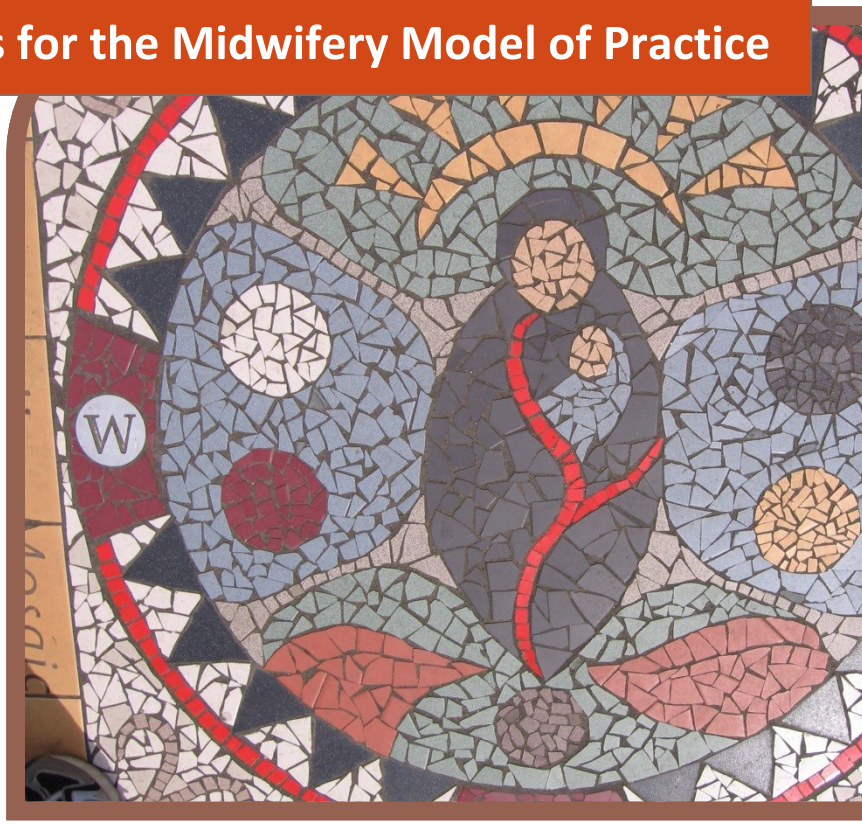
Improving Midwifery Care for Marginalized Women and Communities: Implications for the Midwifery Model of Practice



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Executive Summary

This discussion paper seeks to contribute to the discussion on improving the Midwifery Model of Practice to ensure increased relevance and accessibility of midwifery care for a wider population of women across the province.

Critical health literature challenges providers to consider how health care contributes to the process of marginalization through perpetuating negative stereotypes and social isolation. While broader social relations may not be visible to Registered Midwives who have a relatively privileged position within society, our daily health care interactions are shaped by structural inequities. The existing Model of Practice puts heavy emphasis on building one-on-one relationships between clients and midwives, without emphasis on barriers to health facing women and communities or alternative epistemological approaches to health expertise. The challenge facing Registered Midwifery in BC is ensuring that midwifery care attempts to meet the needs of all women, and does not wind up pressuring women to conform to elusive Eurocentric, heteronormative, and privileged middle-class concepts of health, well-being, and motherhood.

It will require concerted efforts of health care providers to understand how the health care systems in which they operate either contribute to or help shift these ongoing inequitable structures. If the Midwifery Model of Practice is going to change, this provides Registered Midwives an incredible opportunity to explore how our Model of Practice may contribute positively towards resolving health inequities for women in British Columbia by involving women and communities in the process. Changes may involve efforts to adopt culturally safe and trauma informed care within the existing Midwifery Model of Practice. Yet, flexibility within the model itself is integral to innovation and the development of new models. In particular, rigidity in the Continuity of Care requirements make some models untenable at this time. It is possible that alternative options for ensuring continuity might better meet some needs. Holistic models combine deeper attention to social and structural inequities in a collaborative and interdisciplinary practice which frames woman, family, and community as the experts in pregnancy and parenthood. Lay health providers such as Doulas or Grannies may be appropriate care providers for ensuring continuity within flexible models of practice. A variety of such models might be necessary to increase access to care and improve maternal-neonatal outcomes.

Contents

Executive Summary 1

Contents 2

Introduction..... 3

Marginalization..... 3

Marginalized Women's Experiences of Prenatal Care ... 6

How Can Care Be Different?..... 9

Alternative Models of Practice..... 13

Implications for the Midwifery Model of Practice 16

Implications for Midwifery Remuneration..... 19

Conclusion 19

APPENDIX: The Theory of Marginalization..... 20

References..... 21

Introduction

This document is a collaboration of Martha Roberts and Cora Beitel, Registered Midwives at the Strathcona Midwifery Collective. The content of this paper draws extensively on the Masters of Science research and writing of Martha Roberts. The process of this paper involved an extensive review of the literature on poor and marginalized women's experiences of prenatal care and interviews with Registered Midwives in BC in order to further our understanding of midwives experiences of providing care to marginalized women.

The purpose of this discussion paper is to engage midwives in reflection and conversation on the existent Midwifery Model of Practice and potential improvements or alterations in practice structures at a juncture where the Midwifery Model of Practice is under review. In British Columbia, marginalized women are an underserved population who face multiple barriers in accessing prenatal care. This discussion paper seeks to contribute towards the discussion on improving the Midwifery Model of Practice to ensure increased relevance and accessibility of midwifery care for a wider population of women across the province.

Marginalization

In order to improve access to primary maternity care for all women, in particular to midwifery care, it is important for midwives to be knowledgeable about how marginalization has been defined and understood, who marginalized women are, and what barriers women themselves have reported to seeking care.

Marginalization has been defined as how people are pushed to the edge of society through their perceived identities, their place of residence, their kinship and friendship associations, and their daily activities (1). Yet, seeing marginalization as a positional status (such as poor, drug abusing, homeless, etc.) as opposed to interrogating marginalization as a social process can disguise professional biases and social stigmas within health care which directly contribute to the process of marginalization. Critical health literature challenges us to consider how health care contributes to the process of marginalization through perpetuating negative stereotypes and social isolation (2, 3).

It is important to adopt an understanding of marginalization that moves beyond social position to social relations. Marginalization as a process has been described as "the extent to which [people] are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around" (4). The root causes of marginalization are found in economic structures of capitalism and ongoing colonial relations in Canada. The increasingly precarious, feminized, flexible, migrant and cheap waged-labour accompanied by the stagnation of social assistance rates and the consistent roll-back of public services which redistribute public dollars to poor working class families through social programming in British Columbia has had

profound economic and social implications for women and families who struggle on the margins of society (5, 6). While these broader social relations may not be visible to Registered Midwives who have a relatively privileged position within society, Annette Brown highlights that these inequitable social relations do shape our health care interactions and "profoundly influence patient-provider relations" (Browne, 2007, p. 2167: 7).

Health inequities stem from social, political, and economic inequities (8). As the feminist adage reminds us, *the personal is the political, yet there are no personal solutions to political problems*. It will require concerted efforts of health care providers to understand how the health care systems in which they operate either contribute to or help shift these ongoing inequitable structures. If the Midwifery Model of Practice is going to change, this provides Registered Midwives an incredible opportunity to explore how our Model of Practice may contribute positively towards resolving health inequities for women in British Columbia by involving women and communities in the process.

For a short review of the social theories of marginalization, see Appendix 1.

The process of marginalization: historical trauma, and social stigmatization

It is important for midwives to realize that the social processes which marginalize women and communities are often rife with violence. The institutions of Western medicine have considerable power in and control over communities and have been implicated in these processes (9, 10). Structural violence occurs when economic and political structures and institutions render some of less value than others. Structural violence includes war, colonial and neo-colonial occupation, forced migration, economic exploitation, and human degradation (11). Colonization has been described as both a stressor that caused social trauma or a "soul wound" to Aboriginal people" (Moffitt, 2004, p. 324: 1). Structural violence contributes to elevated levels of interpersonal violence and directly results in intergenerational trauma and in social stigmatization (12).

"First Nations women who were seeking health care in rural communities in a Western Canadian province described their sense of being on the outside, lacking entitlement to services, ''intruding on the system,'' and lacking connection to the social processes inherent in the clinics they attended (17). In an effort to transform dismissive interactions into attentive interactions, participants changed their appearance and manner of speaking to overcome perceived cultural differences. These acts of transformation were understood as a means of obtaining credibility and legitimacy as medical subjects. These findings remind us that the micropolitics of health-care encounters cannot be separated from the sociopolitical and historical contexts in which they occur, and highlight the need for analyses that link the dynamics of patient–provider relations to these wider contexts" (Browne, 2007, p. 2167: 7).

The health impacts of trauma and stigmatization cannot be overstated. The resultant stress reactions have tremendous impacts on physical and psycho-social health of communities and individuals. In addition, the relationship between being working class and poor health outcomes has been documented in an extensive body of literature on the social determinants of health (13-15). Communities often lack equitable resource distribution and opportunities and resources that support the health of the most marginalized members are lacking.

The implications of structural violence on the both provision of health care to and establishing interpersonal relationships with marginalized communities are profound. Health care systems are an extension of capitalist and colonial governments (16). As Moffitt describes, "power and control play dominant roles in colonialism creating hierarchy, which puts considerable stress on the health of the people" (Moffitt, 2004, p. 324: 1). Stigma is embedded in health care systems, where "we place blame and responsibility on individuals for what are ultimately the results of social and structural processes" (Van Den Tillaart et al, 2009, p. 154: 2).

Who are marginalized women?

While it is tempting to generate exhaustive criteria for marginalization, the fact remains that marginalization speaks to a woman's broader relationship to social structures and institutions which shape the conditions of their lives. It would be more appropriate to ask whether women have control over the resources necessary for health equity, and if not, what we can do to shift control in favour of those who are currently excluded.

British Columbia has the highest overall poverty rates, 13% of the population lives below the poverty line and over 18 percent of children live in poverty, and the gap between the rich and working poor families continues to widen (6, 18, 19). Increasingly women are facing flexible, part-time, and precarious low-wage work; in particular racialized migrant women face economic hardship and exploitative labour conditions (20). Even families with two adults working full-time struggle to make ends due to low wages and poor access to social services. Economic marginalization, in particular racialized exploitation, results in women relying on precarious labour, dwindling social programs, and increased participation in the informal economy including drug trafficking and prostitution to make ends meet. Increasingly women are homeless or are marginally or precariously housed. It has been reported in the literature that fifty percent of precariously housed women will become pregnant within a year of being homeless (21, 22). Many young pregnant women who are precariously housed were formerly in state care or have had their own previous children apprehended, resulting in tremendous grief (23).

To sum up, marginalized women are those who fall outside the margins of what is considered to normal, socially-acceptable, and appropriate for parenting (24-26). Women face social exclusion and judgment based on social class, racialization,

colonization, immigration status, migration, gender identity, mental health, and / or a history of conflictual or oppressive relations with the state, including the foster care system, state social ministries, and health care. For many women, prenatal care has the potential to inflict emotional harms despite the best intentions of the care providers, who seek to improve maternal-child health.

The challenge facing Registered Midwifery in BC is ensuring that midwifery care attempts to meet the needs of all women, and does not wind up pressuring women to conform to elusive Eurocentric or privileged middle-class concepts of health, well-being, and motherhood.

Marginalized Women's Experiences of Prenatal Care

There is not an extensive body of scientific literature on marginalized women's experiences and perceptions of or preferences for prenatal care. What follows is an attempt to sum up what literature is available on women's experiences in industrialized countries with publicly accessible and publicly funded prenatal care. For some women prenatal care is seen as a trade-off where the perceived benefits must outweigh economic and social hardships of attending care or any perceived risks of interacting with the medical system and health care professionals.

Key themes found in the literature are as follows.

Constrained Access to Care

Marginalized women consistently report constraints in access to prenatal care which range from physical and psycho-social barriers to economic constraints (27, 28). In British Columbia, instrumental and geographic barriers are problematic, given that many women living outside of urban centres do not have choice of care provider or easy access to antenatal care. Many women, in particular Aboriginal women, must leave their home communities to seek care and/or give birth (29). For inner-city women constrained access can stem from economic hardship and inability to take time off work or to find childcare, the affordability and availability of transportation options, and financial strain and inability to pay for care due to a lack of legal immigration status. For racialized and dislocated migrant women, psycho-social barriers to care can include poor language proficiency, fear of state reprisal, deportation, employer violence, and greater risks of spousal/partner violence in the perinatal period. Racialized immigrant women struggle to find services available in their first language. These barriers are major factors why marginalized women book late into care, and pose a significant challenge for women who wish to have midwifery care in communities where Registered Midwives' practices fill quickly, where initial screening takes place to prioritize low-risk women or where long waiting lists are maintained (15, 30-34).

Competing Priorities

Working class women's lived experiences of poverty and marginality lead to constrained access to prenatal care. Precarious and low status employment prevents women from asking employers for time off work. In particular, immigrant women have reported greater competing priorities due to lower social status, greater financial strains, and a greater role in family responsibilities. Further, racialized immigrant women have reported greater inabilities to attend visits due to challenges in juggling paid employment with gendered expectations of reproductive labour in the home (15, 30, 31).

Multiple competing priorities can be linked to severe stress or economic distress. The literature on the relationships of stress and poverty to poor health is extensive, and beyond the scope of this paper, but worthy of future attention (35, 36).

Inadequate or Contradictory Information Provided

Challenges in communication with care providers and confusing or contradictory messages render prenatal care stressful and potentially unhelpful. Care providers, in particular trainees, struggle to communicate with women from different social classes regardless of the racial status of the woman (27, 30). Further, contradictory explanations cause stress and anxiety for women and can lead to unnecessary tests. Women report not being informed of what tests were being ordered or why, nor were women informed about test results (7). Poor and racialized women were far less likely to have medical procedures explained to them and this is far worse for racialized and Aboriginal women (17, 33).

"If I could afford fresh fruits and vegetables, I would have bought them. It would have been more helpful if she'd talked to me about what it's like to struggle to feed yourself and your family and then referred me to the Good Food Box – I only found out about it later from a friend" (Best Start, n.d., p.25: 15).

Best Start found that poor women reported that health care professionals often lacked information about available supportive community resources and referrals, and when health advice was given care providers failed to provide adequate information on appropriate implementation of said advice. In fact, when health care professionals lacked knowledge on how *exactly* to access recommended supportive programs or failed to give *practical step-by-step information* on how to implement recommended actions to improve health, women were far more likely to view interactions with that health care provider as negative (15).

Stigmatization by and Social Biases of Health Care Professionals

Marginalized low-income and racialized women face disparagement and stigmatization within the medical system. Racialized working class women often experience flagrant racism and abuse within the medical system. Overall, marginalized women are

vulnerable to poor care and judgmental attitudes from care providers (37, 38). Judgmental attitudes can include: negative stereotyping of poverty; minimization of impacts of stress, anxiety, and social isolation on health and well-being; assumptions about parenting styles and preferences; and unsupportive feedback over coping mechanisms such as self-medication with drugs, alcohol, or cigarette smoking (15). There is a correlation between economic and social marginalization and poor mental health; women with mental health diagnoses are grossly stigmatized within the medical system and in society as a whole (2).

Health care appointments can be stressful and even distressing for marginalized women (27, 37). Low-income women report that interactions with health care professionals contribute to persistent low self-esteem and that expectations of social bias are a major barrier in uptake of prenatal care (39-41). Women report that the medicalization of social needs, and in particular being forced to provide a medical professional's signature for paperwork for medical leave or welfare benefits leads to feelings of powerlessness and anger (42).

Aboriginal women report care providers exhibit negative cultural biases and social stereotyping, and subsequently report feeling misunderstood and mistreated within the system (7, 17, 43). Further, Aboriginal women also report harms caused by their interactions with health care professionals, ranging from stigmatization and neglect to gross mistreatment within the medical system. Poor treatment in the medical system can lead to great feelings of inadequacy and invalidation as capable mothers that endure and undermine mothering for the long term (2).

Medicalization and Risk

Many women do not view pregnancy as a medical concern and not all women see value in obtaining health care revolving around risk screening during pregnancy. Not perceiving or seeing the need or a benefit is instrumental in determining if women will seek prenatal care (44). This is often the case for pregnant women who come from a culture or a philosophy whereby pregnancy is considered to be a normal healthy part of a woman's life-course and not a medical event (45). Strikingly, Aboriginal women reported that they did not present for antenatal care due to the fact that childbirth was viewed as a normal and healthy process and mothering as a cultural and political responsibility (46 - 48).

Social conflict can be illuminated when interrogating the concept of risk. Referring to women as "at risk" or to social factors largely beyond women's control as "risks" can cause of anxiety and anger for women who are subjected to what Queniart has termed the "risk factor ideology" and an obsession with defining normalcy (49). Poverty, low socio-economic status, self-medication, precarious employment and housing, exposure to violence, and so on are seen as deviant and considered to place pregnant women and neonates at adverse risk of poor outcomes (50).

Women themselves may perceive different risks. While medicine manages social conditions as a form of illness, women may reverse this and view seeing a doctor or a medical care provider as a risk and medical care as a potential source of harm (39). In fact, the medicalization of precarious social status and marginality as a mental health issue is a major recurring theme in the literature on the maternity care experiences of both poor and migrant women.

As Barclay and Kent explain, "labelling women as sick excuses society from accepting responsibility for alleviating the isolation of new mothers, particularly those who are culturally and socially dislocated" (Barclay & Kent, 1998: 51).

Contradictory Discourses on Poverty and Mothering

Working class and systemically marginalized women report that their care providers lack the ability to understand their experiences of poverty and marginalization and to address these issues in the scope of their care (52). Poor women are bombarded with contradictory discourses, public health literature states poor women don't require money to bond with their babies and yet dominant discourses overwhelm poor women with messages of being incapable mothers and a 'risk' to the health of children (24, 50, 53). This bombardment of contradictory messages, combined with judgmental attitudes from health care professionals creates both distrust and even fear of the power of the medical system to wreak havoc on women's lives.

Conflictual Colonial Relations and Forced Migration

For poor Aboriginal women in BC these fears are founded on an ongoing conflictual relationship with the triad of social work, state social services, and health care professionals that combined forces to oversee the 1960s scoop of Aboriginal children from the biological parents and home communities. The relationship between Aboriginal families and maternity care providers remains fraught with tensions based on ongoing targeting of Aboriginal children for apprehension and placement in foster care. Poor Aboriginal mothers continue to be the subject of scrutiny and have justifiable reasons for avoiding situations of power imbalance, in particular when it concerns custody of their children. Women who struggle with mental health and / or addictions have very concrete fears of the involvement of state social workers and child apprehension. For women from racialized immigrant communities, these fears stem from precarious or even undocumented legal status and concerns over deportation (12, 30).

How Can Care Be Different?

The intention of this document is to situation women's lived experiences within a broader discussion on improving access to Registered Midwifery care in British Columbia, and what implications such improvements would have for the Model of Midwifery Care.

The Midwifery Philosophy and Model of Practice have been a great stride in improving the quality and availability of prenatal care in the province, and it is the intention of the following discussion to point to concrete ways in which this Midwifery Philosophy and Model of Practice can be enriched and expanded to be more inclusive of marginalized women.

The authors believe that a variety of programs must to be made available that expand meeting women's non-medical needs within the Midwifery Model of Practice in British Columbia. This position is supported by an extensive review of existing programs in Ontario that target pregnant women of low socio-economic status (15).

In general, offering a wider variety of midwifery practice structures will open up midwifery care to harder to reach populations. A wider variety of practices will benefit certain groups in different ways. For example, midwifery practices which function on a drop-in model co-operated by peer helpers and advocacy workers acknowledges marginalized women's multiple competing priorities and has the potential to tip the 'risk/benefit' balance in favour of booking into care earlier and seeking care more often.

In particular, programs that include Aboriginal community control, that centre Aboriginal health beliefs, cultural traditions, and Elders. However, such program descriptions are beyond the scope of this paper.

> In conversation with Evelyn Harney an Aboriginal Registered Midwife, representing the National Aboriginal Council of Midwives, many of the above points were raised as significant concerns for Aboriginal communities and are tied to their ability to safely access maternity care. She highlighted the importance of supporting Aboriginal communities to direct their own maternity care goals and to be cared for by community members, people who have the opportunity to self-identify as Aboriginal Midwives. She also discussed how a more casual style drop-in prenatal and postpartum care would benefit many clients whose lives aren't conducive to pre-booked scheduled care. These drop-ins would include childcare, snacks and other community resources (93).

What follows below is a brief discussion of some of the favorably-reviewed programmatic elements that meet the particular needs of systemically marginalized childbearing women and their families.

Philosophy

Women have repeatedly reported that care provider bias is a major impediment to satisfaction with prenatal care. It is important for Registered Midwives to examine our own internal biases, and interrogate who we construct as 'risky subjects'. The place to start building midwifery services which are safe and accessible to marginalized women is

to acknowledge that Registered Midwives hold economically-privileged and socially-prestigious positions in society which function to set us apart from many marginalized women and challenge us to understand where women are coming from. Women themselves report that "it is imperative that service providers understand the context of their lives" (Best Start, n.d., p.32: 15).

Cultural safety and trauma-informed care are two examples of methods that health care providers use to bridge the gap between health care professionals personal biases and privileges and marginalized women's lived experiences of structural violence, historical trauma, and a gross lack of the social determinants of health.

While this statement from the Philosophy of Care provides a launching point: "[m]idwifery is holistic by nature, combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of a woman's reproductive health experience" (75) it could be expanded to acknowledge the political and economic underpinnings of health / ill-health and the social and structural determinants of health which have extraordinary consequences for women's experiences of pregnancy and mothering.

Cultural safety

Cultural safety prompts health care providers to examine their internal biases, to acknowledge their own privileges, and increase their competency at providing informed, sensitive, and culturally-safe care to women. The concept of cultural safety was first introduced by nurses and midwives in New Zealand to address the gross inequities in health outcomes among Maori communities and has since been more broadly applied to address mistreatment and stigmatization within health care by Aboriginal and other systemically marginalized populations (7, 54).

The core elements of cultural safety have evolved to include trust and respect, individual and collective autonomy, and social justice, and empowerment (54). The goals of cultural safety include incorporating knowledge of the health-harming consequences of historical processes of colonization, oppression, and social exclusion into the care provider's health practice to create safe clinical experiences for marginalized populations (7, 54). As described by Browne and Fiske, "by examining and contextualizing the complexities of health care encounters involving First Nations women, entrenched attitudes and behaviours that may otherwise perpetuate internal colonialism in mainstream health care begin to shift" (Browne & Fiske, 2001, p. 135: 17).

Trauma informed care

The BC Provincial Mental Health and Substance Use Planning Council defines trauma as "experiences that overwhelm an individual's capacity to cope. Trauma early in life, including child abuse, neglect, witnessing violence and disrupted attachment, as well as

later traumatic experiences such as violence, accidents, natural disaster, war, sudden unexpected loss and other life events that are out of one's control, can be devastating" (55). Trauma is widespread and experienced by many marginalized women; in particular historical and intergenerational trauma has profound implications for entire communities and families. The interconnections between trauma, poor mental health, challenges in maintaining relationships, low self-esteem, and coping through the use of prescribed pharmaceutical or street drugs. Physical health concerns include gastrointestinal irritability, asthma, heart palpitations, chronic fatigue, and chronic pain, including chronic pelvic pain and other gynecological issues. Women who have experienced or continue to experience trauma have complex health and social needs.

Key principles of trauma-informed care include: building awareness among care providers on trauma and the implications of trauma for health and health care; establishing safe and trustworthy environments; having an empowerment model; focusing on recovery as a goal; ensuring adequate opportunities for collaboration and informed choice; focusing on strengths, resiliency, and skills-building opportunities; reducing potential for re-traumatization, being culturally competent and contextualizing women`s experiences, and encouraging consumer input into designing and evaluating services (56, 57). The Trauma-Informed Practice Guide prepared by the TIP Project Team and referenced in this paper is an excellent resource for Registered Midwives.

> "Not that people with good housing and finances don't experience trauma, but there is a bit more --- in how their trauma informs their life. For many of our clients there is no cushion, trauma is screechingly obvious in their lives, and yet has been ignored. Taking that trauma informed approach is an essential part of our practice. And it happens that if you take that approach you're going to hear about it all the time. There are just some days where it's over and over again you hear about it because you're open to hearing about it" (McRae & Wood: 58).

Empowerment

Powerlessness is a fundamental experience in the process of marginalization; embedding the values and practice of empowerment into midwifery services for marginalized women provides an opportunity to engage with women and families in personal transformation. Individual empowerment includes increasing one`s critical consciousness over social context, enhancing control over immediate life circumstances, and working to improve self-esteem; at the levels of organization and community, the goal of empowerment is to work cross-culturally through horizontal collaboration to influence societal change (59, 60). When applied to trauma-informed care, the empowerment model prompts the care provider to relate to women`s experiences, situate them within the broader economic and socio-political context and develop shared critical consciousness, establish mutually-agreed upon goals, establish opportunities for women to engage with others, and ultimately reduce reliance on

professional services and increase mutual aid and resiliency at the level of the community (57).

Alternative Models of Practice

Fundamentals of improved primary prenatal care include shifting services from an institutional to a community-based model, a re-orientation of the professional role, and greater involvement of lay providers and peer-based supports (61). Community-based health care practices include elements of community involvement in design and evaluation of services, greater community involvement in care, and the introduction of group work into the health care practice, and enhanced inter-professional communication and collaboration.

Re-orientation of the Professional Role

The major focus on maternity care for marginalized women and communities is establishing building blocks for healthy mothers, healthy newborns, strong families, and resilient communities. Much of this work is not encompassed within medical care or even health care at all; indeed, much of what we do as compassionate and woman/family centered maternity care providers is address women's and parent's non-medical needs (62).

A re-orientation of the professional role involves shifting the focus of individual or group visits to the expressed needs of women and families over the time-determined medical screenings and tests which are recommended at that time frame. Addressing social needs first as the greatest priority can contribute to a reduced sense of hyper-medicalization and facilitate trusting and meaningful relationships with women.

Community-Based Care & Community Collaboration

Moving from an institutional Model of Practice to a focus on community-based services can take a myriad of forms. It may include meeting women literally where they are at: home, community, coffee shop, or other public place and meeting women where they are at figuratively, in terms of world outlook, social status, and experiences of marginalization (30, 63). Community-based services increase intentional and structured social supports, intentional advocacy, and a reduction in the medicalization of social issues and a lack of the social determinants of health.

> "Be flexible. Tailor prenatal programs to the needs of the community. Ask women to tell you what they need. Involve them in decision making" (Best Start, n.d., p. 7: 15).

Community has been defined in the health literature as "(1) functional spatial units meeting basic needs for sustenance, (2) units of patterned social

interaction, and (3) symbolic units of collective identity (64). Community-based models of health care often have at the core greater involvement of community and peers through the facilitation of social groupings such as parenting classes, women's groups, and other structured social networks (65). Community-based services which involve social networking and mutual aid as a component of care have the potential to reduce women's reliance on the medical system for referral and advocacy, can identify 'natural helpers' and involve them in advocacy and outreach, more deeply involve fathers and other family members in preparation for parenting, fill in gaps for migrant or displaced women who are away from their cultural communities and extended families and potentially reduce post-partum depression and improve coping and mood, and increase access to existing services and encourage mutual aid (15, 33, 66). In particular, supporting the development of peer-networks was identified by Aboriginal women as important part of health-supportive practices (67). It is essential that such community groupings be freely accessible and has no cost associated.

Group care

In 1995 Registered Nurse Sharon Schindler Rising piloted a model of group prenatal care, called CenteringPregnancy, targeted at providing improved access to prenatal care for socially-vulnerable populations combining clinical care and prenatal education in a group setting (68). CenteringPregnancy ideally shifts focus from the traditional professional role, creating much needed space for women to network, share stories and experiences, contribute and strengthen their own knowledge, and develop lasting relationships (68, 69). 'Centering Pregnancy' has been described as an interdisciplinary model of empowerment whereby individual women are empowered to take control over their health, to share resources, strengthen problem-solving skills, and in turn increase the capacity of the community as a whole.

The relationships women build in a CenteringPregnancy group contribute to a strong sense of community, promote community organization, reduce social isolation, and improve women's experiences and perceptions of health (70). Numerous studies demonstrate that group care is empowerment-based care, promoting community, increasing social supports, improving short-term health indicators such as reducing low-birth weight, and ultimately mobilizing women to tackle broader prerequisites for health (71, 72).

Research from the 'All Our Babies' group prenatal care program in Alberta found that 'demographically vulnerable' group participants who scored lower on psychological health in comparison with a control group at the beginning of care scored on par with the control group at the conclusion of care, suggesting that participation in group prenatal care may contribute to improved mental health (73). Yet, CenteringPregnancy is not the only group Model of Practice. Limitations to participation for marginalized women in CenteringPregnancy can include lack of language ability, lack of ability to take time off of work, difficulties in maintaining a set schedule, and being 'crowded out' by middle-class or white women.

Multi-disciplinary Teams & Professional Collaboration

Inclusion of other health care professionals in the provision of prenatal care can help Registered Midwives meet the health care needs of marginalized women outside of the scope of midwifery care without having to refer the woman to an outside program; multi-disciplinary practices ensure appropriate and timely enhanced care for women and newborns. Physicians, Nurse Practitioners, Social Workers, Counsellors, and Nutritionists are examples of other health care disciplines that can be involved in a multi-disciplinary team. Nursing staff in particular, such as Nurse Practitioners, can be essential to building trusting relationships, decreasing hierarchies, and increasing access to public health and community-based services (63). Yet, there also exists a potential to continue the cycle of the medicalization of social needs and over-reliance on health care professionals through professional teams that do not include community members and lay health workers.

Lay providers

While Doulas have been the predominant and most popularized lay health workers involved in the provision of prenatal and postpartum care in North America, the role of the doula is primarily focused on birth support and Doula care has its limitations. There are a number of other exciting examples of how community members can be involved in the provision of care for childbearing women and families.

Some programs in Ontario have built into their teams advocacy workers, 'natural helpers' or other community members who have been identified as someone who women trust and rely on to increase social capital and enhance psycho-social well-being. The role of the advocacy worker has been identified as one that is critical for many women can involve two levels of care: individual support - such as phone calls and referrals, and community action - through mutual support groups of low-income women (15). In Quebec, a very successful pilot program assigned "Godmothers" to poor women; Godmothers also worked on two levels: individual support – making home visits, bringing supplemental food, and providing one-on-one individualized social support, and the collective level – organizing social and recreational activities and informative health promotion meetings whose purpose was to foster non-hierarchical relations and encourage the sharing of life experience (39). Another example is that of "volunteer befrienders" from Northern England where asylum-seeking migrant women were referred by either midwives or refugee organizations and paired with a volunteer, called a "befriender" who then help women navigate a myriad

> "Pregnant asylum-seeking and refugee women often have complex health and social needs which midwives may have difficulty in meeting due to limited resources, but also due to poor attitudes and lack of understanding of their needs" (McCarthy & Haith-Cooper, 2013: 74).

of social services, connect women with social networks already in existence, provide trusted emotional and psycho-social support, and increase reported self-esteem and self-confidence (74). The Best Start review of successful outreach programs identified increasing mutual aid between women as something that women greatly valued and appreciated.

Implications for the Midwifery Model of Practice

It is our hope that the review of the Midwifery Model of Practice as set out by the CMBC will deeply consider the needs of marginalized women and communities in the process of this review. The existing Model of Practice may not preclude the development of any empowerment-based, culturally-safe, trauma-informed care, and community-controlled practices. Yet, it is crucial that any Midwifery Model of Practice review deeply consider ways the existing model might limit innovation with practice models and projects that have potential to address health inequities for marginalized women, families, and communities.

To re-iterate, the best way to meet the complex needs of these communities is by providing variety and flexibility within midwifery services.

Specific Recommendations and Discussion

1) Accountability and Evidence-Informed Practice

Registered Midwives strive to practice in a manner that is both informed by current research and accountable to women, peers, regulatory bodies, health agencies, and the public (76). This professional accountability includes incorporation of both scientific evidence and community input. Yet, at the same time, there is considerable debate over whether the high-intensity, high-frequency model of prenatal care adopted by most developed countries has significantly contributed to a reduction in both maternal-neonatal morbidity or to reducing gross health disparities (77-79) or whether these reductions are more readily facilitated by equitable wealth distribution through progressive taxation and strong social programs which uplift marginalized communities and establish pre-conditions for health and well-being (80).

Further discussion into how prenatal care might be situated within broader social programing in marginalized communities is warranted.

Specific recommendation:

a. That those tasked with the Model of Care review consider evidence for what elements of prenatal care reduce health disparities and improve maternal-neonatal health outcomes in the process of the review (81, 82)[1].

2) Continuity of Care and Shared Primary Care

The Continuity of Care Policy promotes trusting relationships between Registered Midwives and the women and families they care for (83). Yet, specific requirements: a) team size no more than four, b) a known midwife at each birth, and c) at least two antenatal visits with shared-care providers do pose major challenges to midwives and other care providers to participating in collaborative care which may be beneficial to marginalized women in a cost/benefit analysis.

> The supportive relationship "happens in the clinic, it doesn't happen at the birth, the birth if you have the same provider that's just a really nice thing but that's not the piece that sets you up to be ready to have the baby, that's not the piece that feeds you, that's not the piece that helps you get out of a shelter into a house, it's too late, you can't do anything by the time you get to the birth" (Lee Saxell, 84)

After considering how the meaning and practice of continuity may shape care for marginalized women, we wonder if there is potential to include lay providers as important cultural and social actors in the birth process itself. For example, it is highly possible that a doula, an Elder, or another community representative might have a more significant presence at the birth than the medical care provider, whether it's a midwife or physician. In programs actively encouraging the use of lay providers, we feel there is significant weight to their role in ensuring excellence in care for women and families, as well as continuity of care.

Further, when great cultural divides exist between midwives and the populations served, it might be worthwhile to explore the use of Second Attendants as culturally-safe providers.

Specific recommendations:

a. Further study and discussion on why the Model of Practice recommends limiting teams to no more than four midwives;

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[1] Martha Roberts in the process of drafting a PhD research proposal on a similar question of marginalized communities input into models of prenatal care.

b. Deep consideration of whether doulas or other lay health care providers may act as a bridge in providing continuity of care at the birth itself when a known care provide isn't present, or even when there is a known provider;
c. Reconsidering limitations on who may attend as Second Attendant at home births and potentially allowing community members be able to train as second attendants even if other midwives are available;
d. Consideration of expanding the duration of midwifery care to six months or 18 months postpartum to include well-infant and well-toddler care, as well as well-woman care in this period.

3) Informed Choice

Taking additional time to support women through making medical decisions and claiming some degree of control over their birth can be an empowering experience for some women. Yet, informed choice has been criticized as a middle-class concept that is often unfamiliar to marginalized women who, given their systematic exclusion and oppression, face very few real choices into the conditions of their lives. It could be revealing to analyze how the Informed Choice policy encourages women to make some choices in a broader context where many critical decisions have already been made. For example, midwives present women choices around medical tests and procedures and choice of birth place, but perhaps midwives should also consider that women could have input into the model of care they receive.

Specific recommendation:
a. Engage in conversation on how the College of Midwives could include women's preferences for a Model of Practice as an informed choice .

4) Choice of Birth Setting

Finally, while some midwives report that home birth is not an option that is either medically-supported due to active drug-use or other risks, or not of particular interest to their populations (85), it is the experience of other midwives that home birth is of particular importance to many marginalized women, providing a much-needed safe-space away from medical institutions which either have historically, culturally, or legally unsafe and oppressive relations with women (86). It is critically important to protect the option of home birth for marginalized women.

Specific recommendation:
a. In regions where home birth is established, consider creating a process for innovative models of care to opt out of the requirement to offer home birth, and instead direct women who elect home birth to existing midwifery practices.

Implications for Midwifery Remuneration

It is important to consider how expanding the Model of Midwifery Care may open up avenues for acknowledging the extra work midwives do when caring for the needs of more socially complex clients. This, in turn, could start a conversation around additional billing codes allowing midwives to have smaller caseloads when providing more complex care, or for expanding our scope of practice to six to 18 months postpartum to include well-infant and well-toddler care, as well as well-woman care in this period, along with accompanying billing codes. Rural Registered Midwives could particularly benefit from this change as they are the primary maternity care providers in their communities, and rural women often have more complex health needs and face greater barriers in accessing care.

In some ways, the course of care billing structure of midwifery in BC supports midwives to take the necessary extra time with women. This said it would also be beneficial to continue the discussion on involving advocates, peer helpers, and lay health workers in prenatal and postpartum programs for marginalized women; engaging in conversations on how this impacts continuity of care and the need for sustainable funding models is an important part of this process.

Conclusion

The Midwifery Model of Practice review provides the College of Midwives an opportunity to further consider and investigate the evidence for how prenatal care may improve the long-term health and psycho-social outcomes in marginalized communities. Moving forward, the next step is to determine how Registered Midwives may be involved in this process alongside women, families, and communities in whose interests the Midwifery Model of Practice was designed to support.

APPENDIX: The Theory of Marginalization

Everyone has 'theory', whether we know it or not. Theory is the collection of ideas, or the framework, that we use to explain the way the world works. Many feminist theorists believe it is important to expose and identify our own hidden or unarticulated theory in order to grasp the root problems of an issue; an issue such as why poor and marginalized women are a hard-to-reach population.

There are several theoretical traditions which analyze marginalization within colonial and capitalist societies. The following brief overview provides a basic introduction to the importance of social theory in understanding the context within which marginalized women both experience health and make decisions relating to accessing health care. The major theoretical traditions are development theory, critical social theory, postcolonial theory, feminist theory, and intersectionality.

The concept of marginalization has roots in international development theory; in the 1970's economic theorist Samir Amin used the centre-periphery concept to explain the relationship between parasitic social (class) relations under capitalism and oppressive and exploitative relations between nations under imperialism (87). Through colonial conquest, entire nations were forced to an economic periphery in order to provide the raw materials and cheap labour necessary for the burgeoning wealth of the developed nations. Critical social theory extends that critique to examine inequitable economic and power relationships within industrialized societies based on class, with some surviving hand-to-mouth on wage-labour while others hold significant private property, and racialization in the context of ongoing internal colonization in what is now referred to as North America. While critical social theory primarily locates oppression in economic exploitation and unequitable and unjust economic relations, feminist theory contributes an analysis of the role of gendered social relations, of the role of sexual and reproductive roles and gendered social expectations in generating or exacerbating those unequal social relations (88-90). Feminists have also used the analogy of 'margins' in relation to the 'centre' to challenge white chauvinism, Eurocentrism and patriarchal sexism which underpin privilege in society (88).

Postcolonial theory is of particular salience for midwives living in Canada, as it seeks to contextualize contemporary conceptions of race and locate unequitable social relations within the ongoing process of colonization of indigenous territories (7, 91). Postcolonial theory provides "an analytical lens for considering the legacy of the colonial past, and the current sociopolitical climate, as the context in which health care is delivered" (Browne, 2007, p. 2167: 7). More recently, the theoretical work of intersectionality attempts to understand the processes which generate unequal economic and political relations as located in various forms of social difference, including gender, race, and class (92). When applied to women's health, intersectionality aims to clarify that women's experiences of health are, in fact, "both socially constructed and fully 'real'" (Morrow & Hankivsky, 2007, p. 94: 92).

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