =5%
Number of Midwives/Vacancies/Consumer Demand	
Projected Plan: Human Resource Strategy for Midwifery Implementation (1998) projected:	2010: 38 practicing, 15 non-practicing
	2010: 45 funded
Within 2.5 years of legislation there would be 50 midwives each attending 40 births = 2,000 births.	Consumer demand: Percentage of women that sought midwifery care and were declined care in 2011:
By 2005 need: Approximately 140 practicing midwives in the province.	NOR-MAN: 40% RHA Central: 55% WRHA: 70%
Originally (2000), 26 fully funded positions	Brandon: 60%
Education Programs	
Proposal for Bachelor of Midwifery Program at University of Manitoba (1999)	Program was not funded
Aboriginal Midwifery Program implemented by UCN (2006)	11 original students, no graduates, program's conditional approval was rescinded by College of Midwives of Manitoba in 2011.
Pathways Program implemented by UCN (2009)	12 candidates, 10 accepted into program but program currently on hold
University College of the North, Bachelor of Midwifery Program, southern program (2010)	11 students enrolled
Evaluation Framework	
Recommended that Manitoba Health implement a Midwifery Evaluation Advisory committee	Formal evaluation was completed in 2013, information has not been released

Note. Data was obtained from *Human resource strategy midwifery implementation: The Manitoba scene, by* Manitoba Health, 1998. J. Erikson, personal communication, September 1, 2011.

In summary, Manitoba has yet to fully implement midwifery in the province although midwifery is fully regulated. In 1998, the Human Resource Strategy for the Midwifery Implementation Group was tasked with three mandates to develop the following strategies for implementing the profession into the province: a comprehensive plan for the implementation of midwifery sites and services, a payment model, and a plan for the delivery of midwifery education (emphasizing Northern and Aboriginal issues and underserved areas) (Manitoba Health, 1998). The question is why key components of implementation have fallen short, thus creating the end result of a shortage of midwives across the province. Furthermore, in spite of these overt problems over the years, only small initiatives have been implemented to critically evaluate how the program goals and objectives have been met.

Purpose of Study

In order to support midwifery as a viable health care option for women in Manitoba, further research is needed to analyze the factors that have influenced the growth and sustainability of the midwifery profession in this province. Therefore, the purpose of this study is: (1) To describe the utilization of midwifery health care services in Manitoba from 2001/02 to 2009/10 and; (2) To explore factors influencing the implementation and utilization of regulated midwifery services in Manitoba.

Research Questions

This study will consist of both qualitative and quantitative components, with the qualitative component having the most emphasis. The purpose of the quantitative component is to describe the utilization of midwifery services over the past 10 years. The

findings of this analysis will provide important background information and a context for interpreting the qualitative findings. The following research questions will be addressed:

1. Has the number of midwives in Manitoba increased from 2001/02 to 2009/10? Of that number how many were non-practicing vs. practicing? What was the distribution of practicing and non-practicing midwives in each Regional Health Authority (RHA)?
2. What is the percentage of midwifery-attended births from year to year? Has the proportion of midwife-attended births increased from 2001/02 to 2009/10? What percentage of midwifery–attended births were hospital births and what percentage were home births?
3. Are midwifery services available in each of the RHAs in Manitoba? Has the situation changed across time? In those RHAs providing midwifery services, what percentage of women are getting midwifery care?
4. What percentage of midwifery-attended births is among priority populations as defined by the College of Midwives of Manitoba?
5. What are the characteristics of women who receive midwifery services in Manitoba? Do these characteristics differ across RHAs?

The qualitative component will endeavor to understand and deconstruct factors that impact the implementation and utilization of midwifery services. The following specific research questions will be addressed:

6. What barriers and facilitators related to policy, financial or educational resources have impacted the implementation and utilization of regulated midwifery services in Manitoba from 2001/02 to 2009/10?

7. How have structures of power influenced the implementation and utilization of midwifery services?
8. How has the workload and organization of the midwifery profession impacted the utilization of regulated midwifery services in Manitoba from 2001/02 to 2009/10?
9. How has consumer demand influenced the availability of midwifery services across the province? Why has the implementation of midwifery in Manitoba not met the projected targets outlined in the Human Resource Strategy for Midwifery Implementation in Manitoba (1998)?
10. What strategies need to be implemented to improve utilization of midwifery services in Manitoba?

Definition of Terms

Barriers and facilitators.

The Webster's New World Dictionary (1991) defines barriers related to progress as, "anything that holds apart, separates, or hinders" (p. 113). In this study barriers are defined as factors which hinder the implementation or utilization of midwifery services in Manitoba. The word *facilitate* is defined as, "to make easy or easier" (Webster's New World Dictionary, 1991, p. 485). These factors can be grouped into categories of health policy, characteristics of the health delivery system, characteristics of women who access midwifery services, utilization of health services, and constituent influence as conceptualized in the Behavioral Model of Health Services Use (Andersen, 1995).

Utilization.

Utilization encompasses characteristics of the service and resources that directly impact how midwifery services are used or made available within the broader health care system in Manitoba. One indicator of access is the utilization of the service related to type of provider, site, and purpose (Aday & Andersen, 1974).

Implementation.

As mentioned previously, in 1998, the Human Resource Strategy for Midwifery Implementation Committee was mandated to develop a comprehensive plan for the implementation of midwifery in Manitoba inclusive of the following strategies: implementation of midwifery sites and services in Manitoba, a payment model for midwives, and a plan for an education program with a focus on under-served and Aboriginal populations (Manitoba Health, 1998). In the literature, the successful implementation of midwifery in Canada has been viewed as having legislation, a regulatory body, funding, and an educational program (Kaufman, 1991; McMahon, 2000).

Regulation.

Regulation refers to the legal process whereby the proclamation of the Midwifery Act of 2000 declared midwifery in Manitoba an independent, autonomous profession. This Act defines the scope of practice and establishes a self-regulating governing body (Province of Manitoba, 2013).

Constituent.

The Webster's New World Dictionary (1991) defines constituent as "a member of a constituency, esp. any of the voters represented by a particular official" (p. 298). In this

study, constituent influence is examined in relation to how the constituent has impacted the implementation of midwifery in Manitoba.

Consumer.

The Webster's New World Dictionary (1991) defines consumer as "a person who buys goods or services for personal needs" (p. 299). In the context of this study, the consumer is the person who utilizes the services of midwifery. In this study, consumer influence is examined in relation to how the consumer has impacted the implementation of midwifery in Manitoba.

Significance of Study

The shortage of maternity care providers in Canada is a looming crisis. Across Canada, there has been a decrease in family physicians providing intrapartum care for various reasons such as personal life, lack of confidence in obstetrical skills, and fee structures. Obstetricians attend the majority of low-risk births, providing 80% of obstetrical care to women (Canadian Institute for Health Information [CIHI], 2004; Society of Obstetricians and Gynaecologists [SOGC], 2008). In 2001, the CIHI reported less than one in five (19%) family physicians provided intrapartum care. In 2008, a Canadian report revealed that there were 1,650 obstetrician/gynecologists in Canada. Of these, only 1,050 provided intrapartum care (SOGC, 2008). This report brought attention to the rate of retirement among this provider type as also having an impact on the shortage of maternity care providers.

As well as a shortage of maternity care providers, the current system has not adequately evaluated mechanisms to improve access to midwifery care across Canada. For example, the SOGC (2008) report acknowledged that nation-wide, insufficient data

have been collected for the midwifery profession. This is partly due to the lack of an existing standard data collection protocol for all the provinces.

Although preliminary data show favorable outcomes of midwifery care in Manitoba, there are gaps in the data that need to be looked at more closely. In 2005, midwifery data (April 2001 to March 2004) were analyzed and reported by Manitoba Health (Manitoba Health, 2005). In 2001/02, there were 387 cases of completed midwifery care (46% from priority populations), which increased to 704 completed cases of midwifery care (62.6% from priority populations) by 2003/04. In 2001/02, 2.67% of births in the province were attended by midwives. In 2003/04, the percentage increased to 4.89% of births attended by midwives (Manitoba Health, 2005).

The descriptive analysis of the midwifery data is an important step in understanding midwifery in Manitoba over the past ten years. The knowledge gained from understanding practice patterns and trends can contribute to further analysis of how to address midwifery resource allocation. Midwifery practice patterns and trends, such as the availability of midwives in each region and the number of women who accessed midwifery care, will give insight into how to address the factors that impact the utilization of future midwifery services.

An analysis of factors influencing utilization of midwifery implementation is helpful because a deeper understanding can be gleaned from the insights of those who are or have been directly involved in midwifery. The insights gained from a case study analysis such as this one are helpful in “explanation building” around the phenomena (Yin, 2009, p. 141). For example, in the past 10 years the midwifery profession has not met the original targeted goals, and the shortfalls have yet to be analyzed. This analysis

of the factors influencing the implementation and integration of midwifery in Manitoba will provide useful information to other provinces as they work toward successful implementation. Identification of these factors contributes to existing knowledge related to the evolving status of Canadian midwifery (Bourgeault & Fynes, 1996). Ultimately, this new knowledge expands upon an understanding of what facilitates or creates barriers to fully implementing and utilizing midwifery services in Manitoba.

Chapter II: Conceptual Framework

This study was guided by the Behavioral Model for Health Services Use (Aday & Andersen, 1974; Andersen, 1995). This framework conceptualized factors related to the utilization of midwifery services such as health policy objectives and various characteristics of the health care system (Figure 1). For this case study, the Behavioral Model for Health Services Use was adapted to provide an organized framework to conceptualize relevant variables specific to the utilization of midwifery services in Manitoba (Figure 2, adapted). In addition, a feminist interpretive lens was used to understand how the struggles and successes of the midwifery profession reflect a woman's position in the health care system in Manitoba.

Framework for the Study of Utilization

The Behavioral Model of Health Services Use, also referred to as a Framework for the Study of Access, initially focused on health services use (Aday & Andersen, 1974; Andersen, 1995). Over time, however, the model was revised to include external environments (physical, political, and economic) and health status outcomes (Andersen, 1995). This case study does not address health status outcomes. This model conceptualizes how people use health services, defines and measures equitable access, and ultimately aims to influence policy that promotes equitable access (Andersen, 2008). The Behavioral Model for Health Services Use (Aday & Andersen, 1974; Andersen, 1995) was used in this study as a framework to describe various factors influencing the utilization and access of midwifery services, as well as how these factors are interrelated.

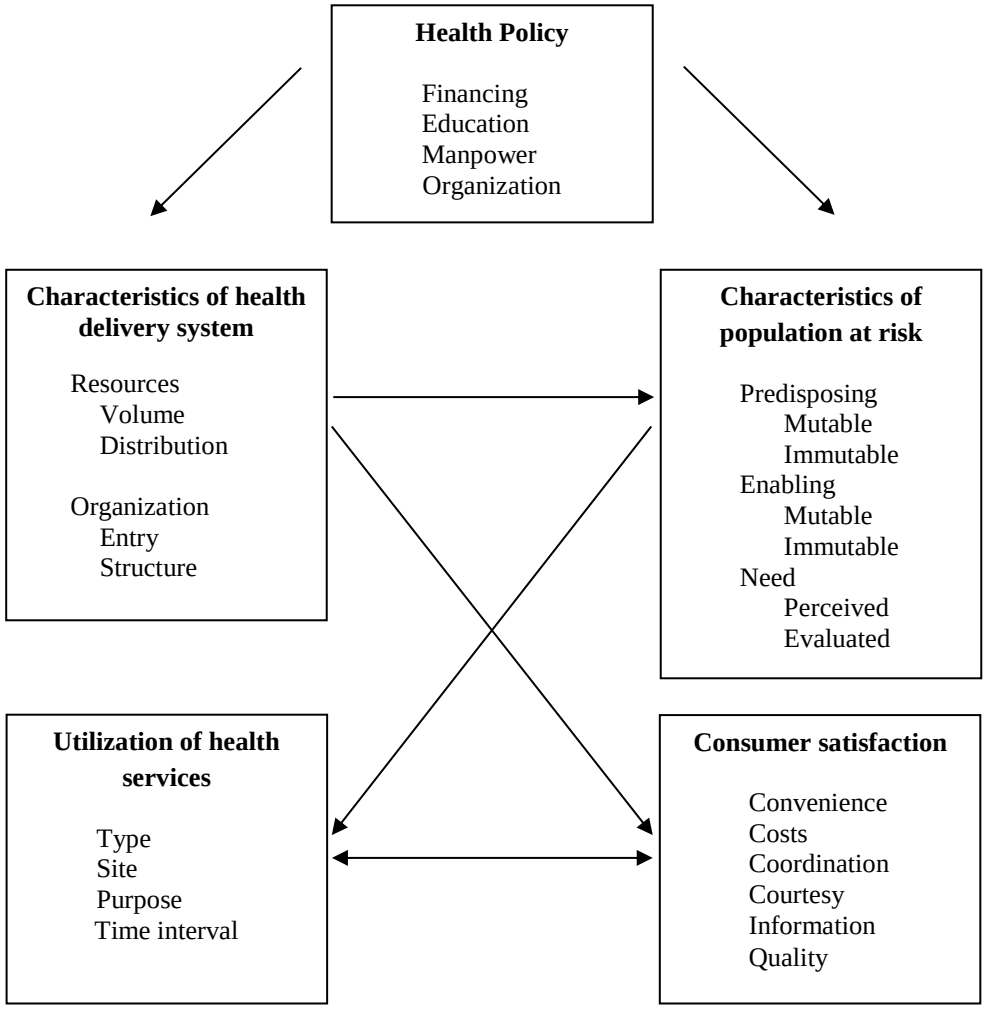

Figure 1. A Framework for the Study of Access. From "A Framework for the Study of Access to Medical Care," by L.A. Aday and R. Andersen, 1974, *Health Services Research, 9*, p. 212. Copyright 1974 by Wiley. Reprinted with permission.

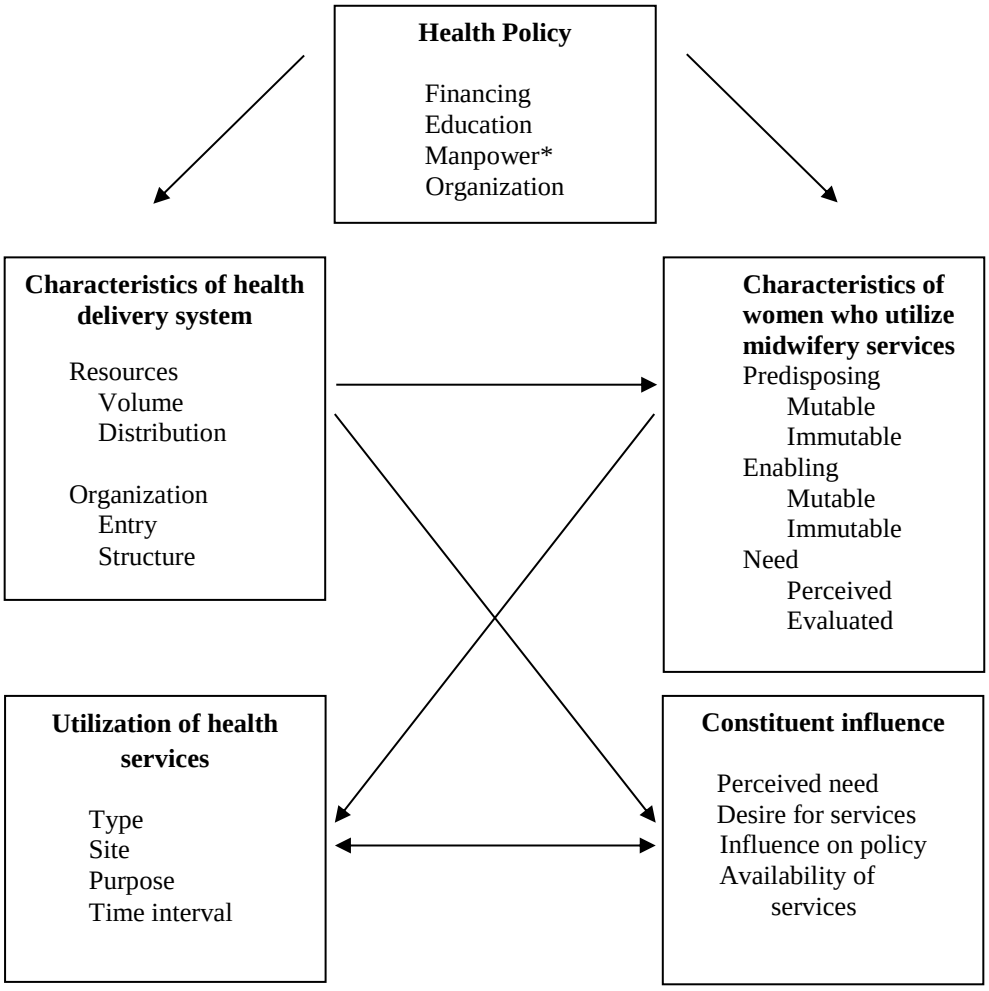

Figure 2. A Framework for the Study of Access (Adapted). Adapted from "A Framework for the Study of Access to Medical Care," by L.A. Aday and R. Andersen, 1974, *Health Services Research, 9*, p. 212. Copyright 1974 by Wiley. Adapted with permission.

*The preferred language would be human resources versus manpower.

This framework demonstrates how various factors are interrelated in regards to health care utilization. The framework originally sought to predict and explain the use of health care in the family unit. Since the implementation of the initial behavioral model in the 1960s, four phases have evolved, with the focus on the individual as the unit of analysis. The model has evolved to identify factors that facilitate or create barriers to the utilization of health services (Andersen, 1995). Although the intended use of the model was focused on access to medical health care, the framework was appropriate to use in the context of analyzing the midwifery health care utilization in Manitoba.

A person's access to health care is classified as a function of three characteristics: (1) Predisposing factors: demographic, social structure, and health beliefs; (2) Enabling factors: personal, family, and community; (3) Need factors: perceived and evaluated. An important concept in health policy research is that of mutability. Mutability refers to the degree to which a variable will impact "behavioral change." If a variable is deemed mutable, it can be useful to analyze how that variable would promote better utilization or access to health services (Andersen, 1995, p. 5). In this model, health policy is seen as an important factor of how a population uses these services. The resources related to health policy are finance, education, manpower, and organization. The qualitative analysis assessed these issues in relation to the implementation and utilization of midwifery services. Characteristics of the health delivery system relate to the distribution and availability of those resources. The quantitative analysis assessed the distribution and utilization of midwifery resources across each Regional Health Authority (RHA) over time.

Characteristics of the women utilizing midwifery services have been described, including demographics of the mother such as age, parity, income quintile, and RHA of residence. Social structures in this study were defined as women who were considered priority populations as per the College of Midwives of Manitoba: single, adolescent less than 20 years, immigrant/newcomer, Aboriginal, socially isolated, poor, and other at-risk women.

Enabling factors are generally viewed as more mutable than predisposing factors (Andersen & Aday, 1978). An enabling factor describes how services are made available to a population (Aday & Andersen, 1974). In this study, enabling factors were defined as the availability of midwifery services and the number of practicing midwives in each RHA. In addition, the model of care can impact how midwifery care is utilized by women. For example, if midwives take small caseloads, fewer women have access to midwifery care due to midwives being at full capacity as defined by their guidelines for care provision.

The need component, when used to analyze the utilization of medical services, implies the "level of illness." It can be broken down into how an individual perceives the need for services, as well as how the professional or the delivery system evaluates if the individual needs the service (Aday & Andersen, 1974, p. 213).

Perceived need for midwifery services was defined by key informants' perceptions of women's need for midwifery care. Evaluated need was defined by the perceived demand for midwifery services. The utilization of health services (midwifery services) was specifically defined by a woman's entry into the delivery system and the type of service the woman received (Aday & Andersen, 1974). Utilization, in this case,

was examined by looking at the number of women using midwifery services over time and in each RHA. The type of service was defined in relation to whether women received a hospital birth or a home birth.

Consumer satisfaction refers to a person's contact with the medical system (Aday & Andersen, 1974). In this study, consumer satisfaction will be viewed through the perceptions of the key informants and will be analyzed in the context of both consumer and constituent influence on the process of implementation. The medical system in this case is the vehicle for the delivery of midwifery services. The intent is to analyze key informants' perceptions of how consumers and constituents have influenced the availability of regulated midwifery services.

Feminist Framework

Feminist scholarship ultimately aims to articulate how feminism can impact and give meaning to the social sciences and humanities (Campbell & Wasco, 2000, p. 775). The diversity of feminist research is driven by the struggles inherent to feminism. Those struggles directly relate to the exclusion of women's voices in research and the socially constructed norms of dominant groups. Further to this definition, feminist research is spurred on by the inherent bias of social sciences, which is characteristic of an androcentric system (Ackerly & True, 2010; Campbell & Wasco, 2000; Stanley & Wise, 1983).

Using feminism to shape research can provide a platform where epistemology, methods, and methodology work synergistically across the research process (Hesse-Biber & Piatelli, 2007). According to Harding (1987), feminist research does not entail one specific method of inquiry. A feminist researcher is challenged to first be aware of how

paradigms have historically favored male-centered problems and then actively work at breaking down hierarchical power relationships between the researcher and the one being researched. This approach seeks to bring women in as part of the research team, thus creating a space for the women's voices to be articulated.

Feminist theory and midwifery philosophy of care go hand in hand. Midwifery care fully supports women's knowledge as central to childbirth practices. Therefore, feminist theory grounds the concept of women and midwives as social change agents promoting women-centered childbirth practices (Rothman, 1989). The relationship among women is central to the practice of midwifery; therefore, a feminist framework powerfully complements midwifery research (McCool & McCool, 1989). The feminist movement is mostly responsible for challenging the "doctor knows best" culture of childbirth and shifting the focus to informed choice and woman-centered care (Yuill, 2012, p. 36). This shift closely aligns with the midwifery philosophy of care. The use of feminist frameworks in nursing research is one noteworthy example of how structures of power influence the position of women in a profession (Barnes, 1999). This example, at least in part, parallels the struggles over position experienced by women in the midwifery profession.

A feminist interpretive lens was used to draw on the insights and struggles of the midwifery profession in Manitoba. Barnes (1999) suggests midwifery research can be approached to analyze the position of midwives in the profession or to develop theory and practice that position women at the center of midwifery activity and inquiry. Two principles should be kept in mind when using a feminist approach to conduct midwifery research: the goal is to improve women's position in society rather than promote the

interests of others, and research should be a channel to facilitate social change. This case study used a feminist lens to underpin the discussion of the findings, in order to bring awareness to factors concerning the utilization of regulated midwifery services that have been buried within structures of power. Subsequently, the goal was to find explicit meaning in how these factors could explain the position of women in the health care system.

In summary, midwifery is a viable option to address the maternal child health care needs of women in Canada as well as globally. In order to support midwifery as a viable health care option for women in Manitoba, further research is needed about the factors influencing the growth and sustainability of the midwifery profession in this province. Other than anecdotal information regarding the shortage of midwives in Manitoba, no critical analysis has been done to explore factors that have influenced the implementation and utilization of regulated midwifery services. To date minimal documented information exists about midwifery in Manitoba. Feminism was used to frame the method of inquiry. This case study was influenced by the epistemology of this researcher's perspective as a midwife, a consumer of maternity health care, a past educator in the context of the maternity care system in Manitoba, and an aspiring academic researcher regarding access to maternity care services and policy-related issues.

Chapter III: Literature Review

The body of literature reviewed includes a historical account of the medicalization of birth, global midwifery, midwifery in Canada (inclusive of implementation processes), and midwifery care related to maternal and child outcomes. After the literature review, a brief chronology of the key events in the history of the implementation of regulated midwifery in Manitoba is provided to give context to the case being studied.

Historical Context of the Medicalization of Birth: Paradigms of Health Care

It is relevant to analyze the historical context of midwifery in relation to patriarchal influence and how male dominance in society has impacted women's childbearing practices. Understanding the position midwives have had in society gives insight to the global struggles of the present-day profession. A fundamental step in understanding the evolution of the medicalization of birth in society is to understand, first, how the role of technology is embedded in a society's core value system. The value system of a society can be reflected in many ways. For example, the use of technology in relation to the treatment of the human body is evidence of a cultural belief within the society (Davis-Floyd, 1994)

Western society is characteristically more associated with advanced technology, lucrative economic endeavors, and patriarchal-led institutions (Davis-Floyd, 1992). As a result, the technocratic belief system has played a dominant role in the childbirth arena. Modern childbirth is heavily influenced by three paradigms of health care: technocratic, humanistic, and holistic. The technocratic model views the body as a machine. The philosophy of the mind-body separation suggests that the body can be manipulated without affecting the mind (Davis-Floyd, 2001). In the 1600s, the first recognition of

mind-body separation was known as the Cartesian philosophy, which would later have a great impact on the medical model of care (Cahill, 2001; Wertz, 1983). Over time, midwifery's place in society was affected as technology evolved and influenced the culture of childbirth (DeVries, 1992; Leavitt, 1989). While technology is neither good nor bad, it is interesting to note how its impact changed traditional patterns of midwifery (DeVries, 1992). For example, initially midwives were not given access to new technologies such as the forceps. Further, their traditional training and knowledge became supplanted by formal training with new technologies. Technology brought new approaches to childbirth practices (DeVries, 1992).

The humanistic approach is the middle ground between the technocratic model and the holistic model. The holistic model focuses on the unity of the body, mind, and spirit. The humanistic model embraces aspects of both the technocratic and holistic models. The humanistic model acknowledges the power of the mind on the body while supporting aspects of healing relevant to both mind and body (Davis-Floyd, 2001).

The technocratic and holistic models tend to be opposite extremes on the paradigm spectrum. The holistic model acknowledges the mind and body as unified while embracing the spirit as part of the whole human. The basis for healing in the holistic model lies in the belief that no single approach can heal a person's health problems. The whole person and the whole environment around that person, therefore, must be considered in the equation to find balance and healing. In Western society, holistic healers may be thought of as the definitive heresy, whereas the technocratic model exhorts power and influence over health care models (Davis-Floyd, 2001). One author delineated several distinguishing characteristics of female midwifery versus male

midwifery (Loudon, 2008). In the 17th century, one of the first groups of men involved in obstetrics was known as barber-surgeons. These men had no medical training yet they proceeded to empirically learn midwifery skills while incorporating instruments such as the forceps (Barlow, 1994; Drife, 2002; Wertz, 1983). The second group of men was known as *accoucheur*, which translated as man-wife. These men were known as surgeons and were often called in to use instruments during an unsuccessful labor (McTavish, 2001, p. 390). The accoucheur was often associated with danger because of the role he played during childbirth. One difference between male practitioners and female midwives was that the latter emphasized the woman's connection to nature (Conger, 1999). This appreciation and awareness of the woman's body as a whole natural body versus "interchangeable parts" (Conger, 1999, p. 47) remains characteristic of the philosophy of modern day midwifery practices. Midwives have evolved alongside conventional obstetrical practices; however, the basic philosophy of care remains congruent with historical descriptions cited in the literature.

Historical Account of Obstetrics and Midwifery

The current trend of technocracy influencing childbirth practices in our Western world moves away from empowering women and can deny them choice during their childbirth experiences. Current beliefs regarding childbirth practices are deeply entrenched in cultural beliefs that have been cultivated throughout history. Technocratic models of care, while not coined as such, were born in the late 1600s. The distinction between the male and female practitioners' concepts of knowledge has defined their respective philosophies of how they have approached caring for a woman. Midwives have had a sense of "knowing" the mother and her body through touch. Male

practitioners' knowledge, however, has been derived from anatomical tables, lectures, and interventions (Conger, 1999, p. 45). As the pregnant woman became increasingly viewed within the field of pathology in the eyes of obstetrics, midwifery too became redefined and managed more by men (Conger, 1999). As pregnancy became viewed as an illness, midwifery care was deemed incompetent (Oakley & Houd, 1990).

The loss of control women experienced when the responsibility for attending childbirth was transferred into the hands of men propagated a culture where women were viewed as passive objects needing medical management during childbirth (Conger, 1999). Factors such as race, class, gender, the evolution of the male midwife, the increase in birth interventions, and issues related to maternal/infant mortality all have contributed to the development of cultural beliefs and practices around childbirth that are ingrained around the world today (Borst, 1998; Cahill, 2001; Drife, 2002; Loudon, 2008; Radcliffe, 1970). Some of these influences can be largely attributed to the demise of midwifery-led care for women (Werner & Waito, 2008). Furthermore, modern science has viewed other knowledge systems such as indigenous knowledge as irrational, superstitious, and alternative. Modern science has therefore been positioned as superior (Skye, 2010).

Until the 1600s, women were exclusively caring for women during parturition and the puerperium (Barlow, 1994). The ideology of childbirth subsequently changed around the world for various reasons. For example, Barlow describes how barber surgeons were the first male professionals to introduce new technologies such as forceps. Control was taken from women as doctors claimed validity based on new techniques and ideas. New ideas such as drugs, forceps, and blood-letting gave men a role in childbirth (Barlow, 1994). Furthermore, as medical education evolved and the use of new technologies

became more prevalent, the midwife was displaced and seen as inferior to doctors (Barclay, 2008; Brodsky, 2008; DeVries, 1992; Leavitt, 1989). Devries (1992) emphasized that the new technologies used in childbirth greatly influenced how society began to view the midwife's traditional practices. For example, the introduction of technology created doubt regarding existing techniques. Globally, medical professionals have also used their status to inhibit the education of midwives (Brodsky, 2008; Devitt, 1979; Yuill, 2012). The power plays over midwives have been attributed to the claims of medicine that it is a science. Medical practitioners were equally enticed by the possibility of the lucrative potential with an obstetric patient (Wertz, 1983).

Global Midwifery

A recent report stated, approximately 350,000 women die from complications of pregnancy or childbirth every year. (United Nations Secretary-General, 2010). The WHO reported that the highest incidence of maternal and perinatal mortality happens in the first 24 hours (Campbell, Fauveau, ten Hoope-Bender, Matthews, & McManus, 2011). The report by Campbell et al. highlights the drastic shortage of midwives around the world related to policy issues, geography, availability of training, infrastructure of health systems, and other issues. The WHO projects the need for an additional 350,000 midwives to integrate midwifery-led, evidence-based care in communities around the world (WHO, 2005). One of the eight Millennium Development Goals (MDGs) is to improve maternal health. The WHO has recommended that every woman and her newborn have access to "skilled care" such as quality midwifery services (WHO, 2013, para. 2).

The re-emergence of the various levels of midwifery as a profession has been critical to its sustainability around the world. Over many centuries, midwifery has evolved into various levels of profession that have distinguished between the skill and educational backgrounds of the individual midwives. For example, in the 18th and 19th centuries, midwives in France were recognized as the educated elite (Campbell et al., 2011). Midwifery was established in Chile and other countries in South America in the 1800s. Chilean midwives work as policymakers within the Ministry of Health as a part of their employment (Campbell et al., 2011). Prior to the legalization of the profession, both in Canada and in the United States midwives were known as birth attendants. Their training was learned by participation and observation or at times by apprenticeship (Bourgeault & Fynes, 1997). While it is not possible to report on the historical accounts of the midwifery profession in every country, it is valuable to understand how the various levels of the midwifery profession are defined globally.

Throughout history, midwives have taken on many titles based on their training and geographic location. The most commonly recognized titles in the profession are traditional birth attendants (TBAs), skilled birth attendants (SBAs), lay midwife, direct-entry midwife (DEM), certified professional midwife (CPM), certified midwife (CM), registered midwife (RM), and certified nurse-midwife (CNM). Traditional birth attendants (TBAs) are more notably recognized in developing countries and typically have no formal education related to the profession (Campbell et al., 2011). The skilled birth attendant (SBA) was defined by the WHO and the International Confederation of Midwives (ICM) to differentiate them from TBAs (WHO, 2013). In the global context, the SBA is an "accredited health professional" such as a midwife, doctor, or nurse who

has been trained to manage uncomplicated pregnancies (Campbell et al., 2011, p. 4). Lay midwife and direct-entry midwife can be synonymous terms. Lay midwifery in Canada and the United States signifies those who have trained in an apprenticeship model and attend to home births. The legal implications of the lay midwife to practice are dependent upon the state or province (Bourgeault & Fynes, 1997). The direct-entry midwife is another title that denotes a midwife as an independent practitioner. Generally, the direct-entry midwife is educated by an apprenticeship model, a university-based program, self-study, or a midwifery school (Midwives Alliance of North America [MANA], n.d.). In Europe, the education standard for direct-entry midwifery is three years (Rooks & Carr, 1995). In 1987, the North American Registry of Midwives (NARM) was established, which allowed a formal route to certify as midwives and be recognized as certified professional midwives (CPM). In the United States, lay midwives as well as CPMs may be certified by the North American Registry of Midwives (NARM). Certified professional midwives are involved in home births and often come from diverse educational backgrounds (Johnson & Daviss, 2005). The second avenue available for a lay midwife is to enter into a university-affiliated midwifery education program to obtain a baccalaureate degree. After certification, the midwife holds the title of a certified midwife (CM) (American College of Nurse Midwives [ACNM], 2005). The certified nurse-midwife (CNM) is recognized as a midwife who has a nursing background. Since 2010, the ACNM has mandated a graduate degree for entry into midwifery practice as a CM or CNM (ACNM, 2010).

In Canada, the model of midwifery is unique in that midwifery is separate from nursing (Bourgeault & Fynes, 1997). In provinces where midwifery is regulated,

midwives must be registered with their colleges to use the title of registered midwife (RM). Additionally, the baccalaureate education programs in Canada are direct entry, which means no credentials are required prior to entry (Canadian Association of Midwives [CAM], 2013c). While there are vast differences in how midwives become educated and practice around the world, Canada and the United States share some similarities in their models of midwifery. Overall, midwives in both countries are autonomous health providers who provide evidence-based care to women before, during, and after their pregnancy (ACNM, 2013; CAM, 2013d). One author points out that while most midwives align themselves with a feminist paradigm, overall the profession does not convey a unified entity (Benoit, 1996). For example, based on Benoit's analysis of midwifery in Canada versus in Sweden, at least three models of practice are apparent; "lay attendance, autonomous professional, and state professional" (p. 217). In spite of the differences in practice, regulation, and education, midwifery around the world shares a core philosophy of facilitating informed choice, respecting women's right to choose, cultural sensitivity, and health promotion (ICM, 2013b).

In Manitoba, the CMM is the regulatory body of midwives. Midwives must register under the CMM to have the title of RM. The midwives of Manitoba have 11 principles which define their model of practice and can be delineated as follows: autonomous health care providers, community input, informed choice, continuity of care, choice of birth setting, two attendants at each birth, collaborative care, accountability and evaluation of practice, accessibility of midwifery care, research on the effectiveness of midwifery care, and midwives as educators (College of Midwives of Manitoba, 2000).

Historical Account of Midwifery in Canada

In Canada, the historical evolution of the midwife demonstrates parallel struggles to those experienced by midwives around the world. Understanding these historical struggles gives a context to certain aspects of the current status of Canadian midwifery. While many battles have been won, resulting in the acceptance of a recognized, valued profession, many roadblocks continue to linger. These existing roadblocks have been consistently seen throughout history. Historically, many of the documented struggles of midwifery in Canada parallel the struggles of the present-day midwifery profession in Canada. Both the current and historical struggles can be summarized as effects of professional imperialism (Benoit, Wrede, Bourgeault, Sandall, De Vries, & Van Teijlingen, 2005; Bourgeault & Fynes, 1996, 1997; Jasen, 1997; Parry, 2008; Plummer, 2000; Relyea, 1992; Rushing, 1991; Werner & Waito, 2008), power differentials related to gender (Benoit, Wrede, Bourgeault, Sandall, De Vries, & Van Teijlingen, 2005; Bourgeault & Fynes, 1996, 1997; Jasen, 1997; Parry, 2008; Werner & Waito, 2008), race (Jasen, 1997), class (Rushing, 1991; Werner & Waito, 2008), state government policy/intervention (Benoit, Wrede, Bourgeault, Sandall, De Vries, & Van Teijlingen, 2005; Bourgeault & Fynes, 1996, 1997; Jasen, 1997; Relyea, 1992; Rushing, 1991; Werner & Waito, 2008), and disunity of professional and educational endeavors (Bourgeault & Fynes, 1996, 1997; Parry, 2008; Plummer, 2000; Relyea, 1992; Werner & Waito, 2008). Some of these effects will be discussed in detail in the following paragraphs and expanded upon in the discussion chapter in relation to the findings in this case study.

Until the 1990s, the Medical Practitioners Act restricted the practice of maternity services to licensed persons of the College of Physicians and Surgeons (Benoit et al.,

2005; Rushing, 1991). A noteworthy example of how men in government influenced the fate of midwifery was with the enactment of the Ontario Medical Act of 1874. This legislation had a significant impact on the future of midwives across the country. Government policy, along with the growth of a male medical profession, positioned midwifery under attack, thus signifying a more overt battle between these two groups (Rushing, 1991). Furthermore, the Victorian Order of Nurses (VON) was established. The VON and the medical profession appeared to be more organized, thus strengthening their oppositional tactics against midwives in the communities (Relyea, 1992; Rushing, 1991).

Midwives continued to practice unregulated and unfunded throughout Canada from the 1940s through the 1980s. The progression of the profession, however, was imminent but not without resistance. For example, influences from the progression of midwifery in the United States, concurrent with the insurgence of the homebirth movement in British Columbia, spurred pan-Canadian midwifery initiatives (Barrington, 1985). In the early 1980s, consumer demand for midwifery services was evidenced by the growing homebirth movement. In spite of this movement, many pressures existed to keep midwifery "alegal." Essentially this meant that midwives were unable to practice in hospitals, unrecognized as a profession, and not funded within the provincial health care system (Connor, 1994; Kaufman, 1991; Menzies, 1989; Plummer, 2000, p.169; Rushing, 1991).

Throughout the 1980s, various endeavors supported the growth of the profession. One such endeavor was a move towards developing midwifery education. In the face of adversity, especially in creating sustainable education programs, the public continued to

advocate for legitimizing midwifery. In 1986, a midwifery education program in Nunavik evolved from the community's response to the negative effects of evacuations to give birth on women and families (Relyea, 1992). Throughout the 1980s, the provinces of Ontario, Alberta, and British Columbia made the most significant progress towards establishing midwifery as a legal, autonomous health profession. Through task forces, advisory committees, and interim regulatory boards, Ontario broke ground first. In 1991, Ontario was the first province to legalize midwifery. A year later the first university-based midwifery education program was implemented. By 1994, as a result of policy initiatives attracting the government's attention, consumer support, and provider shortage issues, Ontario had fully regulated and funded midwifery into the provincial health care system (Benoit et al, 2005; Bourgeault & Fynes, 1997).

Each province has experienced parallel difficulties and successes with implementing midwifery. A multiple-case study design was employed using a qualitative approach to evaluate the integration of midwives into the Quebec health care system (Collin, Blais, White, Demers, Desbiens, & L'Equipe d'evaluation des projets-pilotes sages-femmes, 2000). The findings from this study demonstrated midwives were not well integrated due to the lack of knowledge of other providers regarding the midwifery model, the lack of coordination between medicine and midwifery sites, competition within professional territories, and differences in the cultural practices between midwifery and other providers (Collin et al., 2000). In spite of enacted regulation, Alberta struggled to secure funding for the profession (McKendry & Langford, 2001). Similarly, Alberta midwives had interprofessional and intraprofessional tensions between midwives and other providers (McKendry & Langford, 2001). However, as evidenced by Ontario's

initiatives towards midwifery regulation, difficulties with implementation can be overcome when fundamental elements are successfully implemented. Evidence suggests that successful midwifery integration into Ontario's provincial health system was related to fundamental elements such as the enactment of supportive midwifery legislation, a formal regulatory body, a university educational program, and public funding. Equally important was the diligent and unified preparatory work of consumer advocates and midwives (Kaufman, 1991; McMahon, 2000).

The integration of midwifery into Ontario's provincial health system has been analyzed, well documented, and used as a national and international model (Benoit et al, 2005; Bourgeault, 2006; Bourgeault & Fynes, 1996, 1997; Biggs, 1983; Kaufman & Soderstrom, 2004; Sharpe, 1997). In Bourgeault and Fyne's (1996) analysis of the integration process, successful implementation can be attributed to surmounting the historical struggles of professional imperialism, power differentials between race, class and gender, and other issues. The first success came when midwives and consumer supporters successfully organized a professional organization that represented a unified profession (Bourgeault & Fynes, 1996). Class, race, and gender made a difference in how midwifery was integrated into the system. A specific group within this organization who were white, educated, and articulate based their arguments on research and international comparisons. They were viewed as politically astute (Bourgeault & Fynes, 1996). The lead role of this elite group of women, who were a part of the midwifery feminist movement, at least in part explains Ontario's success with the implementation strategies (Adams & Bourgeault, 2003).

Currently, midwifery has been legislated in the following provinces and territories: British Columbia, Alberta, Manitoba, Saskatchewan, Ontario, Quebec, Nova Scotia, New Brunswick, Nunavut, and the Northwest Territories. In Newfoundland and Labrador, midwifery has been recognized under the Health Professions Act; however, it has not been funded or integrated into the health system. In Prince Edward Island and the Yukon, midwifery has yet to be regulated but both have working groups facilitating the process (Canadian Midwifery Regulators Consortium [CMRC], 2012). Midwifery education can be obtained in the following provinces: Ontario, Quebec, British Columbia, Alberta, and Manitoba (Canadian Association of Midwives [CAM], 2013a). In addition to these midwifery programs, three community-based Aboriginal midwifery education programs also exist in Ontario, Quebec, and Nunavut (National Aboriginal Council of Midwives [NACM], 2013). The successes of these three Aboriginal birthing centers are testimony to how traditional knowledge has been bridged with modern science. These centers have brought back maternal health care, as well as birth, to local communities (Skye, 2010).

Another important endeavor related to midwifery education which has grown the profession in Canada came through the National Midwifery Assessment Project. Between 2003 and 2006, the CMRC conducted the National Midwifery Assessment Strategy project (Beck, Haworth-Brockman, Martin, Kilthei, Rach, Erickson, Klick, Kilpatrick, & Moise, 2008). The project was carried out over three years with the objective of establishing a process to assess the credentials of new immigrants. The final phase of the project provided information to pilot the Multijurisdictional Midwifery Bridging Project (MMBP). The intent of the MMBP was to provide internationally educated midwives

with an orientation and skills assessment to practice in Canada (Beck et al., 2008). In 2009, the first group of students took part in the MMBP pilot project. The funding for this program, however, ended in 2010. Currently, various provinces, including Manitoba, are developing their own bridging programs (CMRC, 2013).

Midwifery Care Related to Maternal Child Outcomes

Several studies demonstrated that midwifery care is safe and associated with positive maternal and infant outcomes (Eide, Nilsen, & Rasmussen, 2009; Flint, Poulengeris & Grant, 1989; Fraser et al., 2000; Harvey, Jarrell, Brant, Stainton, & Rach, 1996; Janssen, Ryan, Etches, Klein, & Reime, 2007; Janssen, Saxell, Page, Klein, Liston, & Lee, 2009; Oakley, Murtland, Mayes, Hayashi, Petersen, Rorie et al., 1995; Ryan & Roberts, 2005). Often women choose a particular provider for specific reasons. Therefore, an accurate comparison between midwifery groups and physician groups is difficult to obtain (Albers & Katz, 1991). Several randomized controlled trials (RCTs) have specifically compared midwifery care to standard hospital care (Flint, Poulengeris, & Grant, 1989), nurse-midwifery care to physician care (Harvey et al., 1996), and midwifery group services to physician group services (Chambliss, Daly, Medearis, Ames, Kayne, & Paul, 1992). In one study in the United Kingdom, women in the midwifery group had lower rates of augmentation, epidural use, intramuscular analgesia, and episiotomy compared to women in the physician group (Flint et al., 1989). A Canadian RCT compared nurse-midwifery care with care from an obstetrician or family practice physician (Harvey et al., 1996). The nurse-midwife group showed fewer episiotomies, as well as a tendency towards less pharmacologic pain relief. Lower intervention rates in the

midwifery group were noteworthy because both groups had the same access to the technology in the tertiary care setting.

Several studies in Canada have compared and examined the birth outcomes between provider groups (Fraser et al., 2000; Janssen et al., 2007, 2009). One study revealed women in the midwife group had lower rates of episiotomy, 3rd or 4th degree tears, and cesarean section in both multiparous and nulliparous groups (Fraser et al., 2000).

Two other Canadian studies investigated outcomes of planned hospital and planned home births between provider types (Janssen et al., 2007; Janssen et al., 2009). The first was a population-based cohort study which analyzed outcomes of a midwife group with a comparison physician group in the hospital setting. Overall cesarean rates were lower in the midwifery group, but there was no difference in cesarean rates in the nulliparous cohort between provider types. Narcotic analgesia and episiotomy rates were lower in the midwife group, however epidural rates were similar (Janssen et al., 2007).

In a more recent Canadian study by the same author, planned home birth with midwives was compared to planned hospital births with midwives or physicians. The rate of perinatal death was the primary outcome measure. The results revealed lower rates of obstetrical intervention such as episiotomy and cesarean in the planned homebirth cohort, and the rates of perinatal death were low and comparable between all three groups (Janssen et al., 2009).

While midwifery has been associated with positive outcomes and lower rates of intervention, it has also been associated with satisfaction with care (Hundley, Milne, Glazener, & Mollison, 1997; O'Brien, Chalmers, Heaman, Darling, & Herbert, 2011;

Overgaard, Fenger-Grøn, & Sandall, 2012; Sutcliffe et al., 2012; Tinkler & Quinney, 1998; Waldenström, Brown, McLachlan, Forster, & Brennecke, 2000). A recent study in Canada used the Maternity Experiences Survey (MES) data (n=6,421) to understand perceptions of maternity care among women who had received midwifery care compared to other providers (O'Brien et al., 2011). A greater proportion of women whose baby was delivered by a midwife rated their overall care as "very positive" compared to those whose baby was delivered by an obstetrician, family practitioner, or nurse/nurse practitioner (O'Brien et al., 2011). Another recent prospective cohort study with matched controls endeavored to understand women's birth experience, satisfaction, and perception of care between two freestanding midwifery units (n=185) and two obstetric units (n=190) (Overgaard et al., 2012). The results demonstrated birth experience and satisfaction with care was more positive with the freestanding midwifery units versus the obstetric units (Overgaard et al., 2012). These and other studies show that women have positive experiences with midwifery care.

Chronology of the Implementation of Midwifery in Manitoba

A brief chronology of events will be presented to provide a context for the case study. In 1981, a key starting point for regulating midwifery in Manitoba evolved out of a study of midwifery law by the Community Task Force on Maternal Child Health in Winnipeg. The Task Force was charged with looking at federal and provincial laws in relation to the practice of midwifery. This report on midwifery laid important groundwork for the inception of midwifery regulation in Manitoba. The report summarized the effect of federal and provincial laws on the practice of midwifery (Community Task Force on Maternal Child Health, 1981). The movement to regulate

midwifery was further spurred on by the overall need to reform maternal child health (Scurfield, 2002).

In 1994, the Minister of Health for Manitoba publicly recognized the need to acknowledge the midwifery profession as an autonomous, regulated, and insured health service in Manitoba. The Midwifery Implementation Council (MIC) was subsequently appointed to develop recommendations for the implementation of regulated midwifery in Manitoba. In 1997, the MIC proposed various recommendations that eventually led to the development of working groups and the assent of the Midwifery and Consequential Amendments Act by legislative authorities in 1997 (Manitoba Health, 1998).

The Human Resource Strategy for Midwifery Implementation projected that within two and half years of legislation there would be 50 midwives, with each attending/caring for 40 births, resulting in approximately 2,000 births per year (Manitoba Health, 1998). The midwifery-attended birthrate was projected to be 14%, which meant that by 2005 approximately 140 practicing midwives would be needed in the province. In June 2000, midwifery was officially regulated in Manitoba. The goals for implementing the midwifery program were to: ensure women had increased access of primary care from a midwife; target priority populations (single, adolescent under 20 years, immigrant/newcomer, Aboriginal, socially isolated, poor, and other at-risk women); and fully integrate midwives into the Regional Health Authorities around the province (Manitoba Health, 2002). The plan for supporting the growth of midwives in the province was implemented through an assessment and upgrade process by the MIC. This process eventually fell under the auspices of the College of Midwives of Manitoba (CMM).

In the late 1990s, a midwifery education movement made strides towards implementing a bachelor of midwifery education program under the auspices of the University of Manitoba. The proposal set forth by those involved had been approved by all University processes but was never funded. As a result, the implementation of a midwifery education program in the province was stalled (K. Robinson, personal communication, September 29, 2011).

Another means to support the growth of midwifery in the communities of Manitoba was the government's announcement in 2004 to implement an Aboriginal Midwifery Education Program (AMEP) in the north. The specific mandate of AMEP was to provide a degree program in Aboriginal midwifery to ensure a central Aboriginal focus. In 2006, eleven students were selected to begin the AMEP in the north (Aboriginal Midwifery Education Program Project Team, 2006). To date no students have graduated from the AMEP. The AMEP was under conditional approval contingent on the graduation of the first class. As a result of having no graduates, the College of Midwives of Manitoba (CMM) rescinded the program approval.

In 2009, the Government of Manitoba announced yet another initiative to support and promote midwifery in the province through the implementation of a Bachelor of Midwifery Program (BMP) for the urban south under the auspices of University College of the North (UCN). A cohort of eight students started the bachelor of midwifery program in the urban south in fall 2011, with no new intakes in 2012. In spite of strategic plans to implement educational programs in the province, there has been only a small increase in the numbers of midwives and no evaluative efforts to restore midwifery services in the north.

Three relevant studies have been identified related to policy and implementation processes of midwifery in Manitoba. In one study, the researcher analyzed factors that had an impact on midwifery legislation such as processes, negotiations, and policy (Scurfield, 2002). In Scurfield's dissertation, she critically examined the rationale for policy decisions specific to the implementation of midwifery in Manitoba. Several approaches were highlighted as unique to legislation in Manitoba. First, the MIC used a consensus decision-making model throughout the process. The consensus decision-making model created an environment where all members of the group could discuss the issue at hand. This process aligns with a non-hierarchical organization structure, whereby a decision is made when everyone comes to an agreement (Scurfield, 2002). Secondly, an "arms-length" committee was used to select public representatives. The MIC made every effort to select the appropriate stakeholders and keep them thoroughly informed with each step. Finally, the development of the Midwifery Act included the option of mediation to address complaints within the health profession legislation in Manitoba (Scurfield, 2002, p. 195). Initially, Manitoba also demonstrated commitment to Aboriginal midwifery and sought input from Aboriginal communities. This grassroots effort demonstrated the government's openness to understanding how to support Aboriginal midwifery (Scurfield, 2002). One recommendation that came from this study was that evaluations about the regulatory processes of this new profession should be ongoing.

Another dissertation focused on stakeholders' perceptions of the implementation of midwifery in Manitoba (Kreiner, 2005). This case study emphasized the importance of successful provincial midwifery education programs as critical to the sustainability of the

profession (Kreiner, 2005). The data for this study came from interviews and documentary sources. One conclusion from the study was that the integration of Aboriginal midwifery into regulated midwifery was feasible (Kreiner, 2005). Three strategies were identified as contributing to the creation of a diverse midwifery profession in the province: revitalizing Aboriginal midwifery, serving rural communities, and serving a socioeconomically diverse client population (Kreiner, 2009, p. e5). These three strategies were integral to how Manitoba midwifery used a community-building approach to address the diverse needs of the population.

A more recent study looked at the barriers and challenges to midwifery practice in a remote First Nations community in Manitoba (Olson & Couchie, 2013). This was an ethnographic study using participant observation and interview data to understand barriers and challenges to midwifery practice in remote settings. The authors state that currently the Canada Health Act does not permit a midwife working in a First Nations community to be paid within the existing system. They argue that tensions between the midwives and the government detract from meeting the immediate needs of people in Aboriginal communities (Olson & Couchie, 2013). One finding from this study highlighted how the policy of evacuation was not congruent with the Millennium Development Goal of having a skilled birth attendant at every birth. This study validates the importance of the midwifery role to bring birth back to the Aboriginal communities. Furthermore, it suggests that steps must be taken to remove policy barriers for midwives to practice in Northern and remote areas in order to repatriate birth to these communities (Olson & Couchie, 2013).

Summary

In summary, patriarchal influence and male dominance appear to be pervasive throughout time in the trajectory of the midwifery profession. As new technologies emerged, along with increased medical training, they became the leverage to phase out midwifery. The culture of maternity care began to change with these two legitimizing forces infiltrating the practice of obstetrics. The struggles of the midwifery profession are not unique to any one geographic location. In fact, influences of gender, race, class, and structures of power have all had an effect on what has been known as the midwifery movement all over the world. Midwifery continues to face opposition, in spite of great strides that have been made to legitimize the profession such as improved training, regulation, and integration into the conventional health care system.

Moreover, in Canada, feminist movements in several provinces pioneered the way to bring about the implementation of regulated midwifery across Canada. Evidence suggests that successful implementation strategies for provinces such as Ontario were related to an elite group of educated women who were on the forefront of policymaking. Consequently, Ontario was one of the first provinces to fully implement midwifery, with regulation, funding, and successful educational programs. On the contrary, while Manitoba had a well-thought-out implementation strategy, minimal growth has been observed and the educational program has had one student that graduated in 2013.

There is a gap in knowledge regarding how initial policy decisions have had an impact on the current state of midwifery in the province. Furthermore, an evaluation has not been conducted of critical components of the implementation strategy such as the educational processes and the utilization of midwives across the province. Additionally, no studies exist to date to demonstrate if midwives are serving the mandated priority

population. Therefore an analysis of barriers and facilitators fills an important knowledge gap and provides useful information for future planning of the midwifery profession in Manitoba.

Chapter IV: Design and Methods

This research used a case study design. In this chapter, the overall case study design will be discussed. This case study used both quantitative and qualitative data to explore factors that have influenced the implementation of regulated midwifery. The intention of understanding these factors was to build an explanation of how they have impacted regulated midwifery in Manitoba. The explanation-building technique used to guide the analyses will be discussed in the Case Study Design section.

After explaining the case study design and discussing the use of mixed methods, the quantitative and qualitative data collection methods will be described. The quantitative data provide context to the case study and describe how midwifery has been utilized since regulation. The qualitative data are the central focus of this case study because the results give a more detailed description of the case being studied. After describing the qualitative and quantitative data collection methods, aspects of researcher reflexivity, validity, and reliability used to ensure rigor and quality in the case study research design will be discussed. Finally, ethical considerations for this study will be addressed.

Case Study Design

Case study research investigates a phenomenon in-depth and in the context of a real-life situation. A case study research design incorporates multiple sources of data to understand the complexities of the case (Yin, 2009). A case study design facilitated a

critical examination of the research questions in this study (what and how) (Yin, 2009). Several noteworthy aspects of case study design are modeled in this study, thus validating the appropriate use of the case study design for this topic (Creswell, 2007). First, a single case (or unit) for the in-depth analysis was identified as regulated midwifery services in Manitoba (present-day system). Second, the case was bounded by "time" and "place." The time period of analysis was from 2001/02 to 2009/10. The place was defined as the province of Manitoba. The inquiry resulted in the specific analysis of many variables and multiple sources of evidence, as well as the triangulation of data guided by relevant theoretical underpinnings (feminism) (Yin, 2009).

As part of the analytic strategy in case study research, it is suggested that the researcher narrow in on an analytic technique to help define what to analyze and why (Yin, 2009). The analytic technique used for this case study was explanation building. This technique looks at how or why something happened and, further, makes assumptions about how or why something happened (Yin, 2009). In this case study, the researcher examined how and why barriers, facilitators, and structures of power have influenced the implementation and utilization of regulated midwifery in Manitoba. Triangulation of data was done to ensure the rigor of the case study, enhance the accuracy of the results, and provide an explanation and meaningful insight into the case of the implementation of regulated midwifery in Manitoba (Woodside, 2010).

Integral to case study design is the preparation of the researcher prior to initiating the study (Yin, 2009). The researcher had done preliminary document analysis and casual interviews with key stakeholders on the policy framework of midwifery practice and the history of the midwifery education programs in Manitoba. Moreover, the researcher had

personally been involved in Manitoba midwifery for five years in the capacity of a practicing midwife and instructor for one of the midwifery education programs.

Various approaches have been recommended to report case study research. A straightforward approach, known as *linear analytic*, has been used to report this case study. In accordance with this approach, the issue has been identified, a review of literature conducted, methods discussed, and findings analyzed and reported. Finally, the discussion has included the implications of the findings and conclusive remarks (Yin, 2009).

Mixed Methods

This case study used a mixed methods approach and incorporated both quantitative and qualitative methods of data for analysis (Yin, 2009). The case study evidence was derived from three sources: documents, administrative data, and interviews. Document analysis and the long or in-depth interview method were used to gather qualitative data. The administrative data were obtained from the Population Health Research Data Repository housed at the Manitoba Centre for Health Policy (MCHP). The Repository is a comprehensive collection of administrative, registry, survey, and other anonymized databases (Manitoba Centre for Health Policy [MCHP], 2013a). Data collection and analysis was an iterative process between documents, interviews, and administrative data. The qualitative study enhanced the quantitative descriptive results as it probed into what factors had influenced the implementation and utilization of regulated midwifery services in Manitoba.

A mixed methods approach is an appropriate research design when a study can be enriched by secondary sources of data (Creswell, 2007). The main investigation in this

case study relied on the qualitative data sources, and the descriptive quantitative piece gave context to the overall situation. The quantitative data were used to set the stage for the qualitative case study findings. The analysis of administrative data described the implementation and utilization of midwifery in Manitoba over the past ten years.

Various types of data collection strategies have been employed in mixed methods research designs. The data collection in this case study occurred sequentially. The qualitative data were collected first, and the quantitative data were collected as a second phase of data collection (Creswell, 2007). While the quantitative data lends itself to giving background information, it remains independent of the qualitative data.

Specifically, a mixed methods sequential transformative strategy was applied with the emphasis on the qualitative component (Creswell, 2009). A sequential transformative strategy emphasizes the use of a theoretical lens to explore a problem using both quantitative and qualitative data sources. In this study, a feminist framework gave contextual meaning to the findings from both qualitative and quantitative data. A sequential transformative mixed methods strategy framed the research question aimed at deconstructing an issue. Furthermore, this strategy is sensitive to marginalized, underrepresented groups, in this case, women. The theoretical lens shaped the direction of the research questions, ultimately exploring the issue. According to Creswell (2009), the difference between using a transformative strategy in a mixed methods approach and other strategies is that the theoretical lens guides the study.

Quantitative Research Method

The first research question about trends in the numbers of practicing and non-practicing midwives was answered using data from the College of Midwives of Manitoba

(CMM) registries, CMM annual reports, and information from the Manitoba Centre for Health Policy (MCHP) *Perinatal Services and Outcomes in Manitoba* report (Heaman, et al., 2012). The remaining research questions were answered using anonymized or de-identified administrative data from the Population Health Research Data Repository at the Manitoba Centre for Health Policy (MCHP) in Winnipeg, Manitoba. Prior to obtaining the data, linkages were made by the Associate Director of Data Access and Use for MCHP to create one data set for the study. Everyone registered for Manitoba Health is assigned a nine-digit numeric identifier known as the personal health identification number (PHIN). At MCHP, the PHIN is scrambled (encrypted) or an alphanumeric identifier is assigned to those who do not have a scrambled PHIN (MCHP, 2012). The data elements and labels for all three data sets were obtained from the MCHP's Associate Director of Data, Access and Use and the MCHP data dictionary.

The data were analyzed using the SAS Statistical Package Version 9.3 and the results are reported according to each specific quantitative research question. To ensure confidentiality and privacy of the data, prior to reporting the output, cells were suppressed if the values were less than six (MCHP, 2013a).

Source of data and time period.

The anonymized administrative data for this case study came from a collection of three databases housed in the Population Health Research Data Repository at the Manitoba Centre for Health Policy (MCHP) from fiscal years 2001/02 to 2009/10:

Population registry.

This file contained the current registry of all individuals registered to receive health services in Manitoba, including demographic information such as age and place of

residence. Those individuals insured federally (e.g., the military) or who are not eligible for coverage are not included. The information in this file was used to determine when residents had left or come into the province, and it helped identify all eligible women that had received maternity care in Manitoba.

Hospital abstract files.

This file contains information on all hospital separations of Manitoba residents. The file includes demographic and clinical information containing up to 25 diagnostic codes and 25 procedure codes. This information was used to track births related to provider type and patients' obstetric and demographic information.

Midwifery summary reports file.

This file contains information abstracted from the midwifery discharge summary form. The midwives complete a discharge summary form for all women in their care over 20 weeks gestation. These forms are submitted to Manitoba Health, where the data are entered into a midwifery database, which is then de-identified and transferred to MCHP on an annual basis. Information includes, but is not limited, to items such as: patient demographics, identification of priority populations, interventions (antibiotics, induction, augmentation, etc.), birth outcomes (birth weight, Apgar score, etc.), place of birth, consultations, and transfers of care and transport (home to hospital, time, etc.).

Population.

The cohort of women was defined as any childbearing woman who had a birth in Manitoba during 2001/02 to 2009/10. There were 132,123 births in Manitoba during this time frame. The data were checked for duplicate records and missing data. Of those births, 6,326 (4.79%) were flagged as midwifery-attended births, which included both

home births (n=1035) and hospital births (n=5238). Full-time midwives complete approximately 35 to 45 cases of care per year, and part-time midwives complete about 12 to 15 cases per year.

Data were analyzed according to income quintile and the RHA of the woman's region of residence. The Manitoba Centre for Health Policy (MCHP) has constructed census income quintiles as a "measure of neighborhood socioeconomic status that divides the population into 5 income groups (from lowest income to highest income)" and according to rural versus urban, with rural/urban rank 1 denoting the lowest income and rural/urban rank 5 denoting the highest income (MCHP, 2013b, para. 1) (Table 2). Income quintiles were based on the assumption that 20% of the entire population falls into each of the quintile ranks (R1-R5 & U1-U5) (C. Burchill, personal communication, March 21, 2013).

Table 2

Census Income Quintiles (Rural versus Urban) from the MCHP Concept Dictionary

Population Type	Rank (Quintile)	Minimum	Maximum	Mean
Rural	1	$6,866.00	$19,803.00	$16,857.07
	2	19,852.80	24,038.27	22,131.48
	3	24,137.00	26,915.12	25,491.65
	4	27,287.00	33,915.53	29,779.15
	5	33,946.16	47,038.52	37,494.37
Urban	1	8,767.00	23,740.00	18,964.24
	2	23,740.00	28,393.00	26,037.00
	3	28,393.00	34,150.00	31,381.63
	4	34,150.00	43,048.00	38,373.23
	5	43,048.00	126,512.00	54,967.41

Note. Table 2 is from Manitoba Centre for Health Policy [MCHP]. (2013b). *Concept dictionary. Construction of census income quintiles (rural versus urban)*. Winnipeg, MB: Manitoba Centre for Health Policy.

The presentation of RHA data warrants clarification due to the recent 2012 amalgamation from 11 health authorities to 5. If the data were abstracted from the Repository, the RHAs were reported as amalgamated, whereas if the data came from another source, the RHAs were reported as the original 11 prior to the 2012 amalgamation. Not all of the original 11 RHAs funded midwives in the first few years after regulation. By recreating the RHA variable to correlate with the current five RHAs, there is a better regional representation of where midwives were located. Table 3 describes how the RHAs were amalgamated in 2012.

Table 3

Amalgamation of RHAs in Manitoba (2012)

Amalgamated RHAs	New RHA name
North Eastman + Interlake	Interlake-Eastern
Burntwood + NOR-MAN	Northern
Central + South Eastman	Southern
Parkland + Brandon + Assiniboine	Western (Prairie Mountain Health)
Winnipeg + Churchill	Winnipeg

Note. From Province of Manitoba. (2012). *Province Announces 11 Regional Health Authorities Officially Merged Into Five New Regions.* [News Release].

Analytic method.

Descriptive statistics were used to answer research questions one through five. Table 4 describes measures of analysis and the definition of terms. Descriptive analyses

were performed using SAS Statistical Package Version 9.3 and by organizing the data and conducting the following statistical analyses:

1. Frequency distributions were conducted to express proportions (percentages) of births to women living in Manitoba who were attended by a midwife and to compare the proportion of midwifery-attended births in Manitoba across years.
2. Measures of central tendencies were calculated for continuous variables such as the mean age of the mother who had received midwifery care.
3. Chi-square, the nonparametric test of difference in proportions across RHAs, was conducted for nominal (categorical) level data such as parity of the women, priority population, age category, and income quintile based on urban versus rural.
4. A one-way Analysis of Variance (ANOVA) test was conducted for the continuous (interval) dependent variable (age) to determine if there was a difference across RHAs. The Least Squares Means (LSM) was used to detect which groups were significantly different with regard to the dependent variable.
5. Cochrane-Armitage trend tests were conducted to determine if there was a significant trend over time for both the proportion of midwifery-attended births and the proportion of priority population clients receiving care from a midwife.

Table 4

Summary of Measures and Definition of Terms

Research Question	Source/Data Analysis
1. Has the number of midwives in Manitoba increased from 2001/02 to 2009/10? Of that number how many were non-practicing vs. practicing? What was the distribution of practicing and non-practicing midwives in each Regional Health Authority (RHA)? Midwife characteristics • Total number practicing/non-practicing per year • Total number practicing per RHA/year	Source: College of Midwives of Manitoba/Manitoba Health Data analysis: The number of midwives (practicing and non-practicing) in Manitoba and in each RHA per year was presented in a table. The Cochrane-Armitage trend test was used to determine if there has been a significant change in the number of midwives in Manitoba over time (using only the Manitoba data because of anticipated small numbers in some of the RHAs).
2. What is the percentage of midwifery-attended births from year to year? Has the proportion of midwife-attended births increased from 2001/02 to 2009/10? What percentage of midwifery–attended births were hospital births and what percentage were home births? Midwifery-attended birthrate • Proportion of midwifery-attended births in in Manitoba each year • Proportion of home births vs. hospital births	Source: hospital abstract database, population registry and midwifery summary files Data analysis: Calculate proportion (percentage) of midwifery-attended births per year (i.e., births attended by a midwife divided by all births in province); used Cochrane-Armitage trend test to determine if there is a significant trend in the proportion of midwifery-attended births over time in Manitoba; calculated proportion (percentage) of hospital births and home births per year among those women having a midwifery-attended birth.
3. Are midwifery services available in each of the RHAs in Manitoba? Have the services changed across time? In those RHAs providing midwifery services, what percentage of women are getting midwifery care? Midwifery services • Availability of midwifery services in each RHA • Percentage of women getting midwifery care in each of those RHAs	Source: midwifery summary files, hospital abstract database, and population registry, Manitoba Health, College of Midwives of Manitoba Data analysis: The availability of midwifery services in each RHA was determined by whether midwives were practicing in the RHAs that offered midwifery services. Calculated the proportion (percentage) of women residing in each of those RHAs with services who received prenatal care services from a midwife and the proportion who had their birth attended by a midwife.

4. What percentage of midwifery-attended births are priority populations as defined by the College of Midwives of Manitoba? Maternal Characteristics • Priority population: Adolescent (<20 years), Aboriginal, immigrant, socially isolated, poor, other • Regional Health Authority district: based on MCHP/MB Health code or mother's postal code	Source: midwifery summary files Data analysis: Number of women in each priority population category was presented in a table and the percentage of midwifery-attended births that fall into at least one category of priority populations was calculated. A trend test was conducted to determine any significant changes over time.
5. What are the characteristics of women who receive midwifery services in Manitoba? Do these characteristics differ across RHAs? Characteristics of women • Age • Parity • Priority population (Y/N) • Urban vs. Rural: based on MCHP data dictionary	Source: midwifery summary files, census files, , population registry, hospital discharge abstract Data analysis: Calculated mean and SD for interval level data (age) and test for differences across RHAs using ANOVA. Calculated proportion of women receiving midwifery services for a variety of categorical (nominal level) characteristics (e.g., primipara vs. multipara, adolescent vs. other age categories; urban vs. rural; income quintile of residence) for province overall and for each RHA. Used Chi-Square for nominal level data to determine differences in proportions across RHAs (parity, priority population).

Qualitative Research Method

Qualitative research methods were the central focus in this study in order to identify and explore factors influencing the implementation and utilization of regulated midwifery services in Manitoba. Document analysis and the long interview method, also known as the in-depth interview method (see definition under interview data plan), were used to gather the qualitative data in this case study. Qualitative research is employed for various reasons, but a focal point of this method is for the researcher to go beyond the known and tap into the world of the participants (Denzin & Lincoln, 2005).

The goal of incorporating a qualitative component to this study was to enhance our understanding of the barriers and facilitators of how midwifery has been implemented and utilized in Manitoba. Unlike quantitative research, the research problem in qualitative

inquiries is often of a much broader nature. The identification of concepts and construction of themes comes from the data (Strauss & Corbin, 2008). The focus of the methodological procedures is inductive, hence the focus is emerging and influenced by the researcher's experience while collecting and analyzing the data (Creswell, 2007).

Throughout the qualitative data collection phase, the researcher continually reflected on principles regarding the feminist approach and what the researcher's position was in relation to this study. Two principles of the feminist approach were kept in mind throughout the qualitative data collection phase. The first goal was to improve women's disposition and, second, to identify ways to facilitate social change with the results of the study (Barnes, 1999). Another consideration was the context so as to avoid blame in any given situation. For example, the researcher continually considered the context of the 24 key informants who were interviewed, as well as the situational forces and the setting (Bond, Hill, Mulvey, & Terenzio, 2000). In this case, there was careful scrutiny of how factors such as the medical model have impacted the sustainability of the midwifery profession in Manitoba. Secondly, the researcher's epistemological assumptions were meticulously surveyed in relation to the research topic. The following questions were considered and integrated into chapter six of the discussion: Who qualifies as knowing? What is subjectively true? What does being objective mean? What is the goal of generating this knowledge? (Harding, 1986)

Document data collection.

Information from documents was one key source of evidence for this case study. Documents can substantiate information from other sources and inferences can be made. The researcher maintained rigor by approaching the document as a form of

communication among certain parties who had specific objectives. The types of documents considered for this case study included evaluations, proposals, reports, archived documents, public announcements (multi-media sources),news releases, and internal records. All documents analyzed were in the public domain and no special permission was required for access.

Through various conversations with key informants and personal research by the researcher, key documents were obtained and analyzed. During the qualitative data collection phase (throughout the interview process and analysis of preliminary documents) information evolved that led to obtaining other key documents for analysis.

The criteria for selection of the sources were based on the information contained in the documents that was considered relevant to the research questions. For example, historical documents archived at the University of Manitoba had information regarding the original proposed baccalaureate of midwifery program that was never implemented.

Document analysis procedure.

The documents were first sorted according to their relevance in relation to the research questions. Secondly, careful content analysis was done, keeping in mind the type and purpose of each document and who was involved. The strategy for document analysis included, first, to review and examine the research questions in relation to the document (Stake, 2010). Second, the researcher critically examined the content to identify the objectives of the document. The contents of the documents were then interpreted according to their objectives and if they validated and enhanced other sources of evidence. If the content appeared contradictory, further inquiry was pursued (Yin, 2009). For example, the researcher contacted the original author of certain documents to validate

information or expand on the understanding or intent of the document. Additionally, a meeting was set up with the CMM to confirm specific statistics regarding practicing/non-practicing midwives, budgeted midwifery positions, and Prior Learning and Experience (PLEA) statistics.

The researcher kept in mind the "written purpose" of each specific document, so as to remain objective with the analysis (Yin, 2009, p. 105). The patterns and sequence of events were noted and used to triangulate the findings with other findings from the data sources. A document analysis guide, based on the research questions, was used while reviewing documents to record findings and to maintain the focus of the study (Appendix D).

Interview data collection and analysis procedures.

Care must be given in selecting participants for a case study. Yin (2009) suggests a screening process to solidify the final number of participants for the case study. Quantity was not the aim with sample selection. The idea was to identify "cultural categories and assumptions" to help understand how the issues at hand were construed (McCracken, 1988, p. 17).

Sampling.

The first step prior to conducting interviews was key informant selection. The selection of key informants for this case study was otherwise known as purposive sampling (Polit & Beck, 2012). The selection of key informants for the long interview was done to understand the culture or complexities of a specific targeted unit of analysis (regulated midwifery in Manitoba) and is not generalizable (McCracken, 1988).

Ultimately, the goal of purposive selection of key informants was to glean from their assumed knowledge related to the identified categories.

Key informants were selected based on assumptions of who would yield the most appropriate information in relation to the case study research questions. The goal was to obtain around four to six participants from each group in order to substantiate the findings and reach saturation from information collected during the long interview (Woodside, 2010).

Operational criteria for participant selection were defined by the following categories: Professional bodies (College of Midwives of Manitoba [CMM], Manitoba Association of Midwives [MAM]), Implementation groups (Working Group, Midwifery Implementation Council [MIC]), Midwives (practicing and non-practicing), Health professionals and relevant personnel who collaborate with the midwifery profession (Medical directors, Nursing directors, Program Coordinators/Instructors of Midwifery education programs, Program Coordinators of the Midwifery Assessment Program, obstetricians and family practice physicians), and Provincial representatives (Manitoba Health, RHAs).

Potential key informants were sent a confidential letter by email via the University of Manitoba server, to explain the purpose of the study with an invitation to be a part of the study (Appendix E). Of the 29 identified key informants from the defined categories who were invited to participate in this case study, a total of 24 key informants agreed to participate in the study.

Field techniques.

The interviews took place from June 2012 to November 2012. Twenty-two of the interviews were done face-to-face, in private locations that were chosen by each key informant. The location ranged from key informant's workplace, to personal home, or to a private room reserved at an institution. Two of the interviews were completed by Skype (audio) due to the remote location and the transience of the key informants. Interviews were done either on non-work time or during work hours. Prior to scheduling any interview conducted during work hours, key informants were asked if there were approval processes needed. No approval processes were needed except for one RHA that required approval from their employee prior to conducting the interview. All appropriate paperwork was submitted to the RHA, and approval was granted in a timely manner to conduct this interview.

Prior to the start of each interview, the key informants signed a consent form, which explained the study protocol and the participant's role in the study (Appendix F). The key informant kept one copy of the signed consent form, and another original signed copy was stored securely in a locked file within a locked office at the University of Manitoba.

Twenty-two of the interviews were tape-recorded by a digital recorder, and field notes were completed by the researcher immediately after leaving each interview. Two of the interviews were recorded with Callnote on Skype. All interviews were uploaded to the secure University of Manitoba server and stored on a shared file created by the University of Manitoba Information Technology (IT) Services. The transcriber signed a confidentiality statement prior to commencing the transcription of the interviews. The IT administrator, transcriber, research advisor, and principal investigator were the only

persons who had access to the folder. After the successful uploading of each file to the secure shared file, each interview was immediately deleted from the digital recorder. The field notes were typed and stored in a three-ring binder.

A semi-structured interview guide was used to conduct the interview (Appendix G). The questions were guided by the theoretical framework and a feminist lens. Appropriate probes were elicited, as needed, to maximize the content of data (Woodside, 2010). After every two to three interviews, the researcher listened to the content of the interview. Information that was gleaned from one interview helped inform and validate subsequent interviews (Johnson, 2002). For example, with each interview the researcher gained more confidence and insight into how questions were asked, paying closer attention to any "leading" that could happen. Furthermore, deeper probing happened at times, which strayed from original interview guide, however, this yielded relevant information to answer specific research questions. This technique was inherent in the process and is justified in qualitative interview methods which discuss the nature of in-depth or the long interview processes (Johnson, 2002; McCracken 1988). After the completion of all 24 interviews, the researcher had gained tremendous insight into the interview process and felt a deeper sense of "owning" the research that was being done.

Most interviews ranged from forty minutes to one and a half hours. Interviews with physicians tended to last less than one hour due to their time constraints. All key informant participants had the opportunity to debrief with the researcher immediately after the recorder was turned off. The interview length was deemed sufficient to answer the research questions, and thick description was noted in almost every interview (Creswell, 2007; Johnson, 2002; Seidman, 2006; Stake, 1995). No follow-up interviews

were needed. However, on three occasions the key informants followed up with information they requested to be added from the debriefing session after the recorder had been turned off. The information from the debriefing came by email from two of the key informants. Another participant debriefed in person and the researcher took notes by hand. All key informant participants were aware that they could request a copy of the transcribed interview to review for accuracy (Stake, 2005). All key informant participants declined and were satisfied to have a copy of the summary of results when they became available.

Each completed interview was assigned a number according to the chronologic order of when it was completed, and no names were attached to transcripts. After the transcription of the interviews, the researcher listened to each interview and compared it to the transcript to check for accuracy. In order to gain insight into the participants' perspectives, the analysis of content was inductive. The interviews were coded by hand. The interviews were read again and the codes were entered into an NVivo 10 software program to organize the data. Thematic analysis was done to understand the complexity of the case. The researcher engaged in the text looking for key "themes, concepts or dimensions" (Hesse-Biber & Leavy, 2004, p. 441; Stake, 1995).

The basic concepts of content analysis were employed to analyze the qualitative data throughout the document review and in-depth interviews (i.e., abstraction of data, creating codes, sub-themes and themes) (Graneheim & Lundman, 2004). Data were initially coded by hand and then categorized in NVivo, and sub-themes were created. Finally, overarching themes evolved in relation to each of the three broad topics. Qualitative description was useful in this study since the goal was to gain straightforward

(low-inference) information to specific questions regarding issues that have impacted the implementation of regulated midwifery in Manitoba. Qualitative description is a fundamental approach towards inquiry (Sandelowski, 2000, 2010). This approach differs from other qualitative methods in that it is less interpretive and draws on the natural state of what is being studied. Qualitative description has low inference so researchers should be able to agree on the facts being studied even when the facts are presented differently. Finally, larger paradigms are capitalized on; for example, in this case study, feminism was the larger paradigm for interpretation (Sandelowski, 2000).

Once the interview text had been coded and themes categorized, a more critical analysis was done using concept mapping to extrapolate relationships between related topics (Stake, 2010). For example, displays of the codes were written on large poster boards to begin collapsing content into themes and sub-themes. The researcher continued to go back to the content of the interviews while defining themes and sub-themes.

Saturation was defined when the maximum amount of information, which appropriately supported each identified theme during the data analysis phase, was reached (Creswell, 2007). Once saturation was reached, aggregated content from the interviews was reviewed again and linked to each overarching theme.

Three preconceived topics (barriers, facilitators, and future strategies and recommendations) were used to specifically guide the interviews. Within the three topics, themes and sub-themes emerged to address the qualitative research questions. Data were initially abstracted and condensed (i.e., “shortening and preserving the core”) (Graneheim & Lundman, 2004, p. 106). For example, similar words or phrases were identified and then divided into the three topic areas. Sub-themes were developed and then compared to

establish dimensions and relationships. Eventually sub-themes were aggregated to form more overarching themes. Throughout the process, definitions or "meaning units" were identified (Graneheim & Lundman, 2004). These meaning units were linked back to each interview accordingly to demonstrate an audit trail (Appendix H).

The Manitoba midwifery community and those involved in it at various levels make up a relatively small number. Due to the small number of key informants and their specific roles in relation to the midwifery profession, no comparisons between groups were made. The researcher only identified participants by the broad stakeholder categories and not by their specific roles. For example, health personnel could be administrators, physicians, nurses, etc., whereas those in the midwife category could be non-practicing or practicing.

Case Study Validity and Reliability

Many perspectives and strategies exist regarding how validity and reliability are conceptually defined and then employed in various research designs (Creswell, 2007; Janesick, 2000). Throughout this study, the researcher was mindful of the inferences made in the analysis (validity) and the consistency of the results over time (reliability) (Creswell, 2007). In case study research, validity and reliability can transpire throughout the study (Yin, 2009). The approach for maintaining the quality of the research is discussed below in relation to the validity and reliability techniques used in this case study.

Construct validity.

To help ensure the comprehensiveness of the findings and lessen the likelihood of misinterpretation of the data, multiple sources of evidence were used. This is a tactic

known as triangulation (Stake, 1995, 2000, 2010; Yin, 2009). In this case study, quantitative, document, and interview data were all used to substantiate the description of the case. Data source triangulation was used to verify information about the case across time and with various stakeholders who were involved (Stake, 1995; Woodside, 2010).

Internal validity.

Internal validity was done throughout the data analysis phase. Inferences between sources of data were critically considered throughout the analysis phase of this case study. The analytic tactic of explanation building was employed to help draw an understanding and explanation of specific events regarding the case of midwifery in Manitoba (Yin, 2009).

External validity.

External validity is important in understanding whether the findings of the case study are generalizable. While in single case studies this can be challenging and the intent is not necessarily to generalize, it can be kept in mind. The findings of this case study may be applicable to other cases of midwifery nationally and internationally (Yin, 2009). Rich thick description was another validation strategy used in this case study. For example, to gain a "deep understanding" of the case, a detailed description of specific events was consistently noted and reported in the findings within the corresponding themes of the study (Creswell, 2007; Woodside, 2010, p. 6).

Reliability.

According to Creswell (2007, p. 135) reliability has "limited meaning" in qualitative research. It is most often used between researchers to compare accuracy in coding. In case study research, however, reliability can be approached by creating a

"protocol" or record of procedures that were completed (Yin, 2009, pp. 41, 45). To minimize error and bias in this case study, meticulous documentation of the case study procedures was maintained throughout the data collection phase (Yin, 2009). The documentation of the case study procedures was organized in a 3-ring binder.

Researcher reflexivity.

Another preparatory step was being aware of reflexivity as a researcher using a feminist lens. Reflexivity is the notion of what the researcher brings to the interpretation of the results and how the write-up of those results will impact those involved (Creswell, 2007). It is impossible to remain completely objective for the simple fact that who the researcher is will be somewhat reflected in the analysis (Bacchi, 2008). The researcher had direct involvement with the 24 key informants; the data collection was interactive between the researcher and the researched. A reflexive journal was maintained throughout the study.

Prior to the study, the researcher reflected on specifics of her background and how that would impact the study. For example, the researcher is Caucasian born in the United States with extensive clinical experience in the areas of maternal child health in various parts of the world. Nurse-midwifery is the researcher's specialty. The researcher has not only experienced the system first hand as a nurse and midwife clinician, but also as a childbearing woman desiring choices around childbirth practices.

In conclusion, the researcher's full interpretation of midwifery in Canada and Manitoba is limited due to a short time of residence and ongoing acculturation to a foreign system. Finally, the impetus to this research evolved from the researcher's involvement in the midwifery profession. The researcher is aware of some of the inside

politics and their impact on the utilization of regulated midwifery services. The researcher's internal involvement has created a disposition of anger and constant deliberation towards systemic politics regarding the sustainability of the midwifery profession in Manitoba. As a result, feminist ethics in research have been conscientiously studied and followed to help guide the feminist theoretical framework proposed to direct the study (Cook & Fonow, 1986). Furthermore, the researcher has kept in perspective the tensions that arise between the researcher and the subjects, which are inherent to the feminist research process as it seeks social change (Acker, Barry, & Esseveld, 1983).

Ethical Considerations

Prior to the commencement of this study, ethical standards were thoroughly considered. Particular consideration was given to protect the anonymity of the research participants. The study was approved by the University of Manitoba Health Research Ethics Board (H2012:116) on April 27, 2012 and the approval was renewed annually (Appendix A). The principal investigator maintained compliance with the Personal Health Information Act (PHIA) by obtaining approval for the quantitative component from the Health Information Privacy Committee (HIPC) (File No. 2012/2013-02) (Appendix B).

The quantitative research for this study was conducted at the Manitoba Centre for Health Policy (MCHP). A researcher agreement was signed with MCHP and was effective as of May 11, 2012. Strict adherence to the policies and protocols for conducting research at the MCHP was followed to protect the confidentiality of the anonymized data. The anonymized data were stored within a secure data laboratory within the University of Manitoba in MCHP's Unix system. The anonymized data used

for this research study contained no identifiable personal information. Personal Health Identification Numbers were encrypted specifically for MCHP so persons are not identifiable. The anonymized data were presented in summary form. Use of the Repository housed at MCHP was fully in compliance with all privacy legislation in Manitoba. The researcher is aware of the rights of individuals in relation to the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act, and will not publish information in a form that could reasonably be expected to identify individuals.

A signed informed consent, fully describing the nature of the study, was obtained from all 24 participants who were interviewed. All participants had the opportunity to ask questions about the study. The following considerations were addressed with each participant and included in the consent form: participation is entirely voluntary; withdrawal can occur at any time by participants' own volition; participants are free to refuse to answer any question at any time; confidentiality will be maintained by scrupulous measures taken by the research team throughout the entire research study; confidentiality is never completely unconditional, however, every effort will be made by the researcher to ensure complete confidentiality of the participants involved; the University of Manitoba Research Ethics Board may access information related to this study in relation to any quality assurance protocols; excerpts from this dissertation will be published and presented in public forums but participants will be protected, as much as possible, from any identifying information (Appendix E). A $20 honorarium was given to each of the 24 participants to acknowledge their contribution to the study.

Chapter V: Results

Chapter five will present the findings from the qualitative and quantitative data analysis. The quantitative results will be presented first and provide context to the overall case study. The main emphasis in this case study was the qualitative component. Two sources of qualitative data were gathered: information from the documents review and 24 in-depth interviews with key informants.

After the presentation of the quantitative data, the findings from the documents will be presented. Finally, the key informants will be briefly described prior to the presentation of the findings from the interview data. Prior to conducting the study, significant issues regarding the implementation of regulated midwifery were known to the researcher. Therefore, this preconceived notion of topics (barriers, facilitators, and future strategies and recommendations) was advantageous to the design of the study and used as the broad topic areas to help understand the case (Denzin & Lincoln, 2000). The three broad topic areas were integrated into the interview guide, and they will be discussed in this chapter in relation to themes and sub-themes that emerged from the interview data.

Results of the Quantitative Component

Results will be presented for each of the research questions.

Q (1): Has the number of midwives in Manitoba increased from 2001/02 to 2009/10? Of that number how many were non-practicing vs. practicing? What was the distribution of practicing and non-practicing midwives in each RHA?

The number of practicing midwives has steadily increased in Manitoba, from 26 in 2001/02 to 40 in 2009/10 (Table 5). The number of non-practicing midwives has also increased, from 5 in 2001/02 to 12 in 2007/08, but then fell to 11 in 2009/10 (Figure 3), based on data from the CMM annual reports (Table 5). Based on the data from the CMM

registries (Table 6), the number of practicing midwives has steadily increased in Manitoba, from 30 in 2006 to 38 in 2010. There is considerable variation in the distribution of practicing midwives among RHAs, with Winnipeg having the most midwives, followed by Brandon and Central (Table 6). Several of the RHAs have not had any practicing midwives (Table 6). The College of Midwives has tracked the provincial numbers of non-practicing midwives in their annual reports from 2001/02 to 2009/10 but because they are not recorded by RHA (Table 5), the question about the distribution of non-practicing midwives by RHA could not be answered. The discrepancies between the two sources of data for Table 5 and Table 6 have been noted and can be attributed to documentation errors by different recorders over time.

Table 5

Practicing (P) vs. Non-Practicing (NP) Midwives by Fiscal Year (CMM Annual Reports, 2001/02 to 2009/10)

Fiscal Year	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
P	26	26	30	25	30	30	32	41	40
NP	5	5	7	8	8	7	12	11	11
TOTAL	31	31	37	33	38	37	44	52	51

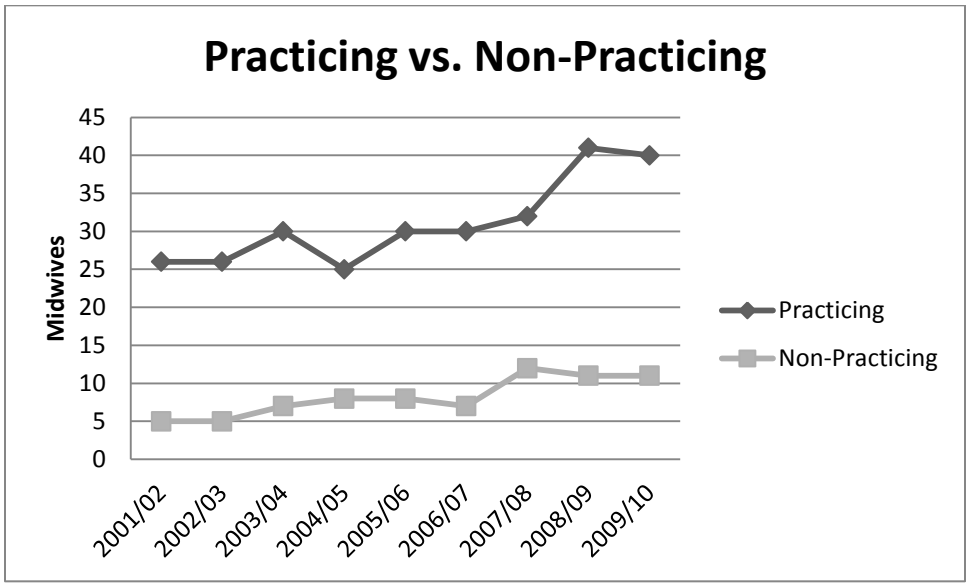

Figure 3. Number of practicing and non-practicing midwives from 2001/02 to 2009/10.

Table 6

Practicing (P) Midwives by RHA from Fiscal Years 2006 to 2010 (CMM Registries, 2006-2010)

RHA	2006/07	2007/08	2008/09	2009/10	2010/11
Winnipeg	18	16	18	21	22
Brandon	4	4	5	5	6
Central	2	3	4	5	3
South Eastman	4	4	4	4	4
Nor Man	1	2	3	3	1
Burntwood	1	1	4	2	2
Churchill	NR	NR	NR	NR	NR
Assiniboine	0	0	0	0	0
Interlake	0	0	0	0	0
Parkland	0	0	0	0	0
North-Eastman	0	0	0	0	0
TOTAL Practicing	30	30	38	40	38

NR=Not Reported

Q (2): What was the percentage of midwifery-attended births from year to year? Has the proportion of midwifery-attended births increased from 2001/02 to 2009/10?

The number of births attended by midwives steadily increased from 407 births in 2001/02 to 862 births in 2008/09, followed by a slight drop to 747 births in 2009/10. The proportion of midwifery-attended births was calculated by identifying all midwifery-attended births and dividing those by the total number of births in Manitoba for each fiscal year (Table 7). The proportion of midwifery-attended births has slightly increased over time. The test for linear trend was statistically significant at $p<.0001$. Figure 4 displays the trend over time for the proportion of midwifery-attended births. Overall, midwives attended 4.79% of the births, whereas other providers (primarily obstetricians and family physicians) attended 95.21% of the births. In 2006, the highest proportion of midwifery- attended births was reported at 5.74% compared to other years. By 2009, the number had dropped slightly to 4.67%.

Table 7

Number of Births and Proportion of Overall Births in Manitoba Attended by Midwives by Year

	2001/02 N (%)	2002/03 N (%)	2003/04 N (%)	2004/05 N (%)	2005/06 N (%)	2006/07 N (%)	2007/08 N (%)	2008/09 N (%)	2009/10 N (%)	Total N (%)
Birth by Midwife	407	505	715	662	775	850	803	862	747	6,326
	(2.89)	(3.64)	(5.06)	(4.77)	(5.41)	(5.74)	(5.21)	(5.50)	(4.67)	(4.79)
Birth by Other Provider	13,670	13,350	13,404	13,217	13,549	13,953	14,615	14,803	15,236	125,797
	(97.11)	(96.36)	(94.94)	(95.23)	(94.59)	(94.26)	(94.79)	(94.50)	(95.33)	(95.21)
Total number of births	14,077	13,855	14,119	13,879	14,324	14,803	15,418	15,665	15,983	132,123

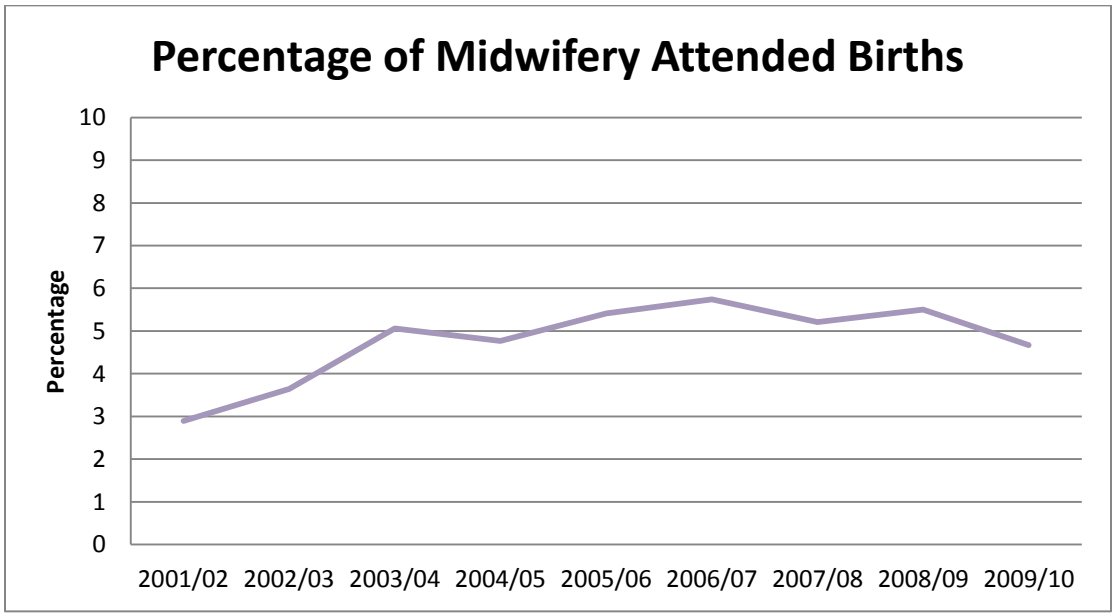

Figure 4. Linear trend over time for the proportion of midwifery-attended births. p<.0001

Q (2) (continued): What percentage of midwifery-attended births were hospital births and what percentage were home births?

Midwives had an increase in the number of both home births and hospital births over time (Table 8). While the number of hospital births nearly doubled from 308 to 612 between 2001/02 and 2009/10, the number of home births increased more slowly from 97 to 127. The overall percentage of homebirths was 16.5% and the overall percentage for hospital births was 83.5%. It is interesting to note that while home births increased, the overall percentage of home births decreased in relation to hospital births (Figure 5). A total of 24 cases were recorded as "other" from 2001/02 to 2009/10. The information for this analysis came only from the midwifery discharge forms; therefore, a discrepancy of total births (n=6273) is noted compared to the total number (n=6326) of midwifery-attended births identified when combining information from both the midwifery database and the hospital abstract file. The 29 missing cases can be attributed to missing midwifery discharge forms (that were either lost or not submitted to Manitoba Health) or place of birth status not being recorded on the form.

Table 8

Number and Percentage of Midwifery-Attended Births by Place of Birth (Home vs. Hospital)

Place of Birth	2001/02 N (%)	2002/03 N (%)	2003/04 N (%)	2004/05 N (%)	2005/06 N (%)	2006/07 N (%)	2007/08 N (%)	2008/09 N (%)	2009/10 N (%)	Total N (%)
Home	97 (23.95)	95 (18.92)	105 (14.77)	123 (18.66)	119 (15.54)	132 (15.60	122 (15.38)	115 (13.50)	127 (17.19)	1035 (16.50)
Hospital	308 (76.05)	407 (81.08)	606 (85.23)	536 (81.34)	647 (84.46)	714 (84.40)	671 (84.62)	737 (86.50)	612 (82.81)	5238 (83.50)
TOTAL	405	502	711	659	766	846	793	852	739	6273

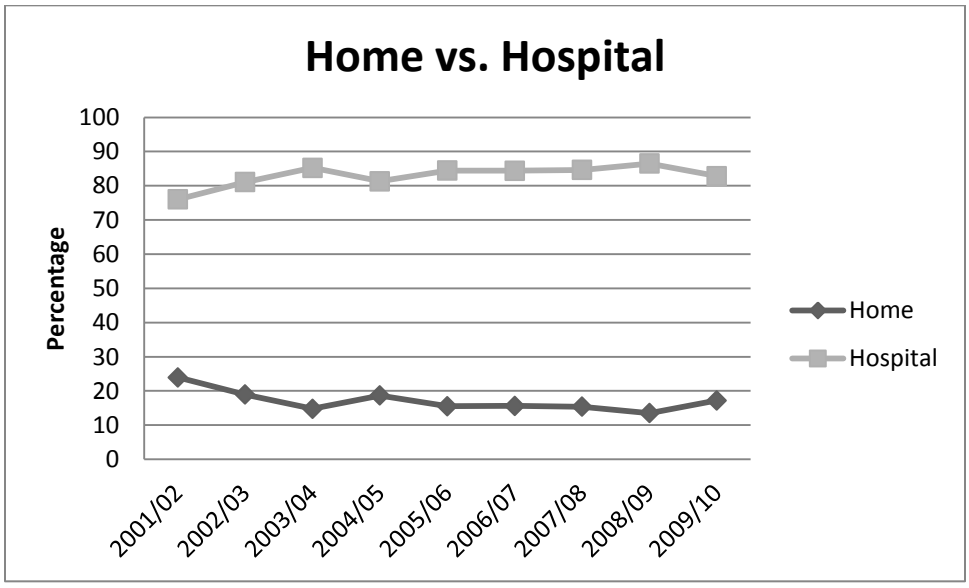

Figure 5. Percentage of home births and hospital births among those births attended by a midwife.

Q (3): Are midwifery services available in each of the RHAs in Manitoba? Has it changed across time? In those RHAs providing midwifery services, what percentage of women giving birth are getting midwifery care?

Table 9 demonstrates the distribution of midwifery-attended births by RHA (recent amalgamation) from 2001/02 to 2009/10. The majority of midwifery-attended births occurred in Winnipeg RHA, followed by Southern and Western RHAs. It is interesting to note that the percentage of births attended by midwives in Winnipeg has dropped over time, whereas in Southern RHA the percentage of births attended by midwives has increased. Figure 6 shows the fluctuation in percentage of all women giving birth in Manitoba who had a midwifery-attended birth in each RHA across time. Table 10 demonstrates the percentage of all women giving birth in Manitoba who had received midwifery care. The highest percentage of all women receiving midwifery care was in 2006/07 (5.74%). That percentage dropped to 4.67% in 2009/10. This drop in numbers could be reflective of midwives leaving practice to teach or midwives taking

leave due to burnout. The decreased percentage of midwifery-attended births may also be related to the overall increase in number of births throughout the province. Southern RHA (6.72%) and Winnipeg RHA (5.20%) had the highest overall percentage of midwifery-attended births, whereas Interlake-Eastern had the lowest (0.99%). Winnipeg and Southern RHAs have a greater number of midwives, which explains why these regions have a higher percentage of midwifery-attended births. Interlake-Eastern does not have midwives. Women who see a midwife, who are from this region, come to Winnipeg for prenatal care and for the delivery.

Table 9

Proportion of All Midwifery-Attended Births that take place in each RHA by Year

RHA	2001/02 N (%)	2002/03 N (%)	2003/04 N (%)	2004/05 N (%)	2005/06 N (%)	2006/07 N (%)	2007/08 N (%)	2008/09 N (%)	2009/10 N (%)	Total N (%)
Interlake-eastern	16 (3.93)	8 (1.58)	7 (0.98)	13 (1.96)	19 (2.45)	14 (1.65)	16 (1.99)	13 (1.51)	9 (1.20)	115 (1.82)
Northern	19 (4.67)	43 (8.51)	90 (12.59)	56 (8.46)	55 (7.10)	45 (5.29)	65 (8.09)	102 (11.83)	55 (7.36)	530 (8.38)
Southern	65 (15.97)	59 (11.68)	122 (17.06)	127 (19.18)	171 (22.06)	214 (25.18)	236 (29.39)	225 (26.10)	210 (28.11)	1429 (22.59)
Western	17 (4.18)	42 (8.32)	72 (10.07)	59 (8.91)	101 (13.03)	144 (16.94)	118 (14.69)	95 (11.02)	98 (13.12)	746 (11.79)
Winnipeg	290 (71.25)	353 (69.90)	424 (59.30)	407 (61.48)	429 (55.35)	433 (50.94)	368 (45.83)	427 (49.54)	375 (50.20)	3506 (55.42)
Total	407 (6.43)	505 (7.98)	715 (11.30)	662 (10.46)	775 (12.25)	850 (13.44)	803 (12.69)	862 (13.63)	747 (11.81)	6326

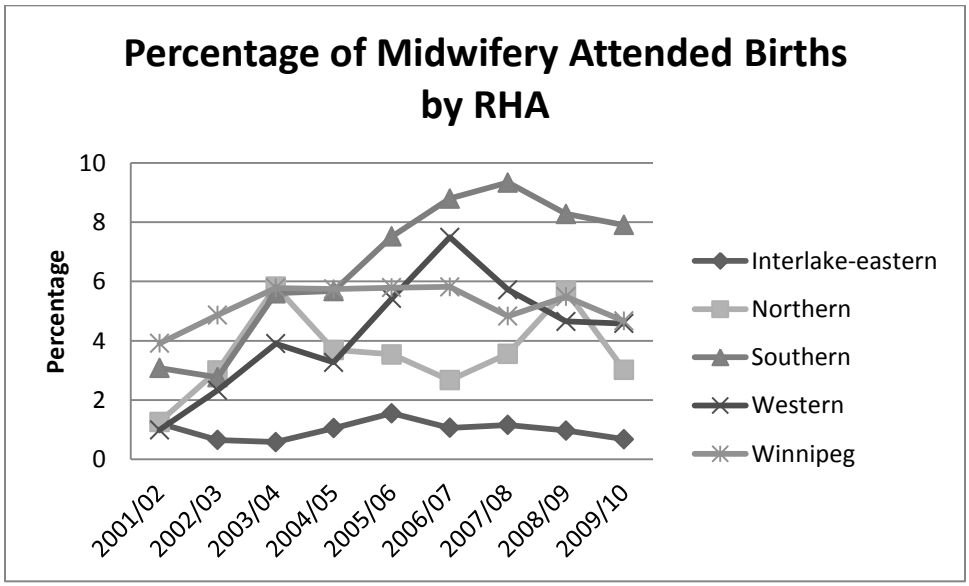

Figure 6. Percentage of all women giving birth in Manitoba who had midwifery-attended births across RHAs.

Table 10

Percentage of All Women Giving Birth in Manitoba Who Had their Birth Attended by a Midwife in Each RHA by Year

RHA	2001/02 N (%)	2002/03 N (%)	2003/04 N (%)	2004/05 N (%)	2005/06 N (%)	2006/07 N (%)	2007/08 N (%)	2008/09 N (%)	2009/10 N (%)	Total N (%)
Interlake-eastern	16/1302 (1.21)	8/1226 (0.65)	7/1207 (0.58)	13/1225 (1.05)	19/1203 (1.55)	14/1312 (1.06)	16/1359 (1.16)	13/1323 (0.97)	9/1323 (0.68)	115/11480 (0.99)
Northern	19/1493 (1.26)	43/1392 (3.00)	90/1454 (5.83)	56/1463 (3.69)	55/1499 (3.54)	45/1642 (2.67)	65/1763 (3.56)	102/1690 (5.69)	55/1769 (3.02)	530/14165 (3.61)
Southern	65/2045 (3.08)	59/2074 (2.77)	122/2057 (5.60)	127/2110 (5.68)	171/2103 (7.52)	214/2217 (8.80)	236/2292 (9.34)	225/2492 (8.28)	210/2444 (7.91)	1429/19834 (6.72)
Western	17/1702 (0.99)	42/1758 (2.33)	72/1773 (3.90)	59/1748 (3.27)	101/1760 (5.43)	144/1779 (7.49)	118/1945 (5.72)	95/1949 (4.65)	98/2043 (4.58)	746/16457 (4.34)
Winnipeg	290/7128 (3.91)	353/6900 (4.87)	424/6913 (5.78)	407/6671 (5.75)	429/6984 (5.79)	433/7003 (5.82)	368/7256 (4.83)	427/7349 (5.49)	375/7657 (4.67)	3506/63861 (5.20)
Total	407/13670 (2.89)	505/13350 (3.64)	715/13404 (5.06)	662/13217 (4.77)	775/13549 (5.41)	850/13953 (5.74)	803/14615 (5.21)	862/14803 (5.50)	747/15236 (4.67)	6326/125797 (4.79)

Q (4): What percentage of midwifery-attended births are priority populations as defined by the College of Midwives of Manitoba?

Of the women having a midwifery-attended birth (N=6326) during the fiscal years 2001/02 to 2009/10, almost half (48.96%) of the births were flagged as falling into one or more of the priority populations (Table 12). The highest percentage (27.33%) of priority population clients was flagged in the category of "poor". The lowest percentage (6.77%) of priority population clients was "adolescent" (age<20) (Table 11).

Table 11

Percentage of Women from Each of the Priority Populations from 2001/02 to 2009/10

Priority Type	Adolescent (<20) N (%)	Aboriginal N (%)	Single N (%)	Immigrant N (%)	Socially Isolated N (%)	Poor N (%)	Other N (%)
Total	428 (6.77)	791 (12.50)	779 (12.31)	693 (10.95)	716 (11.32)	1729 (27.33)	654 (10.34)

The percentage of women having a midwifery-attended birth who fell into one or more priority populations during each fiscal year has slightly increased over time, reaching a high of 54.41% in 2008/09 (Table 12). There was a slight increase in the number of priority population clients seen by midwives in 2008/09, followed by a decrease in 2009/10.

Table 12

Percentage of Women Who Had a Midwifery-Attended Birth Who Fell into One or More Categories of Priority Population

Priority	2001/02 N (%)	2002/03 N (%)	2003/04 N (%)	2004/05 N (%)	2005/06 N (%)	2006/07 N (%)	2007/08 N (%)	2008/09 N (%)	2009/10 N (%)	Total N (%)
No	260 (63.88)	259 (51.29)	355 (49.65)	333 (50.30)	384 (49.55)	461 (54.24)	410 (51.06)	393 (45.59)	374 (50.07)	3229 (51.04)
Yes	147 (36.12)	246 (48.71)	360 (50.35)	329 (49.70)	391 (50.45)	389 (45.76)	393 (48.94)	469 (54.41)	373 (49.93)	3097 (48.96)
Total	407	505	715	662	775	850	803	862	747	6326

In Table 11, the total number of priority population clients for all categories is 5790, and in Table 12 the total is only 3097, because women could fall into multiple categories. Figure 7 displays the trend over time for the proportion of women who fell into one or more priority populations. The increasing trend appears slight but it is significant (p<.0001).

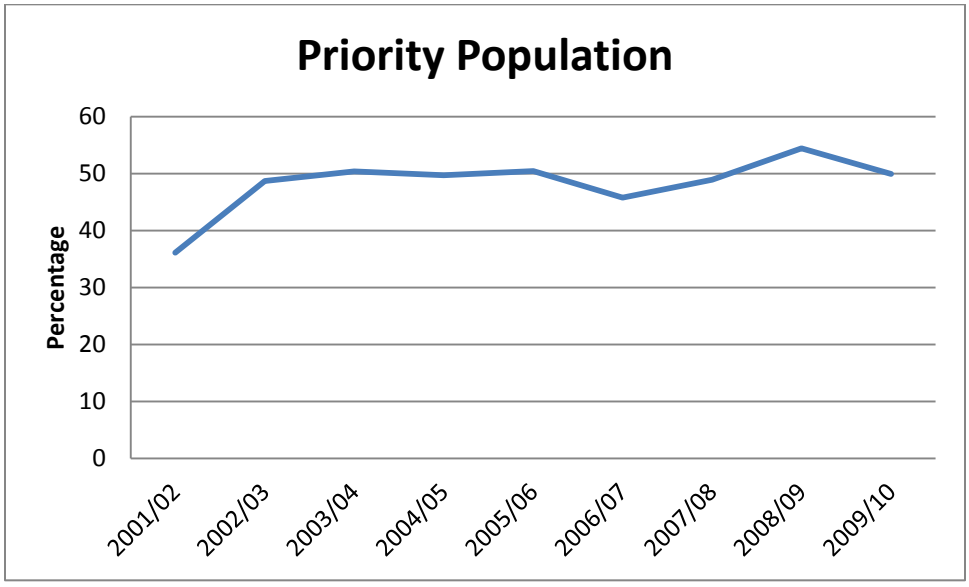

Figure 7. Linear trend over time for the proportion of women who were priority population (p<.0001).

Q (5): What are the characteristics of women who received midwifery services in Manitoba? Do these characteristics differ across RHAs?

The characteristics of women who had received midwifery services in Manitoba were analyzed to understand who received services and if the women's characteristics varied across the RHAs. The variables chosen for the analysis were based on what was abstracted in the midwifery data set. Table 13 describes the age distribution of women who received midwifery care by RHA. Using 3 age groups, the majority of the women who received midwifery care were in the 20-34 year age group. The mean age of women across the RHAs ranged between 25 and 28 years (Table 13). There was a significant difference in mean age across RHAs ($F=35.40$, $p<.0001$). Using the Least Squares Means (LSM) test, the Northern RHA differed significantly from the other RHAs, with a lower mean age ($p<.0001$).

Table 13

Mean Age of Women Who Received Midwifery Services across RHAs

RHA	N	Mean	SD	Range
Interlake-eastern	115	28.78	5.6	17-45
Northern	530	25.26	5.6	14-42
Southern	1427	28.00	5.2	15-46
Western	746	27.74	4.8	15-45
Winnipeg	3506	28.19	5.5	13-45

Parity was grouped as primiparity and multiparity. A primiparous woman was defined as zero births (prior to the current birth) and a multiparous woman had one or more births (prior to the current birth). Table 14 describes the number and percentage of primiparous and multiparous women who received midwifery care in each of the RHAs.

The majority of women who received midwifery care were multiparous. The Chi-Square test for differences showed that the parity of women across RHAs was statistically significant at $p < .0001$ ($\chi 2 = 4$, N = 6269). There were a total of 57 missing cases.

Table 14 displays the data for priority population status by RHA. According to the Chi-Square test for differences, there was a statistically significant difference in the proportion of priority population clients who received midwifery care by RHA ($p < .0001$), with the highest proportion in the Northern RHA (69.43%). There were a total of 223 missing cases. This could be attributed to missing records or data that were not entered correctly or recorded by the midwife.

In both rural and urban groups of RHAs, there was a statistically significant different proportion of women who received midwifery care in each of the income quintiles ($p < .0001$). Due to its density, Brandon was captured as urban but is geographically represented in the Western region; therefore, Western RHA is noted in both rural and urban groups. The majority of women in the rural RHAs were ranked in R5, which is the higher income quintile for the rural category. The majority of women in Winnipeg who received midwifery care were ranked in the two lowest income quintiles (U1 and U2), while the majority of women in Brandon were ranked in U3 (Table 14). There were a total of 19 missing cases between the urban and rural income quintiles. This could be attributed to missing records, data not entered correctly, or the midwife not recording the postal code for the home birth data.

Table 14

Proportion of Women Receiving Midwifery Care by Sociodemographic and Other Characteristics.

Characteristics	Interlake-eastern N (%)	Northern N (%)	Southern N (%)	Western N (%)	Winnipeg N (%)
Age Group					
≤19	7 (6.09)	91 (17.17)	55 (3.85)	35 (4.69)	262 (7.47)
20-34	91 (79.13)	410 (77.36)	1216 (85.21)	656 (87.94)	2847 (81.20)
≥35	17 (14.78)	29 (5.47)	156 (10.93)	55 (7.37)	397 (11.32)
Parity					
Primiparous	33 (28.95)	175 (33.33)	343 (24.12)	301 (40.40)	1380 (39.85)
Multiparous	81 (71.05)	350 (66.67)	1079 (75.88)	444 (59.60)	2083 (60.15)
Priority					
Yes	59 (51.30)	368 (69.43)	772 (54.02)	369 (49.46)	1529 (43.61)
No	56 (48.70)	162 (30.57)	657 (45.98)	377 (50.54)	1977 (56.39)
Income Quintile					
Rural					
R1 (lowest)	14 (12.17)	106 (20.08)	108 (7.56)	56 (23.33)	
R2	19 (16.52)	81 (15.34)	189 (13.24)	76 (31.67)	
R3	14 (12.17)	30 (5.68)	389 (27.24)	82 (34.17)	
R4	24 (20.87)	96 (18.18)	396 (27.73)		
R5 (highest)	44 (38.26)	215 (40.72)	346 (24.23)		
[R4-R5]				24 (10.00)*	
Urban				(Brandon only)	
U1 (lowest)				79 (15.77)	841 (24.06)
U2				134 (26.75)	845 (24.18)
U3				185 (36.93)	667 (19.08)
U4				81 (16.70)	557 (15.94)
U5 (highest)				22 (4.39)	585 (16.74)

*Categories combined because of suppressed cells.

In summary, there has been considerable variation of the distribution of practicing midwives across RHAs from 2001/02 to 2009/10; however, the numbers have steadily increased over time. The number of non-practicing midwives has also increased over time. The highest proportion of midwifery-attended births occurred in 2006/07 (5.74%), with the lowest proportion of midwifery-attended births reported in 2001/02 (2.89%). The majority of midwifery-attended births have occurred in Winnipeg, which is the most

densely populated RHA and has the highest number of practicing midwives. The numbers of both home births and hospital births have increased over the same time period, however, the proportion of home births has decreased from 2001/02 (23.95%) to 2009/10 (16.50%). The highest percentage (27.33%) of priority population clients was flagged in the category of "poor". The lowest percentage (6.77%) of priority population clients was "adolescent" (<20). Finally, the results from analyzing the characteristics of women who received midwifery care demonstrated the mean age of women was between 25 and 28 years. The highest proportion of priority population resided in the Northern RHA. The majority of women receiving midwifery services in the rural areas were in the highest income quintile, whereas the majority of women in the urban areas were in the two lowest income quintiles. Finally, the majority of midwifery clients in all five RHAs were multiparous.

Results of the Qualitative Component: Document Analysis

The documents identified for analysis were organized into six categories: evaluations, proposals, reports, archives, public announcements, and internal records. All documents accessed were from the public domain. The various documents were organized according to the type and source of document (Table 15).

Table 15

Documents Analyzed According to Category

Evaluations

1. Documentation and Evaluation of the Aboriginal Midwifery Education Program (2006)
2. Winnipeg Regional Health Authority (WRHA) Midwifery Program External Review (2008)

Proposals

1. *Proposal for a baccalaureate degree in midwifery* (2000)
2. *Proposal to secure grant funding for the research project "Making the case for expanded midwifery services: Qualitative and quantitative evidence of the value of midwifery services to women in northern, remote and low-income communities in Manitoba"* (2003), Kagike Danikobidan & College of Midwives of Manitoba

Reports/Minutes

1. College of Midwives of Manitoba (CMM) annual reports (2001-2010)
2. College of Midwives of Manitoba [CMM]. (2001). Council of the CMM Minutes.
3. Aboriginal Midwifery Education Program (2006), Health Canada
4. *Birth Centre services report: The first ten months* (October 31, 2011 to October 1, 2012), Winnipeg, MB

Archives

1. University of Manitoba Archives: Faculty of Nursing
    a. Manitoba Government file folder
    b. Midwifery file folders

Public Announcements (multi-media sources)/News Releases

1. (Periodical) Midwifery to become autonomous in Manitoba (1997) *Medical Post*
2. (Periodical) Legalizing midwifery has been a hard labor(1997) *Medical Post*
3. (Periodical) MB spends $1M on midwifery before legalizing its practice: Service to be paid for (1999) *National Post*
4. (Newspaper) University eyes new BMW (1999) Canadian Press
5. (Newspaper) Growing pains dog midwifery in province (2001)
6. (News Release) (2004) First Aboriginal Midwifery Education Program to be established in Manitoba.
7. (Public Announcement) (2006) Health Canada. Aboriginal Midwifery Education Program
8. (Newspaper) Manitoba Health sat on midwife report (2008) *Winnipeg Free Press*
9. (Web) University College of the North (Programs Approved by COPSE in 2009/10) Program Expansion announcement
10. (News Release) (2009) Ministers Announce Expansion of Midwifery Training Program.
11. (News Release) (2010) New birth centre to be developed in south Winnipeg
12. (Newspaper) Birthing Centre disappoints (2012) *Winnipeg Free Press*
13. (Newspaper) Few born at $3.5-million centre (2012) *Winnipeg Free Press*
14. (Newspaper) Winnipeg's new birthing centre 'a colossal failure' (2012) *Winnipeg Sun*
15. (Newspaper)Manitoba mom-to-be miffed she can't use empty birthing centre (2012) *Winnipeg Sun*

Internal Records

1. Resolution from Manitoba Keewatinowi Okimakanak Inc. RE: Midwifery Services to Aboriginal women (2002)

Results of the document review will be presented for the following broad topic areas: barriers, facilitators, and future strategies and recommendations.

Barriers.

Throughout the documents, various key events were identified as having contributed as barriers to the implementation and utilization of the midwifery profession in Manitoba. These key events were related to the implementation, workload, and organization of the profession. The themes linked to the barriers were: power and conflict (levels of management, occupational imperialism, and interprofessional conflict), education, misunderstanding of the role (safety, priority population), and overall capacity of the profession (recruitment and retention, small profession, funding).

Conflict and power.

Conflict and power were defined by the sub-themes of interprofessional conflict, occupational imperialism, and management issues regarding midwives. Conflict existed between the professions of midwifery and medicine. Prior to regulation, resistance to the midwifery profession from the Manitoba Medical Association was documented in the *Medical Post* in 1997. In this article, the medical community voiced their concern about an oversupply of midwives and the remuneration of medical doctors in relation to midwives if both medical professionals and midwives attended the same birth. More specifically, representatives of the medical community stated that doctors should receive equal reimbursement as the midwives (Love, 1997). The Midwifery Implementation Council (MIC) had difficulty getting a "second reading for the Midwifery Act" due to the medical community's concern that midwives would put medical physicians out of business (Square, 1997).

Even after regulation, the midwifery community lacked support to sustain and grow the profession within some of the Regional Health Authorities (RHAs). In 2001/02, the College of Midwives of Manitoba (CMM) annual report documented that some Regional Health Authorities continued to exclude midwifery in their by-laws. The CMM wanted to support the independent practice of midwives; however, the College met resistance from the RHAs. The RHAs perceived midwifery as "less safe" as an independent practice compared to remaining as a RHA employee (CMM Council, 2001). Thus, the RHAs used their powerful position to slow down the uptake of midwifery. In the early years following regulation, the Manitoba government met with the CMM to discuss long-term growth plans for the profession. While these meetings were noted as discussions concerning "government support" for midwifery, no clear plan was put in place for an increase in funding to grow the midwifery profession (CMM, 2002/03; 2005/06a). Again in 2007/08, the need for a long-term plan was discussed with the government; initiatives regarding midwifery education opportunities, as well as recruitment and retention, were also discussed (CMM, 2007/08). Moreover, an annual report indicated that the CMM continued to wait for an evaluation framework from Manitoba Health as an endeavor to make midwifery services sustainable (CMM, 2005/06a). In summary, these meetings with the government did not seem to provide any forward momentum or action for change. The conflict ensued because those in political power could not or would not take action.

Other issues aligned with the theme of power and conflict arose from the hierarchy of management over the midwifery profession. The Winnipeg Regional Health Authority (WRHA) Midwifery Program External Review document (2008) highlighted

problems regarding the management and roles of midwifery by revealing that medical doctors had "minimal understanding" of the regulatory structure for midwives in Manitoba. One significant issue was that midwives were generally over-evaluated by structures of management beyond their regulatory body. Midwives were required to be a part of multiple quality improvement committees, peer reviews, evaluations, and audits within corporate structures as well as those already required by the CMM. The report stated that if midwives were in compliance with their regulatory body, it was "unfair if those compliances are then repeatedly re-examined by an employer, the institutions and other professions' regulators" (Winnipeg External Review Team, 2008, p.20). Furthermore, at that time (2008) the midwives were managed by four different managers, none of whom was from the midwifery profession (Winnipeg External Review Team, 2008). The multiple levels of management created unnecessary bureaucracy, which made executing administrative tasks, such as reimbursement of expenditures and hiring, inefficient and complicated. Moreover, the constant change in management implied that those managing midwifery continued to have knowledge deficits about the Manitoba midwifery employment and practice model, which fed the tensions between midwives and their management.

Interprofessional conflict also emerged early on during the process to achieve regulation. In 1999, discussion about the possibility of midwifery education in the context of the University of Manitoba was happening between midwifery stakeholders and the University. Both parties were concerned about how midwifery would be integrated into this educational institution. While the midwifery community was concerned that the integration of midwifery into the Faculty of Nursing would "jeopardize the integrity and

autonomy of the profession of midwifery" (University of Manitoba [Archives], 1999), the Faculty of Nursing was uncomfortable with the plan for a nurse-midwifery program. A representative of the Faculty of Nursing was documented as stating, "Putting midwifery with nursing…the relationship has not always been cordial," so Nursing asked why the University needed to consider the program: "What is the political fall-out of saying no to the further development of midwifery at the University of Manitoba?" (University of Manitoba Archives, 1999). Consequently, attempts to maintain the professional identity of both nursing and midwifery led to conflict that possibly impeded the University from fully embracing the idea of developing a school of midwifery. Once again, the midwifery community was not in a position of power to influence the education movement at that time.

Misunderstanding of the role.

Shortly after implementation, the *Winnipeg Free Press* reported tensions between hospitals and midwives related to the roles of midwives. As reported by the Winnipeg Free Press, "People are not always aware of what midwives do..." (Rabson, 2001, para. 4). Two documents recorded statements which questioned the safety issues of home birth and the role of the midwife. In 1997, the Manitoba Medical Association voiced "firm opposition to homebirth and midwives providing care to children" (Square, 1997). Another noteworthy example of concerns voiced by the medical community evolved from the WRHA Midwifery Program External Review. The review was the direct result of the inquiry made by a neonatologist to the WRHA "regarding grave concern around safety of homebirth" (p.28). Other professionals indicated their concern with "water birth, uninformed choice, attitude of doctor avoidance by midwives, and concern priority

populations were too high risk for a midwife's care" (Winnipeg External Review Team, 2008, p. 28). The ambiguity of the midwifery role, perceived by the medical community, created interprofessional tensions.

Education.

Another frequently discussed concern in the documents was the overall trajectory of midwifery education in Manitoba. When the proposal for a midwifery program at the University of Manitoba was being developed prior to regulation, support was expressed from both the provincial government and the University. In fact, part of the discussion was focused on a "Western School of Midwifery" at the University. The estimated projected start-up costs and four-year costs to run the program were as follows: Development (January 2001-September 2001): $218,921; Year one: $169,813; Year two (intake 15 students): 306,848; Year three: $408,310 (intake 20 students, 35 enrolled in total); Year four: $492,921 (intake 20 students, 55 enrolled in total). At that time, there was a demand from other provinces to buy seats in this program, which would have offset costs (Executive Committee, Faculty of Nursing, 2000). The government had supported this endeavor with the caveat that they would only cover the costs of the new nursing building foundation, not the other capital expenditures (University of Manitoba Archives, 1998). The Council on Post-Secondary Education (COPSE) also granted their approval to proceed with full development of the midwifery proposal for the School of Midwifery (University of Manitoba Archives, 1999). However, in 2001 when the CMM met with the government, they were told that no new plans for funding midwifery positions were on the horizon. As a result, the CMM was told the resubmission of the midwifery education proposal would not likely get funded (University of Manitoba Archives, 2001). The

CMM voiced concern over the lack of communication with the Education Committee at the University of Manitoba in regards to the proposal (CMM, 2001/02).Understandably, midwifery stakeholders in the project were frustrated or discouraged by the sudden lack of political will. All of the time, money and effort in support of the midwifery education proposal were null and void.

Shortly after the proposal for midwifery education at the University of Manitoba was deferred, the provincial government announced the first Aboriginal midwifery education program in Manitoba (News Media Services, Province of Manitoba, 2004). The government demonstrated a consistent financial commitment to the Kanácí Otinawáwasowin Baccalaureate Program (KOBP). The initial resources allocated for start-up were $116,000 for 2006/07, allowing for $316,000 over two years (COPSE, 2006/07). The total annual budget reported from University College of the North, however, was $459,000 each year from 2006/07 until 2011/12. In 2006, an evaluation was conducted of the implementation process for the KOBP. This evaluation documented areas that could have benefited from additional planning prior to implementing the KOBP. Issues such as program promotion, student and faculty recruitment, and further work with the community were all mentioned (Aboriginal Midwifery Education Program Project Team, 2006). At the same time, the CMM's Education Committee reviewed the KOBP (CMM, 2006/07) and granted it interim approval. Funding ensued, as well. The government stated, based on the "success" of the KOBP (COPSE, 2009/10), that in addition to the KOBP budget allocation, the annual budget allocated for the new Southern Aboriginal Midwifery Program (BMW) would be $400,000 each year from 2010/11 until 2011/12 (M. Buchanan, personal communication, February 7, 2012).

Various problems arose with the KOBP which were documented by stakeholders. More specifically, in 2008/09, the KOBP met resistance from the existing maternity care system in Norway House, which impacted the ability of the program to place students for clinical rotations (CMM, 2008/09). Soon after, the KOBP could no longer be offered due to the attrition of students and faculty (CMM, 2010/11). The standing committee which advised the CMM on issues related to midwifery care to Aboriginal women, known as the Kagike Danikobidan (KD), commented that they were aware of ongoing issues and stated that the University College of the North (UCN) had demonstrated an overall "lack of accountability" (CMM, 2010/11). Furthermore, UCN had not acted on recommendations recorded from the CMM's external evaluation of the KOBP (CMM, 2010/11). With the implementation of the next education endeavor in southern Manitoba, which was a new intake for the program now being called Bachelor of Midwifery Program (BMP), came UCN's announcement that the midwifery program would not be "delivered in its original form" (CMM, 2010/11). There was no documentation of any evaluation or strategic planning for the KOBP program during the years it existed or of any actions taken on the feedback given to UCN about the original KOBP prior to initiating the southern program.

Overall capacity.

The lack of overall capacity of the midwifery profession was associated with the lack of a strategic plan for research and evaluation of the profession in Manitoba, the small number of midwives, and funding issues. In 2003, a team of people (consisting of midwives and one University of Manitoba scholar) wrote a proposal as a first attempt to facilitate midwifery research in Manitoba. The team made various recommendations for

midwifery evaluation and research across Canada. One specific recommendation for Manitoba was that the CMM needed to integrate research questions into their work. For example, the team noted the College had "no statement on how many midwives it believes Manitoba requires, although it argues that the current complement (N=26) was inadequate." (KD & CMM, 2003). The team believed that the College needed to establish a policy on "how many births can be safely attended by midwives, best practices for size of midwifery practice and how to accommodate diverse models of midwifery practice" (KD & CMM, 2003). At that time, the team's endeavor to secure funding for research was challenging because limited options for funding existed due to the requirement of having a principal investigator or university-based researcher in a key role (KD & CMM, 2003). One of the few avenues for funding this initial midwifery research proposal was the Status of Women of Canada. Consequently, the proposal, "Making the Case for Expanded Midwifery Services: A Qualitative and Quantitative Study of Midwifery Service among Northern, Aboriginal and Low-Income Women in Manitoba," was submitted to the Status of Women Canada (SWC). However, the proposal was never funded. According to the CMM, the SWC replied they did not fund "singular" provincial projects (P. Eadie, personal communication, July 6, 2012). Research is seminal to the sustainability of the profession. In essence, the lack of credentialed midwives in academia in the province contributes to the profession's lack of capacity to take on lead roles in formal research projects.

Other issues regarding capacity that surfaced in the documents were linked to the CMM staff's workload, which was unrealistic and unsustainable given the few financial and physical resources available to them. For example, the Winnipeg External Review

Team (2007) recommended against the development of the out-of-hospital birthing centre until further expansion of the overall midwifery program was implemented in Winnipeg. The External Review Team stated that midwives did not have the "energy" for such an endeavor. Nevertheless, in 2010, the government released a statement declaring an "investment of more than $3.5 million in upfront capital costs to develop a birth centre in south Winnipeg" (Province of Manitoba, 2010). The other issue that evolved was that the CMM believed the Manitoba Association of Midwives (MAM) was not functioning at capacity and, therefore, was unable to advocate properly for maintaining and protecting the profession. The CMM recommended MAM membership be a requirement of the midwives in the province (CMM, 2005/06a).

The Winnipeg Birth Centre opened on October 31, 2011 and, soon afterwards, several articles in local newspapers criticized the Centre's capacity. In January 2012, an editorial from the *Winnipeg Free Press* expressed disappointment in "the numbers not stacking up" and the lack of recruitment for midwives and students into the province (Flood, 2012, para. 1). The *Winnipeg Sun* ran a similar article in July stating that "critics accuse government of wasting funds to rush the Centre's opening," but also noting that the "shortage of midwives has often been blamed for limiting the Centre's use" (Pursaga, 2012). Other critics stated there were too few births at the $3.5 million Centre, and that the "College was to blame" for the shortage of midwives (Kusch, 2012). The Birth Centre has continued to garner negative press. More recently, an article reported a story about a consumer who was denied access to the Birth Centre because she was out of region. The consumer's frustration stemmed from her perception that the Birth Centre was underused and that her tax dollars had helped fund it, yet she could not use it (Pursaga, 2013).

The lack of overall capacity was associated with funding issues in two ways. Lack of funding was primarily linked to the lack of funded positions (midwives, preceptors, and coordinators) in the province (CMM, 2002/03, 2004/05, 2005/06a). Secondly, there had been no increase in financial support for the CMM, which had continually not met needs (CMM, 2001/02). In 2002/03, the CMM reported an estimated 1,700 volunteer work hours between the Council and public representatives for the year. In 2005/06, the CMM reported approximately 1,320 volunteer hours for the year. The Winnipeg External Review Team (2008) observed similar issues related to the capacity of the profession. The review team documented there was a "high degree of volunteerism with the profession," and that the "CMM was severely handicapped by lack of sufficient access to financial resources" (p.13). Also noted was the "lack of human resources due to the low midwife population in Manitoba" (Winnipeg External Review Team, 2008, p.13). After the WRHA Midwifery Program External Review was issued, a news release alluded to Manitoba Health as "sitting on a report that found Winnipeg's midwifery program on the verge of collapse" (Skerritt, 2008, para 1). In summary, the midwifery workforce contributed countless volunteer hours to maintain the regulatory part of the profession, as a result of limited allocated resources from the government. Therefore, growth within the CMM has been dependent upon the government's ability to increase financial resources.

Facilitators.

More barriers than facilitators were noted in the document review. However, some of the same documents highlighted promising accomplishments regarding funding in general and funding for midwifery education, as well as other general successes related to the midwifery profession.

Funding.

In 1999, the government announced funding for "One million dollars to create the College of Midwives of Manitoba and license 20 midwives by the following year" (Killick, 1999). Eventually, an announcement came from the Manitoba Keewatinowi Okimakanah (MKO) Inc. Chiefs Special Assembly, thereby ensuring funding for the formation of Kagike Danikobidan (KD) and "endeavors to restore traditional midwifery in Aboriginal communities" (Opaskwayak Cree Nation, 2002). In 2002/03, funding was also secured for one year from Manitoba Health to implement the Prior Learning Experience and Assessment (PLEA) program to assess midwives for licensing (CMM, 2002/03). In 2007/08, dedicated PLEA funding was also approved by the government for the 2008/09 fiscal year. The PLEA program was one avenue to assess and register midwives in the province, and thus it facilitated an increase in the number of practicing midwives (Table 16).

Table 16

Manitoba PLEA Program Applicants

Year	Inquiries*	Completed Assessment & Exam	Successful Completion of Exam	Province of PLEA applicant
2002 to 2006	4 (2004)**	13	10	**6 Manitoba** 3 North West Territories (NWT) 1 Left province
2007	45	7	5	**3 Manitoba** 1 NWT 2 Saskatchewan 1 Alberta
2008	56	7	6	**5 Manitoba** 1 other

Note. From (source: CMM archived annual reports)
*Inquiries do not denote actual number of applicants
**Other years not reported

More funding was announced by the government in 2006, officially securing $1,690,927 from the Primary Health Care Transition Fund for the Aboriginal Midwifery Education Program (AMEP) (Health Canada, 2006). After four years of the KOBP, the government announced an "investment of $400,000 per year for UCN to offer midwifery training in southern Manitoba" (Province of Manitoba, 2009). The Council for Post-Secondary Education (COPSE) announced that the program expansion was based on the "success of the KOBP established in 2006 northern communities" (COPSE, 2009/10).

In 2005/06, the CMM saw an increase of 1.85% in their operational budget, which was the first increase since 1999 (CMM, 2004/05). Manitoba Health incrementally added new positions to the RHAs from 2001/02 to 2010/11. The numbers of funded positions as

recorded by the CMM and Manitoba Health annual reports are outlined in Table 17. From 2001/02 to 2009/10, an increase of 18.5 funded positions was reported from the original 26 funded positions.

Table 17

Reported Funded Midwifery Positions from Years 2001/02 to 2009/10

Year	Manitoba Health Annual Report	CMM Annual Report
2001/02	Reported 26 FTE* Winnipeg (16) SEMan (3) Burntwood (4) Central(2) Brandon (1)	Reported: Winnipeg (16)
2002/03	Reported 30 FTE* Winnipeg (16) SEMan (3) Burntwood (2) Central (3) Brandon (4) NorMan (2)	Not reported
2003/04	None reported	Not reported
2004/05	None reported	Reported: Winnipeg (.5) (clinical midwifery specialist)
2005/06	None reported	2 new positions*** NorMan (1) Burntwood (1)
2006/07	Reported(2) additional positions funded Northern Manitoba***	Not reported
2007/08	Reported "increased number of funded positions in last 3 years. This past year $3.7 million provided to RHAs to fund midwifery positions."	Reported 7.5 positions** Central (4)

2008/09	Reported "increase in midwifery positions (34 to 41.5)"	Not reported
2009/10	Reported "from 2000 to 2009 number of funded positions increased (12 to 44.5)"	Not reported
TOTAL Funded positions from 2001/02 to 2009/10		44.5

*Full Time Equivalent
**Only 4 specified
***Same positions reported in different years

Various avenues of funding have facilitated minimal, yet steady, growth of the midwifery profession in Manitoba. Throughout the fiscal years of 2001/02 to 2009/10, the Government of Manitoba allocated funding for education and assessment processes, which demonstrated a commitment by the government to midwifery. Likewise, although the reporting of numbers is somewhat inconsistent, positions have been incrementally increased during that time period.

Other facilitators included endeavors to promote research and increase capacity within the midwifery community. Since regulation, many stakeholders have worked diligently to create mechanisms of sustainability for the profession of midwifery. In 2003, the CMM was concerned that the (then current) "distribution of midwifery services fails to promote equity" and were also concerned that no province-wide evaluation had been done. The Prairie Women's Health Centre of Excellence (PWHCE) provided seed money for the research proposal to examine these very issues, but as previously mentioned, the proposal was never funded. There was also documentation that CMM was working with Manitoba Health to "develop processes to track data through the midwifery discharge form" (CMM, 2003/04).

Other ongoing work was documented in the annual report as an attempt to build the capacity of the profession. In 2004/05, the CMM recommended that the Manitoba Association of Midwives (MAM) require midwives to register with the professional association. In 2005/06, Manitoba Health encouraged CMM to consider reevaluation of the employment model and that it might "not be sustainable." A focus group was formed a year later, and funding was requested to do the research and evaluation of the employment model. Finally, in 2010/11 a proposal was submitted to Manitoba Health to request that they "take a lead on the coordination of a recruitment and retention strategy" (CMM, 2010/11, p. 4).

After the WRHA External Review Team had examined various aspects of the midwifery program, it gave recommendations. One recommendation was that the WRHA needed to step away from the "role of a regulator" and simply be the "employer." It was also recommended that Manitoba "train more midwives in large numbers" (Winnipeg External Review Team, 2008, p.33) to meet the growing demands, which paralleled the sentiment also made by the team, who stated, "so many demands on a new profession were causing it to fray at the edges" and that it would "die" as a result (Winnipeg External Review Team, 2008, p. 36). Other suggestions were to buy seats in other Canadian education programs, evaluate the model of practice, and place midwifery in a "department of its own" (Winnipeg External Review Team, 2008, p. 35). Finally, the Birthing Centre was not seen as a priority since "much needed expansion of midwives" should be the first priority (Winnipeg External Review Team, 2008, p.37). In summary, small strides were made with the integration and validation of the profession. At the same time, key stakeholders had targeted critical issues which needed evaluation.

Strategies that improved utilization.

There were a few other successes in facilitating the implementation and utilization of midwifery in Manitoba. Midwives were slowly being integrated with other professional organizations, as the CMM reported they had official representation on the Perinatal Review Committee of the College of Physicians and Surgeons of Manitoba (CMM, 2003/2004). Another avenue to increase midwives in the province originated from an Agreement on Internal Trade (AIT), which stated the official inclusion of the midwifery occupation and which, in turn, gave reciprocity to midwives from other regulated provinces (CMM, 2008/09). Finally, the WRHA External Review awarded credit to the CMM for functioning at full capacity in spite of limited resources, which was evidence of their accomplishments of a well-developed and established set of standards, policies, guidelines, and bylaws. Their "joint standards and guidelines for transport from home to hospital" was well established (Winnipeg External Review Team, 2008, p. 14). Furthermore, a collaborative integration strategy for nursing and midwifery was completed that demonstrated guidelines for Public Health Nurses and Midwives working with perinatal families (Winnipeg External Review Team, 2008). One other success for the midwifery community was the opening of the first midwifery-led Birth Centre in Manitoba. The first initial Birth Centre report claimed it had "exceeded the expectations for the Birth Centre's first year of service based on their projected resources" (*Birth Centre midwifery services report*, 2012). It was reported that the first year's target was 100 births and in the first 10 months after opening there had been 93 births.

In summary, the documents analyzed were retrieved from the public domain and then organized into six categories. Using the document analysis guide (Appendix D) to direct the analysis, the information from the documents was organized into themes and sub-themes in the following topic areas: barriers, facilitators, and future strategies and recommendations. Barriers included issues related to power and conflict, education of midwives, misunderstanding of the role, and overall capacity of the profession. Facilitators included funding that supported the overall profession through positions and educational endeavors, and attempts to promote research and evaluation. Finally, various strategies were indicated to improve utilization and grow the profession. For example, integration strategies with other health care providers (hospitals, emergency medical services, and public health) appeared successful (CMM, 1999). The Agreement on Internal Trade (AIT), which allowed midwives from other provinces to be licensed in Manitoba, was a step forward to improve and increase utilization. Another strategy to improve utilization was the development of a new Birth Centre in Winnipeg. These were all efforts to increase capacity and utilization within the midwifery community.

Results of the Qualitative Component: Interviews with Key Informants

Key informant description.

The key informants consisted of 24 participants who were purposively selected based on their knowledge about the implementation of regulated midwifery in Manitoba. They were also selected based on their current or historical involvement with the profession in Manitoba. Key informants were recruited from the following categories:

1. Professional bodies (MAM, CMM) (n=4)
2. Implementation groups (Working Group, MIC) (n=5)

3. Midwives (practicing and non-practicing) (n=4)
4. Health professionals and relevant personnel who collaborate with the midwifery profession (Medical directors, Nursing directors, Program Coordinators/Instructors of Midwifery education programs, Program Coordinators of the Midwifery Assessment Program, obstetricians and family practice physicians) (n=7)
5. Provincial representatives (Manitoba Health, RHAs) (n=4)

The College of Midwives of Manitoba and the Manitoba Association for Midwives represented the professional body category. The four participants from the professional bodies were women; all had bachelor degrees and three had practiced or were practicing as midwives in Manitoba. All four women had some involvement with the implementation of midwifery in Manitoba, either pre- or post-regulation.

Representatives of the implementation groups consisted of five participants who had engaged in either the original Working Group on Midwifery or the Midwifery Implementation Council (MIC). One participant had been directly involved with the original Working Group on Midwifery. Three participants had been directly involved with the MIC. One participant had been involved with midwifery integration issues during implementation. One of the five participants was also involved with the Aboriginal Midwifery Education Program (AMEP Project Team).

The midwifery group was represented by four midwives. All four participants were women. Two of the participants had nursing backgrounds and had completed international midwifery programs. The other two midwives had been trained in Canadian baccalaureate midwifery programs. Three of the midwives were currently practicing and

one was non-practicing. The degree of involvement with regulation and implementation varied from no involvement (n=2) to some pre-regulation involvement (n=2).

The fourth group was the largest group, consisting of seven health care personnel who had direct involvement with the midwifery profession. This group consisted of two men and five women. The backgrounds of the participants included medicine, nursing, and administration. The involvement of these participants with the midwifery profession was diverse. Two participants had been involved pre-regulation. Two other participants had some type of involvement with midwifery education planning in the province. Finally, two of the participants routinely collaborated with practicing midwives.

The final category consisted of four provincial representatives. All four participants in this category were women. Each of these participants had either a master's or a bachelor degree. All had worked for the government and had some involvement with the midwifery movement in Manitoba. One had specific involvement during the proclamation of the Midwifery Act and another had involvement with the AMEP Project Team.

In this section of the chapter, themes and multiple sub-themes for each topic area will be extensively discussed bearing in mind the relationship of each to the qualitative research questions. Direct quotes from the key informants found to be most representative of each theme and sub-theme will be embedded throughout to validate the overall themes. Due to the small community of people involved in the Manitoba midwifery movement, the source of the participant will only be denoted as "P#" (P=Participant number).

Barriers.

Theme One: Conflict and power.

Four themes emerged under the first topic of barriers. The first theme that emerged from the data related to conflict and power. The concept of conflict and power was supported by three sub-themes that illustrated aspects of conflict and power. These aspects of conflict and power have had significant impact on how midwifery services have been used or made available within the broader health care system in Manitoba. Participants expressed that factors related to policy and political will were significant barriers to growing the profession.

The nature of the beast.

The nature of the beast refers to the power of policy, conflict, and issues of gender in the context of government structures. For example, participants commonly identified policy and political will within structures of power such as the Regional Health Authorities (RHAs) as influential. The structure of the RHAs has significant implications regarding how midwifery services are accessed and how a midwife practices. It appeared that fiscal restraints and the priority of services in the provincial budget were significant barriers to the expansion of midwifery services across the province. One representative of an implementation group commented on political will:

> Health care costs are escalating out of control and midwifery is seen as extremely expensive. Midwives are seen as expensive practitioners…It looks like a very Cadillac service…It's really challenging these days to find the money to provide all the health care services that people want – there's huge demands, huge demands on health ministers and there's only so much money to go around. So I

> think it's partly money and political will, and those two things are hand in glove. (P3)

While fiscal restraints appeared to be a significant barrier, many participants voiced midwifery was simply not a priority budget item for the government, especially within each RHA. Participants specifically noted the RHAs were a powerful entity within the Manitoba government which had influenced numerous other barriers to the full implementation and utilization of midwifery services. One provincial representative explained how midwifery can be low priority within an RHA:

> They're always prioritizing…If you've got a regional health authority where your budgets are tight and they may be wishing they had more midwives but they don't think those midwives are available anyway…they're going to quickly move to another program and spend the resources and time on that. (P23)

Another common barrier that arose was the disposition of a midwife as an employee of the government. A common concern among participants was that midwives ultimately struggle with being an "employee" of the health care system as opposed to being an independent practitioner. The RHAs were seen as an oppressive structure of power over the midwifery program through its levels of management, implementation of policies, and oversight of midwives as employees. For example, participants often described how there were too many levels of management over the midwifery program, and this resulted in disempowering the midwife. One midwife commented:

> I feel like there are a lot of bureaucrats, like we have a lot of higher up, a lot of admin. In our program, which is kind of insane and must cost a lot of money and, you know, we've got a clinical midwifery specialist, we've got a manager, we've

> got a primary care manager, we've got a birth center manager, we've got a manager at each clinic…You know, it's like… where it could facilitate midwifery implementation, it certainly hasn't, and it's very unfortunate and it's just sort of created this weird hierarchy that, where there's this perceived, like, thing that is being looked after but it actually isn't… (P24)

A health professional explained how the voices of midwives were silenced:

> There are some employment environments silencing the voices of midwives or show of any kind of publicity…that has to be preapproved and you're not allowed to make statements or talk to the media…which I think is, from my perspective in living in a free, a democratic country, have a little bit of trouble with that. (P19)

The various conflicts between the structures of power and the midwifery profession were commonly linked to issues of gender. Gender was perceived as an influence on policies at the RHA level. Policies were viewed as inhibiting a midwife's practice and male-driven in the context of structures of power. One representative of the implementation groups shared how gender appeared to influence structures of power which, in essence, control the midwifery profession:

> And I think they [old male doctors] are very strong and very powerful, and I think they make their views known, and I think administration and … the supervisors or program developers or supervisors of midwives are women, and so I think they feel a lot of that pressure coming from their male colleagues...I think, you know, want to be sure that screw-ups don't happen or, you know, midwives don't cross the line…The final issue was the RHAs back to they're being cautious and

> worried and fearful, said, oh no… I think what they were saying is "We want control; we want them to be employees." (P10)

One participant from a professional body articulated "midwifery was a movement about bringing women choice" (P8). However, many participants commented that policies devised at the RHA level often restrained midwives from fully supporting women in the informed choice model in which midwives practice. One midwife shared the opinion that health policies are "controlling and judgmental of women's choices, lifestyles and decisions" (P16). One of the midwives discussed how a policy about looking after a certain number of clients from outside the boundaries of one midwifery practice inhibited the midwifery model of practice:

> A policy came from somewhere at the top and had a very interesting play out, you know, where the midwives were consulted in the beginning about … what they thought about this idea…So we [midwives] were asked our input but it was not accepted really. And what happened around that was then we got a directive that we would be doing this thing and so ended up having to really sort of dilute our model in terms of offering care that women had to come to us for…We were not allowed to, you know, see them in their homes. They were not going to reimburse us for any travel outside of the perimeter, but we still had to care for these women. They had to agree to come into town for their visits, come into the hospital in Winnipeg to have their babies, and then we couldn't do their postpartum care. (P1)

Gender appeared to play a role in the power plays between midwives and other health professions. The power plays did appear gender-specific, thereby implying that

men were always to blame for the exercise of power over women. While many participants identified the male gender as a significant barrier, some participants commented that women play power cards against themselves. For example, one participant stated gender was not specific to government structures but played out in the specialties. A health professional remarked on how currently the specialty of obstetrics is dominated by women:

> The funny thing is the specialty; the physicians are now mostly women in obstetrics…So female gender doesn't just go to government or to the midwives but it's also in the specialty per se, and much of the people who criticize the midwives or have some issues with them are actually the women here. (P13)

Furthermore, integral to the midwifery role is the passion to advocate for the woman. Consequently, this may appear radical or disrespectful towards other health care professionals (men or women) in the context of a structured health care system. One person from a professional body stated: "Women midwives break rules because women want them to break the rules; they would rather stand for women than the rules" (P6). A great deal of the time, the male gender was deemed as a symbol of power. One participant from the implementation groups speculated that men do have the most power in the health care system:

> I do wonder if midwives were all men, for example, would we be so quick to control, well not, you know, ensure that rules are followed or that there were, you know, strong administrative conditions…I sometimes think the gender issue plays out in terms of who, who has the most power within the health care system. I think it is men. (P10)

Several participants pointed out how the dynamics of gender influenced who had power. In the case of the administration of the health care system and policymaking, the power was viewed by a member of the implementation group as "mostly in the hands of men" (P10). However, not all agreed that male gender was ultimately a factor for creating barriers for the midwifery profession. For example, historically and more recently there has been a strong representation of women in government. One health professional argued that given the "high percentage of women in current government leadership roles, that gender has very little influence at this point in time" (P20).

Those in power determine where and how health care resources are allocated. While gender has been mentioned as a determinant of health in health promotion frameworks, it has not been critically analyzed in relation to other health promotion variables (Gelb, Pederson, & Greaves, 2012). It is noteworthy to observe in the themes how being denied access to midwifery care, in essence, positions gender as a determinant of health in relation to access of a desired health service. In spite of women wanting the choice of midwifery care and many of them being denied access to midwifery care because of a shortage of providers, the profession has neither been validated nor prioritized within government. One health professional remarked: "I don't know that midwives have been, actually, been taken seriously. I think because …we are female, so that the ones in power, especially the male government…that are in power, I don't know if they've taken us seriously enough" (P15).

Participants frequently commented that women struggle more to have a voice in deciding their choices in health care. For example, gender was highlighted many times as having played a major influence on how decisions have been made within structures of

power, which ultimately impact the midwifery profession. At the same time, the technocratic culture of Western society has not fully embraced the concept of midwifery care. One midwife suggested it was more a "traditional Western society mindset that created opposition to the midwifery profession, as opposed to gender issues" (P16).

Tenuous leadership within the profession.

Tenuous leadership within the profession emerged as the second sub-theme under conflict and power. While there has been some midwifery representation at a government level, lack of political advocacy remains a barrier. A provincial representative noted that a "…woman's right to choose really comes from the political environment that is supportive of that view…Supporting women's choices would entail the political environment to treat women as equal and to believe women have the right to choose" (P7). Many other participants agreed a lack of leadership to champion the cause created a barrier to how midwifery has been implemented, utilized, and sustained. Another provincial representative commented on the importance of a champion for the cause:

> Part of the problem, too, is unless you've got some champions of these particular kinds of services, there are so many competing issues out there by so many groups…So that even at the Regional Health Authority service delivery level, in some ways it can be squeaky wheel getting the grease. So unless you've got someone there championing the sustainability of a relatively new program, which midwifery is, it can slip backwards. (P23)

The power of political advocacy was also emphasized as equally critical to the movement. In discussing both these issues, participants often alluded to the fact that maintaining political advocacy was a challenge. Most participants felt political advocacy

was crucial in maintaining power or a voice in the issue at hand. Unfortunately, many recognized childbearing only impacts people during a specific window of time in life and then they move on. A provincial representative explained how challenging it was to maintain political advocacy with the midwifery movement:

> It's such a snapshot in the time of your life and then you're done and you're raising your kids and you're moving on…The lobby…the faces are always changing because …once your youngest is three, four, five, you're not focused on that [need/desire for midwifery care]. (P12)

Turf and power.

Turf and power was the third sub-theme that evolved under the conflict and power theme related to issues regarding professional conflicts. Some conflicts stemmed from turf wars among midwives and physicians. As one health professional stated, "…We needed to put the ground rules first about who does what and where and when…When midwifery started, the family physicians felt as if we [obstetricians] were moving them out of the way" (P13).

Participants specifically acknowledged interpersonal conflict between the health professionals and midwives in the context of the Manitoba health care system. The profession of nursing played a significant role by demonstrating their resistance to the profession of midwifery in Manitoba. As evidenced from one health professional's perspective:

> We had a few minor glitches at the very beginning with other health care professionals such as nurses really being a bit resistant to working with us…I think because we were a new profession and we were able to give nursing orders

> just as physicians do, and I think that nurses were not open to that…But I think they definitely felt threatened… Number one, maybe we were taking over some of their job description or their territory, like public health, because there are some overlaps in that as well, and then working in the hospital with labor and delivery nurses. (P15)

It was interesting to note that while most participants felt midwifery experienced the greatest degree of resistance from other health professionals, at the same time, midwives created resistance against others in the health care system. One health professional shared the experience with midwives:

> But there's still in some of the midwives prejudice against us [physicians]…I don't know who it was that came up to me, and they said to me, "Oh well, are you going to start sending medical students here [Birth Centre] so they can learn how to do low-risk deliveries?" And I was reasonably polite in answering. And the answer was no, because we do very well with low-risk deliveries in our hospital setting, and we don't need to send them to the Birth Centre…So there's that element in midwifery that does not respect our ability to deliver a low-risk pregnancy. (P20)

Intraprofessional conflict was also a common concern expressed as a barrier that relates to conflict and power within the midwifery profession itself. In the beginning, nurse-midwives experienced tension with non-nurse midwives. The differences in philosophy of care between various midwives have created a barrier. One noteworthy example of why these differences exist was portrayed by one person from the implementation groups: "There are still philosophical differences, but you even see those

between, you know, two different nurse midwives and, you know, who have nursing background, and two different midwives who came through a different route" (P14).

Another common feeling expressed by participants was that midwives can be their own "worst enemies." A participant from the implementation groups noted how intraprofessional conflict can be detrimental to the profession:

> I think midwives can be their own worst enemy or they can make, they can elevate their own profession to a level where they are seen on equal footing with other professionals and well-respected and integrated….We've come a really long way but we're not there yet in terms of them being a cohesive, respectful group that really is proud of all of them. There are still some divisions and, you know, a sort of preference to work with this one versus this one. Well, you know, you need to figure out how to work with everybody and, yes, I do get the different philosophy and different… and women's choice. And women choose; they self-select a midwife and that kind of fits for them, right, but so I get all that. But I think that's how they're their own worst enemy because those kinds of interpersonal things suck the energy out of people. (P 18)

Resistance from nursing and medicine, turf wars (inter/intraprofessional), and medical dominance were highlighted as key barriers that inhibit the profession to maximize its autonomy. The issue around medical dominance intermittently came up throughout many of the interviews. Medical dominance has been coined as "occupational imperialism" as it inhibits midwifery's ability to expand its own territory to meet the needs of the community (Larkin, 1983). Participants agreed that midwifery faced challenges of being an inferior profession to nursing and medicine. While

interprofessional conflict has been apparent between the nursing, medical, and midwifery communities in Manitoba, medical dominance over midwifery has currently and historically garnered criticism for inhibiting the growth of the profession. One sentiment regarding this issue was shared by one of the midwives:

> It was, as always, the doctors and the nurses lined up against (a) anybody else who wanted to do anything. Doctors not wanting anybody to interfere on their turf, you know, naturally. Basically saying, no birth is a normal birth until after, and then we'll tell you whether it was normal….I think on the part of many physicians, although a lot of them have come around. There was there was enormous hostility to and fear around anybody taking anything away from them. (P1)

Other noteworthy examples evolved from the interviews of how occupational imperialism by the medical profession, in relation to the midwifery profession, has played out. For example, one provincial representative explained how the medical profession maintains their territory:

> I think that if we're going to go into a larger post-secondary program you have to have the capacity to hire the grads, which is a wholesale change in how we do medicine in Manitoba…If you're going to graduate twenty or thirty people, that's a lot of people to move into the system…And then that really changes what happens with pregnancy, labor, delivery, births…And so we'd have to wholesale look at what we're doing differently, and then the OBGYNs would flip out because it would be a huge part of their income. (P7)
>
> ***Interviewer:*** …How would it be, how would it be a huge part of their income?

> [P7 responds:] Lost….It would be shifted to…midwives…And doctors generally are status quo stakeholders…They like the system as it is because it has them at the top; it has them making a lot of money. (P7)

In summary, structures of power, gender, issues of political advocacy, and inter/intraprofessional conflicts were threads to the theme of conflict and power. Historically and currently, midwives have been subjected to the reign of structures of power, inclusive of other professions. However, midwives, at least in part, have some responsibility in the way they have positioned themselves as professionals.

Theme Two: Education.

Education was a prominent theme under barriers. The two sub-themes that emerged demonstrated challenges within the system: types of training and the plight of midwifery education in Manitoba. These sub-themes evolved from participant interviews as issues that have inhibited the full implementation and utilization of midwifery services in the province.

Types of midwifery training and assessment.

The first sub-theme focused on how the different types of midwifery training and assessment have created barriers. Participants brought attention to the issue of midwives having such a diverse background. There have been inherent challenges related to the various types of training Manitoba midwives have brought to the table. While it was acknowledged that the diverse educational backgrounds may bring richness to the profession, it has also created barriers. The identified barriers were attributed to the foreign trained midwives' lack of knowledge regarding the model of practice of midwifery in Manitoba, the lack of assimilation of their own skills within Manitoba

midwifery standards of practice, language barriers, and other issues. One health professional commented on how variances in how the midwife is trained have created "angst" amongst the physicians:

> For example, so many of the midwives that are, are from out of the country, Australia or English, U.S.…And they come here and try to make sense of, you know, everybody sometimes talk a different language, and they try to make sense of how things run…That's part of the angst of the physicians they had at the very beginning, 'cause every midwife coming from a different background was doing different things, you know…Their ideas, their way of pain control, their ideas of pushing, their ideas of delivering, their ideas of episiotomies, of stitching, etc. Everybody was doing different things, depending on their training. (P13)

The Prior Learning Experience and Assessment (PLEA) program was noted as one avenue to increase the number of midwives in the province. In 2008, the PLEA ended and was replaced by a national initiative to provide gap training and the assessment of midwives, called the Multi-jurisdictional Midwifery Bridging Program (MMBP) (Canadian Midwifery Regulators Consortium [CMRC], 2011). Nonetheless, one health professional commented that the endeavor of the College of Midwives of Manitoba (CMM) to streamline how midwives were assessed and the gap filled via the MMBP created a barrier to increasing the access to midwives in the province. The new mechanism in place to gap-train and assess was located in other provinces, and some felt it was not feasible for eligible persons to complete the program given the financial investment required. The participant stated:

> It is incredibly challenging for someone, an internationally educated person who has come here from a different country, hoping to start tomorrow as a midwife, and three years later they're working delivering pizza or as a homecare person. They cannot take time off from a minimum wage job to go and participate in MMBP. (P4)

The plight of midwifery education in Manitoba.

The participants highlighted that the plight of midwifery education in the province has long been a contentious issue, since the regulation of the profession. The issues regarding midwifery education in the province were discussed by all participants to some extent during the interview. Many stakeholders felt that not having a solid educational strategy embedded in the implementation process was a significant flaw within the process. Moreover, many felt discouraged that the original midwifery education proposal at the University of Manitoba never came to fruition. A provincial representative commented on how the gap happened with implementation, wherein midwifery education was a critical component to growing and integrating the profession:

> So, you know, as graduates start to come out of the profession, I think that's critical, and it was a big gap when we did not have an education program in Manitoba in terms of growing the profession, developing an understanding…You know, it was a real gap in terms of credibility of the profession when we didn't have an education program. (P9)

The University of Manitoba was seen as the logical place to house the original proposed midwifery education program. At the time, however, one of the great debates

was if and where midwifery would fit at the University of Manitoba. One participant from the implementation groups recalled some details of the debate:

> So I think people were still trying to figure out where midwifery would fit…The School of Midwifery would have been separated from nursing. There was some, some worries about that from certain sectors…And if I recall, nursing was not the most, they weren't, they weren't hugely enthusiastic; let me put it that way…Frankly, nobody took a huge leadership role…I honestly think if somebody had stepped up and said, this is what really needs to happen, let's go get on with it, I think maybe something could have been negotiated, but everybody was sort of, you know, lukewarm. (P10)

With one exception, participants consistently noted that midwifery education was one of the most profound barriers impacting the capacity of the profession in the province. Many participants outlined their concerns regarding the institution that was chosen to house the original Kanácí Otinawáwasowin Baccalaureate Program (KOBP) in northern Manitoba. The University College of the North (UCN) was believed to lack the capacity to deliver a successful and sustainable midwifery program in Manitoba. One health professional described the issues regarding UCN's capacity to deliver the program as follows:

> But they didn't have people there physically who were able to develop the program, so I think that's partly why it ended up being developed outside the auspice of the institution….There was a dithering, dithering, dithering on actually getting the funding forwarded and so that you could get started to the point that they actually had half the length of time, eighteen months, to actually do all the

> work for a three-year program…When the program was launched in ’06 we had two instructors, one in each location, neither of whom had appropriate degrees, being at least a master’s level…They were attempting to be practicing midwives full time as well as full-time instructors. It just fell apart. They [instructors] didn’t have the support they needed from UCN, from communities, from the dean, from anybody to actually accomplish those roles. (P4)

As well as a lack of capacity, the University changed the focus to exclude curricula from the original Aboriginal midwifery program. The program no longer contained an Aboriginal focus, and this did not bode well within communities across Manitoba. Participants from various key informant groups commented that the change in focus detracted midwifery resources aimed at improving maternal child care in Aboriginal communities in the north. Two different participants from professional bodies voiced significant concerns. One expressed the following perspective:

> UCN is calling it KOBP/Bachelor of Midwifery now…And the College has said, uh-huh, like KD [Kagike Danikobidan] is saying, uh-huh, this is not KOBP anymore, you know, and the students who are thinking they’re coming into this amazing Aboriginal, you know, focused baccalaureate program, it’s not…It’s not the original Aboriginal midwifery program that everybody signed onto. It’s a completely different program. (P8)

The second participant commented:

> The question mark is that there’s sort of persuasion to, for the understanding that, that we accept this program as the KOBP Program. It has been altered to a degree

and utilization of the name, so I know the Aboriginal committee is struggling with that. (P17)

In contrast, another participant had a divergent viewpoint and was skeptical about the benefit of having a midwifery education program in Manitoba. The participant commented that education costs and training for people who cannot find work in health care was money that should not be spent. This health professional specifically stated, "It is better to draw midwives from other well-developed midwifery programs, and once those provinces have filled their mandate, we get their students without the cost of training them" (P20).

The theme related to education draws attention to the inherent problems of how midwives are trained and the lack of leadership and infrastructure needed to launch a successful midwifery education program in the province. The diversity of the midwives' backgrounds could help explain how other professionals often misunderstand the role of the professional midwife. Integral to any sustainable health profession is a solid educational program. Consequently, when student midwives do not have a consistent presence in the clinical setting, the midwifery profession does not have the opportunity to integrate itself as part of the norm.

Theme Three: Perceptions of the profession.

The third theme comprised barriers related to perceptions of the profession. Within the perceptions of the profession, stereotypes and misunderstanding of the professional scope of practice evolved as problematic for the profession in gaining credibility.

Stereotypes.

Many participants believed the society in which we live perceived the midwifery profession as antiquated. The attribution of these common stereotypes to midwifery appeared to dilute the overall presence of the profession. Ultimately, these stereotypes have impacted midwives' status negatively in other professional circles. Consequently, the issue of women's choice seemed secondary because midwives did not appear to be valued as a legitimate health care provider. The public's skepticism and stereotypical views of midwives was notable in the interviews as discussed by a health professional and a provincial representative. One of them explained that "I would have to say that there was probably a lot of skepticism on the part of the public because they didn't know. Everything they knew about midwifery perhaps came from a book, from folklore, from poor reports, etc." (P4).

The second participant expressed:

> I think in the case of midwifery, as well, part of the, some of the issues around the implementation of midwifery initially were still the stereotypical views held by some lawyers, bureaucrats, physicians, particularly men in those professions, you know, who still saw midwives as, you know, non-professional, you know, hippy, dippy, granola belt, you know, all of those stereotypes about midwifery. That's really how they viewed. They didn't see it as a profession. They didn't and they didn't get it in terms of the fact that women wanted choices in terms of that. (P23)

Misunderstanding of the professional scope of practice.

A similar issue regarding perceptions of the profession was in relation to the misunderstanding of midwives' professional scope of practice. Participants remarked that the media has played a role in portraying midwifery as an unsafe profession. Two

participants from the implementation groups and the provincial representatives voiced that unfortunately when a bad outcome happens with midwifery care the media garners the public's attention. As one provincial representative stated, "It [bad outcome by midwife] gets steamrolled [by the media] into something that is untrue..." (P23). The other comment made was, "Whenever there's a problem [bad outcome by midwife] it really gets the press" (P7). Perceived misunderstandings regarding safety and the skill set and training of midwives were raised by the participants. One participant from the implementation groups gave details of how midwives' skill sets are called into question and misunderstood in the health care system in which they work:

> So early on, I think it was lack of understanding that midwifery was a regulated profession, that they actually had training and experience and expertise to offer. There was controversy around, you know, home births and the sector of health care system believing that, that was an unsafe practice…I think there's still a little bit of misunderstanding, I think there are individuals that will never really buy in… I think it's a culture. I think it's the culture of doctors, doctor knows best, you know. And home birth was always, before regulation, was seen as so outside of the norm of the medical system, that people were uncomfortable…You know, we ran into situations early on where they didn't realize that midwives actually brought equipment and oxygen and, like, so we had sessions, midwives bring their birth bag, open them up, and say, "This is what we bring to a home birth," and then people go…ohhh…Because they really think, I don't know what they thought midwives did at a home birth…They were shocked that midwives actually had a bag of equipment, they brought oxygen, they had a way to warm

> the baby, they had, you know, IV stuff and, like, I think they thought it was truly no intervention, like, a midwife was just sitting there watching this natural thing happen. (P18)

The opening of the Birth Centre provoked strong emotions about safety and the cost-effectiveness of this type of maternity care in the context of a multi-million dollar maternity care facility. One health professional felt that "there was lots of money spent on this thing and now it's [Birth Centre] underutilized," and compared it to the medical model of maternity care: "[The Birth Centre does] forty-six deliveries in six months. We do forty-six here [hospital] in two days" (P13). But safety issues were also associated with the Birth Centre environment, similar to the issues of the homebirth setting. A participant from the professional bodies briefly highlighted an exchange between professionals in one Birth Centre presentation: "…A number of the male physicians were very worried about the Birth Centre and having no physicians available" (P17).

The stereotypes and misunderstanding of the professional scope of midwives have fostered a culture of uncertainty within society regarding aspects of the model of midwifery care. Understandably, the way midwives have been perceived contributes to the continual battle to establish credibility within society and the professional domain.

Theme Four: A precarious profession: lack of capacity.

The final theme that emerged was in relation to precariousness of the profession. Various aspects of the profession are linked to barriers which have impacted how midwifery services are used or made available within the broader health care system in Manitoba. One participant alluded to the midwifery profession as being "precarious" because of all the instability and lack of growth in the profession (P1).

The lack of capacity addresses several specific issues that have impacted why the midwifery profession has struggled to grow. Issues related to recruitment and retention have influenced the lack of capacity. One health professional commented: "Midwives were leaving the province because they are realizing it is not a sustainable profession" (P15). According to participants, recruitment and retention initiatives had not been addressed and thus were a barrier to increasing access to the services. One health professional identified a specific issue related to the problem: "I think also, like, having more provincial recruitment, right now every RHA is on their own trying to recruit and so it's not very effective" (P21).

Another common issue related to lack of capacity within the profession cited barriers within the current model of practice and employment. The model of practice was commonly perceived as a barrier which has impacted the capacity of the overall profession to provide greater access to midwifery services. The model of practice, as defined in chapter two, limits the capacity of a midwife's caseload. Generally, a full-time midwife will take on approximately four to six clients per month, while a part-time midwife will take on one to two clients per month. One participant from the implementation groups commented:

> I haven't seen any reason to not have the kind of model care that we have in this province with forty primary cases for those who are working full time, but I just don't think it's sustainable when there's no new growth of the midwifery so that people can take a break, so midwives can take a proper holiday and have locums fill in for them, and I just think it leads to burnout. You just can't keep relying on the same people for fifteen years to do the same work all the time. (P5)

As well as the model of practice, the model of employment was associated with barriers which impacted the capacity of the midwifery program to expand services. Participants perceived many initial benefits to the salaried employment model. It currently, however, was seen as a barrier that decreased the capacity of the profession to grow, inhibiting access to the services. Barriers have been created by the circumstances that the employment model appears to perpetuate, such as lack of accountability among midwives, lack of choice for midwives with regards to employment setting, and limited caseloads per midwife. One midwife divulged how the salaried employment model had possibly contributed to decreasing women's access to midwifery services:

> So I see that as a barrier because we are not servicing the number of women we could be, and we're not functioning as optimally as we could and, and I would say that, that is a huge problem right now in Manitoba and, as we've seen, there's just general not as much accountability with regards to the, like, numbers and caseload number…I just mean, like, there's no manager saying, "Hey you're full time, how come you don't have forty people in your care?"…And I think people are abusing the system, you know…I just don't think if somebody was to do a cost analysis, like, that just would reflect very poorly on the employee model. (P24)

A lack of unified voice, attributed to the many unions representing midwives, was also identified as a barrier resulting from the current salaried model of employment. One health professional spoke to this issue:

> Midwives don't appear to have a unified voice…Within each Regional Health Authority, my understanding is there's a separate sort of union for each one, and

> so if you've got 44 practicing midwives working in ten different health regions, you've ten voices basically rather than a single voice. (P4)

Additionally, a midwife commented that changes within the profession were attributed to: "A few invested individuals, and there was a lack of communication and representation for the overall majority" (P16).

Many participants deliberated about common concerns of direct access to midwifery care, essentially, what are the determinants of who gets care. While midwifery in Manitoba was founded on the tenets of equity and access, the philosophy of the model of practice has been called into question, at least in part because of the lack of availability of the services. Participants questioned whether midwives' caseloads truly targeted 50% of the defined priority population. One health professional observed: "But then their caseloads get quite full quite quickly and make it hard for them to accept some of their priority populations" (P22). Although there were common reasons given for accepting women into care, such as being a previous client, coming from a priority population, or based on the midwife's preference, the majority of participants attributed a woman getting midwifery care to availability and timing; otherwise, it was due to luck. A health professional commented on determinants of midwifery care for women in the province:

> Well, availability of one [midwife]. You know, if she [pregnant woman] wants to have a midwife then she has to find a midwife who could take her on, in practice, and that's the crazy thing about, you know, listing high-risk women [referring to priority populations] as being the best for midwifery care because they're the ones least likely to access midwifery care because you have to have the knowledge

> where to phone, when to phone, phone early, and there will be some patients that can't get midwifery care because the midwifery practices are full. (P20)

The participants also expressed concern with the lack of capacity in the profession in relation to ensuring midwifery access in rural and remote areas. Two participants commented that the efforts to integrate services in the north were met with resistance by certain communities. One provincial representative stated, "This resistance came from the First Nations people's fear of going backward. Thus midwifery care was perceived as second-hand care" (P9). In general, the majority of the participants felt the province had fallen short of providing access to these underserved areas, predominantly in the north. Two participants, from professional bodies and health professionals, elaborated on the importance of maintaining equity and access as foundational to the nature of midwifery services, especially for northern communities. One of them explained:

> I maintain this sort of passion for this issue of equity and access, and I think that is a really key piece that can't be forgot. I don't think it has. I think there are pockets where it is, but the fact that we really don't have, there's … like, three midwives that work in the north, and one's on maternity leave, and one's retired, and the other one can't do birth…I'm talking about this other aspect – northern midwifery, rural midwifery, newcomers, remote people in the remote, adolescents, Aboriginals, all those pieces. That was the focus of midwifery in Manitoba…I think people will forget about equity and access priorities because they will be so drawn into the moment of today, which is we're overwhelmed, or there's too many, no one gets any care, or this and that but what were we really built on? (P6).

The other participant expressed:

> As we know, in Canada, because we have too much geography that women die being transported to tertiary care centers, and we know that children die because the mother isn't there to protect them from fires and other things that happen because of some of the disasters that happen and alcoholism. So to say, well, if a mother comes to Winnipeg to have her baby but, you know, four of her five children die in a house fire, well, who are we helping here?…That baby was born fifteen minutes after the induction or he was born in bed with a nurse. How much did a doctor need to be involved in that?…Zero. (P19)

Finally, lack of capacity in the midwifery profession was linked to midwifery being a small, vulnerable profession. Job vacancies, lack of preceptors/instructors, and the midwives' multiple roles all increased the strain on a small profession. The lingering fear of losing the profession demonstrated why midwifery's vulnerability was portrayed by one participant from the implementation groups as follows:

> I saw the profession as having struggled so hard, fought so hard to get what they got, but they were not flexible enough at that point to, to believe that they made it, and to do some trusting and then make some accommodations…I think they had fought so hard to get what they got, didn't feel they gotten it all, but were struggling just to, didn't want to give an inch on anything they won, hard won, and so couldn't negotiate anything 'cause they think, they were so afraid of losing something. (P3)

The lack of capacity of the profession was demonstrated by the constant state of job vacancies. Participants commented on various factors that resulted in jobs remaining

vacant and how this created a magnitude effect on a small profession. Factors such as retirements, maternity leaves, and sick leaves were all identified by one person from the professional bodies:

> But, you see, still the rural areas are still struggling. Like, now you have, you have eight new midwives in the city of Winnipeg, and you have all these rural places that are going, like, there are these retirements. There's two retirements this year. There's maternity leaves that cannot be refilled. There are people going on sick leave. (P6)

Many participants mentioned that midwives have too many roles to fill. Some felt this had a domino effect on the capacity within the profession to fill preceptor and instructor roles with qualified midwives. Overall, many participants acknowledged a small body of people was a substantial barrier to increasing capacity because people are burned out with the current workload. One person from the professional bodies indicated there are not enough people to get the work done, especially with the efforts to expand the overall profession:

> As you continue on without the education piece sufficiently in place and, again, the association piece sufficiently in place, you start to see the impact on the regulation side, 'cause it's difficult to get, you know, when you don't have enough people to do all of the work that the College needs, needs to do. You don't have enough people to support the new practitioners. You don't have enough people to support the education program and that sort of thing. (P11)

In summary, access to midwifery services is compromised by multiple factors related to the profession's lack of capacity to meet the demands. Consequently, the

profession is constrained by mandates from the model of care, difficulty recruiting and retaining midwives, and midwives committed to too many roles. The profession remains in a precarious and vulnerable state due to increased demands without a consistent increase and retention within the workforce.

Facilitators.

The second topic focused on facilitators. While more themes aligned with barriers, participants commonly highlighted a strong feminist movement and successful implementation strategies as positive influences on the profession. Many initial strategies were successful at facilitating growth in the midwifery program, which at least in part grounded the program so it could continue to make incremental progress.

Theme One: Feminist movement: constituent influence.

One midwife referred to midwifery as a "strong movement, a feminist movement" (P2). This participant believed, however, that the "feminist" view was a "narrow view of midwifery" (P2). Overall, participants believed women's strong desire for choice of birthplace and maternity care providers was the impetus to the midwifery movement in Manitoba. A participant from the professional bodies noted how supporting women's choice was in essence the core impetus in fighting for the viability of the profession: "Midwifery is really a movement about bringing women choice…Because without midwifery these [hospital] policies that are being written probably wouldn't have choice written anywhere" (P8).

The implementation of midwifery in Manitoba has been ascribed as a feminist movement. A consumer is the person who utilizes or "consumes" the midwifery service. The term *constituent* is used more broadly to encompass users and non-users of the

service who are specifically strong advocates for midwifery services in the province. Participants used both *consumer* and *constituent* to define the public. It is important to point out that constituent influence, as opposed to just consumer influence, made a huge mark on the progress of the midwifery movement.

The majority of participants credited constituent influence as having a positive and significant impact on the implementation process. Constituent influence was also highlighted as a reason the Birth Centre came to fruition. As one participant commented:

> I think the Birth Centre was driven by consumers. It was not driven by, you know, yeah, midwives are supportive, but it wasn't just because midwives wanted a fancy place to work. Consumers came together and said, "We want a choice," you know, "We want something that's not a hospital." (P10)

An initial core group of women cultivated midwifery in Manitoba, thereby bringing attention to the demand for the services, as mentioned by one person from the implementation groups:

> But certainly there was a an articulate and well-organized group of women who understood midwifery, believed in it, and fought for it for years and years in Manitoba, as there is with every other women's issue in Manitoba…For example, if it had come about that it was going to be nurse-midwifery, that you had to be a nurse first and then a midwife, there would have been an outcry from the women's community such as hadn't been seen since the fight fought for Family Law Reform. It didn't go that way. It went, you could be a nurse or you could be a midwife and you could be both, whatever. (P3)

Theme Two: Successful strategies.

Successful strategies were fundamental in how the midwifery program was initially implemented in the province. Sub-themes of these strategies were regulation, funding, integration into the health care system, and the implementation of the Birth Centre.

Regulation.

Participants commented on how implementation was successful, and the majority of participants believed midwifery in the province had been fully implemented. Some participants shared mutual feelings that integration had worked. The development of transport and emergency protocols were given as examples. A member of the implementation groups noted that although there had been challenges, "…it [midwifery] didn't fade away or crumble and didn't result in a debacle and disaster and dead babies and dead moms" (P10). Most outlined various successes in the strategies to implement midwifery in Manitoba. For instance, a participant from the professional bodies commented on the fact that regulation was adequate since it included key components to support the profession:

> There was a very good human resource strategy…We've been well regulated…Midwives have been very equally a part of that regulation process. So as far as setting our standards, of being careful and aiming for safe practice, I think that regulation has done very well. Funded? Yes, we've been funded…The funding system is not a problem….We went through processes, we were assessed, the law was proclaimed, we were regulated, we had a regulatory body that made standards for us, the funding model was set as a salary model through the

> Regional Health Authorities…In those first years many people were happy with what was happening. (P6)

Funding.

The participants consistently noted that milestones such as regulation, funding, and integration were all successful components of implementation. Midwifery, as a funded service, was recognized as something that facilitated access to these services. As noted by one midwife, "I think because it is a funded service that it definitely takes away the barrier for most women" (P16). An original member of one of the implementation groups commented on the successes leading up to the proclamation of regulation in 2000, which facilitated integration:

> We…and our supporters persuaded the government not to pass the Act until there were midwives ready to practice… We learned a great deal from BC and Ontario. They had wonderful advice, and there were things we saw that we thought, we'll, we'll do that differently, such as involving and trying to be responsive to Aboriginal women, as I've described. So I felt in 2000 that we had done quite well to that point. We had a small core of midwives meeting the competency list that we had ratified. They were employed. It was going to be a funded service so women would not be out of pocket. There was no hitch in care for those women who were already working with a midwife outside the system. (P5)

Integration.

As a result of these initial integration strategies, participants commented that integration was successful. One participant from the professional bodies group voiced: "…what's forefront in my mind is that we stop talking about implementation and that

it's, it's sort of a seamless system" (P17). Integration was markedly fostered by undertakings such as the employment model, co-location of midwives with physicians, and collaborative work with the government and other health professionals. The employment model was consistently highlighted as an important and successful integration strategy, as explained by one implementation group participant:

> You know, you had to force the integration, and we were a bit concerned about the fact that integration hadn't been optimum and things that happened, and so we wanted to ensure integration…The employment model has worked in that regard, in that, you know, we've got midwives in different clinics…At least they're there and, you know, some of the, you know, doctors know they're there. They can't avoid them. They can't. They have to deal with them. (P10)

Implementation of the Birth Centre.

In spite of some of the controversy of having the Birth Centre in Manitoba, some participants felt it demonstrated the government's commitment. Furthermore, it was one more avenue to increase the positions of midwives in Winnipeg. As one participant from a professional body noted:

> Now there's been a huge influx of new positions being filled in Winnipeg. Part of that is because the Birth Centre, and it's attracting attention, and new grads are thinking what a great place to work, and they've done a bit of recruitment, I think, or maybe it's word of mouth recruitment because a few midwives have come here and, you know, from Ontario programs. (P6)

In summary, successful strategies, such as the profession attaining regulation with funding, and setting successful mechanisms for integration, all have demonstrated the

public's interest, support, and motivation to realize this new profession. Additionally, the constituent influence played an important role in garnering the government's attention to implement the service. Finally, more recent endeavors, such as the opening of the new Birth Centre in Winnipeg, demonstrate the government's commitment to women's health care services in the province.

Future strategies and recommendations.

The first two topics (barriers and facilitators) have been broken down into specific common themes identified by the key stakeholders. The themes and sub-themes help explain how and why these barriers and facilitators have impacted the implementation and utilization of midwifery in Manitoba. Key stakeholders were also given the opportunity to discuss at length what they deemed as critical endeavors for the future direction of midwifery in Manitoba. Therefore, the third topic aimed to understand what future strategies and recommendations should be examined. Four themes related to future strategies and recommendations arose from interviews with the key stakeholders: avenues for midwifery education, refocusing management strategies, evaluation of the midwifery program, and the need for more research.

Theme One: Ensure avenues for registration and education.

The first theme, to ensure avenues for midwifery education, was almost unanimously suggested by participants. Some participants strongly suggested it was critical not only to implement a sustainable midwifery education program, but that a school of midwifery should exist in the context of other health professions. Two participants, from the health professionals group, suggested the educational program also needed to match the demand for midwifery-funded positions. One person stated the

importance of "…government funds matching educational positions" so that midwives who graduate can go directly into positions (P22). Another participant pointed out, "…if you ever start training people that can't find work in health care, that's money that you should not be spending" (P20). Overall, participants deemed "growing our own" as critical to the sustainability and full integration of the profession. One midwife articulated the importance of having an integrated school of midwifery:

> If you had a school of midwifery in Manitoba that was part of the University of Manitoba, and you have a large number of students, and they started doing their practicum in the hospitals like the medical students, and they become fully integrated into the system. (P2)

The other common issue mentioned was that gap training needed to be addressed and embedded into the midwifery education program. The assessment of prior learning was seen as an essential strategy to target trained professionals, who had previous midwifery training, but just needed assessment and gap training to be eligible for registration as a midwife in Manitoba. Gap training was recognized as a need and an important tactic to increase the number of licensed practicing midwives in the province. Furthermore, it was noted that gap training would provide another avenue for midwives to become registered so they could practice legally. One health professional commented:

> The strategy of trying to … look at different programs such as the PLEA to try and get more practicing midwives in the province was probably initially a good one. It just was incomplete because of the gap-filling aspect…I think we've got the people who are already trained partly. Can we not find ways to help those

> people bring up their education to the level that's equivalent in whatever fashion we do that? (P4)

Finally, many participants felt it was very critical to continue to focus on midwifery training in the northern communities. One participant commented on the need to refocus the commitment in the north and rural communities:

> I am still very dedicated to the idea of training…Aboriginal midwives in the north. I think we need to address the issue of, of women having to leave their, go so far away from home. Maybe they can't birth in their community, but wouldn't it be nice if they could birth closer to their community?…It seems to me like there's a resignation that, you know, women will travel to Winnipeg …We have to make a much stronger effort to reach out to that population. (P10)

Theme Two: Refocus management strategies.

The second theme encompassed policy issues related to management and accountability issues within the midwifery profession. Many participants felt more accountability and leadership was needed within the government, but also within the direct management of the midwifery profession.

Government/RHAs.

Several areas of concern surfaced during the interviews such as the need to refocus issues within the government. Moreover, the midwifery work environment was consistently highlighted as needing attention, followed by action. Another topic mentioned was the need for a recruitment and retention strategy. Several participants also suggested that the RHAs should be mandated to implement midwifery programs. One provincial representative addressed many of these matters:

> I think we need to refocus a little bit more, pay a little more attention, get those positions filled, work with regional health authorities, almost another kind of targeted piece of work with the regions to make sure that midwifery is not, you know, on the backburner in the regional health authorities. So education, some targeted work with the regional health authorities regarding, you know, active recruitment into those positions, additional positions, deployment into every region in the province and then, as soon as we've got sufficient resources, doing some communication campaign. (P9)

The majority of participants commented there was a need for improved accountability frameworks within government. In June 2011, Manitoba Health contracted local entities to conduct an evaluation of midwifery services in the province. In spite of the government's attempts to manage and evaluate the midwifery program, there has been a sentiment of dissatisfaction with the outcome of these initiatives. This was expressed by one midwife:

> I think communication of what the issues are and then having good forums for problem-solving would be helpful. So I think your uncensored Manitoba health survey of this, of these issues, is very helpful because the survey that was done by the Manitoba Health group not that long ago was obviously catered to an agenda, I believe. (P16)

Work milieu.

Some participants commented on the work environment as a factor contributing to burnout and high rates of attrition for the Manitoba midwives. One participant from the implementation groups noted the work environment needed to be made "more humane

for midwives to be midwives" (P10). Along with the need to improve the work environment, integration issues within the work environment were also highlighted. Health professionals voiced their observations related to the work that still needed to be done with integration. According to one health professional:

> There needs to be other policies in place or protocols or guidelines in place that say, you know, okay, well, we've got this many midwives, so you're on call for the next 48 hours, and then the next midwife, like some kind of a rotational call system, where it actually prevents you from working a 100 hours a week. (P15)

Another health professional elaborated:

> I think we have further to go. I think there's still work to do around understanding each other's roles and shared philosophy and, you know, I think when we have midwives in, working in the health care system, that helps promote that kind of normal birth philosophy. But I think we need to sort of, a large infiltration of midwives to grow that even more, and to bring nursing fully on board with that and physicians fully on board with that too, or more on board with that. (P21)

Theme Three: Evaluation of the midwifery program.

The third theme addressed the need to evaluate the overall midwifery practice, which encompassed the model of practice and the model of employment. The model of midwifery practice in Manitoba delineates 11 fundamental principles (defined in chapter three), as defined by the CMM and (CMM, 2000). The employment model in Manitoba is based on a salaried model. In Manitoba, the provincial government provides funding for midwifery positions, therefore most midwives are salaried employees of RHAs (CMM, 2005/06b). Participants voiced the need to evaluate the mandate for priority

populations and home birth, as well as the need to evaluate the current model of employment.

Evaluate model of practice.

A critical examination of how priority populations are defined arose from the interviews. As one health professional reported, priority populations were not well defined; thus an evaluation of the current definition was warranted:

> I also think we need to better define those [priority populations], if we're going to, to really be serious about trying to give priority to our priority populations. We haven't defined those well. We haven't defined them well provincially or regionally…This woman's an immigrant but she's lived in the country for ten years, so really is she an immigrant? Like, I would argue that, right?…Or is it a newcomer who to me is, like, you know, less than three years in the country of whatever, right?…I think it's very subjective. (P21)

A participant from the professional bodies indicated midwifery in Manitoba recognizes "histories of oppression" and remains committed to providing access to vulnerable populations (P6). Many believed this focus needed be maintained and supported. Further, giving women choice of birthplace was considered important to the midwifery philosophy. However, some participants suggested an evaluation of the original mandates (priority populations and home birth) embedded in the model was needed, as the original intent may no longer be as applicable in the present-day setting. According to a participant in the health professional group:

> I'd take away the obligation to participate in home births. It does not make any sense in terms of the skill set...and the UK's never had that and they've … had

> years of experience with very well-functioning midwifery scene … and allow some flexibility in the models where midwives work. (P20)

Evaluate model of employment.

The stakeholders from the health professional group suggested an evaluation of the salaried employment model would be beneficial to help understand if it is still the most appropriate model.

Another participant among the health professionals stated the following:

> I think our province needs to change our payment model; it's not just about the money. It's not about the salary or I'm not saying, oh we need an increase in our salary. I'm saying I think we need to change the structure of the employee/employer relationship or structure because if we were more independent practitioners and we owned our own practices and we worked for …fee for service or per course of care, we would own it. (P15)

Theme Four: Research.

Finally, a theme related to research was the fourth-most emphasized strategy emerging from participant interviews. Participants articulated the need for more research in relation to the utilization/distribution of midwives and the initiatives of the midwifery profession in the province. Participants felt a more critical analysis was needed to understand funding issues with midwifery positions, which would help to inform the government more accurately about the facts. As one health professional participant commented in relation to funded positions and research, "…so instead of just doing a little bit of midwifery…we need to decide if we want to do midwifery or not" (P22).

Many participants voiced concern regarding aspects of Manitoba midwifery which hadn't been well articulated in formal research. One health professional outlined gaps with midwifery research in the province:

> I think they need to look at everything more globally. You know, do the sound work on how many women in Winnipeg actually would prefer midwifery care and not pie in the sky numbers and, and look at how to fill the needs outside Winnipeg…So there's this almost, like, religious fervor around midwifery, but not actually looking at the numbers and true need…And that's harmed it I think. (P20)
>
> ***Interviewer*:** …It's harmed…? What has it harmed…?
>
> The same health professional responded:
>
> The rational distribution of midwifery resources in Manitoba…You've got to do it based on real good solid data, and you've got to do it in partnership, and each partner has to respect each other's abilities. (P20)

It appears that any future strategy must address a more successful mechanism for midwives to attain training and registration in the province. Other strategies need to target accountability within management structures where attention has been given to issues yet action has not been evident. Finally, evaluation and research go hand in hand to improve the delivery of the program. Without an effective documented evaluative strategy, it is hard to explore what specific research initiatives need consideration.

In summary, the quantitative data demonstrated which RHAs had midwifery services, the proportion of midwifery-attended births, proportion of home versus hospital births, proportion of priority population clients, and the number and characteristics of the

women seeking midwifery care. Three overarching topics, barriers, facilitators, and strategies/future recommendations were pre-defined based on the specific focus of the interview questions for this case study. Various themes and sub-themes were discussed to help explain how midwifery had been implemented and midwives had been utilized across the province. Furthermore, the identification of specific themes and sub-themes within these three topics helps explain why and how certain issues were barriers and why and how some issues facilitated the implementation and utilization of midwifery in the province.

Some of the more common barriers identified were related to structures of power, lack of overall capacity within the profession, lack of a sustainable midwifery program, professional conflicts, misunderstanding of the midwifery role, and occupational imperialism. The RHAs appeared to have a powerful influence on many facets of the midwifery profession. First, each RHA had the freedom to choose whether it would fund midwifery. The quantitative results demonstrated variation in practicing midwives across RHAs, where five of the original eleven RHAs had not funded midwifery. Second, policies within the RHAs had not historically included midwifery input. For example, ultimately the midwife is accountable to the management and processes within each health authority. Policies and procedures are in place to hold each health professional accountable to safe practice; however, these very policies had been seen as a barrier to the autonomy of midwives' practice. The data from the documents and the interviews showed how the management over midwives, and the policies that inhibit autonomy in midwifery practice, had been attributed to job stress. This at least in part explains the increase in non-practicing midwives over time.

The CMM is an influential and powerful entity, as well. The College has the authority to regulate the overall profession in Manitoba. Although the CMM does not control how midwifery is funded provincially, the College controls the processes and protocols related to midwifery practice. At times, the College had been seen as not being flexible, especially regarding mandates for home birth requirements for midwives. Again, the lack of flexibility regarding requirements for currency and licensure might also explain why the number of non-practicing midwives had increased and why the number of practicing midwives had not increased at a higher rate. These mandates impact whether trained midwives are eligible for licensure in the province. Finally, the lack of political advocacy was seen as a barrier. While there had been phases when political advocacy had been strong within the midwifery movement, overall it had not been consistent. In both the documents and the interviews, findings revealed the need for more consistent and effective leadership to help sustain the profession.

The lack of capacity encompassed several key factors as barriers. According to the findings from the document and the interviews, it was apparent that a recruitment and retention strategy had not been a priority of the government. The model of employment was identified as another barrier which needed to be scrutinized. Finally, though midwifery was funded, the distribution of funds seemed scarce due to fiscal constraints on the provincial government's budget. Furthermore, resource allocation decisions are in the hands of those in the government. Ultimately, elected government officials prioritized where dollars would be spent within the health care system.

Midwifery education was a crucial topic noted in the documents and discussed among the participants. Many felt it was a missed opportunity arising from inadequate

championing of education from the beginning. In theory, the KOBP was a stellar program which focused on training midwives in the north. Unfortunately, once midwifery education was implemented, an inherent institutional struggle was noted, thus yielding only one graduate as of June 2013. Most of the problems were attributed to the lack of capacity and leadership within the institution to create a sustainable midwifery education program. Further, the lack of graduates has directly impacted the number of practicing midwives in the community.

Professional conflicts were highlighted as a barrier. Participants discussed issues related to interprofessional conflicts and intraprofessional conflicts. The findings from the documents and interviews revealed how the medical and nursing professions demonstrated resistance against midwifery as a profession. In spite of various efforts to integrate the midwifery role, territorial issues between the three professions remained. Midwives were also seen as their "own worst enemy." A common sentiment noted among participants was that "in-fighting" created a negative presence for midwifery and was a drain on energy for the profession.

Some of the interprofessional conflict was attributed to the continued misunderstanding of the midwifery role. Participants agreed midwives were still stereotyped as "hippy" or "anti-establishment," a perception which therefore has affected their credibility. A lack of understanding of their skill set and training, and thus their professional role, was perceived as a barrier to growth in the profession.

The findings from both the participants and the documents highlighted how occupational imperialism permeated the midwifery profession, in subtle but powerful ways. The professional bodies in medicine have money, high membership, and power.

These attributes are important in the political landscape. The CMM is the regulatory body of midwifery; however, midwifery management falls under primary care in family medicine. The dichotomy between the subordination and autonomy of the midwifery profession is complex. Historical oppression of midwifery continues to play itself out in the context of a modern, regulated profession. The outcome of historical oppression continues to be a modern-day barrier for midwives to fully practice autonomously.

Various facilitators were identified such as constituent influence related to a feminist movement, and successful strategies were identified as; funding, integration strategies, and the implementation of a birth centre. The findings from the interviews revealed how constituent influence had an impact on various facets of the implementation processes such as regulation. The document analysis also revealed how the constituent had a voice in various endeavors related to the midwifery movement.

The findings from the interviews and documents demonstrated how funds had been consistently allocated for the new positions and programs (i.e. PLEA, education). The findings from the quantitative data indicated a modest increase in the proportion of midwifery-attended births which reflect the increase in budgeted positions over time. The slight increase in practicing midwives is also likely due to an increase in budgeted positions over time.

Other facilitators noted from the documents and interview data were the successful integration strategies such as those related to the employment model. Many participants felt that the employment model adequately integrated the new profession. On the contrary, the employment model appeared to limit how midwives work in province and how many women could access the service. The modest increase in the

proportion of midwifery-attended births could be attributed to the current model of employment.

The final topic explored was future strategies and recommendations. Participants identified a need to refocus management strategies within the government. Throughout the documents, various improvement initiatives (evaluations, data tracking mechanism) were discussed. There was no apparent follow through with such initiatives. Furthermore, results from the study show how an evaluation of the model of practice and the model of employment is needed. Finally, the documents had evidence of research initiatives, however participants noted more research is needed to make it a more credible profession.

Chapter VI: Discussion

This study used a case study approach to explain factors that have had an impact on the implementation and utilization of midwifery services in Manitoba from 2001/02 to 2009/10. This chapter will discuss the key findings in relation to the conceptual framework for the Behavioral Model of Health Services Use (Aday & Andersen, 1974; Andersen, 1995). A feminist interpretive lens was used throughout this study; such a lens will be integrated in this chapter to draw on the insights and struggles of the midwifery profession in Manitoba. Likewise, the findings will be substantiated by relevant and current literature, with an emphasis on Canadian midwifery. After the discussion of the findings, the strengths and limitations of the study will be briefly highlighted. Implications for practice, policy, and future research will be discussed in relation to the specific findings from the quantitative and qualitative data. Finally, the chapter will conclude with plans for knowledge translation.

Results Related to Framework and Existing Literature

From the time of its initial implementation to the present day, the midwifery program in Manitoba has experienced both barriers and facilitators, which have had an impact on the full utilization, growth, and sustainability of this health service. This case study revealed that various aspects of implementation, such as regulation, funding, and integration into the health care system, have been successful. Other aspects of implementation, however, such as establishing a successful midwifery education program, remain a challenge.

The results will be discussed in relation to the major characteristics of the following five modified components of the framework developed by Aday and Andersen

(1974): health policy, consumer influence, characteristics of the health delivery system, utilization of health services, and characteristics of women who utilize midwifery services.

Health Policy

The findings in this study were consistent with the literature from other provinces regarding the impact of policy initiatives related to the implementation of the midwifery profession. For example, Ontario, Alberta, and British Columbia initially fought for fundamental aspects of midwifery: midwifery regulation, education, integration into the health care system, and a publicly funded service (Bourgeault & Fynes, 1996; McKendry & Langford, 2001; Rice, 1997). As demonstrated in the findings, Manitoba's policy goals appeared to establish fundamental aspects to fully implement midwifery services in the province. In June 2000, the Government of Manitoba followed through with the commitment to offer access to midwifery health services by proclaiming the Midwifery Act (Province of Manitoba, 2000).The Manitoba government had in essence met their initial policy goal. The enactment of this policy fulfilled the government's commitment, set forth in the1994 public announcement, to regulate midwifery. Manitoba appeared to have a sustainable midwifery implementation strategy, as evidenced by endeavors to publicly fund the service (Killick, 1999), ensure accessibility to services by the Aboriginal population (Olson & Couchie, 2013), and fund a midwifery education program in the north (Health Canada, 2006).

Access to health services or, in this case, midwifery services is realized through utilization (Andersen, 1995). Aday and Andersen (1974, p. 208) suggest that access is more of a "political idea versus an operational idea," which makes it hard to effectively

evaluate programs. The Manitoba government made a political decision to implement midwifery. The policies to support the midwifery program, however, were not cohesive and lacked an evaluation and strategy to effectively move the profession forward. The findings from this study provide support for Aday and Andersen's (1974) framework for health services use. The interrelation of health policy variables such as finance, education, manpower, and organization explains how midwifery health services were utilized.

Finance.

Finance or funding was one characteristic of health policy perceived as both a barrier and a facilitator that affected the utilization of midwifery services in Manitoba. Funding for midwifery services has been a challenge in other provinces, where the government's voice has reflected the rhetoric of women's choice but its commitment has often been vague (Rice, 1997). Alberta's regulation of midwifery was different from regulation in British Columbia, Ontario, and Manitoba in that the government had taken no initiative to fund midwifery services in the public health care system (McKendry & Langford, 2001). While Manitoba had publicly committed to funding the service (Manitoba Health, 1998; Killick, 1999), participants noted that structures of power such as the RHAs created barriers to implementing midwifery services across Manitoba. The fiscal restraints of the RHAs created a barrier by controlling how and if midwifery services would be made available in each RHA across Manitoba. There was neither a mandate from the provincial government for RHAs to implement the service, nor a clear plan to increase funding across the province for midwifery positions (CMM, 2002/03, 2005/06a). The administration of each RHA had to recognize midwifery services as a

needed priority for that region to advocate for the service. Furthermore, each RHA then had the liberty to choose if they would apply for funding from Manitoba Health. In 2002, six of the original eleven RHAs applied and were approved for midwifery funding; however, due to fiscal restraints, only five received the funding (Haworth-Brockman, 2002). As evidenced by the data from the CMM registries (2006-2010), only five of the original eleven health authorities had midwifery services available during the time period of 2006 to 2010.

Participants commented that health services were prioritized for funding and that midwifery appeared to be a lower priority for health care dollar allocation. Participants in this study often expressed that the government was the gatekeeper of midwifery, in essence, by controlling the funding. Paterson (2011, pp. 491-492) notes that the regulatory "governance structures" of midwifery act as the "gatekeeper" of the profession. This author questions why midwifery legislation, which is supposed to protect the public, assumes that women are incapable of making informed decisions regarding the birth process. Likewise, Paterson questions why women need protection in this context.

The CMM (2005/06a, 2007/08) documented that the midwifery workforce had contributed countless volunteer hours due to limited allocated resources from the government. The Winnipeg External Review Team (2008) also confirmed that the CMM lacked sufficient resource. Furthermore, it indicated that if there were more midwives in the province, the number of paying members would increase the financial resources for the CMM. As a result, the CMM would be less financially dependent on the government. The midwifery profession in Manitoba remains dependent upon the state (i.e., Manitoba

government), reflecting their historical relationship. Literature on the relationship between the state and professions supports and explains these findings (Coburn, 1993; Sandall et al., 2009). During the early 1970s, when universal health insurance was implemented in Canada, government policies reinforced medical dominance over maternity care services. Essentially, social professionalism was played out by physicians to protect their self-interests in the market. Physicians monopolized the market for maternity care services to create economic security for themselves (Coburn, 1993; Sandall et al., 2009). Consequently, female-dominated "semi-professionals" such as midwives remained on the periphery of maternal child policymaking (Sandall et al., 2009, p. 544). Midwife participants in the study commented on how their voices were not heard within higher levels of administration, which could indicate they had a "semi-professional" presence in political circles.

On the other hand, financial resources were also viewed as a facilitator to the utilization and growth of the profession. The substantial amount of money committed to support midwifery services from 2001/02 to 2009/10 gives the impression that women's voices were being heard at a policy level. Many participants agreed the government's commitment to fund the services contributed partly to the successful implementation of the services. This study revealed that the government demonstrated financial commitment to midwifery services in the following ways:

1. Initial funding of $1 million (Killick, 1999).
2. An increase in the CMM operational budget (CMM, 2004/05).
3. Increased number of funded positions (CMM, 2001/02, 2004/05, 2005/06a, 2007/08).

4. Funding for the Prior Learning and Education Assessment (PLEA) process (CMM, 2002/03, 2003/04, 2004/05, 2005/06a, 2006/07, 2007/08, 2008/09).
5. Funding for an Aboriginal Midwifery Education Program (Health Canada, 2006).
6. Funding for the expansion of midwifery education in southern Manitoba (Province of Manitoba, 2009).
7. The implementation of a $3.2 million Birth Centre (*Birth Centre midwifery services report*, 2012).

Health policies related to the funding of midwifery contributed to the modest increase in the number of midwives in the province. However, there seemed to be a lack of accountability and few mechanisms for monitoring these financial decisions. The government had an inherent responsibility to determine if the investment of funds would yield the intended outcome. Furthermore, the process lacked an internal system of checks and balances needed for a coordinated and well-articulated plan to ensure progress and sustainability.

Education.

The strongest and most recurring theme that emerged from this study was the lack of a successful midwifery education program. Canadian midwifery was founded on the three pillars of a strong midwifery profession as defined by the International Confederation of Midwives (ICM), which are education, regulation, and association (ICM, 2013a). A key element of the profession that has been missing in Manitoba is a sustainable and rigorous education program. This situation has resulted in a lack of graduates to add to the number of midwives in the province.

The training of midwives has a direct impact on the socialization of the occupation. Results from Benoit's (1989) study demonstrate how the workplaces of midwives impact how they use their esoteric knowledge of the profession. For example, midwives in Labrador and Newfoundland have been professionally socialized by three types of training: traditional apprenticeship, vocational school, and university education. Vocationally prepared midwives, compared to the other two models of training, have had more balanced, science and practical experience (Benoit, 1989). In Ontario, the apprenticeship model evolved into a standard baccalaureate program for integration into the system (Bourgeault, 2000). Stakeholders believed that regulated training would legitimize and facilitate integration into the health care system; however, some midwives and birthing women viewed it as exclusionary (Bourgeault & Macintosh, 2000). Midwives are specifically challenged to preserve their esoteric knowledge in the context of higher education (Benoit, 1989). In Manitoba, the title *registered midwife* (RM), does not distinguish a midwife's level of education. Perhaps, this was one endeavor to preserve and protect the esoteric knowledge of the midwifery philosophy of care (from all backgrounds), which is integral in maintaining professional identity. Davies (1996) reflects on the struggles of the 19th and 20th century women who were entering into a profession. Women met resistance from male counterparts because the values of a male-dominated profession were countercultural to that of a feminist. The author goes on to state that formalized training equates with science, which is "central to a claim to professionalism" (p. 669). Therefore, the profession "controls the knowledge" (p.669). In Manitoba, the profession of midwifery has made several attempts to control the knowledge, thus preserving traditional skills and philosophy of the trade. This is

evidenced by the successes of a self-regulated profession which has defined principles and processes for the midwifery model of care in Manitoba. The findings from this study highlight, however, how structures of power have created barriers for midwives to fully expand the profession. Furthermore, these barriers have created consistent tensions between the midwives and the system in which they work. Specifically, midwives have lost some control of their profession by not having a strong midwifery educational program. Some have voiced concern regarding midwives not having a formal degree. For example, Rooks and Carr (1995) pointed out that as the proportion of midwives with degrees increase, those without degrees may not be considered professional. The lack of a strong educational program has influenced how the midwives have been professionally socialized into the health care system. Midwives in Manitoba continue to face battles to justify their professional status within the system. Their backgrounds are unknown to their health care colleagues, and the midwifery education students have not had a strong presence in the clinical setting.

Benoit's analysis of the socialization of midwives provides insight into why the education programs in Manitoba have been hampered at different stages. For example, the first debate within the University of Manitoba demonstrated interprofessional conflict between nursing and midwifery regarding where the program would be housed (University of Manitoba Archives, 1999). This illustrates midwives' efforts to protect how midwives would be educated. While the government publicly pushed for the approval of the Baccalaureate of Midwifery degree (BMID) at the University, it did not grant the necessary funding (CMM, 2001/02). The political will within the government to implement midwifery education looked as if it had momentum and a clear direction. The

ultimate decision by the government not to fund the BMID left many unanswered questions with the public and the stakeholders about why the tone had changed. Many participants felt an opportunity was missed when education was not championed from the beginning. The participants commented that if the University of Manitoba had started the program six or seven years ago, midwifery would have a different workforce in Manitoba today.

The initial investment of $1.6 million over four years for the original BMID program at the University of Manitoba could potentially have yielded a substantial return on investment. It was estimated that approximately 55 students would have been enrolled by the end of year four. It was projected that by the fourth year of existence the program could have graduated approximately 15 to 20 students each year thereafter. By 2012, there might have been approximately 100 to 140 graduates from the program (Executive Committee, Faculty of Nursing, 2000). The program could have been financially feasible due to the demand of people seeking midwifery education from within and outside of the province. Likewise, the University of Manitoba appeared to have the internal support and infrastructure to deliver the program (Executive Committee, Faculty of Nursing, 2000). The proposal for the BMID had a grounded rationale and was endorsed across disciplines within the University. The proposed School of Midwifery within the University of Manitoba seemed to be a promising avenue to meet the growing demand for midwives in the province.

Midwifery education in Manitoba was revived when the government announced the implementation of an Aboriginal Midwifery Education Program, known as Kanácí Otinawáwasowin Baccalaureate Program (KOBP) (News Media Services, Province of

Manitoba, 2004). The KOBP was a landmark in Manitoba history because it was the first Aboriginal midwifery baccalaureate degree program in the world. The program was focused on training midwives in the north who could then provide culturally appropriate, community-based care (Kreiner, 2009). Extensive work went into planning the KOBP. Consultations with Aboriginal community members occurred in both 1993 and 1997 to ensure midwifery would be sustainable in the northern communities (Working Group, 1993; Equity and Access Committee, 1997). Furthermore, the small workforce of registered midwives in Manitoba endorsed the need to engage community partnerships to foster midwifery in non-urban and minority communities (Kreiner, 2009).

The policy decision to implement the KOBP addressed two issues. First, it gave the impression that midwifery education was a priority, as evidenced by the government's investment of close to $2 million between 2006 and 2012 (COPSE, 2006/07; COPSE, 2009/10; M. Buchanan, personal communication, February 7, 2012). Second, a four-year baccalaureate degree would be established in accordance with the original recommendation from the Midwifery Implementation Council (Working Group, 1993). The Working Group believed that in order to integrate and establish credibility with other health professionals, midwives would benefit from having equivalent academic credentials. Furthermore, access to midwifery services in Aboriginal communities would be realized (Working Group, 1993).

In spite of the extensive efforts of the Aboriginal Midwifery Education Program Project Team, the program was vulnerable from the start. First, there was not enough time to develop the program because of the government's time constraint on the funding mechanism. One participant stated that funding was released a year and a half into the

three-year funding period. Second, the program was developed outside of the University College of the North (UCN). The UCN was left to manage the program with very little support and guidance. Participants stated there were difficulties with the recruitment of instructors, lack of clinical sites and preceptors, and lack of overall capacity of the University College of the North (UCN) to manage the program. Moreover, the feedback given to UCN about the original KOBP was not acted upon prior to pushing forward with a southern program (CMM, 2010/11). As of 2012, the program had not produced any graduates (M. Buchanan, personal communication, February 3, 2012). As of June 2013, however, one student had graduated from the southern program and eight students were enrolled (L. Ross, personal communication, September 19, 2013). Unlike other provinces, Manitoba had a unique opportunity to preserve the apprenticeship model through the Kanácí Otinawáwasowin Baccalaureate Program (KOBP). This endeavor could have contributed to reviving the Aboriginal midwifery model, which supports a culturally-based, indigenous knowledge framework of health (Skye, 2010).

Given the amount of time, energy, and money invested in the original Aboriginal midwifery program in Manitoba, it was unfortunate that an evaluation coupled with strategic planning efforts were not apparent during each year of the program's existence. Neither a strategic plan to revive the northern KOBP program, nor a transparent evaluative mechanism for the southern Bachelor of Midwifery program (BMP) program has been evident.

In contrast to the situation in Manitoba, successful educational endeavors in other provinces have been documented. In southern Ontario, an Aboriginal midwifery program has been successfully established at the Six Nations Maternal and Child Centre. This

Centre is an example of the importance of providing Aboriginal midwifery education and traditional education to the indigenous communities (Carroll & Benoit, 2004). The successes can be attributed to community-based partnerships and Ontario's legislation. The Regulated Health Professions Act of 1991, in Ontario, exempts Aboriginal midwives. This allows for traditional healers and Aboriginal midwives to provide services within the Aboriginal community (Carroll & Benoit, 2004, p. 274). In addition to preserving traditional practices, provincial ministries have been actively supporting Aboriginal healing and wellness endeavors (Carroll & Benoit, 2004).

Other provinces have demonstrated how a successful baccalaureate program is critical to the sustainability, growth, and credibility of the midwifery profession. Provinces such as Ontario and British Columbia have recognized that baccalaureate-level midwifery education was essential to increase the credibility of midwifery in the health care system. In spite of the controversy about how to educate the midwives, Ontario and British Columbia established a baccalaureate program instead of a community-based apprenticeship (Bourgeault & Fynes, 1996; Bourgeault, 2000; Rice, 1997). Ontario's midwifery education program was established right after legislation, and followed by the admission of 18 students in the first cohort (Newswire, 1996). Baccalaureate education for midwives was also seen as important to the integration of midwifery in Quebec. Two studies from Quebec noted that a university degree for midwives was recommended (Blais et al., 1994b; Hatem-Asmar, Blais, Lambert, & Maheux, 1996). In 2010, the Canadian Association of Midwifery (CAM) provided a fact sheet displaying the 2010 status of midwifery education in Canada. Table 18 displays a comparison of the

programs. It is interesting to note the progress of midwifery education in other provinces compared to the lack of graduates in Manitoba.

Table 18

*Midwifery Education Programs: Seats, Enrolment, and Graduates (April 2010)**

Midwifery Education Program	Funded seats (per year)	Current enrolment (all 4 years)	Graduates since program inception	Anticipated graduates 2010
McMaster University (ON)	30	103	163	13
Laurentian University (ON)	30	98	115	16
Ryerson University (ON)	30	126	162	18
University British Columbia	10	47	57	10
Université du Québec à Trois Rivières	24	74	52	18
University College of the North (MB)	14	10	0	0
Total	138	458	549	75

Note. Information taken from the Canadian Association of Midwives [CAM], 2010, *Midwifery education in Canada 2010, updated fact sheet (April 2010),* p. 1.
*Information provided by respective university midwifery education programs for this fact sheet.

The findings in this study demonstrate how a lack of cohesiveness among policies have influenced midwifery education in Manitoba and had an impact on the overall capacity and credibility of the profession. Beyond not increasing the number of midwives was the impact of not increasing the actual "presence" of the profession in the province. For example, participants noted that by not having a functional education program, midwifery students have not been present in the clinical milieu with other health profession students. Additionally, one participant stated that the current program has been

questioned, which has resulted in a loss of confidence (in the current educational program). The instability of the past and current midwifery education programs has had a profound impact on the accessibility of midwives in Manitoba.

Resources (manpower) and organization.

The resources and organization of the health care system are included in the Behavioral Model of Health Services Use (Aday & Andersen, 1974; Andersen, 1995) and are considered attributes of health policy. Variables within these attributes can explain how resources and the organization of the midwifery profession have impacted the utilization of the services. The study findings indicate midwifery was seen as a precarious profession in Manitoba due to the lack of capacity. The lack of capacity was linked to the effects of recruitment and retention issues, the model of practice and employment, the lack of access to the services, and being a small profession. In addition, the profession has experienced tenuous leadership, which reflects issues related to the manpower and organization of the system to deliver the service. Finally, successful implementation strategies illustrate the resilience of the profession and the ability to remain viable. In spite of many barriers, the profession has used manpower-related and organizational efforts to develop foundational mechanisms such as standards, policies, guidelines, and bylaws (Winnipeg External Review Team, 2008).

Several key factors have acted as barriers resulting in the lack of professional capacity. Many participants mentioned recruitment and retention strategies were not a priority of the government. While discussions have addressed initiatives for recruitment and retention, no plan has been solidified or executed (CMM, 2007/08). Participants also highlighted the need to streamline recruitment and retention strategies across the

province. Some of the literature have examined why midwives do not stay in practice. One literature review identified issues such as bureaucracy, lack of autonomy, and job dissatisfaction that needed to be addressed to retain midwives (Shen, Cox, & McBride, 2004). In a more recent pilot study, McCool and colleagues conducted surveys with 58 midwives from 12 countries regarding retention issues and other barriers to practice (McCool, Guidera, Reale, Smith, & Koucoi, 2013). The study concluded that midwives' experiences with adverse outcomes and certain barriers from physicians need further study to understand how they contribute to midwives remaining in practice (McCool et al., 2013). Unlike in the midwifery profession, recruitment and retention efforts for physicians, nurses, and allied health professionals had been ongoing (Manitoba Health, 2011/12). Currently, a Nurse Recruitment and Retention Fund (NRRF) and a Physician Recruitment and Retention Strategy entice nurses and physicians to work in areas of need across the province. Grant money up to $4,000 is available to nurses, and physicians can access resettlement funds up to $20,000, to incentivize them to work in rural areas across the province (Manitoba Health, 2011/12). One key problem with midwifery in Manitoba is that while it has been adequately funded, other key components, such as recruitment and retention strategies, have not been developed to effectively move the profession forward. Discussions have been documented regarding the need to develop evaluation, data collection, and long-term growth plans; however, such initiatives appear to have ended at the discussion stage (CMM, 2002/03, 2003/04, 2004/05, 2005/06a).

Two issues with the organization of the profession involve the lack of political advocacy and the current implications of the employment model. One missing piece that is needed to maintain momentum is consistent political advocacy, which should be led by

the professional association. While there have been phases when political advocacy has been strong within the midwifery movement, overall it has not been consistent. Participants identified a need for more consistent and effective leadership to help sustain the profession.

A strong professional association is another ICM pillar of midwifery that is lacking in Manitoba (ICM, 2013a). Political advocacy happens at various levels yet according to the ICM the three pillars of education, regulation, and association have to interconnect to maximize the functioning of the profession (ICM, 2013a). The former president of the ICM stated, "The Association is the voice of the community" (B. Lynch, personal communication, March 12, 2013). The professional association needs to have a strong political presence in its jurisdictions. In 2005/06, the CMM recommended mandatory membership in the Manitoba Association of Midwives (MAM) yet no mandate was ever initiated. Due to Ontario's well-organized professional association, midwifery has had a powerful impact on the political scene (Kaufman, 1991). Participants in this study stated the professional association of midwives has not been able to effectively maintain political advocacy in Manitoba because membership is not mandatory.

Ontario has experienced the successful integration of midwifery, which is evident by their large professional association, three successful education programs, and independent practice (Bourgeault & Fynes, 1996). The convergence of multiple factors explains certain outcomes of Ontario's successful implementation trajectory. First, the Ontario Nurse-Midwives Association (ONMA) and the Ontario Association of Midwives (OAM) were successfully integrated into a unified profession through the Association of

Ontario Midwives (AOM). Second, representatives from the AOM were considered "elite" women who were white, articulate, well-educated, and politically astute (Bourgeault & Fynes, 1996, p. 250). The Association of Ontario Midwives (AOM) is an example of how a strong association can have a large impact on the growth and sustainability of the profession. It is a requirement for active midwives in the Province of Ontario to be members of their College of Midwives, as well as their professional association, in order to practice in the province. Currently, the AOM has over 600 members (Association of Ontario Midwives, personal communication, April 24, 2013). The Midwives Association of British Columbia (MABC) does not mandate membership; however, many midwives choose membership to obtain the liability insurance that is offered through the Association. Currently, the MABC has approximately 200 members and it is growing steadily (Midwives Association of British Columbia, personal communication, April 24, 2013).

The second barrier identified that inhibits capacity, reflecting the organization of the profession in Manitoba, was the current employment model with salaried positions. Participants stated that the model of salaried employment facilitated the initial integration of midwives; however, it currently contributes to the barriers which have an impact on the utilization of the profession. In 1999, a Policy Committee analyzed compensation for the Manitoba midwives (Haworth-Brockman, 2002). The Policy Committee took into consideration the course of care or fee-for-service model of payment in Ontario and British Columbia. The final decision by the Policy Committee, with input from Manitoba Health and many RHAs, was in support of the salaried employment model for two reasons. First, the Committee felt it would be hard to target the priority populations in the

context of a fee-for-service model. Second, the salaried employment model appeared to be more conducive to integrating the midwives into the health care system (Haworth-Brockman).

Specifically, the effect of this employment model policy meant publicly funded midwives were mandated to be employees of the RHAs. Participants critiqued the salaried employment model for inhibiting autonomy because of RHA policies. They also noted that the low number of clients seen relative to the salary of a midwife was not justifiable. Between 2001 and 2010, no formal evaluation of the employment model was conducted to analyze the effectiveness or the economic feasibility of the model. The common sentiment among participants (midwives and non-midwives) was that there had been a general lack of accountability with caseload numbers and that 40 primary cases a year per full-time midwife was too low and not sustainable. Several other factors within the model of employment were perceived as barriers. Participants pointed out that issues such as maternity leaves, retirements, and sick leaves left unfilled vacancies and resulted in practices unable to take full caseloads.

Additionally, the employment model is the reason each RHA manages the midwives. The RHAs' management and policies over midwives have created the most tension. At the same time as some RHAs were funding the services, they seemed to be conveying mixed messages about their supposed buy-in to provide widespread access to the regulated health service. According to a CMM annual report (CMM, 2001/02), RHAs were not in favor of midwives practicing independently because midwifery was perceived as less safe outside the auspices of the RHAs. It appeared that from the beginning, structures of power such as the RHAs wanted to maintain control over the

midwifery profession. These decisions were based on the perception that midwifery was unsafe outside the hospital setting.

Another policy effect on the midwifery profession was linked to the RHAs' management policies. The midwives have interacted with multiple layers of management within the RHAs, and whenever their input was sought they felt their voice was not heard or considered. Both the documents and interviews revealed how midwives were overly evaluated and managed by their employers, the RHAs. The excessive management of the midwives was interpreted as lack of knowledge within the systems of the regulatory structure for midwives. Regulatory bodies for the Canadian midwifery profession exist to protect the public by ensuring the safe practice of registered midwives. These Pan-Canadian regulatory bodies set standards for midwifery practice, education, and continuing competency (CAM, 2013b). The regulatory bodies of Canadian midwifery neither evaluate nursing and medical practices nor audit nursing and medical processes. As evidenced by the WRHA Midwifery External Review Team, midwives have been evaluated by audits beyond their own regulatory body by the Winnipeg Regional Health Authority (WRHA), College of Physicians and Surgeons of Manitoba (CPSM), hospitals where they work, community midwifery clinics, and other clinic-based governance structures. A lack of knowledge about the regulatory structure for the midwifery profession feeds the fear within these powerful systems.

Consequently, similar to the political environment in Ontario, the scientific-medical discourse is embedded in the health policy in Manitoba, which has been viewed as undermining women's subjective and intuitive knowledge of the birthing process (Paterson, 2011). Multiple layers of management have been put in place and policies

implemented to control the profession and create a sense of accountability. These policies, however, disregard the women's intuition as "authoritative knowledge" in reproductive health care practices (Davis-Floyd & Davis, 1996). Doyal (1996) identifies professional domination as a key factor that determines how women have had to make decisions about their own health care.

Policies and procedures are in place to hold each health professional accountable to safe practice; however, these very policies have been seen as a barrier to the autonomy of midwifery practice. The midwives of Manitoba have held firmly to their 11 principles, which define their scope of practice. In this study, participants commented that midwives felt the RHAs' policies challenged their autonomy and informed choice model of care. This indicates the midwives have been challenged by existing policies within their role as an "employee" under the RHAs' structure of power. These challenges have stemmed from the differences between how the midwives and other health care professionals within the RHA health system have defined the principles of their models of practice. Similar struggles with maintaining the midwifery philosophy have created tensions between midwives and the health care system, and have contributed to interprofessional conflict in other jurisdictions. In an analysis of integration issues of midwifery in British Columbia the following question was of primary concern: "How can midwives gain the support of dominant players in the health care system without sacrificing the crucial elements of independent practice?" (Kornelsen, 2000, p. 15) This question articulates the effects of the struggle of midwifery professionals for autonomy not only in British Columbia but also in Manitoba, as found in this study. Kornelsen noted that demanding autonomy creates alienation from the professions of medicine and nursing, yet not

protecting the philosophy of midwifery places the model of care at risk of being altered. Ultimately, the effect of the struggle for autonomy explains, at least in part, why the interprofessional relationships of medicine, nursing, and midwifery have been strained (Kornelsen).

Finally, the findings that emerged from the participants and the documents revealed that the implementation of a $3.5 million birth center in Winnipeg was a point of contention within the general and health care community. One example, based on feedback from the Winnipeg Regional Health Authority review of the midwifery services, indicated that construction of the proposed Birth Centre could not be recommended due to the lack of capacity of the profession (Winnipeg External Review Team, 2008). Instead, the review recommended waiting until the profession was essentially more stable. The Birth Centre was implemented despite this recommendation. Much criticism ensued and was directed at such issues as the economic infeasibility of the facility due to a lack of capacity within the midwifery profession. The implementation of the Birth Centre underscored the need for a critical examination of how decisions are made to increase the capacity of the midwifery profession. The Birth Centre evolved as a result of many years of hard work by key stakeholders invested in maternal child health efforts in Manitoba. Due to the lack of capacity of the midwifery profession, the Birth Centre has been portrayed at times as a waste of the government's money (Flood, 2012; Kusch, 2012). Consideration should be given to historical and current factors which have affected how the Birth Centre functions. For example, the domino effect of not having a successful education program, limited fiscal resources for the increased funding of positions, and retention and recruitment issues has directly impacted how the Birth

Centre currently functions. These issues, at least in part, explain why the facility does not operate at full capacity.

The Birth Centre admitted 111 women, with a total of 93 births, in the first ten months, which was below the projected capacity and generated negative publicity in the media (*Birth Centre midwifery services report*, 2012). The argument could be made that the public does not understand that the estimated amount of services delivered for the first year was based on the capacity of midwifery resources, the operational logistics of a new facility, and the demand from the consumer (*Birth Centre midwifery services report*, 2012). For example, a total of 2,923 midwifery visits was reported. Moreover, the Birth Centre accepted students for clinical placements from Quebec, Ontario, New Zealand, and the University College of the North. The demand for services was reported as having exceeded the capacity, with 979 requests for care from the team of 8 midwives at the Birth Centre (*Birth Centre midwifery services report*, 2012).

Another issue revealed in this study related to the safety of out-of-hospital births. The CMM has mandated certain requirements for midwives to maintain their registration in the province. Every five years, each midwife is required to report caseload numbers, which is known as the *currency of practice*. The midwife is required to provide care to at least 60 women during this time period. Forty women must be attended as the primary midwife, of whom ten must be hospital births, and ten must be out-of-hospital births (CMM, 2009). The health care professional participants mentioned that professionals of medicine had continued to express apprehension regarding the safety of out-of-hospital births, more recently in relation to the Birth Centre. Safety around out-of-hospital births has also been a contentious issue in other provinces (Kornelsen, 2000; McKendry &

Langford, 2001; Paterson, 2010; Vadeboncoeur, Maheux, & Blais, 1997). Recent and past evidence demonstrates favorable maternal/fetal outcomes and support for out-of-hospital births attended by midwives (Benatar, Garrett, Howell, & Palmer,2013; Birthplace in England Collaborative Group, 2011; Fraser et al., 2000; Gaudineau, Sauleau, Nisand, & Langer, 2013; Hutton, 2009; Jackson et al., 2003; Janssen et al., 2002, 2009; McIntyre, 2012; Ryan & Roberts, 2005; Simonet et al., 2009; Stapleton, Osborne, & Illuzzi, 2013). A recent large prospective cohort study in the United States (n=15,574) presented findings that showed favorable outcomes in birth center models (Stapleton et al., 2013). In this study, of the 15,574 women planning a birth center birth, 84% of them actually gave birth at the center; they had low intervention rates and no maternal deaths. In spite of the evidence, the safety of out-of-hospital births continues to raise concern within the health care community. Safety regarding out-of-hospital births is related to the politics of the professionalization of midwifery. This issue has historically been used by medicine as a way to leverage against the midwifery profession in the political arena (Bourgeault, 2000; Doyal 1996; McKendry & Langford, 2001; Rushing 1991). Specifically in Quebec, physicians have made safety their "work," and the home birth issue has provided a means to stall government progress on midwifery issues (Paterson & Marshall, 2011, p. 100). Similarly, in Alberta, the push to amalgamate nursing education with midwifery education appeared to be a "countermovement" from doctors and nurses to inhibit home births (McKendry, 1996, p. 296). More recently, however, a mixed methods study explored providers' experiences with home birth practices (Vedam et al., 2012). The three groups of participants included Canadian registered midwives (n=451), obstetricians (n=245), and family physicians (n=139). This

Canadian study found that education about home birth and exposure to home birth practices influenced how physicians and midwives viewed the safety of home births. This Manitoba case study revealed similar findings: one participant voiced that non-midwife providers did not realize the extent of the equipment that midwives brought to home births, thus influencing the physicians' attitudes regarding the safety of home births. Furthermore, participants frequently commented on how other providers did not understand the extent of midwifery training. This case study provides supporting evidence that demonstrates how a lack of knowledge about home birth practices and midwifery training and skill sets influences other providers' views of the safety of home births.

Although the literature supports the safety of out-of-hospital birth, Bortin and colleagues argue that home birth studies do not address the feminist perspective on birth (Bortin, Alzugaray, Dowd, & Kalman, 1994). The place of birth becomes an issue of power and control. Important aspects of a feminist study should explore the relationship between the environment and provider on birth outcomes. A woman's right to choose "where, how, and with whom she gives birth" is a basic right that is at risk in the birth process (Bortin et al., 1994, p. 148). A recent qualitative study used a grounded theory approach to examine why women in British Columbia (n=18) and Ontario (n=16) wanted home birth (Murray-Davis et al., 2012). The following factors were identified as motivations for choosing a home birth: internal motivation, which included wanting comfort, control, and family involvement; information gathering; and taking ownership and feeling empowered from the decision-making process (Murray-Davis et al., 2012). Given that generally women are self-determining in their health care decisions and want

choice, it is critical to deconstruct what factors influence choice in childbirth practices. From a feminist perspective, the place of birth debate requires an analysis of why policy decisions or the culture of health care label out-of-hospital births as unsafe. In this study, these factors can be linked back to the root of policy decisions. Results showed the RHAs' policies and professional imperialism (discussed later) were two factors that contributed to the struggle of midwifery in Manitoba. Unfounded, negative perspectives about home births in the political and medical spheres have had vast social and political implications regarding women's choice for their maternity care. Furthermore, feminists have challenged empirical knowledge and the science of medicine by asking if we are including the epistemology of women's voices and considering how women are positioned in science (Davis-Floyd, 1992; Davis-Floyd & Davis, 1996; Fonow & Cook, 1991; Harding, 1991; Kinser & Lewis, 2005; Reinharz, 1992; Stanley & Wise, 1983).

Women involved in the midwifery movement in Canada have made their voices known regarding maternity care by advocating for the implementation of midwifery (Haworth-Brockman, 2003; Kaufman, 1991; McMahon, 2000). Specifically in Manitoba, women's voices have been heard, as evidenced by the government's action to implement midwifery. The struggles of the Manitoba midwifery profession identified in this study require a clear articulation of how and why more efficient processes have not been in place to stabilize and grow the profession. In Manitoba, women's voices have been quelled by policy decisions, as well as the lack of recognition of women's knowledge around childbirth and their desire for choice of provider and birthplace. As one participant stated, Manitoba does a "little" midwifery and people there need to decide if they want to do midwifery or not.

Constituent Influence

In the conceptual model, consumer satisfaction is operationalized as a person's attitude toward the health care system, essentially, based on their experience of it (Aday & Andersen, 1974). This study did not directly examine consumers' perspectives, but asked participants how they thought consumers had impacted policy related to midwifery services. Midwifery in Canada has been notably influenced by feminist groups. In essence, these feminist groups have been described as well-articulated, organized groups of consumers or constituents (Bourgeault, 2000; Kornelsen, 2000; McKendry & Langford, 2001). In the case of Ontario, these so-called "elite" women were politically savvy and grounded their arguments on research and global reviews (Bourgeault & Fynes, 1996, p. 250). Similarly, the successes with implementation in Manitoba were associated with an articulate, well-organized group of women who persevered through many trials until the regulation of midwifery became a reality (Haworth-Brockman, 2003). Particularly in this study, it was noted that women's desire for choice was the impetus for political advocacy to implement midwifery. Midwifery advocacy, however, did not stem exclusively from the consumer group but from a vast group of people committed to advocating for women's choice of birthplace, provider, and woman-centered care (Haworth-Brockman, 2003). The consumer movement in Quebec had been less strategic and organized, which may have stalled the process of regulation (Vadeboncoeur, Maheux, & Blais, 1997).

Characteristics of the Health Delivery System

Characteristics of the health delivery system were operationalized as the volume and distribution of midwifery services across the province over time. The actual

utilization of the health services was operationalized as home versus hospital birth and the provider of the birth (i.e., midwife or other). The volume and distribution of midwifery services has slowly increased over time in Manitoba. The slow growth can be explained by the supporting data related to funding issues, the lack of capacity, and the instability of the midwifery education program. According to CMM annual reports (2001/02, 2009/10), there were approximately 31 registered midwives in Manitoba in fiscal year 2001/02 and 51 in 2009/10. While the number of midwives in the province doubled from 2002/03 to 2009/10, the number of non-practicing registered midwives has continued to increase from 5 in 2001/02, to 12 in 2007/08, and to 17 in 2010/11 (CMM, 2001/02, 2007/08, 2010/11). The number of non-practicing midwives in Manitoba is indicative of the strain the midwives have experienced in this province. Participants noted that the attrition of midwives is affected by the ongoing maternity and sick/stress leaves and retirements. Two other variables (midwifery education and funding) were also highlighted in this study and can explain the "whys" of slow growth. The lack of graduates from the education program directly impacts the number of midwives in the province. At the same time, if Manitoba was producing twenty midwifery graduates a year, it does not mean the government would fund that many positions for employment. Therefore, the lack of funding for positions, the unsuccessful education program, and the impact of employment leaves are interrelated and explain the disjointedness of the profession. There is an overall lack of strategy to systematically address the incongruent processes that continue to keep the profession in a state of crisis.

The increased number of registered midwives in the province is correlated with the increased use of the services and access to the services. Nonetheless, the proportion of

births attended by midwives continues to fall short of the original human resource strategy, which projected that 14% of births would be attended by midwives within 2.5 years of implementation. Overall the number of births attended by a midwife has increased from 407 (2.9% of all births) in 2001/02 to 747 (4.7%) in 2009/10. In the recent *Perinatal Services and Outcomes in Manitoba* report, the proportion of births attended by a midwife ranged from 2.5% in 2001/02 to 4.7% in 2008/09, with a statistically significant linear trend test, which is consistent with the findings in this study (Heaman et al., 2012). However, the number of births attended by a midwife showed a subsequent decrease from 803 (5.5%) in 2008/09 to 747 (4.7%) in 2009/10, despite the fact that Manitoba had its highest number of practicing midwives, reported at 40, in 2009/10 (CMM, 2006-2010), and despite an increase in the overall total number of births in the province. Possible reasons for this decrease are the limited number of midwives practicing at capacity and midwifery caseloads that are not always full.

Utilization of Health Services

The three mainstays of midwifery care in Manitoba are continuity of care, choice of birthplace, and informed choice (College of Midwives of Manitoba, 2012a).

The choice of birthplace explains the "site" where the midwifery service has been utilized (Aday & Andersen, 1974, p. 214). The majority of women in the study received hospital births over time. The actual percentage of home births has only slightly increased over time. Two components of the Philosophy of Care document state, "Midwives respect the woman's right to choice of caregiver and place of birth…" and "Fundamental to midwifery care is the understanding that a woman's caregiver respect and support her so that she may give birth safely, with power and dignity" (CMM, 1995, para. 2). Based on

this philosophy, midwives are required to offer a woman a home birth; however, factors such as the availability of midwives determine if a woman can actually have the choice of birthplace. Two birth attendants must be present at a home birth. If a practice does not have a second midwife available at the time of birth, the woman is required to go the hospital to deliver her baby. Another factor that determines if a woman will get a home birth is her pregnancy risk status. If women do not have the option of midwifery care, they subsequently do not have the choice of birthplace. This is an example of how the centrality of women's needs is not addressed in their birth options.

Characteristics of the Women Who Utilize Midwifery Services

The characteristics of the population help describe who is using the services. The objective of analyzing the characteristics of the women utilizing midwifery services is to determine what categories of women had actually utilized to the service (Aday & Andersen, 1974). According to the conceptual framework, predisposing characteristics such as age, parity, income status, region of residence, and priority population status are immutable. Therefore, these variables are less likely to be targeted by health policy to improve access to the service, unlike system characteristics. In Manitoba, access to midwifery services has been controlled by health policies such as those which define who are eligible for midwifery services (Manitoba Health, 2002). The CMM has also influenced who is eligible for midwifery care through their equity and access statement (Haworth-Brockman, 2003). While equity and access to midwifery care have been a priority, the mandate to provide care to priority populations is one of the two goals under the purpose of the mandate. The second goal is to "demonstrate the efficiency and effectiveness of midwifery care" (Manitoba Health, 2002, para. 2). This appears to be a

contradiction in policy, whereby the government uses the underserved to sell the importance of midwifery services to the community. The proclamation of the Midwifery Act could delude women into thinking that midwifery would be a viable option for all women. Such a perspective was supported by the Health Minister's announcement after the proclamation of the Midwifery Act, "With this proclamation our government has broadened the care options available to women and their families" (Province of Manitoba, 2000, para. 1).

Contrary to participants' concerns about whether the priority population had access to midwifery services, close to 50% of the midwives' caseloads targeted the priority population between 2003/04 and 2009/10, with a decrease in 2006/07 to 45.8%, as reported on the midwifery discharge summary forms. The highest percentage of the priority population was flagged as being poor (27%), which indicates either midwives are targeting women of lower socioeconomic groups or women in lower incomes are seeking midwifery care. However, service to low-income women varied by residence in a rural or urban area. Women were more likely to receive midwifery care in the highest income rural area (R5) and in lower socioeconomic urban areas (U2, U3), which is congruent with results presented in the *Manitoba Perinatal Services and Outcomes* report (Heaman et al., 2012).

The majority of women seeking midwifery were in the age group of 20 to 34 years; this is consistent with the *Manitoba Perinatal Services and Outcomes* report (Heaman et al., 2012). In general, the mean age of women receiving midwifery care ranged from 25 to 28 years of age across the province, which signifies midwives may not be reaching the adolescents deemed as a priority population. The majority of women

seeking midwifery care were multiparous, which may be due to midwives giving priority to returning clients. These findings are similar to the findings from the *Manitoba Perinatal Services and Outcomes* report, which showed a higher proportion of multiparous women (5.2%) received midwifery care than primiparous women (3.5%) (Heaman et al., 2012).

Other Findings

The conceptual framework in this study was helpful for understanding health policy and how it affects the characteristics of the system, utilization of midwifery services, and consumer influence. The model focuses on infrastructure and program development, which results in "expanding access vis-à-vis new programs and facilities" (Shaw, 2012, p. 554). Essentially, this case study aligns with the model by indicating ways the Manitoba government supported the expansion of midwifery services via infrastructure and program development from 2001/02 to 2009/10 through funding positions, implementing education programs, establishing assessment processes, and opening a birth center.

What the model does not address are the specifics of the culture of health care personnel or the gender issues within the system and how they may impact access and utilization. Gender as a health risk needs to be further explored. The feminist perspective could inform the model by analyzing how professional groups within the system influence utilization of maternity care systems. The four levels of gender (roles, identity, relations, and institution) could be used to contextualize gender in relation to other characteristics of the health care system (Gelb, Pederson, & Greaves, 2011). For example, gender roles could be contextualized by analyzing how the behavioral norms of

women relate to their experiences and expectations of available maternity care services. Gender identity could reflect how women see themselves in the context of a biomedical model. Gender relations could be contextualized by analyzing how women view their choice of provider and who they deem as the knowledge expert. Finally, institutionalized gender could demonstrate how the distribution of power in the system impacts the social norms for women (Gelb, Pederson, & Greaves, 2011).

In this study, noteworthy findings that evolved associated with barriers were related to the dynamics of gender, the conflicts of interprofessional and intraprofessional relationships, and professional imperialism. Parallel struggles with the implementation of midwifery services across Canada have been fraught with challenges related to the autonomy of the profession, government pushback, and the hegemonic medical discourse (Benoit et al., 2005; Bourgeault, 2000; Kornelsen, 2000; McKendry & Langford, 2001; Paterson, 2011; Rice, 1997; Rushing, 1991; Vadeboncoeur, Maheux, & Blais, 1997). Gender has historically influenced the organization of the midwifery profession. For example, one author suggests feminist ideologies were used in Canada to challenge medical claims that natural childbirth was unsafe (Adams & Bourgeault, 2004). In British Columbia, the impetus for the Homebirth Demonstration Project was to demonstrate safety. This was yet another example of how medical hegemony necessitated certain actions for midwives to justify their practices (Rice, 1997).

Similar findings from this case study validate findings from two separate case studies of Alberta and Quebec. These two studies endeavored to understand how the legalization of midwifery in each of those provinces differed from that of Ontario, with the Alberta study also drawing on comparisons with the success in British Columbia

(McKendry & Langford, 2001; Vadeboncoeur, Maheux, & Blais, 1997). A longitudinal case study of midwifery's professionalization in Alberta theorized that the lack of governmental support after legalization was related to two issues; inter- and intra-occupational conflict and the province's influence on initiating, implementing, and then restraining midwifery's professionalization (McKendry & Langford, 2001). In this Manitoba case study, participants voiced concerns about midwifery's struggle to practice full autonomy as a profession related to structures of power such as medicine and the government. In Alberta, midwives also underwent a tremendous struggle to establish credibility and maintain autonomy within the health care system. The Alberta midwives' lack of ability to grow the profession was related to the marginalization of the profession by medical dominance. Medical dominance appeared to inhibit full autonomy, and lack of funding was related to the right wing government's "cost control policies" (McKendry & Langford, 2001, p. 540). On the other hand, the governments of Ontario and British Columbia maintained their commitments to women-centered health care, which resulted in establishing successful educational programs and funding for the profession. As a result, over the first six years of licensed and paid midwives in Ontario, the number of midwives tripled, and similar increases occurred in British Columbia (McKendry & Langford, 2001). A study of Quebec's professionalization of midwifery also revealed opposition from the medical profession and difficulties in maintaining political advocacy (Vadeboncoeur, Maheux, & Blais, 1997). This case study showed that collaborations with the medical associations were initially sought by the government. Unfortunately, as the reality of midwifery regulation became imminent, the tone changed. The sentiment of the medical community was reflected in a statement by one of the participants in the

study by Vadeboncoeur and colleagues: “As long as they are our assistants, no problem…” (Vadeboncoeur et al., 1997, p. 456).

Professional conflicts were highlighted as a barrier. Participants discussed issues related to interprofessional and intraprofessional conflicts. In Manitoba, the medical and nursing professions have demonstrated resistance to midwifery as a profession. From the outset of regulation, representatives of nursing have expressed negative connotations about the role of the midwife. A survey administered to practicing maternal-child nurses in Manitoba was completed to understand what they thought of the midwifery model (Katz, 2001). One finding from the study was that 86% of the respondents projected maternal morbidity and mortality would increase with the introduction of midwifery into the health care system (Katz, 2001). In other provinces, such as British Columbia, Ontario, and Quebec, contentious issues between midwifery and the nursing and medical communities have always existed (Blais et al., 1994a; Blais et al., 1994b; Bourgeault & Fynes, 1996; Bourgeault, 2000; Kornelsen, 2000; Kaufman, 1991; McKendry & Langford, 2001). Specifically, in Manitoba, British Columbia, and Ontario evidence suggests such conflict has possibly stemmed from initial endeavors by midwifery task forces, which worked to preserve the autonomy of midwifery from nursing and medicine. Territorial issues between nurse midwives and non-nurse midwives have also been documented in studies across Canada (Blais et al., 1994a; Blais et al., 1994b; Collin et al., 2000; Kornelsen, Dahinten, & Carty, 2003; Hatem-Asmar, Blais, Lambert, & Maheux, 1996; McKendry & Langford, 2001; Vadeboncoeur, Maheux, & Blais, 1997). In Quebec, a qualitative grounded theory study demonstrated how intra-occupational conflict stemmed from other providers’ lack of knowledge about the midwifery profession (Collin

et al., 2000). It appeared that the isolation of the midwifery profession prior to regulation in Quebec had a negative impact on how midwives were perceived in the context of a modern health care system. The midwives in Alberta experienced resistance from their nursing and medical colleagues as well. Representatives of nursing and medicine battled against the Alberta Association of Midwives as they fought for an autonomous scope of practice (McKendry & Langford, 2001). For example, the Physicians College at that time tried to control who midwives should report to and how they should practice (McKendry & Langford, 2001. p. 536). Manitoba midwives have similarly experienced the dominance of other health care providers. For example, the Winnipeg External Review Team (2008) reported that midwives were over-evaluated by other professions. The concept of a dominant profession is well analyzed by Witz (1992). In this Manitoba case study, as well as other cited Canadian literature, medicine and nursing could be perceived as the dominant professions (Witz,1992) since they have managed to be politically influential in shaping how midwifery has evolved.

In the early years after regulation, a study using a survey in British Columbia found that midwives and nurses worked alongside of each other in what is known as "parallel practice" (Kornelsen, Dahinten, & Carty, 2003, p. 127). With midwifery as a newly emerging profession, parallel practice was an effort to protect the model of midwifery as opposed to working in a collaborative relationship with nurses. This was a circumstantial, but also strategic, approach used by the midwives to communicate their boundaries in the health care system (Kornelsen, Dahinten, & Carty, 2003). Alberta midwives demonstrated similar in-fighting, specifically between non-nurse midwives and nurse midwives (McKendry & Langford, 2001). In this case study, the in-fighting in the

early years after regulation was specific to non-nurse midwives and nurse midwives; however, in general, midwives were seen as their "own worst enemy." A common sentiment noted among participants in this study was that "in-fighting" created a negative presence for midwifery, as well as an energy drain for the profession. Similarly, in-fighting among the midwives in Quebec created disunity within the profession, but more importantly portrayed the profession as disjointed in the eyes of the government (Vadeboncoeur, Maheux, & Blais, 1997).

Within structures of power, gender was viewed as a barrier to accessing the provider type and choice of birthplace that women desired. Historically, physicians in Manitoba held the attitude that men with formal training were far superior to midwives and made childbirth safe. Secondly, doctors paid for their formal training and therefore believed their investment in medical school warranted a more lucrative pay for attending childbirth (Werner & Waito, 2008). The concept of gender has been used to help understand health-seeking behavior in women as it associates power with gender (Currie & Wiesenberg, 2003). Women can be viewed as powerless with regards to their health-seeking behavior if the outcome of their health in a patriarchal setting is viewed as beyond their control (Currie & Wiesenberg, 2003). For example, in the context of this case study, a woman's decision to utilize midwifery care is considered health-seeking behavior. The findings from quantitative data showed an increase in practicing midwives over time but the numbers remained well below projected targets (Manitoba Health, 1998). Participants also verbalized that the small number of existing midwives impacted the profession's overall capacity to grow due to the many demands on the individual midwife. Therefore a woman's decision to access a midwifery provider and her choice of

birthplace was beyond her control because of the limited midwifery resources available to women in the province. The territorial nature of maternity care providers fostered conflict between genders. Power plays were noted as a two-way problem. First, other health professionals were seen as intolerant of the midwifery profession. Likewise, health professionals often interpreted the midwife as not wanting to integrate into the mainstream health care system.

Gender relations or ideologies have historically influenced and shaped how professions are defined (Adams & Bourgeault, 2004). Midwifery has fought against gender inequalities in establishing the legitimacy of the profession. Feminist authors have argued that women have been denied their rights to control their own reproductive health (Davis-Floyd, 1992; Davis-Floyd & Davis, 1996; Doyal, 1995, 1996; Patel & Al-Jazairi, 1997; Paterson, 2010, 2011). Doyal (1995, p. 212) suggests women have moved past gender barriers that influence their health by creating "feminist alternatives", such as developing a women's health center or a birthing center. These endeavors align with feminist principles, and place women at the center of their own care.

Historically and in current times, medicine has drawn on science to control the practice of midwifery (Adams & Bourgeault, 2004; Rushing, 1991). Medical dominance has been coined as "occupational imperialism" in relation to interprofessional conflicts (Larkin, 1983). Occupational imperialism has kept midwifery in Manitoba aligned with and dominated by the scientific discourse of medicine, and similar experiences have been evident in other provinces such as Ontario, Alberta, and Quebec (Blais et al., 1994a; Bourgeault, 2000; Bourgeault & Fynes, 1996; McKendry & Langford, 2001; Paterson, 2010; Paterson & Marshall, 2011; Vadeboncoeur, Maheux, & Blais, 1997). Some

participants commented on how an increased number of midwives could threaten physicians' income because the paradigm of obstetrics would change if midwives led the way in maternity care.

The medical profession has a strong influence in the political arena due to the large number in the professional association; physicians have a much stronger influence at the legislative level. Midwives in the Manitoba case study discussed how their voices had been silenced by policy initiatives coming from structures of power within the government. The influence of the male gender was often perceived as swaying the female supervisors of midwives, which created barriers for midwives to execute full autonomy with their clients. It seems that the playing field between non-nurse midwives, nurse midwives, nurses, and medical professionals has never been leveled in Manitoba. Similar to midwives in other settings, medical dominance has been seen as a barrier to midwives practicing autonomously (Pollard, 2003). It appears that medicine and nursing position midwifery as a radical profession, and likewise midwifery positions medicine and nursing as the culprits for inhibiting the full autonomy of women in their practices.

Gender ideologies and occupational imperialism have permeated the midwifery profession in subtle but powerful ways, which could be seen as means to control or contain the profession (Paterson, 2010). Prior to regulation, the medical community in Manitoba initially voiced concern regarding an oversupply of midwives (Love, 1997) and the fear of being put out of business (Square, 1997). Other concerns about the midwifery model of care that were discussed by participants and noted in the documents were linked to opposition to home birth, (Love, 1997; Square, 1997) midwives' independent practice (CMM, 2001, November) and mechanisms of evaluation for midwives (Winnipeg

External Review Team, 2008). In Ontario, midwifery has offered insight into feminist policy; however, mainstream midwifery has been seen as representing a more medical model (Paterson, 2010). The scientific discourse of the medical model has somewhat shaped how midwifery policy has been implemented in relation to medicine's concerns of the safety, competence, and expertise of maternity care. In this sense, midwifery has moved away from being centered on the woman's reproductive rights towards the midwife as the primary decision-maker (Paterson, 2010). In Manitoba, these same concerns have created tensions with professional groups and structures of power, whereby midwives have had to justify their role as autonomous primary care providers, in spite of existing regulation. Although British Columbia and Ontario have had many successes, some communities within those provinces have experienced resistance from the medical community, which has created barriers for access to midwifery services (McKendry & Langford, 2001).

Some of the interprofessional conflict can be attributed to the continued misunderstanding of the midwifery role. Participants agreed that midwives were still stereotyped as "hippy" or "anti-establishment," which therefore affects their credibility. A lack of understanding of their skill set and training, and thus their professional role, has been perceived as a barrier to growth in the profession.

Strengths and Limitations

Some strengths of this study warrant highlighting. The administrative data obtained from the MCHP provides population-based data on all births, and is linked to census data, which is not readily available in all provinces. Data quality is ensured by the MCHP through a rigorous evaluative process on the completeness of the data set (MCHP,

2009). For the qualitative component, because midwifery is an important topic which has garnered attention across the province, 24 stakeholders were willing to be interviewed, and each had a diverse perspective. The turnaround time to recruit participants into the study was less than two weeks, with only one or two follow-up emails required. Overall, the participants were interested in the topic and ready to discuss the issues at length. The information from the interviews was often quite dense. At times it was challenging for the researcher to pare down quotes because of the desire to provide a voice for people who had so willingly participated in this study. Furthermore, this study employed mixed methods. The findings from the document review enhanced the study. The triangulation of the data provided an in-depth and rich perspective on Manitoba midwifery since regulation. Finally, the other strength of this study was the researcher's expertise in clinical midwifery and historical involvement with midwifery in the province. More recently, her work as a clinical midwife in the Central Regional Health Authority (from 2006 to 2008) and the Winnipeg Regional Health Authority (summer 2013) allowed her, in some ways, to experience first-hand the realities of the findings from this study.

This case study also has limitations. The study relied on interviews as the primary source of data. The quality of the interviews was influenced by individuals' time constraints, recall bias, and personal philosophy and stance towards the midwifery profession. Many participants communicated burnout from the profession. Occasionally, it was evident that participants had specific frustrations with the issue and had to be somewhat redirected during the interview process. Likewise, while some participants offered invaluable information, at times the recall of information was difficult due to the time that had elapsed since their involvement in the midwifery movement. Most

participants were busy professionals. In particular, time with physicians was limited to less than an hour for the interview process. While the researcher's personal experience with midwifery added strength to the study, it also created bias in her viewpoint. Finally, in examining various documents, the inconsistent reporting of data was often noted between sources.

Limitations with the quantitative data in the midwifery summary file included the poor tracking of data in the early years of implementation of midwifery, with the possibility that not all discharge summary forms had been submitted to Manitoba Health and entered into the data set. The discharge summary form has been revised in the last 10 years; however, not all midwifery practices implemented the revised form in a timely matter, so data for some of the new fields were missing. Midwives have not always filled out the forms consistently, and discrepancies in the data can also be due to the subjective nature of what is being recorded. The interpretation of what to record may differ from midwife to midwife.

Finally, caution is needed in generalizing the results to other provinces or countries, because the case study focused on the implementation and utilization of midwifery in Manitoba. However, many of the themes arising from the interviews were consistent with findings from studies conducted in other Canadian provinces.

Implications for Practice and Policy

This is the first case study in Manitoba to critically analyze barriers and facilitators that have impacted the implementation and utilization of midwifery services across the province. By identifying factors such as barriers related to structures of power, education, and lack of capacity, this study has contributed new insights and knowledge

about critical next steps to consider in efforts to sustain the profession in Manitoba. Beyond the analysis of barriers, this study has also highlighted what has gone well and validated the profession's progress and work related to health policy.

The most critical issue to consider based on the findings of this study is the direction of midwifery education in the province. The profession will not gain credibility among other professions with the current state of the education program. The province needs to address the direction of the program because a solid educational program is fundamental to the identity of the midwifery profession. Without the proper resources to facilitate an academic program, it remains to be seen if the current program can produce qualified midwives eligible for licensure in Manitoba. In order to generate new midwifery knowledge within the profession, it will be critical for some midwives to consider graduate work in order to participate in midwifery research and education endeavors. The government needs to be more transparent about the reality of future funded midwifery positions in relation to the potential future intake of students into the educational program. Likewise, if the province is serious about educating midwives, then the RHAs need to be mandated to include the service in their fiscal budget every year.

Secondly, the pros and cons of the salaried employment model were discussed at length in the interviews. The participants voiced concern over the lack of accountability resulting in the low caseload numbers of some midwives. The original salaried model served a purpose; however, consideration should be given to a fee-for-service model. An analysis would facilitate a better understanding of other models of employment and whether they would be more cost-effective and increase access to midwifery services. Currently, the salaried employment model does not equate with increasing utilization or

sustaining the profession over the long term. Multiple models of employment should be considered as options for midwifery practice. Furthermore, the analysis needs to provide guidance to midwives on how to successfully run an independent practice.

Most of the literature has demonstrated the overall cost-effectiveness of midwifery services. A more detailed cost-analysis needs to be done in relation to the caseload numbers of midwives in this province. The model of care needs to be carefully factored in throughout this analysis, while considering the existing literature related to cost analyses of midwifery care from across Canada (Chamberlain, Nair, Nimrod, Moyer, & England, 1998; Giacomini & Peters, 1998; O'Brien et al., 2010; Reinharz, Blais, Fraser, & Contandriopoulos, 2000). In Alberta, the results from a matched case-control design using administrative data supported the integration of the midwifery model. The results showed a cost savings to the system of $1,172 per course of midwifery care compared to standard care (O'Brien et al., 2010). In Quebec, a matched case-control study between physicians (n=1,000) and midwives (n=1,000) analyzed the cost of care (Reinharz et al., 2000). The results support the Alberta study by demonstrating that physician care ($3,020) was slightly more expensive per client than the care provided by midwives ($2,294).

The final recommendation relates to data tracking. From the inception of the midwifery program to 2012, Manitoba Health has not generated annual statistical reports for midwifery services (J. Watt, personal communication, June 20, 2012). There needs to be a mechanism in place that streamlines the tracking of data related to the number of midwives, the reasons for attrition, and other relevant information that would be useful to researchers and policymakers. Currently, no data-tracking mechanism is in place at the

CMM beyond Excel sheets and the documentation provided in annual reports. The existing mechanism requires a tremendous amount of work to locate critical information that is not always consistently recorded. Moreover, it is time-intensive to manually create these types of records, and the recorder may change from year to year, which means the format of what is being abstracted could change.

Implications for Future Research

Little formal research has been done in Manitoba to generate evidence to support midwifery practice. The safety of midwifery practice continues to be questioned by other professions. It is critical to study maternal/fetal outcomes related to midwifery care in Manitoba and to produce publications like those disseminating results across Canada. A formal study would provide credible evidence to justify the benefits of midwifery care and add to the existing body of literature related to birth outcomes across Canada (Fraser et al., 2000; Hutton, Reitsma, & Kaufman, 2009; Harvey, Jarrell, Brant, & Stanton, 1996; Janssen et al., 2002; Janssen, Ryan, Etches, Klein, & Reime, 2007; Janssen et al., 2009). Furthermore, given the high percentage of women turned away from midwifery care, another study needs to address the outcomes and satisfaction with care of those women who sought midwifery care but who were turned away. Given the attention being paid to the local Birth Centre in Winnipeg, a future study also needs to address the outcomes of maternity care (not just births) related to midwifery care in the Birth Centre.

Finally, midwifery policy research is critical in order to demonstrate cost-effective care in times when fiscal restraints in health care determine what is deemed an essential health service. Specifically, in rural and remote areas, obstetric policy has profound economic implications on the family and the health care system. Birth has yet

to be repatriated back to many Aboriginal communities in Manitoba. A policy analysis needs to engage stakeholders in the remote Aboriginal communities to understand how to re-implement a sustainable apprentice-based model of midwifery education. In order to successfully revive Aboriginal midwifery and ensure Aboriginal women have access to the services, it will be imperative to train midwives within their own communities. In summary, midwives in academia need to be actively involved in research endeavors at both policy and local levels. Without their voice at the table, midwives will not be able to influence the many decisions made which impact the delivery of their services.

Knowledge Translation Plan

Given the inherent struggle to implement, grow, and sustain the midwifery profession across Canada, it is vital that the key results and recommendations from this study are disseminated in a timely manner. The plan for dissemination will include ensuring the protocols of the Manitoba Centre for Health Policy and Health Information Privacy Committee (HIPC) are followed prior to the presentation and publication of results. Presentations to local groups will be important to facilitate strategies of what the next steps should entail. Finally, another priority will be to mobilize key stakeholders for roundtable discussions on the feasibility of the next steps for research and program planning based on the previous recommendations.

Conclusion

In conclusion, the three pillars of a strong midwifery profession are education, regulation, and association (ICM, 2013a). In Manitoba, two of these three pillars have not been fully implemented. Thus far, there has been no cohesive plan for integrating the necessary components to grow and sustain the profession. This study demonstrated how

the discursive culture of midwifery politics interacts with the health care system and how policy was incongruent with the outcomes. The application of feminism to midwifery needs to ensure strides in the right direction; engaging in collaborative efforts with other health care professionals must be an important objective. There needs to be awareness that feminist principles, while central to the foundation and philosophy of midwifery, should not segregate or polarize the profession even more. Midwives need to work towards a productive dialogue with each other, as well as with their nursing and medical colleagues, to ensure that women continue to have choice. Finally, in order to move forward, the following aspects must be addressed with an objective and focused strategy: the direction of the education program, midwifery advocacy at a policy level, mandated membership to the professional association, and the accountability processes within the government.

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Appendix A: Approval from University of Manitoba Health Research Ethics Board (HREB)

UNIVERSITY OF MANITOBA | BANNATYNE CAMPUS Research Ethics Boards

P126 - 770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Tel: (204) 789-3255
Fax: (204) 789-3414

APPROVAL FORM

Principal Investigator: Ms. K. Thiessen
Supervisor: Dr. M. Heaman

Ethics Reference Number: H2012:116
Date of Approval: April 20, 2012
Date of Expiry: April 20, 2013

Protocol Title: A Case Study of the Implementation of Regulated Midwifery in Manitoba

The following is/are approved for use:

- **Research Study Protocol and Consent Form, Version dated April 5, 2012**
- **Invitation to Participate in Research Study, Version dated April 5, 2012**
- **Data Capture Sheet, Version dated March 5, 2012**
- **Document Analysis Guide, Version dated March 5, 2012**
- **Interview Guide, Version dated March 5, 2012**

The above underwent delegated review and was **approved as submitted** on April 20, 2012 by Dr. John Arnett, Ph.D., C. Psych., Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your submission dated April 5, 2012. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations of Canada*.

This approval is valid for one year only. A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval must be sought form the relevant institution, if required.

Sincerely yours,

John Arnett, Ph.D., C. Psych.
Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above Ethics Reference Number on all correspondence.
Inquiries should be directed to REB Secretary
Telephone: (204) 789-3255 / Fax: (204) 789-3414

UNIVERSITY OF MANITOBA | BANNATYNE CAMPUS
Research Ethics Boards
APPROVAL FORM

P126 - 770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Tel: (204) 789-3255
Fax: (204) 789-3414

Principal Investigator: Ms. K. Thiessen
Supervisor: Dr. M. Heaman

Ethics Reference Number: H2012:116
Date of Approval: April 27, 2012

Protocol Title: A Case Study of the Implementation of Regulated Midwifery in Manitoba

The following is/are approved for use:

- **Amendment to database per letter dated April 25, 2012**

The above was approved by Dr. John Arnett, Ph.D., C. Psych, Chair, Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your submission dated April 25, 2012. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations of Canada.*

A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval must be sought from the relevant institution, if required.

Sincerely yours,

John Arnett, Ph.D. C. Psych.
Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above Ethics Reference Number on all correspondence.
Inquiries should be directed to the REB Secretary **Telephone**: (204) 789-3255 / Fax: (204) 789-3414

UNIVERSITY OF MANITOBA | BANNATYNE CAMPUS
Research Ethics Boards

P126 - 770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Telephone 204-789-3255
Fax 204-789-3414

HEALTH RESEARCH ETHICS BOARD (HREB)

CERTIFICATE OF ANNUAL APPROVAL

PRINCIPAL INVESTIGATOR:	INSTITUTION/DEPARTMENT:	ETHICS #:
Ms. K. Thiessen	UofM / Nursing	HS15201 (H2012:116)
HREB MEETING DATE (if applicable):	**APPROVAL DATE:**	**EXPIRY DATE:**
	April 10, 2013	April 20, 2014
STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (if applicable):		

PROTOCOL NUMBER:	PROJECT OR PROTOCOL TITLE:
NA	A Case Study of the Implementation of Regulated Midwifery in Manitoba
SPONSORING AGENCIES AND/OR COORDINATING GROUPS:	
MHRC	

Submission Date of Investigator Documents:	HREB Receipt Date of Documents:
March 5, 2013	March 12, 2013

REVIEW CATEGORY OF ANNUAL REVIEW: **Full Board Review** ☐ **Delegated Review** ☒

THE FOLLOWING AMENDMENT(S) and DOCUMENTS ARE APPROVED FOR USE:

Document Name(if applicable)	Version(if applicable)	Date

Annual approval

*Annual approval implies that the most recent **HREB approved** versions of the protocol, Investigator Brochures, advertisements, letters of initial contact or questionnaires, and recruitment methods, etc. are approved.*

Consent and Assent Form(s):

CERTIFICATION

The University of Manitoba (UM) Health Research Board (HREB) has reviewed the annual study status report for the research study/project named on this ***Certificate of Annual Approval*** as per the category of review listed above and was found to be acceptable on ethical grounds for research involving human participants. Annual approval was granted by the Chair or Acting Chair, UM HREB, per the response to the conditions of approval outlined during the initial review (full board or delegated) of the annual study status report.

HREB ATTESTATION

The University of Manitoba (UM) Health Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulations of Manitoba. In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in Division 5 of the Food and Drug Regulations of Canada and carries out its functions in a manner consistent with Good Clinical Practices.

QUALITY ASSURANCE

The University of Manitoba Research Quality Management Office may request to review research documentation from this research study/project to demonstrate compliance with this approved protocol and the University of Manitoba Policy on the Ethics of Research Involving Humans.

CONDITIONS OF APPROVAL:

1. The study is acceptable on scientific and ethical grounds for the ethics of human use only. ***For logistics of performing the study, approval must be sought from the relevant institution(s).***
2. This research study/project is to be conducted by the local principal investigator listed on this certificate of approval.
3. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to the research study/project, and for ensuring that the authorized research is carried out according to governing law.
4. **This approval is valid until the expiry date noted on this certificate of annual approval. A Bannatyne Campus Annual Study Status Report** must be submitted to the REB within 15-30 days of this expiry date.
5. Any changes of the protocol (including recruitment procedures, etc.), informed consent form(s) or documents must be reported to the HREB for consideration in advance of implementation of such changes on the **Bannatyne Campus Research Amendment Form.**
6. Adverse events and unanticipated problems must be reported to the REB as per Bannatyne Campus Research Boards Standard Operating procedures.
7. The UM HREB must be notified regarding discontinuation or study/project closure on the **Bannatyne Campus Final Study Status Report**.

Sincerely,

John Arnett, PhD., C. Pysch.
Chair, Health Research Ethics Board
Bannatyne Campus

Appendix B: Approval from Health Information Privacy Committee (HIPC)

Manitoba
Health
Health Information Privacy Committee
4043 – 300 Carlton Street
Winnipeg MB R3B 3M9
Phone: (204) 786-7204
FAX: (204) 944-1911

May 1, 2012

Kellie Thiessen
Room 268, Helen Glass Centre for Nursing
89 Curry Place, University of Manitoba
Winnipeg, MB R3T 2N2

File No. 2012/2013 – 02

Dear Ms. Thiessen:

Re: A Case Study of the Implementation of Regulated Midwifery in Manitoba

Thank you for submitting the requested documentation and providing clarification (i.e., Employment/Income Assistance data will no longer be accessed) for the above named project. The Health Information Privacy Committee has now ***approved*** your request for data for this project.

Any significant changes to the proposed study design should be reported to the Chair/HIPC for consideration in advance of their implementation. Also, please be reminded that *all manuscripts and presentation materials resulting from this study must be submitted for review at least 30 days prior to being submitted for publication or presentation.*

Please note that a Researcher Agreement will need to be completed before work on this project can commence. This will be initiated by MCHP. If you have any questions or concerns, please do not hesitate to contact Lisa LaBine, Committee Coordinator at 786-7204.

Yours truly,

W. Gary Cavanagh, B.Sc.Pharm., R.PEBC.
Chair, Health Information Privacy Committee

Please quote the file number on all correspondence

c.c. D. Malazdrewicz
M. Heaman

Appendix C: Behavioral Model of Health Services Use-Variables

Table 1: Categories of Variables

Research Objectives:

1. To describe the utilization of midwifery health care services in Manitoba from 2001/02 to 2008/09
2. To identify and explore factors influencing the utilization of regulated midwifery services

Variable	Operationalized	Explanation
Predisposing Factors	Age Parity Area of residence (Urban vs. Rural) Service accessed in RHA Priority population Adolescent (<20) Aboriginal Single Immigrant Socially isolated Poor Other	Immutable* Exogenous predictors
Enabling Factors	Availability of MW services in each RHA Model of care (average caseload per full-time midwife/part-time midwife) Number of practicing MW in each RHA	More mutable* Endogenous These explain how MW services are available to women
Need	Number of women seeking care (perceived)	Perceived by the individual Evaluated by the delivery system as to whether the service is needed
Utilization	Number of women receiving midwifery care Home birth Hospital birth	Describes an individual's entry into the system and what type of service received

Mutability is how the degree of the given variable will impact health care utilization

*Immutable=variable would not change health care policy decisions

*Mutable=likely to have some impact on change of health policy decisions

Appendix D: Document Analysis Guide

The following guide will be used when analyzing documents related to this study. The goal in using the guide is to facilitate a focused approach. The intent of the document analysis is to extrapolate the most relevant information that will help answer the research questions.

Key themes to be aware while analyzing the documents are:

1. Barriers to implementation and utilization of midwifery services
2. Facilitators to implementation and utilization of midwifery services
3. Issues that influenced implementation and utilization of midwifery services
4. Issues related to workload and organization of the midwifery profession
5. Initiatives that address specific targets projected by the Human Resource Strategy for Midwifery Implementation in Manitoba
6. Information about suggestions/strategies to improve utilization of midwifery

Appendix E: Invitation to Participate in Research Study

Research Project Title: A Case Study of the Implementation of Regulated Midwifery in Manitoba

Principal Investigator: Kellie Thiessen, RN, PhD student, Department of Applied Health Sciences, Room 268 Helen Glass Centre for Nursing, University of Manitoba, Winnipeg, MB R3T 2N2. Phone 316-978-5733

Research Supervisor: Dr. Maureen Heaman, Professor, Faculty of Nursing, Room 268 Helen Glass Centre for Nursing, University of Manitoba, Winnipeg, MB, R3T 2N2. Phone 204-474-6222

Sponsor: Manitoba Health Research Council PhD Dissertation Award and Manitoba Centre for Nursing and Health Research Award

Purpose of Study:

My name is Kellie Thiessen and I am a doctoral student in the Applied Health Sciences Program, Faculty of Nursing at the University of Manitoba. The research focus for my dissertation is midwifery in Manitoba. More specifically in my research, I will endeavor to understand factors that have influenced the implementation and utilization of regulated midwifery services in Manitoba since its formal regulation in 2000. My research will be a case study and I will collect both quantitative and qualitative data. In an effort to explore how midwifery services have been utilized over the past ten years, I will be describing midwifery services using administrative data from the Manitoba Centre for Health Policy (MCHP). Secondly, I will interview key informants who have specific knowledge about midwifery in Manitoba since regulation.

The key informants have been identified from five sub-groups of people that have been actively involved with the implementation of midwifery, including registered midwives, practicing and non-practicing midwives, other health care professionals who work with midwives, provincial representatives, representatives of professional organizations, and those involved with assessment and educational initiatives, Your name has been identified as a possible key informant in the current and/or historical trajectory of midwifery in Manitoba. The intent of this letter is to invite your participation in an in-depth interview which will provide important information regarding midwifery in Manitoba.

Procedures:
If you agree to participate, I will interview you on your perspective of various factors that have influenced the implementation and utilization of midwifery services in Manitoba. The interview will be in-depth, so it will take about one to two hours with an additional second interview if needed. The interview will take place at a time and location that is convenient for you. A formal written consent will be obtained from you prior to commencing the interview.
The interview will be audio-taped and later transcribed. Interviews are slated to take place between May 2012 and July 2012.

Confidentiality:
All information gathered for this study will be kept strictly confidential. The results of the study will be based on group data. All names will be removed from transcripts of interviews. A copy of your interview transcript will be given to you for feedback. You will have the opportunity to edit information that you feel may identify you or others. The researcher will make every effort to meticulously review the content of the transcript to facilitate anonymity for the participants involved. There is no guarantee of unconditional confidentiality. Individual identities will not be disclosed in any reports or publications resulting from this study.

Risks:
There is minimal risk associated with your participation in this study.

Benefits:
There are no direct benefits involved in participating in this study. However, your involvement in this study will allow you to share your knowledge in relation to historical and current information on processes related to the utilization of midwifery in Manitoba. Your contribution is important for the completion of my dissertation which may ultimately contribute new information to help sustain and grow the midwifery profession in Manitoba.

Remuneration
An honorarium consisting of a $20 gift certificate will be given to those participating in this study.

Voluntary Participation and Withdrawal:
Your participation in this study is completely voluntary and your decision about whether or not to participate will not affect your employment in any way. You are free to refuse to answer any of the questions you are asked. You are also free to withdraw from the study at any time, without any prejudice or consequence.

Feedback to Subjects:
A summary of the results of the study will be made available to those participants who request a copy.

If you are interested in participating in this project please email the Principal Investigator (PI), Kellie Thiessen at: umthi277@cc.umanitoba.ca. She will then contact you to arrange a time and place for the interview. If you have additional questions before deciding to participate please contact Kellie Thiessen at 316-978-5733.

Thank you for your interest in this study.

Kellie Thiessen, RN, PhD (c)

Appendix F: Research Study Protocol and Consent Form

Research Project Title: A Case Study of the Implementation of Regulated Midwifery in Manitoba

Principal Investigator: Kellie Thiessen, RN, PhD student, Department of Applied Health Sciences, Room 268 Helen Glass Centre for Nursing, University of Manitoba, Winnipeg, MB R3T 2N2, Phone 316-978-5733

Research Supervisor: Dr. Maureen Heaman, Professor, Faculty of Nursing, Room 268 Helen Glass Centre for Nursing, University of Manitoba, Winnipeg, MB, R3T 2N2. Phone 204-474-6222

Sponsoring (Funding Agency): Manitoba Health Research Council PhD Dissertation Award and Manitoba Centre for Nursing and Health Research Award

This consent form, a copy of which will be left with you for your records and references, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Study protocol

Interviews will be conducted with key informants. Research participants are intentionally selected based on their knowledge and involvement in implementation and utilization of midwifery in Manitoba. The interview will be in-depth, so it could take about one to two hours with an additional second interview if needed. The interview will take place in a professional and confidential location such as your workplace or a room reserved at the University of Manitoba. The interview will be audio-taped and later transcribed. You will be asked a series of open-ended questions about factors that influence the utilization of midwifery services in Manitoba. If you agree to participate in this study, the consent form will be signed at the beginning of the interview.

Risks

There is minimal risk associated with your participation in this study.

Confidentiality

Results from this research will be published and presented in public forums. Every effort will be made by the researcher to ensure complete confidentiality of the participants involved. The interview will be tape-recorded and notes will be taken by the researcher throughout the interview. The transcripts of the interviews and any notes will not contain any personal identifiers, therefore will be anonymous. There is no guarantee of

unconditional confidentiality. Certain conditions may require that the researcher reveal personal information. For example, disclosure would happen if the information was required to be reported by law, or if the

University of Manitoba Health Research Ethics Board needed to review the study for quality assurance purposes. All information obtained from the interview process will be kept separate from your identifying information. Only the principal investigator and research supervisor will have access to the information collected from the interviews. The information will be kept in a secure locked file cabinet in a locked office. All audiotapes will be destroyed and any notes will be shredded once transcription is completed. Upon completion of the study all transcribed data from the interviews will be maintained for 7 years in a securely locked environment and then destroyed.

Debriefing

Debriefing will be done immediately after the data collection. The debriefing will provide a time to allow the participant to reflect on the process and modify content if needed.

Dissemination of Results

Once the results have been transcribed and analyzed, a brief summary of the results will be sent to each participant upon request. The final results for the dissertation will be made available after the oral defense has been successfully completed. Finally, these results will be published.

Remuneration

An honorarium consisting of a $20 gift certificate will be given to those participating in this study.

Voluntary participation and withdrawal

Your choice to participate in this study is completely voluntary. You may at any time choose to withdraw from the study. If you choose to withdraw, please discuss this with the researcher and the researcher's advisor. If any new information evolves that the researcher feels may impact your willingness to remain in the study, this will be immediately communicated to you.

Contact for questions

If at any time you have questions regarding the study please contact the following research team: Kellie Thiessen (316-833-3860 or 316-978-5733) or Dr. Maureen Heaman (204-474-6222). For questions regarding your rights as a research participant, please contact the Bannatyne Campus Research Ethics Board Coordinator, Shelly Rempel-Rossum (204) 789-3389.

Statement of consent for research participants:

I, _____have fully read this study protocol and understand it to the best of my knowledge. All my current questions have been answered by Kellie Thiessen or Dr. Maureen Heaman. By consenting to participate in this study, I understand the following:

- My participation is entirely voluntary.
- I may withdrawal at any time by my own volition
- I am free to refuse to answer any question at any time. Confidentiality will be maintained by scrupulous measures taken by the research team throughout the entire research study.
- Confidentiality is never completely unconditional but every effort will be made to keep information about each person confidential.
- I authorize the University of Manitoba Research Ethics Board to access information related to this study in relation to any quality assurance protocols.
- Excerpts from this dissertation will be published and presented in public forums but participants will be protected, as much as possible, from any identifying information.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Bannatyne Campus Research Ethics Board. **If you have any concerns or complaints about this project you may contact any of the above-named persons or the** Bannatyne Campus Research Ethics Board Coordinator, Shelly Rempel-Rossum **at (204) 789-3389. A copy of this consent form has been given to you to keep for your records and reference.**

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix G: Interview Guide

Introduction: Thank you for agreeing to participate in this interview today. I hope to gain an understanding of the historical and current factors influencing implementation and utilization of midwifery in Manitoba. Your involvement and knowledge of the midwifery scene in Manitoba will contribute greatly to this process of deconstructing these issues. Ultimately, I hope the findings will provide new information to support and help with decision-making on how to increase the utilization of midwifery services in the Manitoba.

Prior to starting this interview I would like you to understand that I have been personally and professionally involved in the midwifery scene in Manitoba for the last 6 years. It is important for me to be as objective as possible. Please answer these questions to the best of your knowledge. Please do not withhold information based on the assumption of my personal involvement with midwifery in Manitoba.

Biographical/historical/personal background

I'd like to start with some questions about your professional background and involvement with midwifery in Manitoba.

Professional background/training

a. What is your professional background or training?

Historical relationship to midwifery in Manitoba

b. When was your first involvement with implementation of midwifery in Manitoba? Tell me how you have been involved over the years to current day?
c. Why were you involved? In what capacity?

Current involvement with Midwifery in Manitoba

d. In what way are you currently involved with midwifery in Manitoba?
e. Are you currently involved with midwifery in other parts of Canada or the world? If yes, in what capacity?

Factors influencing implementation and utilization of midwifery in Manitoba

I'd now like to focus on the factors influencing the implementation and utilization of midwifery in Manitoba.

1. What do you think about midwifery in Manitoba in general?
2. What do you think are the most important factors influencing implementation of midwifery in Manitoba and why?

PROBE: what other factors have had an impact on midwifery services in Manitoba?

Health policy related factors to utilization of midwifery services

2. How does policy influence midwifery services? What has happened in the past with policy?
3. How does health care policy regarding a mother's choice of health care reflect a woman's position in society?
4. Midwifery is predominately a women's profession, providing care to women. How do you think this has influenced its implementation?

PROBES:

Financial resources

Can you tell me about any financial barriers to implementation of midwifery?

How about available financial resources and their impact?

Educational resources

What about educational resources? How do you think the workload and organization of the profession plays a role in how midwifery services are made available?

PROBES:

Manpower & organization of midwives in Manitoba

What are barriers or facilitators?

Characteristics of the Manitoba midwifery population

5. What do you think determines if a woman gets midwifery care?
6. How do you think women perceive midwifery care?
7. How do you think cultural beliefs of a woman influence her decision to seek midwifery care?

PROBES:

Availability of regulated midwifery services in Manitoba (Enabling factors related to utilization)

Tell me more about the impact of cultural beliefs?

Perceived Need of regulated midwifery services

Tell me how you think a society's perceived need of these types of services impact the implementation and utilization?

Consumer influence

8. How do you think consumers have influenced (or in what ways?) midwifery services in Manitoba?
9. How do you think consumer influence impacts policy related to midwifery services?
10. How do you think women have perceived midwifery services in Manitoba?
11. Why do you think women want midwifery care?

PROBES:

Convenience, costs, coordination, courtesy, information & quality

Can you tell me more about the importance of consumer influence?

Future directions

12. If you could change anything about midwifery in Manitoba, what would you change?
13. What direction do you think midwifery needs to take in Manitoba?
14. What strategies are needed to improve utilization?

Appendix H: Themes, Sub-Themes, and Definition of Source

Topic: Barriers Theme	Sub-Theme	Definition & Source
1. Conflict and Power	a. The nature of the beast	The power of policy & political will (24) • Fiscal restraints (P:1,2,3,7,9,10,13,15,20,21,23,24) • Midwifery as low priority(P:1,6,7,8,9,11,12,16,17,18,20,22,23 • Management & policies over midwifery (P:1,6,9,8,10,11,14,15,16,17,18,19,20,22,24) Impact of gendered health care (24) • Power plays (P:2,3,4,5,6,7,8,9,10,13,15,16,20,21,22,23) • Gender as a determinant of health status (P:1,3,5,6,7,8,10,11,12,14,15,16,18,19,23,24)
	b. Tenuous leadership within the profession	Political advocacy (8) • Lack of champion/leader (P:1,5,6,11,14,21,23) • Maintaining advocacy (P:5,11,12)
	c. Turf and power	Interprofessional conflicts (13) • Health professionals and midwives (P:1,2,3,5,6,7,8,10,12,13,14,15,17) Intraprofessional conflicts (9) • Midwifery community (P:2,3,4,13,14,15,18,19,20) • Occupational Imperialism (15) (P:1,3,4,7,9,13,14,15,16,17,18,19,21,22,23)
2. Education	a. Types of midwifery training and assessment	Manitoba midwives breadth of training (P:1,2,4,8,13,15,21,22,24)
	b. The plight with midwifery education in Manitoba	Gap with implementation (P:2,3, 6,8,9,11,12,13,15,16,17,18,21,23) University of Manitoba • Missed opportunity (P:1,5,10) University College of the North • Lack of capacity (P:4,5,6,8,9,10,11,12,13,14,16,17,23,24) • Change in focus (P:8,11,12,13,17)
3. Perceptions of the Profession	a. Stereotypes	Perceived characteristics of the midwifery profession (P:2,3,4,6,16,14,23)
	b. Misunderstanding of the professional scope	Safety (P:2,9,10,11,13,17,18,19,22,23)(Birth Centre P12,13,17,22) Skill-set/training (P:3,4,5,6,7,9,10,11,12,14,15,17,18,22,24)
4. A Precarious Profession	a. Lack of capacity	Recruitment and retention (P:6,8,10,11,16,18,19,21,22) Model of practice/employment • Lack of unified voice (P:4,6,15,16)

Topic: Barriers Theme	Sub-Theme	Definition & Source
		Access • Determinants of receiving care (P:1,3,5,6,7,8,9,10,11,13,16,18,19,20,21,22,23,24) • Equity and access (P:3,9,11,12,22,18) Small vulnerable profession • Job vacancies (maternity leaves, sick leaves, burn-out, retirements, urban vs. rural) (P:1,3,4,5,6,10,11,12,14,15,17,18,22) • Multiple roles of midwives (P:1,4,5,8,11,12,16,17,18,19)

Topic: Facilitators Theme	Sub-Theme	Definition
5. Feminist movement	a. Constituent Influence	Women's choice (P:2,3,5,6,7,8,9,10,11,14,15,16,19,20,21,22,24) Midwifery Advocacy (P1,2,3,5,7,6,8,9,10,11,12,13,14,15,16,18,19,20,22,23,24)
6. Successful Strategies	a. Regulation b. Funding c. Integration d. Implementation of the Birth Centre	Aspects of successful implementation strategies • Adequate regulation (P:6,7,11,14,21,22) • Funded (P:1,5, 6,7,9,14,16,18) • Practice standards (P:6,11,19,22) • Integration Employment model (P:1,6,9,10,18,24) Health care system (P:5,6,9,10,11,13,14,15,18, 19,20,21,22,23,15,17,21,22,23) Birth Centre influence (P:6,22,8,10)

Topic: Future Strategies and Recommendations Theme	Sub-theme	Definition
7. Ensure Avenues Registration and Midwifery Education	a. Types of training	School of Midwifery/University Program (P:1,2,3,5,9,10,11,12,13,14,17,18,19,23,24) Implement gap training (P:3,4,5)
	b. Maintain midwifery priority in the north	Re-prioritize midwifery training in north(P:6,8,10,17,19,20,23)

Topic: Future Strategies and Recommendations Theme	**Sub-theme**	**Definition**
8. Re-focus Management Strategies	a. Government/ Regional Health Authorities (RHAs) b.Work milieu	Accountability frameworks within government (P:5,8,12,14,15,16,18,23,) Implement recruitment and retention strategies (P:6,21) Mandate RHAs to implement midwifery programs (P:1,9,18) Improve work conditions (P:1,10,11,12,15,17,18) Improved/continued integration strategies for midwives (P:7,9,13,19,20,21)
9. Evaluation of midwifery practice	a. Evaluate model of practice b. Evaluate model of employment	Evaluate mandate for priority populations/homebirth (P:3,6,9,10,13,20,21) (P:1,4,6,9,11,13,15,18,19,24)
10. Research	Needs analysis	Research midwifery initiatives related to supply and demand (P:4,10,11,17,20,22)