Culturally Safe Care & the Ontario Midwifery Model: Exploring the Challenges of Serving Uninsured Immigrant Clients

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Isuri Herath

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Abstract

Immigrant women's healthcare has been one of the major areas of research in the literature on settlement in Ontario, but little research exists on the relationship between immigrant women and their healthcare providers, and even less that is from the perspective of the healthcare provider. This study used semi-structured interviews with 10 midwives who serve uninsured immigrant clientele in order to understand how they navigate challenges to provide culturally safe care. Discourse analysis revealed that participants discussed barriers that were both logistical and conceptual in nature when providing care to uninsured immigrant clients. Midwives indicated that logistical barriers and fear of providing insufficient culturally safe care were factors that made practices more reluctant to take on uninsured immigrant clients. Their discussion of culturally safe care was informed by the Ontario midwifery model, but their strategies for delivering culturally safe care often involved a renegotiation of this model.

Keywords: culturally safe care; midwives; immigrant women; uninsured clients; Ontario midwifery; healthcare.

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Introduction

Immigrant women's healthcare has been one of the major areas of research in the literature on settlement in Ontario. Though research on the reproductive health concerns of immigrant women has typically focused on barriers preventing access to care, the relationship between immigrant women and their healthcare providers, especially from the perspective of the provider, remains undertheorized. Within the broad category of "immigrant women," women who have precarious status are particularly vulnerable in the healthcare system, as they typically do not have health insurance. This study used semi-structured interviews with midwives who serve uninsured immigrant clients in order to understand how they navigate tensions and challenges that arise during the course of care and how they conceptualize their provision of culturally safe care within this relationship.[1] Discourse analysis revealed that participants discussed barriers that were both logistical and conceptual in nature when providing care to uninsured immigrant clients. Midwives indicated that logistical barriers and fear of providing insufficient culturally safe care were factors that made practices more reluctant to take on uninsured immigrant clients. Their discussion of culturally safe care was informed by the Ontario midwifery model, but their strategies for delivering culturally safe care often involved a renegotiation of this model.

I. Context of Study

Previous research conducted in the UK indicates that midwives sometimes discriminate against their immigrant clients,[2] but there is little research on how midwives navigate

[1] While I will be expanding on this term in my literature review, I wanted to briefly define culturally safe care as one that is concerned with ameliorating the "power imbalances, institutional discrimination, colonization, and colonial relationships" that contribute to adverse health outcomes for patients.
Rachelle D. Hole, et al., "Visibility and Voice: Aboriginal People Experience Culturally Safe and Unsafe Health Care," *Qualitative Health Research* 25 no. 12 (2015): 1663.

[2] For example, Bawadi's work covers in great detail the discrimination faced by pregnant Muslim women in the UK healthcare system. It is often assumed that they cannot speak English, especially if they are wearing a hijab. Bawadi

discrimination and provide culturally safe care in Canada, particularly in the Ontario context. Midwifery, which was legalized in Ontario in 1994 after a long campaign,[3] is attracting a more diverse clientele, including immigrant populations.[4] This is partially because of efforts on the part of midwives to prioritize marginalized communities.[5] Considering that midwives serve an increasing number of racialized and immigrant clients[6] and that they are now formally educated on issues of diversity in the Midwifery Education Program (MEP),[7] it would be useful to examine how the profession has shifted to accommodate these clients in its model. I focus on uninsured immigrant women in order to understand how midwives navigate relationships with clients who typically choose their healthcare provider under greater financial restrictions and may opt for midwifery because it may be the only free or low-cost form of healthcare they can access

Neither the Ontario Health Insurance Plan (OHIP), the Interim Federal Health Benefit (IFHB), nor private health insurance cover the following groups: new permanent residents during

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also points out that these women reported having their concerns not taken seriously and being belittled by their healthcare providers. Hala Bawadi, "Migrant Arab Muslim Women's Experiences of Childbirth in the UK," (PhD diss,, De Montfort University, 2009), 56-7.

[3] Daviss offers an overview of the differences between the goals of the alternative birth movement and the related but distinct push to legalize midwifery in Ontario. Betty-Anne Daviss, "Reforming Birth and (Re)Making Midwifery in North America," in *Birth by Design*, eds. Raymond Devries, Cecilia Benoit, Edwin. R. Van Teijlingen, and Sirpa Wrede, (New York: Routledge, 2001).

[4] Karline Wilson-Mitchell and Manavi Handa, "Infusing Diversity and Equity into Clinical Teaching: Training the Trainers," *Journal of Midwifery & Women's Health* 61, no. 6 (2016): 726.

[5] There have been efforts made by the Interim Regulatory Council on Midwifery to reach out to these and other marginalized groups. Examples of vulnerable populations include "Aboriginal, Mennonite, immigrant, and refugee women, francophones, lesbians, teen mothers, incarcerated women, women with disabilities, and women in Northern communities." Anne Ford, and Vicki Van Wagner, "Access to Midwifery: Reflections on the Ontario Equity Committee Experience," in *Reconceiving Midwifery*, eds. Ivy Lynn Bourgeault, Cecelia Benoit, and Robbie Davis-Floyd, (Montreal: McGill-Queen's University Press, 2004): 246-253.

[6] I do not mean to imply that only racialized and immigrant women are in need of culturally safe care, but research has shown that these clients are treated relatively poorly by the healthcare system in Canada—they report having their wishes ignored and their complaints not taken seriously by healthcare professionals. Sapna Patel, and Iman Al-Jazairi, "Colonized Wombs," in *The New Midwifery: Reflections on Renaissance and Regulation*, ed. Farah M. Shroff, (Toronto: Women's Press, 1997): 59.

[7] Farah M Shroff, "All Petals of the Flower: Celebrating the Diversity of Ontario's Birthing Women within First-Year Midwifery Curriculum," in *The New Midwifery: Reflections on Renaissance and Regulation*, ed. Farah M. Shroff, (Toronto: Women's Press, 1997): 261.

the first three months of their arrival; refugee claimants and failed claimants, as well as successful refugee claimants who are not covered under the IFHB; and undocumented and/or irregular migrants.[8] The majority of uninsured individuals in Ontario are immigrants, although there are Canadian-born individuals who opt out of health insurance for religious reasons.[9] Midwives in Ontario have called for the provincial government to cover the healthcare of uninsured clients, and as a result of these efforts, uninsured clients receive free midwifery care if they are residents of Ontario. Nonetheless, even though midwifery services are covered, clients are still responsible for other expenses, such as prenatal tests, medication, consultations with specialists, and hospital fees. Often, because of their financial restrictions, uninsured individuals are referred to midwives by doctors or community health centres.[10] I have decided to use these relationships as an entry point into understanding how midwives provide culturally safe care. These relationships are more likely to involve challenges and tensions, simply because these clients do not have the same degree of choice when entering into midwifery care than clients with health insurance who are choosing midwifery care over physician care.

There is an understanding in midwifery that the profession has improved in terms of social and cultural awareness and that it emphasizes caring for "diverse" populations precisely because of the importance it places on socially just practices.[11] However, there is insufficient research on uninsured immigrant women in Ontario to determine how midwives provide

[8] Karline Wilson-Mitchell and Joanna Anneke Rummens, "Perinatal Outcomes of Uninsured Immigrant, Refugee and Migrant Mothers and Newborns Living in Toronto, Canada," *International Journal of Environmental Research and Public Health* 10, no. 6 (06, 2013): 2200.
[9] Bennett and Burton have explored the experiences of midwives who provide services to both of these groups of women, the latter usually consisting of women from Old Order Amish and Old Order Mennonite communities. Nadya Burton and Nicole Bennett, "Meeting the Needs of Uninsured Women: Informed Choice, Choice of Birthplace and the Work of Midwives in Ontario," *Women's Health and Urban Life*, 12 no. 2 (2013): 26.
[10] "Uninsured Clients," Association of Ontario Midwives, http://www.ontariomidwives.ca/support/uninsured, accessed September 5, 2017.
[11] Nadya Burton and Rachel Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," *Canadian Review of Sociology/Revue Canadienne De Sociologie* 51, no. 3 (2014): 283.

culturally safe care to this specific group of "diverse" clients. As demonstrated in the literature review, researchers have largely ignored issues concerning racialized and immigrant women. It is crucial to understand how midwives navigate challenges that arise with uninsured immigrant clients, not only for the midwives who work with these populations, but also for the profession in general, particularly since it purports to be committed to social justice and providing reproductive care to the most marginalized groups. Examining the relationships midwives have with marginalized clients can help the profession understand how to strengthen its commitment to all birthing bodies.

Because I am most interested in understanding the ways in which midwives conceptualize their care of and relationships with uninsured immigrant women, I focused on the experiences of midwives rather than those of their clients. As many researchers have noted, the viewpoints of midwives are underexplored, especially on the topic of culturally safe care.[12] Additionally, midwives have a wider range of experiences with both insured and uninsured immigrant and native-born clients, whereas clients only have their own birth stories to tell. While the experiences and narratives of clients are valuable, they are not as useful for answering my research question. Finally, I should note that because of this exclusion of uninsured immigrant women's voices, I cannot speak for them, nor claim to represent them. When I am pointing out instances of racism or essentialism, I am careful to qualify the reasons for which it is inappropriate only within midwifery's purported values.

II. Research Question

My research question arises from the gap between midwifery's purported valuation of the importance of culturally safe care and the absence of literature that investigates the ways in

[12] Jane Cioffi, "Caring for Women from Culturally Diverse Backgrounds: Midwives' Experiences," *Journal of Midwifery and Women's Health* 49, no. 5 (2004): 437.

which practising midwives in Ontario are engaging with those values, especially in relation to immigrant clients. Because the current form of North American direct-entry midwifery came out of the alternative birth movement, it is grounded in a feminist praxis that emphasizes women's ability to choose which birth plan is best for them.[13] Yet, early research on immigrant women and midwifery in Ontario dismisses the wishes of immigrant women to give birth in a hospital because it ties those wishes to colonial influences in their home country.[14] What is especially troubling about these attitudes is that they homogenize the experiences of immigrant women by assuming that the colonial context of their home countries entirely determines how they will choose to give birth. This removal of agency is ironic, considering the Ontario midwifery model's insistence on viewing women as active agents, a perspective inextricable from culturally safe care. My research question attempts to bridge these two related but seemingly contradictory pieces of information: that the project of midwifery is grounded in social justice and respect for the agency of its clients, and that immigrant women's disinterest in midwifery care might have reduced them to "colonized wombs" in the eyes of Ontario midwifery. My research explores how midwives in Ontario conceptualize culturally safe care when serving a clientele that now includes a greater number of immigrant clients than it did at the time of the profession's legalization.

In this study, I have asked how midwives navigate the challenges and tensions that arise in their professional relationships with uninsured immigrants in order to provide culturally safe care.[15] By tensions, I mean any challenges or conflict that arise from the differences of opinion

[13] For more on the ABM, see Daviss, "Reforming Birth and (Re)Making Midwifery in North America."
[14] Patel and Al-Jazairi, "Colonized Wombs," 64.
[15] While I want to avoid reifying an already problematic identity category, I still use the term "uninsured immigrant women" to refer to a group that is socially constructed as racialized, impoverished, and marginalized within Canadian society. Rose Baaba Folson has unpacked the various significations bound up in the idea of the "immigrant woman" and she argues this identity tends to stick to racialized bodies within Canada.

between the midwives and clients regarding the nature of the care being provided, or when clients need a different kind of care than what midwives are used to providing. After reviewing the literature, I decided to focus specifically on whether midwives navigate these challenges and conceptualize culturally safe care in a manner that respects cultural differences and reads individuality and agency into the choices made by their uninsured immigrant clients.

III. Researcher Location

My location as a researcher is informed by my experiences as a feminist, doula, activist, racialized immigrant woman, and academic. At the time of writing this, I am also a few weeks away from beginning my studies in the Midwifery Education Program at Ryerson University. As someone who wishes to become a midwife, who possesses an academic background in women's studies, and who has trained as a doula, I share many values of the midwifery profession in Ontario. The axioms I am bringing to my research are that all women deserve culturally safe care and can identify for themselves what is best for their bodies. Though these are values championed by midwifery, I nonetheless investigated whether these claims are true to life in relation to legally and socioeconomically marginalized groups of women.

I was both an insider and an outsider to the 10 midwives I interviewed. These midwives were all educated and practising in Ontario, and the majority of them were white and over 30. I was an insider because of my involvement in alternative birth practices through my work as a doula, and because I am well versed in the feminist theories fundamental to midwifery. This seemed to put my participants at ease, as they may have felt that I was not trying to paint an unflattering picture of the profession. Berger discusses the potential benefit of the insider-outsider role when conducting research, which may cause participants to feel more comfortable

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Rose Baaba Folson, "Representation of the Immigrant," in *Calculated Kindness: Global Restructuring, Immigration and Settlement in Canada,* ed. Rose Baaba Folson, (Halifax: Fernwood, 2004): 30.

opening up to an individual because of shared traits or similar social positioning.[16] Despite sharing many similarities with my participants, a few crucial components of my identity may have made accessing their opinions particularly challenging. I am a young woman of colour from the Global South, and it may be that the white midwives I interviewed did not feel comfortable discussing instances of racism or culturally insensitive behaviour with me.

Berger mentions disrupting the "discourse of the 'other'" is a central part of ensuring that the power dynamic between researcher and participant is a relatively ethical one.[17] However, the power dynamic between me and my participants is not a straightforward one. My participants all had more social status and economic capital than I do within Canadian society. They may have actually 'othered' me as a racialized woman or simply felt uncomfortable admitting to conscious or unconscious and unintentional racist assumptions or behaviour. However, as a researcher, I still had a lot of power during our interactions. Midwifery is still marginalized in the Canadian context, and questioning its professional practices may make it more vulnerable to criticism from the mainstream, even when such questioning acknowledges the tremendous benefit midwifery has provided to its clients. My goal with this project was neither to romanticize my participants nor to focus on their failings as healthcare providers, but to explore the ways in which they cared for a particularly vulnerable population, both as individuals who are deeply committed to the care work they provide and practitioners of a profession legitimized by the exoticization of Third World Women's bodies.[18] My position within this project and this community is one that is best defined as hopeful—both because I see much value in midwifery care, but also because I acknowledge the ways in which midwifery is a profession that has historically had a harmful

[16] Roni Berger, "Now I See It, Now I Don't; Researcher's Position and Reflexivity in Qualitative Research," *Qualitative Research* 15, no. 2 (2013): 220.
[17] Ibid., 221.
[18] This historic engagement is an important part of the context of this project that I explore in my literature review.

engagement with racialized women. This project was my attempt to grapple with these questions for myself, and explore the ways in which Ontario midwifery engages with these bodies when they are present in the Global North.

IV. Organization of the Major Research Paper

This paper begins with an overview of the literature on immigrant women's healthcare and midwifery in Ontario. Then, after identifying the gaps in the literature surrounding midwives' relationships with their uninsured immigrant clients, I outline the theoretical framework I have constructed to understand the aspects of culturally safe care most crucial to my research question. I discuss the methodology of this project and challenges I encountered while recruiting, interviewing, and analysing my data. The results of my interviews with participating midwives are presented thematically, and I discuss the ways in which these themes reveal how participants conceptualize and deliver culturally safe care. I conclude by discussing the areas of culturally safe care and uninsured immigrant populations that require further research.

Literature Review

Immigrant women's reproductive healthcare has been conceptualized as an important factor in their integration and settlement in Canada. Much attention has been paid to the considerable issues that concern both the access to and the delivery of reproductive healthcare services. Immigrant women have spoken of feeling disempowered or discriminated against by their healthcare providers and the healthcare system in general.[19] Bierman, Ahmad, and Mawani have developed a useful theoretical framework for conceptualizing immigrant women's health determinants at the micro-, meso-, macro-, and geopolitical levels.[20] Geopolitical factors include reasons for migrating and immigration policies, macro-level factors include policies and culture within the host country, and micro-level factors include literacy, language, and health beliefs. While micro- and macro-level factors have been explored in the literature, meso-level factors have remained marginal. Examples of meso-level factors include discrimination and access to healthcare services—these are determinants that are neither specific to the individual, nor generalizable to the entire host country.[21]

An excellent entry point into understanding meso-level factors is the relationship between immigrant women and their healthcare providers. Exploring and theorizing this dynamic allows for a richer understanding of how it shapes the experiences of immigrant women in the healthcare system. This study focuses on how culturally safe care is conceptualized and delivered by midwives in Ontario. Culturally safe care is largely bound up in the relationship between a healthcare practitioner and their client, which makes it an excellent factor to consider when

[19] Patel, and Al-Jazairi, "Colonized Wombs," 59.
[20] Arlene Bierman, Farah Ahman, and Farah N. Mawani, "Gender, Migration and Health," in *Racialized Migrant Women in Canada: Essays on Health, Violence and Equity*, ed. Vijay Agnew, (Toronto: University of Toronto Press, 2009): 104-5.
[21] Ibid.

theorizing meso-level healthcare determinants. While this relationship has been generally understudied and undertheorized, it is a particularly marginal topic in the literature on midwifery—a profession arguably more centered than others on the relationship between its practitioners and clients. With this in mind, the following literature review has two related goals in order to contextualize this relationship. The first is to briefly review the literature on immigrant women's reproductive health concerns in the Ontario context and understand the importance of culturally safe care for these populations. The second is to investigate how immigrant women have been presented in the literature on midwifery and how they might be positioned within the Ontario midwifery model.

I. Barriers for Immigrant Women in Healthcare

Oxman-Martinez, Abdool, and Loiselle-Léonard outline of some of the barriers immigrant women and refugees face when they arrive in Canada. They emphasize social factors that operate on a personal level, such as social isolation, physically and financially abusive partners, and traumatic pre-migration experiences.[22] Gagnon et al. note that in addition to the language barrier, finding a family doctor, finances, transportation, and physical distance from healthcare services, there are also structural barriers to access that stem from healthcare practitioners themselves.[23] For example, some nurses have refused to care for Canadian-born infants whose mothers are covered under Canada's Interim Federal Health Program (IFHP) because they were not sure if the services were covered by this health plan.[24] Lu Wang has explored the impact of geography on the ability of Chinese immigrants to access "culturally

[22] Jacqueline Oxman-Martinez, Shelly N. Abdool, and Margot Loiselle-Léonard, "Immigration, Women and Health in Canada," *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 91 no. 5 (2000): 391.
[23] Anita J. Gagnon et al., "Developing Population Interventions with Migrant Women for Maternal-Child Health: A Focused Ethnography," *BMC Public Health* 13 no. 1 (2013): 473.
[24] Lisa A Merry et al., "Refugee Claimant Women and Barriers to Health and Social Services Post-Birth." *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique* 102, no. 4 (2011): 288.

diverse family physicians." She found that there were strong preferences, both stated and revealed, for Chinese physicians among her participants.[25] The reason given for this preference is similar to the one stated by Muslim women in George, Terrion, and Ahmed's study: participants wanted to avoid cultural misunderstandings and language difficulties.[26]

Culturally safe care is clearly a necessity for diverse groups, who may be marginalized because of "social context, socioeconomic status, gender, sexuality, language differences, and religious and ethnic backgrounds."[27] However, the perspectives held by and the roles played by the healthcare professionals who serve these populations remain largely understudied and undertheorized, especially in the context of reproductive healthcare. The focus is on ways in which the women's "culture"[28] impedes their healthcare, rather than the ways in which insensitivity and neglect within the healthcare system may be a key determinant in the services they receive.[29] Bierman, Ahmad, and Mawani remark that culture is often theorized in the literature on health beliefs, behaviours, and practices in reductionist and essentialist ways that do not take into consideration the heterogeneity and complexity found within cultural groups.[30] Johnson et al. agree with this assessment, as they claim that the focus on cultural difference

[25] 80% of her participants stated that they preferred a physician of Chinese ethnicity, and 96% were using only Chinese physicians. Only one participant stated that there was a preference for a non-Chinese physician.
Lu Wang, "Immigration, Ethnicity, and Accessibility to Culturally Diverse Family Physicians," *Health and Place* 13 no. 3 (2007): 660.
[26] Pamela George, Jenepher Lennox Terrion, and Rukhsana Ahmed, "Reproductive Health Behaviour of Muslim Immigrant Women in Canada," *International Journal of Migration, Health, and Social Care* 10, no. 2 (2014): 92.
[27] Burton and Ariss, "Diversity in Midwifery Care," 266.
[28] While this paper does lean on this term as though it is a coherent one, I wish to acknowledge that it is a deeply problematic concept as well. Uma Narayan offers a wonderful complication of what she calls the "package picture of culture," by pointing out that there is so much diversity within cultures that to think of them as stable or homogenous does disservice to those within them, as well as to those who study them.
Uma Narayan, "Undoing the "Package Picture" of Cultures," *Signs* 25, no. 4 (2000): 1084.
[29] Bierman, Ahman, and Mawani, "Gender, Migration and Health," 123.
[30] Ibid.,123.

between immigrant women and their healthcare practitioners actually obscures the broader structures of power that shape these women's experiences in the healthcare context.[31]

Bierman, Ahmad, and Mawani have responded to this reductive portrayal of barriers by proposing a new conceptual framework that seeks to incorporate the bodies of literature on the social determinants of health, gender equity, ethnic and racial health inequities, and migration and settlement.[32] Their framework takes into account the factors that shape the experiences of immigrants with healthcare both pre- and post-migration, and divides them amongst the macro-, meso-, micro, and geopolitical-levels.[33] Organizing them in this way allows for a greater level of engagement with the larger power structures that impact immigrant women's health behaviours and health outcomes. It also becomes clear that the macro- and micro-level have already been theorized within the literature on immigrant women's healthcare access. The meso-level includes health services and discrimination, and it is here that culturally safe care can inform this framework by highlighting the importance of the relationship between practitioners and clients.

One of the most important aspects of this relationship to explore is how healthcare providers navigate tensions that arise during the course of care, as well as how these providers conceptualize the role that culturally safe care might play in the care. Research on midwives is especially lacking. Newbold and Willinsky have attempted to address this gap by conducting interviews with reproductive healthcare professionals who work with immigrants.[34] These healthcare professionals identify challenges based on a difference in language and culture when

[31] Joy L Johnson et al., "Othering and Being Othered in the Context of Health Care Services," *Health Communication* 16 no. 2 (2004): 255.
[32] Arlene Bierman, Farah Ahman, and Farah N. Mawani, "Gender, Migration and Health," in *Racialized Migrant Women in Canada: Essays on Health, Violence and Equity*, ed. Vijay Agnew, (Toronto: University of Toronto Press, 2009): 104-5.
[33] Ibid.
[34] K. Bruce Newbold, and Jacqueline Willinsky, "Providing Family Planning and Reproductive Healthcare to Canadian Immigrants: Perceptions of Healthcare Providers," *Culture, Health & Sexuality* 11 no.4, (2009): 374.

serving immigrant women.[35] These are the same issues that immigrant women also identify when discussing their reproductive healthcare. Interestingly, while their participants identified issues with gender, their observations extended beyond how their own gender might affect their interactions with female immigrant clients. They also used a racialized conception of gender to explain how these women might not be making decisions in collaboration with their partners, mentioning that their clients sometimes have to make reproductive healthcare choices behind the backs of husbands because of the controlling nature of these men.[36] While it is not necessarily problematic to identify these dynamics, it is certainly reductive to attribute them to the men's cultural nature.

These findings are consistent with the research conducted by Johnson et al. in "Othering and Being Othered." The authors discuss the toll that culturally insensitive healthcare can have on South Asian women and found there were three main forms of othering taking place: essentialist explanations, racialist explanations, and culturalist explanations.[37] Essentialist explanations are narratives ascribed to South Asian women that arise from "ahistorical and abstracted" overgeneralizations about "culture, race, location, social background, and healthcare practices."[38] Racialist explanations portray South Asian women as passive and helpless.[39] Healthcare practitioners were also shown to conflate the language barrier that immigrant women faced with their race. They assumed that visible minorities would not speak English, and that this is what prevents them from being able to access adequate healthcare.[40] Culturalist explanations, similar to the racializing and essentializing explanations, drew on stereotypes of South Asian

[35] Ibid.
[36] Ibid., 376.
[37] Johnson et al., "Othering and Being Othered in the Context of Health Care Services," 267.
[38] Ibid., 260.
[39] Ibid., 263
[40] Ibid.

women as passive, helpless, and ignorant about their health.[41] These approaches to South Asian women's health behaviours by healthcare practitioners allow racist and sexist biases to influence their perceptions of these clients.

II. Importance of Culturally Safe Care

Culturally safe care is especially important to vulnerable populations because of the systems of discrimination that affect the quality of their healthcare. A great deal of the literature arguing for culturally safe care in the Canadian context is based on the needs of Indigenous communities. Hole et al. discuss the cultural safety model,[42] which they describe as a model in which "the healthcare practitioner/educator/professional, whether Indigenous or not, can communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm."[43] What is crucial to the cultural safety model of care is that it extends its analysis beyond the individual relationship between the practitioner and the patient, in order to understand the "power imbalances, institutional discrimination, colonization, and colonial relationships" that determine the healthcare that patients are able to access.[44] Patients who were interviewed mention the marginalization they experienced at the hands of healthcare practitioners, including having their wishes ignored, being judged harshly by the hospital staff because of their identity, and not being believed when they reported problems with their health.[45]

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[41] Ibid., 262

[42] A model of care that emerged from work within New Zealand's Maori population. I mention this specifically because I do not wish to ignore the importance of this model for the care of Indigenous communities. Even though I am discussing culturally safe care in the context of immigrant populations, it is still important to acknowledge the roots of this concept. However, it may also be useful to understand how there are strategic alliances that can be built between Indigenous communities and immigrant populations in navigating the colonial violence found in the Eurocentric medical model of care.
Rachelle D. Hole, et al., "Visibility and Voice: Aboriginal People Experience Culturally Safe and Unsafe Health Care," *Qualitative Health Research* 25 no. 12 (2015): 1663.

[43] Ibid.

[44] Ibid.

[45] Hole et al., "Visibility and Voice," 1668.

As Vogel points out, the concept of cultural safety relies heavily on the patient's perception of the relationship. If Aboriginal participants reported feeling unsafe in a hospital environment, then they have most likely not received sufficient culturally safe care. A client's feeling of safety is a better indicator of whether they are receiving culturally safe care than how those who are managing the practice feel about it.[46]

What is interesting is that many of the factors Hole et al. identify as the cause of unsafe environments for Aboriginal people are similar to those immigrant women identify when receiving reproductive care in Ontario. For example, Shroff illustrates that immigrant women report difficulties during childbirth and attribute them to the way they are treated by physicians in hospital settings. She points out that there is an assumption that if clients do not speak English, medical professionals feel as though they do not have to worry about consent to the same degree.[47] However, Shroff pushes the discussion further than the issue of language barriers, and insists that "cultural appropriateness" is also a key to understanding how to deliver accessible care.[48] Another common problem that has been reported is the inability of healthcare practitioners to sensitively and appropriately interact with women who have undergone female circumcision. Up to 87% of Somali women in one study reported hearing hurtful comments from their healthcare practitioners on the subject of their circumcisions.[49] Furthermore, Sikh women have been shaved against their will by hospital staff while giving birth, while other women have been given instructions repeatedly by nurses that explicitly go against cultural advice given to

[46] Lauren Vogel, "Is Your Hospital Culturally Safe?" *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne* 187 no. 1 (2015): 13-4.
[47] Shroff, "All Petals of the Flower," 279.
[48] Ibid., 278.
[49] Gina MA Higginbottom, et al., "Immigrant Women's Experiences of Maternity-Care Services in Canada: A Systematic Review Using a Narrative Synthesis," *Systematic Reviews* 4, no.1, (2015): 25.

them by older female relatives, only to be then shamed by the nurses when they hesitate to comply.[50]

Culturally safe care does not have a single definition, but researchers in the field of midwifery have theorized various elements that go into providing it. While earlier conceptions such as "cultural awareness" and "cultural sensitivity" focused merely on recognizing cultural differences and avoiding offending clients, eventually the focus shifted to actively empowering and supporting clients across cultural differences. Cioffi notes that merely recognizing cultural difference is insufficient, and the "cultural competency" model actively incorporates the client's values and needs into their care.[51] Denman-Vitale and Murillo argue that in order to provide "culturally competent" care, healthcare professionals must understand their own culture's "values and beliefs" in addition to other cultures'. Williamson and Harrison suggest that Denman-Vitale and Murillo's approach might actually lead to harmful, stereotypical generalizations that neglect treating patients as individuals.[52] On similar grounds, Cioffi discusses how her study on midwives revealed that while they are able to clearly display knowledge and recognition of the beliefs and practices of other cultures, they are not equally capable of articulating intracultural differences—that is, seeing women as individuals and understanding that there is significant variation within cultural groups.

An integral aspect of culturally safe care is a nuanced understanding of agency. Indeed, this is the piece that seems to be he necessary step between merely understanding cultural difference and striving to understand clients as individuals, rather than as homogenous members of a cohesive culture. While there are feminist schools of thought which argue that systems of

[50] Patel and Al-Jazairi, "Colonized Wombs," 59.
[51] Cioffi, "Caring for Women from Culturally Diverse Backgrounds," 437.
[52] Moira Williamson, and Lindsey Harrison, "Dealing with Diversity: Incorporating Cultural Sensitivity into Professional Midwifery Practice," *The Australian Journal of Midwifery* 14, no. 4 (2001): 23.

domination effectively create cultures where agency cannot be a meaningful concept for marginalized populations, I believe it is impossible to develop a framework for culturally safe care that does not understand agency in a more nuanced way.

Finally, culturally safe care demands reflexivity on the part of the practitioner. De Souza notes that unlike cultural competence or cultural sensitivity, cultural safety requires understanding oneself, and not just "the other."[53] This shifts the focus of the care from looking at the individualized needs of the client and understanding the broader sociopolitical context that the healthcare provider and client are positioned within.[54]

III. Ontario Midwifery Model of Care

Many of the issues identified by immigrant women are addressed by the midwifery model of care, which emphasizes continuity of care and providing the clients with as much agency in their healthcare decisions as possible.[55] However, while a significant amount of research clinically explores the reproductive health concerns of immigrant women, little is written on the relationship between midwives and their immigrant clients and how culturally safe care is actually conceptualized and delivered. Especially needed is an understanding of how this relationship might be informed by the broader Ontario midwifery model.

Current writing on the diversity within Ontario midwifery has mainly focused on how professionalization systemically excluded racialized immigrant midwives. Professionalization is a topic that has been covered by Bourgeault, Benoit, and Nestel, among others. Nestel's work specifically engages with the racialization of midwives and the consequent exclusion of racialized midwives from the Ontario midwifery movement. She argues that racialized and

[53] Ruth De Souza, "Migrant Maternity," (PhD diss., AUT University, 2011), 14.
[54] De Souza, "Migrant Maternity," 14.
[55] Margaret MacDonald, *At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home,* (Nashville: Vanderbilt University Press, 2007), 45-7.

immigrant midwives were excluded from the push to legalize midwifery in Ontario because it was believed they would threaten the legitimacy middle-class, white, educated midwives wished to associate with the profession.[56] The campaign to have midwifery recognized as a legal and legitimate healthcare profession necessarily excluded midwives of colour, especially those from the Global South.

Nestel points to the irony of this exclusion, as Ontario midwifery, and the alternative birth movement more broadly, has used the writings of anthropologists that glorify the birthing practices of women and their midwives in the Global South in order to legitimize itself. The anthropological roots of the midwifery movement influenced the problematic assumptions of childbirth reform activists about the birthing bodies of Third World Women and their immigrant counterparts in the Global North. Nestel explains how Mead and other anthropologists glorified the childbirth experiences of Third World Women in order to claim that women in the First World had lost the ability to birth "normally" because of the technology involved in birth interventions. She points out that these anthropologists romanticized and glorified the non-technological manner in which these women laboured without acknowledging the risks present, as demonstrated by the relatively high mortality rates.[57] The exoticizing assumptions and totalizing narratives about the bodies of Third World Women became central to the alternative birth movement, and subsequently Ontario midwifery, because they informed their arguments for natural childbirth, which they considered the ideal state for women. Nestel astutely notes that while these anthropological accounts seem to champion values of diversity and inclusion, they actually reinforce absolutist notions of difference by essentializing the identities of Third World

[56] Sheryl Nestel, *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery*, (Toronto: University of Toronto Press, 2006).
[57]Sheryl Nestel, ""Other" Mothers: Race and Representation in Natural Childbirth Discourse," (master's thesis. University of Toronto. 1994), 25-7.

Women, as well as the cultures they were from.[58] However, this research is over two decades old, and the ways in which the Ontario midwifery community may have reconfigured these views in light of their changing clientele has not been explored. Furthermore, the current literature on midwives and their clients does not sufficiently explore how the profession's understanding of culturally safe care has been informed by this anthropological model.

MacDonald's *At Work in the Field of Birth* describes how "nostalgic notions of natural birth experienced by traditional non-Western women" in Ontario midwifery were informed by anthropological examinations of birth in the Global South. However, MacDonald's work fails to engage with the effects of these imaginings on immigrant midwives or immigrant clients. Her research acknowledges the literature used by midwives for educational purposes that draws heavily upon reductive and racist anthropological accounts of birth in other cultures.[59] Despite this, she does not complicate the essentializing and fetishizing of Third World Women's bodies and births in contemporary midwifery.

While knowledge and epistemic privilege are rarely mentioned in writings on midwifery, it is important to draw out and explore the construction of knowledge in this profession. Just as important is the proper situation of midwifery's differences from the medical system in which it participates and from which it distinguishes itself.[60] A crucial dimension I will briefly explore is the ways in which midwifery produces and legitimizes knowledge. Davis-Floyd, a cultural anthropologist, and Davis, a midwife, have explored how midwives highly value intuition as authoritative knowledge and how this is directly at odds with the technological model of birth. Davis-Floyd has argued that diagnostic technologies in childbirth construct the fetus as a

[58] Ibid., 32.
[59] MacDonald, *At Work in the Field of Birth,* 54.
[60] Ibid. 157.

separate being from its mother, and in doing so, medicalize pregnancy and render women invisible and inaudible.[61] The medical model of childbirth lends authority to knowledge that is bound up in machines and those who know how to manipulate and interpret them. These machines are valued over bodies, and consequently, technology is valued over nature.[62] The authors go on to demonstrate that there are women in the United States who "supervalue" nature and their bodies over science and technology, and this leads them to ground themselves in a "holistic model of birth," which is promoted by the home birth movement.[63] This movement can be understood as "egalitarian, nature- and female-oriented, and based on right-brained principles of holism and connection," while medical "technocracy" is "hierarchical, male-dominated, machine-oriented, and based on left-brained principles of separation and discrimination."[64] We can see how contemporary midwifery has defined itself in opposition to the medical model.

In terms of the specific relationship between midwives and clients in the Ontario midwifery model, Benoit has usefully theorized a few of the pervading tensions, including those that came about because of professionalization. She argues that professionalization might estrange midwives from their clients by portraying midwives as labourers rather than partners. [65] Benoit's approach to the client/midwife relationship insists on taking into account the diversity of both midwives and clients, demonstrating that midwifery is not actually a straightforward partnership between the two.[66] Her sample group of midwives, however, did not discuss

[61] Robbie Davis-Floyd, and Elizabeth Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth," *Medical Anthropology Quarterly*, New Series, 10, no. 2 (1996): 237.
[62] Ibid.
[63] Davis-Floyd and Davis, "Intuition as Authoritative Knowledge," 239.
[64] Ibid.
[65] Benoit acknowledges the argument that professionalization of midwifery will ruin the otherwise harmonious partnership between midwife and mother, but she points out that this model assumes that midwives and clients do not experience power differentials informed by race, class, or immigration status.
Cecilia Benoit, "Uneasy Partners: Midwives and Their Clients," *The Canadian Journal of Sociology* 12, no. 3 (1987): 276.
[66] Ibid.

racialized or immigrant bodies. Despite this, Benoit points out a tension that exists for culturally diverse clientele within midwifery. Lower class, ethnic, and rural women often err on the side of avoiding natural childbirth and embracing the rare opportunity to be medicated and managed by someone else, which is at odds with the midwifery model.[67] These clients fall outside of what Benoit calls "ideal clients" in the eyes of the "new midwifery" that was struggling for institutionalization across Canada.

Sharpe has also taken up the shift in relationships between midwives and their clients after professionalization. Midwives in her study stated that they were "delighted" with the diverse clients that they were seeing, but that they were "wary" of clients who did not behave in a manner that matched the values and philosophy of Ontario midwifery.[68] Sharpe notes that there is no evidence that her participants treated their "non-ideal" clients any differently, even though they did not enjoy serving these clients as much as the ones who agreed with them by being pro-breastfeeding, wanting to resist medicalization, and asking for home births.[69]

I do want to specifically distinguish the Ontario midwifery model from the alternative birth movement, home birth movement, and childbirth reform movement. While these are all interconnected movements, I am specifically addressing the Ontario midwifery model, as it is the most specific to the context in which I did my research, and is also the only one with a codified set of values. MacDonald offers a useful overview of the Ontario midwifery model and its three central tenets—informed choice, continuity of care, and choice of birth place. Central to the Ontario midwifery model is the belief that women should be active agents in their own pregnancy and labour. Informed choice is linked in midwifery to the deeper philosophical belief

[67] Benoit, "Uneasy Partners: Midwives and Their Clients," 278.
[68] Mary Josephine Donovan Sharpe, "Intimate Business: Woman-Midwife Relationships in Ontario, Canada," (PhD diss., University of Toronto, 2004), 372.
[69] Ibid., 373.

that the healthcare practitioner's relationship with the client should be egalitarian rather than hierarchical. This means that the client's wishes are respected, even when they are different than community norms.[70] Continuity of care in the Ontario context is a model that tries to ensure that a small team of midwives will care for a woman throughout her pregnancy and postpartum period.[71] Continuity of care is often linked to the capacity to provide a high quality of care—midwives are able to get to know their clients better through longer appointments over the course of their entire pregnancy, and this helps them make choices as partners and provide them with tailored care.

IV. Immigrant Women and Midwifery

The assumptions and attitudes toward Third World women reveal themselves in pieces written about immigrant clients, sometimes with titles as fatalistic as "Colonized Wombs," a chapter in Shroff's *The New Midwifery: Reflections on Renaissance and Regulation*. Through interviews, Patel and Al-Jazairi draw on the voices of immigrant women and explore their reasons for not seeking out midwifery. The authors claim that immigrant women of colour have more faith in the "technomedical machine" because of imperialist and misogynist impulses.[72] Because midwifery has been marginalized by colonial systems in their home countries, the assumption is that these women are not making thoughtful, informed choices by preferring to give birth in hospitals. This highly condescending characterization denies women agency and portrays them solely as victims.[73] Their preferences become reduced to the colonial legacy that

[70] "Informed Choice," Association of Ontario Midwives. http://www.ontariomidwives.ca/midwife/philosophy/informed, accessed September 5, 2017.
[71] "Continuity of Care." Association of Ontario Midwives. http://www.ontariomidwives.ca/midwife/philosophy/continuity, accessed September 5, 2017.
[72] Patel and Al-Jazairi, "Colonized Wombs," 64.
[73] An interesting perspective to bring into this discussion would be the work that has been done around another practice that Third World Women are imagined to be victimized by—sex work. Kamala Kempadoo has imagined a framework that allows feminism to take into account the structural and historical context for women in the Global South while still accounting for their agency within these systems. She argues that in this school of thought, women

haunts their homelands. Even the reluctance of research participants to endorse traditional midwifery—they insisted it was really a choice every woman had to make for herself—was interpreted as submitting to imperialist forces.[74] Rather than engaging with the complexity of choices and recognizing and respecting agency and resistance, these midwives instead dismiss the idea that demanding medical care in a host society might be an act of survival. This is a deeply problematic attitude that strips immigrant women of agency in their healthcare decision making.

New empirical research on midwifery practices are needed as Patel and Al-Jazairi's, Nestel's and MacDonald's work is now more than a decade old, and may not any longer reflect the current relationships between immigrant women and their midwives. New empirical research is also needed due to changes among the clients of midwifery. Because midwifery has been publicly funded, midwives are now getting clients who are different from the women who made up the alternative birth movement and specifically demanded home births.[75] Whereas the alternative birth movement primarily consisted of white, middle-class, well educated women, midwives are now increasingly serving racialized, immigrant, and lower-class clients.[76]

MacDonald notes that some midwives resent the fact that these clients may not be choosing midwifery because of its political roots, but instead viewing it as a "consumer choice."[77] Although MacDonald does not clarify which group she is referring to, there are two

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are self-determining and capable of navigating these violent systems for their own advancement. While she speaks to trafficking specifically, this framework is useful for unpacking how immigrant women navigate medical and midwifery models when deciding how they will experience childbirth.
Kamala Kempadoo, "Victims and Agents of Crime: The New Crusade Against Trafficking," in *Global Lockdown: Race, Gender, and the Prison-Industrial Complex*, ed. Julia Sudbury, (New York and London: Routledge, 2005): 36.

[74] Patel and Al-Jazairi, "Colonized Wombs," 66.

[75] Margaret MacDonald, "Tradition as a Political Symbol in the New Midwifery in Canada," in *Reconceiving Midwifery*, eds. Ivy Lynn Bourgeault, Cecelia Benoit, and Robbie Davis-Floyd, (Montreal: McGill-Queen's University Press, 2004): 56.

[76] Wilson-Mitchell and Handa. "Infusing Diversity and Equity into Clinical Teaching," 726.

[77] MacDonald, "Tradition as a Political Symbol in the New Midwifery in Canada," 56.

possible groups of clients that this evaluation might apply to: wealthier white women who want midwifery because of its quality of care, rather than its political background; and uninsured clients who are choosing midwifery because it is free, rather than because of the type of care it represents. I would suggest that Third World Women might find themselves in in a catch-22, wherein they are either "colonized subjects" who meekly submit to the medical model, or they are "bad" midwifery clients who cannot understand or engage in the countercultural aspects of midwifery. Either way, they are positioned as subjects who cannot critically engage with their own birthing experiences.

Perhaps the most comprehensive work on diversity in the context midwifery care in Ontario is that of Burton and Ariss. Their 16 interviews reveal how midwives frame their efforts to "support social diversity" as a continuing challenge to the medicalized model of childbirth.[78] Interviewed midwives actively deployed some strategies to help ensure that their more vulnerable clients would be able to access their services. This included offering birth spaces in their clinics, which were mostly used by uninsured immigrant women who could not afford hospital care, but who did not want to give birth at home for reasons of space, lack of privacy, and distance from hospital.[79] Midwives also kept late-to-care spots open for clients, which were mostly used by vulnerable populations who may not have had any prenatal care before accessing midwifery.[80]

While Burton and Ariss' study did an excellent job of exploring how midwives from both dominant and marginalized communities view incorporating diversity into care, it did not explore the question of how midwives actually conceptualize culturally safe care and how they

[78] Burton and Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," 283.
[79] Ibid., 276.
[80] Ibid., 276

deliver it. The authors mention how midwives value "cultural humility"—an incorporation of self-reflection and awareness of one's own social location into the provision of care.[81] However, the article's focus was on midwives' conception of "diversity" rather than culturally safe care. Nonetheless, midwives did speak of the importance of being "exposed" to other cultures and actively needing to pursue this cultural competency.[82] Burton and Ariss explore how midwives provide culturally safe care to clients, but narrow their focus on the ways in which clients were accepted into midwifery practices in the first place. While the authors did an excellent job of exploring how midwives conceptualize diversity, it left the question of how midwives take these conceptions forward in relationships with individual clients largely undertheorized.

Uninsured clients are a significant group of midwifery clients, if only because midwives had to negotiate with the Ontario government for permission to provide them with care without charging them. Bennet and Burton have written on uninsured clients, but their focus has primarily been on religious communities that opt out of health insurance.[83] Other groups that do not have insurance include refugee claimants, permanent residents who have a three-month waiting period before being eligible for OHIP coverage, and undocumented and irregular migrants.[84] Because midwifery claims and strives to be grounded in social justice, centering uninsured immigrant clients in research would provide a useful way of understanding how midwifery provides culturally safe care to some of its most vulnerable clients.

[81] Ibid., 281.
[82] Ibid., 277.
[83] Burton and Bennett, "Meeting the Needs of Uninsured Women," 26.
[84] Wilson-Mitchell and Anneke Rummens, "Perinatal Outcomes," 2200.

Theoretical Framework

This project's theoretical framework draws on a few emerging concepts from varied bodies of literature. While conducting my literature review, I noticed that although some elements of culturally safe care were important to my research question, there was no single coherent framework that articulated all the dimensions of culturally safe care. In order to best understand how to analyse the responses of participants and answer my research question, I developed the following framework to conceptualize culturally safe care. By no means do I assert it to be an all-encompassing model of culturally safe care, but the aspects I have chosen are the ones that will best address the gaps in the literature that I have identified.

Let me also note that the aim of this project is not to understand whether or to what extent midwives deliver culturally safe care, but rather to understand how midwives themselves conceptualize culturally safe care, and whether their understanding of it incorporates the elements that have been ignored—with negative consequences—in the literature on uninsured immigrant clients. With this in mind, the four elements of culturally safe care I will be using are:

i. Cultural Difference: Do midwives understand that the needs and values of their clients might differ from theirs?

Cultural difference can be understood as an acknowledgement of the differences between cultural groups. As stated above, Cioffi notes that the acknowledgment must go beyond recognition and work towards proactive engagement with these differences.[85]

ii. Intracultural Variation: Do midwives understand that the needs of the client might be different from those of other members of the same culture?

[85] Cioffi, "Caring for Women from Culturally Diverse Backgrounds," 437.

While one must recognize how cultural groups can vary from one another, Cioffi highlights the necessity of understanding that members within the same cultural group can have vastly different needs and values. According to Cioffi, midwives had an easier time identifying cultural difference than intracultural variation,[86] a concern I felt important to address here.

iii. Agency: Do midwives speak of their clients in a way that reads agency into their actions?

I did not come across writing about agency and culturally safe care in the Ontario context, but I would suggest that recognition of agency is crucial to understanding culturally safe care, especially because its absence is what leaves the notion of "colonized wombs" unquestioned, with serious negative implications for the midwife-client relationship. It is essential to ascribe agency to racialized women in order to move away from problematic notions of "saving" them and towards understanding how these women navigate systems of power in strategic and complex ways.

iv. Positionality: Do midwives understand how their own identities and social positioning shape their relationships with their clients?

Midwifery is a profession deeply invested in reflection.[87] Personal identities influence how midwives conceptualize the way they practice midwifery.[88] While the examination of its practices is needed in order to improve the care it provides, equally important is the reflection on the identities of midwives inasmuch as they shape the care they deliver.

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[86] Cioffi, "Caring for Women from Culturally Diverse Backgrounds," 440.

[87] We can see examples of this integration of self-reflection in numerous studies that midwives are conducting within the profession to better understand how practitioners come to more nuanced understandings of how to best serve diverse populations.
Lesley Briscoe, "Becoming Culturally Sensitive: A Painful Process?," *Midwifery* 29, no. 6 (2013): 560.

[88] Holly Powell Kennedy, Debra Erickson-Owens, and Jo Anne P. Davis, "Voices of Diversity in Midwifery: A Qualitative Research Study," *Journal of Midwifery and Women's Health* 51, no. 2 (2006): 88.

The examination of these four aspects of culturally safe care allows for a nuanced engagement with the discourses midwives present regarding their relationships with their uninsured immigrant clients.

Methodology

This study uses semi-structured interviews to explore the experiences of midwives in great depth. Rather than using a tool like a survey to collect a broad but superficial understanding of all midwives in Ontario, I am employing a qualitative methodology. Because of the small sample size, as well as regional differences within the province, I will not be able to generalize my findings to all midwives in Ontario. Instead, the methodology of this project is focused on generating an understanding of the varied and complex experiences that midwives have with uninsured immigrant clients, as well as the multiple and contested ways in which they navigate tensions and conceptualize and deliver culturally safe care. As one of the goals of my project is to problematize essentialist ways of delivering culturally safe care, treating my participants as though they were reducible to a single viewpoint would not be useful.

The primary strategy used to analyse the data was discourse analysis (DA). As De Souza has pointed out in her own research, DA, rather than approaches like grounded theory or phenomenology, is increasingly used in midwifery research because it is useful for understanding the relations of power shaping what participants say.[89] Because DA has been interpreted and applied differently in a wide variety of academic disciplines,[90] it is necessary to situate exactly what one means when claiming to apply DA as a primary research strategy. In my case, I will be using a type of postcolonial DA, much like De Souza, in order to investigate how systems of colonialism, race, gender, and class intersect and inform the context in which my participants discuss their uninsured immigrant clients. Like De Souza, I am careful to distinguish between attempting to find a "true" experience of my participants—as with a phenomenological

[89] De Souza, "Migrant Maternity," 31
[90] Anne Nixon, and Charmaine Power, "Towards a Framework for Establishing Rigour in a Discourse Analysis of Midwifery Professionalisation," *Nursing Inquiry* 14, no. 1 (2007): 72.

approach—and instead deconstruct the power relations that inform the discourses my participants produce.[91] Of particular interest to me is the way in which the Ontario midwifery model informs the participants' views on uninsured immigrant women and the importance of providing culturally safe care.

I. Data Collection

i. Sample and Recruitment

My sample consists of midwives who have worked with uninsured immigrant clients in Ontario. This means it excludes midwives who have not worked with an uninsured immigrant client. I conducted interviews with midwives who have practised in Ontario, as long as they received their midwifery training in Canada.[92] I spoke with 10 midwives, a number that allowed me to navigate the time and space limitations of my project while allowing me to enrich the trustworthiness of my data.

Because I was only recruiting from a small community (there are more than 700 midwives in Ontario),[93] in addition to employing snowball sampling, I sent flyers and emails to midwifery practices and birth centres to recruit participants in Toronto and Ottawa. I believed that snowball sampling would increase the chances that participants trusted me, and I did end up getting a number of referrals. When distributing recruitment flyers to midwifery practices, I would visit the facilities, introduce myself, and leave flyers with administrative assistants. This was a deliberate strategy on my part to try to put a face to the research and the flyers asking for participants, as I hoped that this would establish trust and make practices more likely to advertise

[91] De Souza, "Migrant Maternity," 31.
[92] Although I did not specify this in my inclusion criteria, all of my participants ended up having attended the Midwifery Education Program in Ontario. I did not have any participants who had completed the "bridging program" (International Midwifery Pre-registration Program) after receiving their primary midwifery education outside of Canada.
[93] "Midwifery Q & A," Association of Ontario Midwives. http://www.ontariomidwives.ca/midwife/q-a, accessed September 5, 2017.

my research to their midwives during their weekly meetings. Additionally, I emailed practices in Ontario with information about my study and a call for participants. I also made a request to the Association of Ontario Midwives to include my call for participants in their weekly newsletter, as well as on their social media.[94]

ii. Tools and Procedures

In terms of research questions and practical considerations regarding the sample, the most appropriate and fruitful data gathering technique was conducting semi-structured interviews, between an hour and an hour and a half in duration. This was the ideal length for an interview, as I did not want to tire out my participants or compromise the depth and quality of my own observations. As midwives are extremely busy, I had a difficult time finding participants and coordinating a time that worked for both of us, and participants frequently cancelled or rescheduled at the last minute because of the on-call nature of their profession. The interviews took place in a variety of locations, depending on the comfort and availability of the participants. I interviewed them in person if it was convenient for them, or over the phone, if they were not able to meet in person. In the end, I conducted all but two interviews over the phone. I found that my in-person interviews were not significantly more candid than those done over the phone.

My interview guide was structured in such a way that it led from general questions about working with uninsured immigrant clients to more specific inquiries about the nature of the challenges that arose and how midwives would navigate these; as well as how midwives conceived of culturally safe care and their role in delivering it. Shenton discusses iterative questioning as a strategy to expose contradictions in participants' accounts.[95] I built iterative

[94] See appendix 3.
[95] Andrew K. Shenton, "Strategies for Ensuring Trustworthiness in Qualitative Research Projects," *Education for Information* 22 no. 2 (2004): 67.

questioning into the interview guide, and I was careful to note whether my participants think that tensions arise from the social positioning and identities of these particular clients, or if these are simply tensions that exist between midwives and all clients.[96] Despite building this into my interview guide, I ended up not needing to use it, as all my participants stated that their uninsured immigrant clients typically had needs that were different from their other clients. However, in the follow-up sections, I still include questions that allow midwives to discuss challenges they encounter, or simply detail encounters they have had with uninsured immigrant clients. This provides the opportunity to check for latent beliefs that might not have been drawn out by more explicit questions.

iii. Data Organization

I audio-recorded all interviews, but I wanted to err on the side caution and put my participants at ease, so I did not attempt to record every physical gesture in writing. Additionally, I had to balance obtaining candid responses with giving the participants enough time to reflect on the different tactics they have used to navigate tensions with their clients. As soon as the participants confirmed that they were interested in being interviewed, I sent sample questions along with the consent form. This let participants prepare for the interviews while allowing me to capture candid moments and let them speak casually. After conducting the interviews, I transcribed them as soon as possible.

The need for confidentiality informed every step of my research process, but was especially relevant to the organization of the data. Because the participants discussed sensitive information, their identification could negatively affect their careers and their status within the midwifery community. Their identities are protected in a number of ways. Only the consent

[96] See appendix 1.

forms signed by the participants contain identifying details, and these forms were kept in a secure electronic location, along with the interview transcripts, accessible only by my supervisor and myself. All of these materials will be destroyed after seven years. Additionally, I limit descriptive details of any one participant in order to reduce the likelihood of their recognition. I avoided the use of pseudonyms so as to avoid the coalescence of too many details around one particular individual.

II. Data Analysis

After transcribing the interviews from audio recordings, which allowed me to familiarise myself with the data, I did a round of open coding with each interview by hand, using post-it notes to colour code for different themes and write observations down next to the data. I carefully read through the interviews and coded for every theme that I noticed, and I then identified all of the themes that were both related to my research question and discussed in the majority of the interviews. I chose to limit the scope of this research on those particular themes in order ensure a thorough exploration of the topics important to the majority of the participants, rather than that of ones mentioned only in passing. The major themes that arose were (1) language barriers, (2) the role of spouses and families, (3) financial barriers, (4) the attitudes of hospital staff, (5) the extra work involved in serving uninsured immigrant clients, (6) clients' preference for hospital care, (7) clients' attitudes towards midwives, (8) the clash of the midwifery model with medicalized models of childbirth, and (9) the role of culture. The examples I chose to include in my results section were selected because of their relevance to the themes.

After I had coded for major themes, I began to look for patterns in how midwives were speaking about their uninsured immigrant clients with regards to cultural differences, intracultural variation, agency, and their own positionality. By drawing these four elements of

the discourse on culturally safe care to the surface, I was able to determine whether the midwifery community had developed more nuanced attitudes, as well as which strategies midwives currently use to explain and navigate tensions, compared to those documented in the older literature.

Results

A substantial number of themes emerged during these interviews. While I do not have the space to fully discuss all of them, I am going to organize my findings by moving from the more concrete issues that my participants raised to the more conceptual, philosophical barriers to access that arose. When I first began this research, I wanted to focus on the barriers to access experienced by uninsured immigrant women, but when I discovered that midwives in Ontario had advocated for uninsured women to be able to access their services for free, I switched my focus to how midwives conceptualized providing culturally safe care to these clients. I believed that there may no longer be significant barriers to uninsured immigrant clients getting into the care of midwives. However, as I started interviewing midwives, I quickly discovered that there are still barriers to access that midwives identified. I have organized these challenges thematically. While the results section is organized into challenges that were more logistical in nature and then those that were more conceptual, I do want to point out that for all of the participants, asking about the more philosophical challenges when providing culturally safe care to uninsured immigrant clients inevitably led back to discussions of the logistical factors. Even though I have separated them here for the sake of clarity, they were thoroughly entangled in the interviews.

Before going into a discussion of themes, I wanted to provide an overview of the demographics of the participants. They all practiced in urban settings. Most of the midwives had been practising for under six years, with a few who had been practising between 8 to 17 years. All but four identified as white, and of those four, only three identified their family background within the Global South. The youngest participant was in her late 20s and the rest were distributed evenly between their early 30s and mid-40s.

The themes that I will be addressing are (1) language, (2) the role of spouses and families, (3) finances, (4) hospital staff, (5) the extra work involved in serving uninsured immigrant clients, (6) preference for hospital care, (7) attitudes towards midwives, (8) the clash of the midwifery model with medicalized models of childbirth, and (9) the role of culture. After explaining these themes, I will discuss the ways in which midwives navigate these challenges and their conceptions of culturally safe care.

I. Logistical Barriers

i. Language

Every single participant identified language as one of the most prevalent barriers to providing care to uninsured immigrant women. Midwives discussed the difficulty of providing informed choice to clients when they felt uncertain about how much they could communicate during appointments without interpreters present. Appointments often took twice as long as with English-speaking clients. Even though many of the midwives I spoke to had used Interpretalk, a translation service that is accessible by calling a phone number, there were still practices that had not heard of this service. Even the midwives who had used it pointed out that often it was too much work to connect to it just to ask a couple of questions, and that it was sometimes more difficult to access in hospital-settings. One of the strategies that came up in multiple interviews was the use of phrase sheets that had common expressions and requests written in English and in another language. Midwives could point to the phrases that they wished to express, such as "turn to your left," "turn on your side," or "push," instead of relying on a translation service. Medical emergencies with non-English speaking clients presented a particularly challenging set of issues around consent and informed choice. A midwife noted:

> "I think [emergency situations] end up looking a little more like a medicalized hospital experience in the sense that if they can't communicate with somebody and there's an

> emergency happening or there's a care plan that needs to change, it might end up with me just motioning to somebody or talking in a louder voice because I'm not sure they can understand me and that's my go to thing. Or sort of just doing something without asking first, because it's important clinically and not being able to have that conversation with people first and that is a huge challenge…And that happens with English speaking clients too, where they say that "there were all these people in the room and they were just doing stuff to my baby and doing stuff to me and nobody took the time to explain to me what was going on." And there could be a lot of trauma around that. And for somebody who doesn't speak English who you can't communicate with, that's a really hard piece. Because what do you do? How do you make sure they're not going to have that experience? It's really hard."

Midwifery is a profession that is deeply concerned with informed choice, and midwives expressed a struggle with emergency clinical decisions that was not necessarily unique to uninsured immigrant clients, but certainly magnified in their case, because they are unable to explain what is happening to their clients and unable to consult with them on what they might like to have happen to their bodies. One midwife attempted to resolve this tension by pointing out that women want good clinical care for themselves and their babies, and that a midwife's job can include interpreting this on behalf of her client. She noted that "providing safe care is what the woman wants us to do" and that "hopefully at that point [I]'ve built some trust" with the client.

However, despite these issues, midwives also noted that the issue of language was sometimes not as daunting a challenge as they thought it would be. Especially during labour, most participants were quick to point out that gestures, mimicry, and short phrases were often enough to support their clients. Pointing between their own legs to indicate that they wanted to do a vaginal exam, exaggerating their own breathing to demonstrate how clients might want to try breathing, and getting into various birthing positions to provide an example for their clients to follow were all mentioned as strategies that these midwives used to communicate with their clients. Another popular strategy was using phone apps, or Google Translate.

What was especially interesting was one midwife's observation that "human comfort and pain is universal" and that "I don't think you need that many words to support someone through the pain of labour." She noted that "we underestimate how much is understood despite language." Birth is seen as an event in which language sometimes falls away, and mothers and midwives rely on gestures, facial expressions, and noises for communication more than verbal communication.

Language also came up in the context of racialization. Racialization is important in healthcare because of the ways in which racialized women are often seen as less intelligent or less capable decision makers, especially if they struggle with English or have an accent. When I asked one participant whether her uninsured immigrant clients were typically racialized, she began talking about her Polish clients, who were not necessarily a visible minority, but who were marked as different by their accents, or sometimes by their lack of proficiency in English. She complicates the notion of racialization by pointing out that "they're white, but we can't provide care to them in English." It was interesting that language and race became bound together in this manner, but it becomes clearer when we consider what another participant noted about her experience providing care for a client who seemed to lack language skills.

> "Like, I had one client, I remember beating myself up for so long afterwards. She was very, very, very quiet. She wasn't a recent immigrant, but she was an immigrant. Very, very quiet. If you asked a question she would say "yes" or "fine". Never a complaint, never anything and I kept thinking "Am I getting through to her, is she understanding me?" All that stuff. And after the baby was born her husband told me that she had a PhD in god-knows-what back home, but she was the most educated woman I'd met to date and I really beat myself up for making assumptions that because she was quiet, that she was either less educated or less intelligent or didn't understand me. She just didn't have anything extra to say to me. She was like, "everything's fine." Literally it was fine, her pregnancy was fine, everything I explained she understood, so when I asked "Do you have any questions" and she said no, it was because she didn't. She understood everything better than I did. So I found that a huge learning moment to not make assumptions. An accent does not make you less intelligent."

Here we can see that this participant is unpacking her assumptions about a client that arose because of the seeming lack of language skills that the client was exhibiting. It is especially interesting to note that this midwife is herself racialized, although she did not have an accent. It is clear that language does not merely affect the concrete interactions that midwives have with their clients, but also influences the assumptions that can be made about a client's intelligence, class, and education-level.

ii. Spouses and Families

Closely related to the issue of language is the role that spouses and family play in the relationship between uninsured immigrant women and their midwives. Family dynamics were often at play in ways that midwives found frustrating to try and manage. One participant reflected on how immigrant families often operated in a manner that was different from what the Ontario midwifery model anticipates. The Ontario midwifery model sees decision making as an individual act, but as one midwife pointed out:

> "Their families are so involved. And because there's often a language barrier, the families are involved out of necessity, because someone has to speak, someone has to translate. But then also because the families are very, very tightknit, which is lovely, but can be…it's a challenge to how midwifery often operates in Ontario where the client is in charge. Because in those demographics, in that family situation, it's not just the client's choice, it's what the family defines as best. So the midwife has to challenge that, to say "what do you want, client?" and she says "let me find out what the family wants." Look, I don't care what the family wants, I want to know what *you* want. But that's not how they operate. So that…mentality around "just because I was taught to operate this way doesn't mean that's how every family operates, right?"… There will always be a family member involved in those kinds of conversations, involved in those decisions, involved in those clinic meetings, because that's how that family operates. And I'm not saying it's good or bad, it's just how they operate, and it might be different than how I operate, or how we've been taught to operate here as midwives in Ontario."

Indeed, the issue of language and family seemed to be inextricable in most of the interviews. Another midwife pointed out that it is not always straightforward to try and remove relatives or

friends from acting as interpreters for their clients, as it can hurt the client-practitioner relationship:

> "I think when you have an interpreter involved it's way easier…Situations that are the most challenging are when you have a husband and a wife come from another country, or someone who brings a friend to the appointment and doesn't want an interpreter, because their friend or their husband will say "Oh, I can translate, it's fine." …[T]hey have their own interactions going on in those situations, and you might have a whole conversation about an informed choice discussion about something and not really have any idea at the end of the day whether that person really understood what you were saying or whether the person who was interpreting was telling them something different…Those, I think are sometimes the most challenging scenarios and what adds to it is in an effort to try and maintain the safety of the space and not want to offend or make the family feel like you don't trust them or anything like that, to really build that trust, you might not push to have an interpreter…"

The same midwife spoke about the challenges involved in speaking to their clients without their husbands being present and how she might strategically go about this:

> "I had a husband and a wife come… she spoke only Arabic, and his English was good but—quite good in understanding but his communication ability wasn't strong, and they had a son already and she would just nod and smile, she was really happy to be there, and whenever you'd say something, she'd just nod and smile and at one point I just said "you know, we have this interpreter service, I can just put them on the phone and you don't have to interpret anything." And I got this sense that he felt he would be putting us out in some way…he didn't want to put that burden on us, he wanted to take care of it himself. He was really pushy about it, "no no no, no interpreter, I'll do it, I'll do it, I'll do it," and so that's what we did. And it was only after a few visits that we were finally able to sneak it in, when he was busy with his son in the other room, and it was like "No, you're busy with your son, stay here, it's okay, we'll take care of it" and we were able to get an interpreter, but that I'd say is a pretty common scenario."

Another participant shared her experience with a client who only spoke to her in English after the birth:

> "We've had clients who we didn't know they could speak English until the end. We're like "oh my gosh, you speak perfect English, but your husband always speaks for you." And we had no idea, because he would speak to her in whatever native language it was, and she would reply back to him in that and he would speak to me in English."

However, many of the participants also pointed out that they were grateful for the presence of family members who were able to provide translation. One midwife was able to point out the North American context that was informing how she was feeling about these clients:

> "There's the fact that her husband is always there and he's [doing] a lot of the talking and knowing that in a white, Canadian middle-class context, that might be alarming or even annoying sometimes, in this context I'm grateful for his presence because he is the translator when our translators are not available."

Similarly, a couple of the racialized midwives were quick to point out that the presence of a spouse during appointments does not necessarily mean that the client is being made uncomfortable to speak freely. One of the midwives pointed out the role of the Midwifery Education Program (MEP) in shaping her attitudes towards the dynamic between spouses and clients:

> "Because the way we speak about it at school…it was always about trying to get through that. Not that it was ever okay. So I had a belief that every time the husband speaks for the wife, that's a big thing. Sometimes it's how they operate—he's not lying to her, she's not lying to him, he's translating accurately and that's fine. But that's how they operate, that's their level of respect for each other, whatever, that's what they're used to. Nothing's wrong with it. But when I was at school, it was like "try to get the woman away." Make sure he's not lying to her, you don't know what they're saying when they translate—which is true. You don't know. But it doesn't mean that it's bad. And there was always an air of "we have to protect this woman from the evil husband who might be trying to control her" and it was that overall air and I don't think that's necessarily true, I think it's disrespectful…that's how they operate, you know?"

This midwife found it reductive and culturally supremacist to assume that clients needed to be protected from their husbands.

Another racialized midwife discussed the implications of not accepting family as interpreters by pointing out that female clients might not be comfortable discussing personal details with a stranger, especially a stranger of a different gender. This participant argued that having a personal interpreter might actually lead to a more accurate translation of what the pregnant client might want to communicate, as her interpreter would know her better. The participant also noted the racism that could be at play in trying to separate clients from their families:

> "I think of that as racist, somehow immigrant women are less able to vocalize and more vulnerable and less able to say what they want for themselves, or to have autonomy in

> their relationships… With some clients, I have other midwives say "Oh my god, the husband always answers for his wife and it's so sexist and drives me crazy" and I have to say…I'm also very aware that what you see publicly has very little to do with what internal relationships are like…My dad spoke more when we were out, but my mum wasn't demure, it was just a social thing, but when we closed the door, my mum ran the house…"

Her suggestion was to complicate the scenario by looking at the nuances of communication between the couple.

> "So when people say that, I'm like, look at their affect. I think we can tell the subtle ways people communicate quite, actually. If you're looking down, not nodding at your husband, not responding, a husband who is answering without looking at his wife, that's very, very different, but I think it's interesting that when we see in the West, when we see that, a woman is talking less and a man is talking more, we automatically take it as that is her being oppressed, where I'm like, that's a Western way to look at it, the other is that that's just how that's they're more comfortable."

The participants expressed the difficulties that can be present in trying to make the Ontario model of midwifery work for immigrant families. The model assumes that individuals make decisions, and the participants noted that trying to apply this paradigm on immigrant clients by separating them from their families could be culturally insensitive.

Finally, some participants also noted that spouses and families often had opinions on what clients should be doing with regards to prenatal tests or birth plans. This could become difficult for clients and midwives to navigate, especially if the client was receiving financial support for the pregnancy from that family member. Participants noted that family members who were financially involved in their clients' lives would often make demands that took decisions out of the hands of the clients. Finances also factored into family dynamics. Spouses would sometimes become upset if their wives had to be transferred to the hospital for care, or had to undergo medical procedures, as that would drive up the cost of the delivery.

iii. Finances

As already mentioned above, finances were a major concern when providing care to uninsured immigrant clients. Other than language, every single participant repeatedly raised the theme of financial barriers, and this concern dominated the discussion on cultural safety. Every participant noted that their uninsured immigrant clientele were usually relatively impoverished. However, multiple participants noted that clients were often in a range of financial situations, depending on their status as a refugee claimant, permanent resident, or visa holder. One midwife astutely noted that among her uninsured clients, there were different kinds of difficulty with resources that would affect maternity care:

> "Sometimes they're clients who are here because their husbands are on a job, so they're not necessarily monetarily poor, they're probably just resource poor. So they've recently moved and they don't have a car yet. You know, that kind of thing. They have the funds for a car, but they haven't gotten one yet, because they just got back."

One midwife pointed out that, contrary to popular belief, clients sometimes thought that aspects of the Canadian healthcare system were inferior to the care they would receive in their home country:

> "For many countries, pregnancy is the one thing that *is* covered, even if you don't have healthcare, so it's weird when they come here and it's not covered."

Hospital fees and other fees associated with tests made things particularly difficult for clients who were living in poverty. Hospital fees are different at each hospital in Ontario, but only one of the midwives interviewed had admitting privileges at a hospital that had significantly reduced fees for uninsured clients. Midwives pointed out that their clients were often willing to pay the high hospital fees:

> "Even clients who seem to not be able to afford the hospital fees will opt for the hospital. Not always, but that's something you see a lot. Is someone who you think has financial issues, doesn't have access to help or support financially, and they'll somehow come up with a deposit of $500 for the hospital, because it's that important for them to be there."

> "I'm amazed at how much people will scrounge together for the hospital, even if it means less food."

Midwives also pointed out that if clients ended up not going to see specialists for medical conditions, it made midwives more reluctant to serve them in the future, because those pregnancies became more risky, and there was a higher chance of adverse outcomes that could have repercussions for the midwife or the practice. The theme of midwives avoiding taking on uninsured immigrant clients because of the higher risk of an adverse outcome came up during multiple interviews. It is striking how closely this worry is tied to the financial situation of the client.

Some of the participants seemed to frame their clients' overwhelming desire to be able to afford a hospital birth as sometimes causing them to make decisions that jeopardized the health of their baby, stating that "they'll skip all kinds of prenatal visits, but they want to have their baby in the hospital." This midwife is asserting that some of her clients show a clear interest in hospital births, despite seeming disinterested in other aspects of the baby's care. Others indicated their surprise that clients would choose to give birth in a hospital, despite their dire financial situation. However, one racialized midwife pointed out that it might be the very poverty that these clients are living in that compels them to seek out hospital births, arguing that "the impoverishment makes it more so that they want a hospital birth. They don't want to feel like "we're so poor we can't have our baby in a hospital."" This same midwife pointed out her tactic for discussing finances during appointments:

> "So #1, most of the clients who walk in my door, I know are walking in my door because they don't have the money to go anywhere else. So part of how I navigate that in midwifery is instead of starting by talking about informed choice, I actually say "one of the things we do is talk about the model of midwifery, but for you, because I can see that you don't have a health card, I'm going to guess that one of your concerns might be how much this costs, so why don't we start with that?" Everyone glazes over, and at the end want to know how much it is, so I start with that."

We can see that she is discussing informed choice, but contextualizing it for the economic situation of her uninsured immigrant clients. She understood the reality of her clients' situations, and changed her practices accordingly.

Another barrier that was related to finances was the lack of knowledge on the parts of midwives themselves about the funding model. Although all of the midwives that I spoke to understood the funding model well enough to explain the basic aspects to me, several of the participants noted that it was difficult to keep track of exactly what was and was not covered under the funding agreement:

> "Just the fact that we—it seems like every time we have an uninsured client, we don't remember what's covered, there's questions from people—"is this covered" or what the hospital fee is, or what's covered by our program. Do you have to pay for your epidural? Most people—most hospital staff—will say yes, but according to the program through the AOM, no, you don't have to pay… I'm pretty sure I have an accurate understanding of it. And part of the problem with school; is that they don't prepare you for it. And [the fees are] different at each hospital. So we could use a resource that shows what's been covered at each hospital. Aside from language, my second biggest challenge is actually knowing what is covered under this program and to know it with confidence. Usually I end up saying "I don't know, go talk to the hospital's financial services." But is that providing good care? They know us, they trust us, why can't we give them a straight answer? We could at least say "well, I think it's this. They'll be able to confirm it, but this is what I think it is." But I don't even know that, I don't really have a clue. We're guessing every time we go through it."

Here we can see that finances are a difficult piece to navigate for both clients and midwives. This midwife noted that being able to navigate both the funding model and the hospital's fees is an important part of providing good care to her uninsured immigrant clients.

iv. Hospital Staff

Another challenge that was mentioned by almost every participant was the suspicion that was directed towards their clients by hospital staff. Midwives told story after story of negative experiences with hospital administrators, anesthetists, and obstetricians who would refuse their

services unless they had payment in hand. One midwife shared a difficult experience with hospital staff refusing to let an uninsured client leave the hospital with her baby:

> "We ended up going to the hospital and having a C-section…24 hours later, she wants to leave the hospital, but the baby is in the nursery, medically clear to leave, but they tell us that they're not going to release the baby until the hospital bill is paid….I had to call a lawyer. The nurses and hospital admin both insisted she wasn't allowed to take her baby, so I had to get a lawyer on the phone."

There was also an upsetting story that another midwife shared of a client who had to go to the hospital because of a fetus that died an intrauterine death. The obstetrician attending her refused to induce labour or even confirm that the baby had died with an ultrasound until he had payment in hand. There are similar stories of women being denied epidurals and even C-sections until the doctors had payment from these clients. Midwives did point out that often these attitudes arose from having had clients leave the hospital without paying, but they still found it frustrating because the suspicion that was directed at their clients was also perceived as a mistrust of their own claims as healthcare professionals. One midwife was discussing how frequently she had to advocate on behalf of her clients to get their newborns OHIP cards:

> "…it also annoys me that there should be questions about [whether my clients will stay long enough to pay], because, if I tell them that this person is a resident of Ontario, I know this because I know the client, then I want that to be taken seriously, I know my clients, I know the difference."

She found it frustrating that hospital staff were typically suspicious of whether her clients had a legitimate claim to OHIP for their babies if they themselves did not have health insurance.

Participants also identified the need to not risk angering the hospital staff, as their admitting privileges as midwives were still relatively new. One participant pointed out that they are the "new kids on the block," they often "keep their heads down" and try to advocate on behalf of their clients in as unobtrusive a manner as possible.

Midwives did report some positive interactions with hospital staff that actually made providing care to their uninsured immigrant clients easier. One midwife drew a connection between higher rates of immigration to Canada and the hospital's supply of diverse doctors and nurses who spoke languages other than English. She was grateful because in cases that she did have to transfer care to the hospital, she could often find a healthcare practitioner who spoke the same language as her client, which made the transition easier. Another participant saw the ways in which midwives provided culturally safe care to their clients as paving the way for other healthcare professionals. In the hospital setting, she would see doctors begin to mimic the way she would treat her client, and that would result in better care for her client from her entire team, and not just her midwives.

v. Extra Work

There were many challenges that midwives mentioned when providing care to uninsured immigrant clients that were seemingly minor issues, but that created a lot of work for midwives, and that sometimes had adverse consequences for the health of the client and baby. Examples of these included clients being late or not showing up at all for appointments with midwives or physicians to whom midwives had referred them, either because of transportation or childcare issues; needing extra time during appointments because of language issues; not possessing medical documents, or only being able to provide medical documents in languages that midwives could not read; not understanding how to use the paging system and consequently going to the hospital when they were not ready to deliver; not being able to afford vitamins or over the counter medications; not having a working cell phone from month to month; and sometimes coming into care late into their pregnancy without having received any prenatal care. Many of these issues meant that the client's health was jeopardized relatively more than Canadian-born,

English-speaking clients. Many of the midwives pointed out how these issues might be unappealing for midwives to work with:

> "We live in a society with low risk tolerance, especially around childbirth…people feel like they're putting themselves at medical and legal risk…so they won't provide services."

Midwives also noted that their clients were often afraid to access social services, or even go to the hospital, because they had fears of being reported to immigration or having their child apprehended because of their poverty. One midwife pointed out that midwives did not always want to engage with non-clinical aspects of care:

> "…that's another reason midwives don't want to do this, they don't want to spend their day trying to figure out the "social stuff."…The social stuff has such big implications for the clinical outcome that it's an important part of the care."

Indeed, one midwife put it very well when she stated, "we're a little bit the social worker, settlement worker, translator and midwife." Midwives who cared for uninsured immigrant clients often took on multiple roles to try and get their clients the care they felt they needed.

II. Conceptual Barriers

i. Preference for Hospital Care

Despite the difficulties that clients encountered with the hospital staff and the relatively high fees, midwives still identified a clear preference for hospital care expressed by their uninsured immigrant clients. While most of the participants did explicitly indicate that their clients' choice of birthplace was not something they wished to pass judgement upon, a few midwives did speak frankly about the typical disappointment that accompanied the decision of any low-risk client opting for a hospital birth:

> "I think midwives might just generally have a bias towards home birth, it's the same way that we feel about any low-risk person who doesn't want to have an out of hospital birth."

Part of this disappointment might be in assisting at births that other healthcare professionals would also be able to attend, rather than home births, which are usually births that only midwives can attend, as obstetricians and family doctors would not typically assist at those deliveries.

All of the participants connected the decision to give birth at home with financial motivators. A participant noted that "some people who are especially strapped for cash will opt for home birth just to avoid some of those costs of staying at the hospital, even though it wouldn't necessarily be their first choice." Another midwife pointed out that clients who are only doing home births for financial reasons might not benefit from it in the same way that clients who are choosing it because they believe it will be more comfortable for them than a hospital birth. Most of the midwives who were interviewed expressed frustration that their clients were not able to choose their birthplace without considering financial factors.

> "I always want clients to choose what they want, not based on money, but it's the reality. We have the great advantage of having the birth centre in Toronto, but at the government level, hospitals are run like a business and they can charge whatever they want, but I think there should be some policy where pregnant people without status wouldn't have some special rate at their hospital. They should have the opportunity to choose what they feel more comfortable with, not based on money affecting their choice."

One of the participants gave me examples of scripts that she might use when discussing the choice of birthplace with her client:

> "…at the same time we say "even if [they]'re not planning a hospital birth, we still advise [them] to go to the financial services part of our hospital and talk about the cost, so at that point they have an idea of what they might be in for, and then we talk about home versus hospital, like we do with all of our clients, and especially in the case of people who are really hesitant to choose a home birth, we try to instil some confidence in them with the equipment that we carry and the training that we have. And we can transfer if we need to, in the case of an emergency."

By encouraging her clients to gather information so they know about what their situation might be in the case of an emergency transfer of care, she is articulating how she is providing informed choice to her clients, despite the restrictions on their ability to freely choose.

In addition to money, participants also identified cultural reasons for choosing hospital care. One midwife described what she saw as her clients' motivations in having a hospital birth and related it to the experiences of family she had in South Asia:

> "The clients that I'm thinking of have been Pakistani. And I've come to understand, through my relationship with my in-laws, that having a baby with an OB in a hospital is socially acceptable, and they would be mortified to tell people they had their baby at home, even if it costs them $2000."

The same midwife brought up a motif that was raised by other participants—that it is the clients' perceived sense of safety that caused them to choose the hospital. Another midwife took this concept further, and discussed how the context of migration might make hospital births especially sought after because of this perceived sense of safety:

> "…having birth in a hospital is the gold standard of care, that's the safest, perhaps one of the reasons that they wanted to come to Canada was to have their baby in a safe place, which they see as a hospital."

Here we can see the midwife is exploring the ways in which her uninsured immigrant clients might be uniquely situated to desire hospital births. She understands that their desire for a hospital birth might be connected to their decision to migrate to Canada.

Another participant was able to connect migration, class, and hidden homelessness by pointing out that often the conditions that uninsured immigrant clients were living in might not be the most suitable for a home birth, not just because of a lack of space, but because of the lack of privacy. Oftentimes the clients that she saw were living in one room apartments, or in apartments that had multiple families living in them. The space of "home" as conceived by midwives in the earlier push for midwifery legalization might not as readily apply to these clients.[97] However, she also pointed out that it should be up to the client to make those

[97] MacDonald discusses the various ways in which the term "home" have been imagined in Ontario midwifery. She notes that although home birth invokes the image of a middle-class, urban, and private space, this is not always the environment that midwives are working in.
MacDonald, *At Home in the Field of Birth*, 144-5.

decisions—she noted a troubling trend of midwives deciding that some living spaces were unsuitable for home birth, and that some neighbourhoods were seen as too dangerous to attend home births in:

> " I don't think as women we should shame each other if we don't feel safe, our plan will be that both midwives go together, or that the client's partner meets you and walks you in…I've had midwives outright say "we don't do home births in that area, because we don't feel safe."…That's the sort of internal barrier that has a lot of undertones of racism, but there's also some real concern there…"

This participant pointed out that that resulted in uninsured immigrant clients having less choice about where they would give birth, which she found "disturbing."

Interestingly, spaces like birth centres or delivery rooms in clinics were sometimes considered by clients, which midwives attributed to the potential institutional authority offered by these spaces:

> "Before we had the birth centre, I would say most of the immigrant and ESL clients that I was seeing would choose hospital, hands-down. And they would never entertain the idea of home birth. Some people would, but the majority would say "no, we're going to a hospital. Of course that's where you have your baby, we have access to all the care, we want the doctors there, we want the nurses there." And now that the birth centre is around, that's changed, I think. What I'm seeing is that when clients hear that they can have their birth in an institution, in a recognized, established institution that looks very new and modern and in some ways looks like a hospital, and it's also free, that's a big appeal to people."

The same midwife went on to note that the current information that is being collected in Toronto indicates that the birth centre is actually drawing more from immigrant clients who would otherwise opt for a hospital birth, rather than those who would choose a home birth.

Despite the overwhelming preference for hospital care, one participant did note that oftentimes, clients who started out positive that they wanted a hospital birth would find themselves considering home birth when they had spent some time in midwifery care and started trusting midwives as healthcare professionals.

ii. Midwifery Model vs. Medicalized Model

Closely related to clients' preference for hospital care is the discrepancy between the roots of midwifery in Ontario and the medicalized model of childbirth that many participants identified as the dominant model in the Global South, where many of their clients were coming from. As one midwife put it, "it's not a segment of the population that seems that motivated to have a natural, unmedicated birth." However, many participants in this study expressed discomfort passing judgement on situations back in their clients' home countries—they stated that they felt they did not have sufficient information to talk about how experiences of birth in the Global South might affect how their clients felt about their services. There was only one participant who freely spoke about her clients desiring hospital births or high rates of intervention because of the culture of birth in South Asia. Several midwives offered viewpoints that seemed opposed to this way of thinking about clients, including one who insisted that midwives should not make assumptions along these lines, even in the face of positive reinforcement from the clients:

> "So I think that the way that I see [culturally unsafe care] playing out is in the assumption making. Whether it's myself or a colleague, the assumption is that this client, because they come from this part of the world, will want this. Or, because they've had this kind of a birth previously, they'll want this. And unfortunately, sometimes it's reinforced by the client themselves saying, "you know, back home, doctors were king. So we're only coming to a midwife because you're free." So the perception is that they want a medical birth but we're offering a natural birth, or maybe they want all the bells and whistles because they don't really feel safe, but we're free so it's the unpacking of that. Treat each client and their needs and their wants for this pregnancy, for this birth, individually."

The connection between midwifery in a client's home country and their understandings of midwifery care in Ontario were sometimes presented in a neutral and innocuous manner, such as with an immigrant midwife who explained that she drew on her knowledge of the culture of birth in her home country in order to explain to her uninsured immigrant clients what her role would be:

> "Often they don't know the differences between a doctor and a midwife, or a big part of that initial education is to explain to them how our model of care works, and what we do, how we do, because it is quite different than their own countries. I happen to be quite familiar with midwifery in some of the countries, particularly the ones I've worked the most with. So I kind of explain the differences or the equivalents. I have spent a lot of time educating about the safety of midwifery care for those that think that midwives are only in indigenous communities, very rural, I guess what I'm trying to tell you like traditional midwives, that's what they're familiar with."

What was especially interesting was the ways in which midwives drew upon institutional images—not to assert their power as an authority over their clients, but to put their uninsured immigrant clients at ease, as their clients associated these images with professionalism on the part of their midwives. One midwife made the following observation about her clinic:

> "Yeah, sometimes, although I think the physical space speaks a lot. I think coming into a physical clinic and seeing midwives with a stethoscope around their neck is an image that people relate to."

This demonstrates that although midwives frequently find themselves at odds with the medical model, they are still capable of drawing on aspects of it to achieve their own care-related goals, such as establishing trust with their clients. Midwives are still not entirely removed from the medical model, however, as they do place a high degree of emphasis on clinical care. A white midwife mentioned that although the midwives in her practice consulted about clinical matters quite often, but did not necessarily sit down and discuss how to provide better culturally safe care, partially because they were all so busy:

> "I would say in practices, we place way more importance on the clinical side of things rather than the other stuff, which is very important."

This was an interesting deviation from the traditional narrative of Ontario midwifery, which is that the social and cultural aspects of care are valued as highly as the clinical and medical. However, it was a sentiment I heard repeated from other midwives—providing good clinical care is often the priority, and understandably so.

A couple of midwives were critical in positioning their own expectations against the reality of working with uninsured immigrant clients. They discussed the disjuncture between what midwives might desire from participating in births:

> "I don't know if it's a challenge, but it's sort of something midwives are going to have to reimagine and are already starting to reimagine, is what it means to have a midwife and what kind of work we're trying to do, because there is a very different perception of what constitutes good healthcare and sort of the ideal way to have a baby coming from immigrant uninsured people from other countries, and that for a lot of midwives requires a 180 in their thinking about "why did I become a midwife? Because I wanted to do lovely, natural home births," but maybe what that means is doing a lot of hospital births for people who don't have healthcare who really want it. So that's a big challenge I think for people and a big shift in thinking."

This midwife is pointing to an important tension between the historical values and expectations of the Ontario midwifery community and the needs of its increasingly diverse clientele.

iii. Attitudes Towards Midwives

While the midwives noted that caring for uninsured immigrant clients sometimes did not align with their expectations before entering the profession, there was also a theme that emerged of how their uninsured clients felt towards them. Midwives described the feeling of being unwanted:

> "I think we're spoiled as midwives, because we're used to being the highly coveted, trendy cool care providers. So it's an interesting place to navigate being unwanted and still believing that you're providing care that's really important. And that's a barrier. Midwives are like "well, if they don't believe in the midwifery model, why would I take them into care?" And for me, that's the colonized, privileged way of looking at things—we've decided we're the best and these people don't think that, so why would I go out of my way to do extra work?"

Indeed, the attitude towards midwives as less desirable healthcare providers than obstetricians was one that came up in the majority of interviews. One of the issues raised by participants was the relative likelihood of their uninsured immigrant clients leaving their care once they received OHIP. They explained to me that in Ontario, a midwife is only paid for a course of care if the

client has been in their care for 12 weeks, or if the midwife has attended the birth. One midwife discussed how her practice attempted to navigate this issue:

> "We try when we take people into care to feel them out and see if they're just wanting free care until they get an OB, we won't usually accommodate them. But sometimes people come and you don't know that that's their plan. I think people sometimes intend to do that but then they end up liking midwifery care….I think people kind of get won over and stay."

Similarly, other midwives also noted that many clients who intended on leaving ended up remaining in the care of their midwives because they "value the care so much." Participants told me that clients who were referred by friends or family were less likely to leave than those who had been referred by physicians or community healthcare agencies. Surprisingly, one midwife argued that it was actually a good experience for midwives to have to experience clients leaving their care for an OB:

> "I think midwives are not used to having clients leave when they get OHIP, going to the doctor with the fancy degree. I think some midwives are like "I don't want to take clients and use up a spot if there's a chance they'll leave partway through their care."… I think that there's a tendency to say "oh man, now I've done all this work that I can't bill for" but there's another part of me that's like, welcome to healthcare. It's easy to be altruistic and like "I'm taking care of these impoverished immigrant women and you don't care" when you're getting paid for it. And when any of us do work that we don't get paid for, I'm like, it's good for us to see what it's like. Like with OBs whose clients leave them for midwives."

Another participant explained why she was resentful of clients who decided to leave her care:

> "A new mom who's had twins or has three kids at home, she needs someone who is available to come to their house for their postpartum visits. And those spots are taken up by someone who's biding their time with a "lesser caregiver" so they can get an OB… I'm not your first choice, but [I'll] do for now. That's like being the back-up date at the prom, it's insulting. I want you to be in my care because you want a midwife, and you genuinely want a midwife."

This same midwife pointed out that clients sometimes thought that her training was much less formal and rigorous than it actually was, especially when comparing midwives to doctors:

> "[quoting client]: "I didn't know how skilled you were, how trained you were, I thought it was a weekend course.""

However, most midwives noted that their clients were usually incredibly grateful for their care, sometimes to the point that midwives felt uncomfortable, because they felt they did not deserve the amount of praise that was being directed towards them. A large component of the gratitude was that clients did not have to pay out of pocket for midwifery care:

> "I think at first they just come in very blank and very not knowing what to expect…But when I explain the kind of care that they get from us, including the continuity of care, the very personalized care they receive, …that we're primary care providers, and they get the same care, I think they actually feel very incredulous that they can receive this kind of care for free here."

> "I find that most of the time, when you sit a client down who doesn't have health insurance and you tell them that all the care that they get is free and they have access to all of the exact same care, they kind of go, "oh my god, that's amazing." In some form or another. Like, "I didn't realize that; when whoever sent me here sent me, I didn't realize it was going to be free." And a lot of people you see hanging on to the edge of their seat until you get to that part, waiting, like, "How much is this going to cost?" So most people are very appreciative."

Midwives encountered a range of attitudes towards their care, but overall found that once clients had been in their care, they were satisfied with the quality and especially happy about the relatively low-cost.

iv. Role of Culture

The way that midwives discussed the role of culture was relatively sparse, despite explicit questions about how they provided culturally safe care to clients. One of the topics that recurred was the role of gender in interactions that the client was having with healthcare practitioners. Midwives identified transferring care at hospitals to be especially stressful, because Muslim clients were often uncomfortable with an obstetrician of a different gender than them.

> "So because we only deal with low risk healthy pregnancies, from time to time we have to transfer care to obstetrics, and there's the chance that you might have a male. Most clients come into care knowing most midwives are female, and having the change of plans can cause a lot of anxiety in clients.

How do you navigate that when it happens?[98]

So we tell them that we try to advocate for them whenever possible, so even though the OBs need to be involved for the safety of mum and baby, we still stay as an advocate or as emotional support, when it comes to things like vaginal exams or other procedures, we ask the obstetrical team if they're comfortable with us doing that for them, they're still calling the shots, but we can try to do those exams. If we can't, we prepare the client for that possibility and we try and stay close by to provide a familiar face and comfort.
So when you say you prepare them for it, what does that typically look like?
We say "based on what we're seeing from your health right now, we have concerns and our requirements make us consult with the obstetrical team, I'll do my best to consult with a female provider if it isn't something that's urgent, but if there's a transfer of care, there's no guarantees that person will be the one who is delivering, and even if you do have a female staff on, there's often male residents and they're often involved in the care. That being said, I know it's important to you that you have female providers, so I'll ask to do some sensitive checks and see what they say.""

We can see the ways in which midwives try to prepare clients to handle a potential transfer of care involve walking them through the possibilities and providing reassurance that they will do their best to advocate for them.

Sometimes midwives encountered clients whose cultural beliefs went against their clinical recommendations. For example, there was a midwife who had a client whose religious leader told her one of her breasts had poisoned milk. The midwife discussed how her team did not try and argue with the client or her religious leader, and focused their energies on figuring out how to help her do her feeding just from her one breast. Another participant described a common issue she encountered with conducting stress tests:

"…this comes up all the time, when we do a non-stress test for a baby, so when we're checking to see if the baby is happy, if there's reduced fetal movement and we want to assess the baby's well-being, one of the things that I would say are pretty universally recommended clinically, is to drink a glass of ice water before you do the stress test, because the ice water, or something cold and probably to eat something, because the sugar and the coldness of the drink that you're drinking can kind of wake your baby up. I don't know if there's much evidence to that, but we *all* recommend it. *All* midwives recommend it. And when you have a Chinese client who comes into care, who is not supposed to be eating anything cold in the pregnancy, they're only supposed to be eating hot foods, they'll look at you and go "oh, okay, I'll do that." And when you ask them,

[98] Text in bold indicates that the researcher is speaking.

> "did you have a glass of ice water," they'll go, "no, we're not able to eat that or drink that." And you know, at this point, I can say to people "I understand that culturally this might not be something that you do, so you have to decide what your comfort is, but clinically, this will help, and if you decide to do it differently, that's fine" but I think sometimes when our clinical recommendations go against the cultural practices, there can be a little bit of a gap that grows in some ways."

Again, we can see how this participant does not pressure her client into acting in a way that they would find uncomfortable, but instead, gives a recommendation and allows the client to make their own decision. Another midwife mentioned her discomfort with advising clients to avoid fasting, as she did not know how this might be perceived in the client's community:

> "It's my understanding that pregnant women are given a pass on Ramadan, but have to make it up later. But lots of clients try and feel unwell, so I struggle with that. Like, what's the best way to advise someone when I don't know about all the implications going on there?"

Midwives also spoke about how avoiding generalizations was an important component of culturally safe care:

> "I want to try very hard…to treat each person as an individual, regardless of the similarities that they may have with a previous client from the same section of the world, same culture, same religion, I'm still going to say "I want you to make the decisions and I want to give you all the information I can and if you think that you can't to a decision by yourself we'll come to a decision together based on what your needs are.""

Closely related was the idea that they treat their uninsured immigrant clients the same as their Canadian-born and/or insured clients:

> "I would say I tend to treat people all kind of the same unless they make specific requests. I wouldn't say I've gone out of my way to make people feel comfortable, unless they're things I would do for everyone…I don't ask my clients if there's something I can do for them, I rely on them to bring it up for me.
>
> **So how do you create space in the relationship for that?**
>
> Sometimes I just ask—have you considered a birth plan? This is what a birth plan looks like, this is what we do that's routine, but just let us know…So I guess asking about the birth plan is a way to open that up."

Many participants noted that they would also ask all clients if there were any cultural or religious rituals that would be important for them during or after the birth:

> "And I'd say that those things come up more, we do ask clients when they come into care, is there anything about you or your cultural background or any practices or expectations you have for your care that would be useful for me to know to be able to provide better care to you? And I leave it open when I ask clients, because for some people that's having an only female care provider, or making sure that their hair is covered during the birth."
>
> "I ask all of my clients "is there anything—religious or cultural beliefs" you want me to be aware of" but I ask that of everyone."

A midwife noted that culturally safe care is often assumed to only be relevant for racialized women, which is an assessment she does not agree with:

> "There's still so much exoticization…recently I was filling out a survey that asked "how often do you have to provide culturally safe care" and I was like, this right here shows the racism in that question, because I provide culturally safe care to my white clients, just like I do my new immigrant clients."

Yet, despite this outlook, participants often immediately contradicted themselves after stating that they wished to treat everyone equally by admitting that there are often circumstances that are specific to uninsured immigrant clients:

> "…I focus on everyone as an individual and I don't treat my refugee clients any different—I treat everybody the same, although there are the situations where somebody is coming from Somalia and when you're doing an internal, you're thinking "is this person circumcised, has there been any genital mutilation" and I think you do your history before you do your physical, sometimes that stuff will come out, but it won't always."

Midwives also focused on not making generalizations about uninsured immigrant clients. They saw assumptions as antithetical to culturally safe care. One midwife even ended her interview by inviting me to consider the tension in my research between wanting to honour the complexity of immigrant populations and needing to find trends in order to advance an argument of some kind:

> "You can grab ten women from the same country and talk to them, and there will be shared themes and experiences, but there will be particular nuances. Anyways, I have my lingering thought, as I was answering your questions. I felt like I was making a lot of generalizations, because how else do you talk about a big, very diverse group of people?"

This same midwife also gave an interesting account of how she built safety into her practice in an intersectional manner—not shying away from issues of gender and sexuality:

> "So I feel that the cultural safety comes in with not making assumptions-just because it applies to this person, doesn't mean it will apply to that person. Cultural safety is not making assumptions. When I see a client wearing specific clothing doesn't mean she's going to do x, y, or z. Cultural safety for me is asking questions—how do they want to be identified. In the context of gender identification and pronouns used. That's a subculture, but part of cultural safety. And not being afraid to ask questions if there are things about their culture that I don't know-how do they do this or that, are there any cultural or religious considerations they want me to be aware of or participate in. For me, that's how to provide culturally safe care."

The detail about asking for pronouns caught my interest, and I asked if she did this with all her immigrant clients:

> "I do it in a way that's like planting a little seed. I do know that some of the places where my clients come from, there's still so much of that macho culture and homophobia, and by showing that openness, that there isn't just one way of making a baby, planting that little seed, it starts opening that dialog. They don't know what their kid is going to be like. It's a little opening for themselves to be up front and open.
>
> **So do you ever find that there's pushback from your clients when you ask? Do they get uncomfortable?**
>
> No, some clients who are not very familiar might laugh or ask "what??" cause they don't understand. Then I just explain what I mean and that's it. I haven't experienced any pushback myself."

Midwives also discussed their own positionality as Ontario midwives, and how this affected their perception of how to provide culturally safe care. One midwife noted how Western culture is positioned as normative:

> "North America is not a culture, it's a norm, and everything else is a culture. It's that idea. We're never the culture, we're the way it should be, everyone else is the culture you have to navigate around."

This statement clearly demonstrates that this midwife is critical of the positioning of Western culture as neutral and normative, because it necessitates a view of other cultures as deviant and a burden.

The same midwife discussed the importance of resisting making judgments of your clients.

> "…the number one thing, this sounds so simple, but it's so hard, I'm a huge believer in autonomy, it's the beginning and end of women's healthcare. So what am I doing to let this person have as much autonomy as I can? And a huge part of that is to not judge. Who am I to judge who should have a kid or not? Extreme poverty, not the best relationship [with their partner], struggling with parenting, coming back for their fourth or fifth kid. Cultural norms may be highly relevant or totally irrelevant depending on who the client is…moments of judging still happen, but you have to try not to. Letting yourself be human and dealing with it, instead of pretending that you never have judgement, a lot of the culturally safe care speak is the language you use, and not feeling authentic as a person."

It is striking that she feels that even a silent judgment can influence the type of care she provides to her clients. She links the attitude midwives bring to their practice to the quality of care they provide.

One participant told me about a client she had who was treated terribly by hospital staff when she came in with an intrauterine death. She described how the client was denied an ultrasound to confirm that the fetus was dead, as well as induction to pass the tissue, until the doctors had "cash in hand." The midwife went above and beyond to provide service to her, but also ascribed very little agency to the client:

> "I ended up staying with that woman 36 hours, I didn't leave her side, I didn't want to leave her alone, because she couldn't advocate for herself.
>
> **Did she speak English?**
>
> She did, yeah. But I think she was Middle-Eastern, very quiet, very subservient, and she would have just done what anybody said to her. So I wanted to make sure I was there, so she wouldn't be pushed around."

One participant mentioned that even though the Ontario midwifery model values informed choice, midwives needed to think through the implications of how this process might shift with different types of clients in order to provide culturally safe care:

> "I ease people into the volume of info that comes with informed choice, because I think that culturally that's what they find overwhelming, especially when they're dealing with all these other factors."

Finally, there were a few comments about how participants felt like there were anxieties around providing inadequate care to racialized populations. A white midwife revealed her own caution during her interview:

> "I find it hard for me as very Caucasian, as white as they come, I haven't had a lot of exposure and experience…I'm always very cognizant of not wanting to offend anyone and saying the right things or wrong thing—even in this interview right now—because I don't want to sound ignorant, so I absolutely think it's super important to provide culturally safe care…I think it comes down to: treat everybody equally, don't treat anybody differently than anybody else—but it's hard, because some of these people have been marginalized, so you need to find a balance between that and not being offensive or racist, which I find hard, because I don't want to be offensive."

A racialized midwife described the current moment she felt in midwifery, and how she felt that a culture of political correctness might actually be hindering immigrant clients from accessing midwifery services:

> "We're in this weird white guilt place of people being so worried that they're going to make a mistake that they're not providing care that I think they should…I don't know if that's the response to race politics…It's gone from "we don't serve these people because they're less than we are" to "we're going to serve these people, but the way that we want" and now it's "we don't want to make a mistake with anybody, so we're not going to serve these people." How does it always end with the same conclusion? ...I think people are worried they won't be culturally competent enough, or they won't do a good enough job."

This midwife is pointing to a fascinating notion—that the current moment in Ontario midwifery might emphasize culturally safe care to such a high degree that midwives are too anxious to take on uninsured immigrant clients and risk making a mistake with their care. What is especially interesting is the connection between the ways in which the logistical barriers make it more difficult for midwives to navigate the cultural pieces of care. The language, financial, and logistical barriers not only increase the risk of an adverse health outcome, but also make the delivery of culturally safe care more challenging.

Discussion

In starting this research, my aim was to identify barriers to reproductive healthcare access that stem from cultural and ideological differences between midwives and their immigrant clients, rather than the logistical barriers already discussed in the literature. Against my initial expectations, the participants actually identified many other barriers to performing culturally safe care besides those that arise from differences in values between them and their clients. Furthermore, the participants continuously drew connections between the logistical challenges that they faced and the broader political moment in midwifery. Both of these factors influenced the attitudes that midwives had towards uninsured immigrant clients. These findings inevitably shaped the structure of my discussion, complicating my initial assumptions about the midwife-client relationship. This section is organized around a discussion of the four components of culturally safe care I consider central to how midwives conceptualize their relationships with uninsured immigrant clients: understanding of (1) cultural differences, (2) intracultural variation, (3) agency, and (4) positionality.

I thought that because midwives in Ontario had advocated for their care to be provided free of charge to uninsured clients,[99] these clients no longer experienced barriers to access because of the attitudes of midwives. My assumption was that the primary barriers were a lack of knowledge about midwifery services and an inability to physically access this care. However, the interviews reveal that although many midwives in Ontario are engaging with the question of how to provide culturally safe care to uninsured immigrant women, there are still many tensions that may hinder these clients from being accepted into midwifery care. These tensions do not

[99] Uninsured Clients," Association of Ontario Midwives, http://www.ontariomidwives.ca/support/uninsured, accessed September 5, 2017.

necessarily arise from differences in values, but from the ways in which clients differ from those the Ontario midwifery model expects to serve.

I. Cultural Differences

One of the most fundamental components of culturally safe care outlined in the literature on midwifery is the "acknowledgement and legitimization of cultural differences while planning care."[100] Not surprisingly, all the participants were able to identify "cultural differences" between themselves and their uninsured immigrant clients. Midwives spoke of specific rituals, beliefs, and values that their clients engaged in, and they also discussed the ways in which they tried to accommodate their clients. What became especially clear over the course of the interviews was that for midwives, cultural safety was often tied to the recognition of gender dynamics. This reinforced the existing research, as healthcare practitioners often identify anxieties surrounding male healthcare professionals and the presence of male partners as challenges in providing care to immigrant women.[101] Informed by the midwifery model and its emphasis on providing women with continuity of care and recognizing their agency during labour, participants discussed how they attempted to improve transfers of care to male healthcare providers by remaining by their clients' sides in order to support them. Participants were also able to recognize that spouses and family might play a bigger role during appointments than what the Ontario midwifery model anticipates from white, middle-class families. A few participants were able to push this cultural awareness further, and view the family's participation not necessarily as a challenge, but also as a positive aspect of the care dynamic. This finding shifts the conversation beyond what has been previously discussed by Kushniryk, Titus-Roberts, and Wertz, as their research showed that

[100] Burton and Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," 267.
[101] Newbold and Willinsky, "Providing Family Planning and Reproductive Healthcare to Canadian Immigrants," 376.

healthcare providers were encouraged to merely tolerate this dynamic, rather than embrace and work with it.[102]

One of the central approaches to culturally safe care defined by the midwives is that it requires actively addressing cultural differences. Some participants tended to emphasize that culturally safe care was an active process that had to go beyond simply seeking not to offend. Other participants emphasized that they were happy to accommodate cultural difference, but did not ask clients about specific beliefs or rituals, relying instead on their clients to bring this to their attention. Most participants, however, stated that asking about rituals and beliefs was something they did with all clients, regardless of ethnicity.

Only a few times during these interviews did essentialist "cultural explanations" threaten to remove nuance from midwives' perceptions of their uninsured immigrant clients. While most of the participants felt as though they could not speak to the experiences of their clients from the Global South, there were a few instances of essentialist explanations that served to reduce uninsured immigrant women's desires to birth in a hospital to simply being a product of their 'culture' and their desire to avoid being "mortified" by the response of relatives back home. Here we can see similar rhetoric to that used in "Colonized Wombs": that the culture of these women's home countries force them into situations over which they have no control.[103] Nonetheless, this manner of recognizing cultural difference appears to be anchored in a generalized understanding of culture that is then rigidly applied to individuals, instead of observing cultural differences on a case-by-case basis with input from the clients.

[102] Alla Kushniryk, Jolene Titus-Roberts, and Emma Wertz, "Immigration as a Catalyst for Increased Health Awareness: Immigrant Women Define Health and Health Decision Making," *Journal of Immigrant & Refugee Studies* 12 no. 3 (2014): 187.
[103] Patel and Al-Jazairi, "Colonized Wombs," 64.

Participants identified moments in which their clinical expertise was not in line with their client's cultural beliefs. There were instances of Chinese clients not wanting to consume something cold before a stress test, Muslim clients wanting to fast during Ramadan, and even a client who had been told by a religious leader in her community that the breastmilk in one of her breasts was poisonous. Without exception, participants indicated that they did not pressure clients to disregard their cultural beliefs, and tried to work within the parameters established by those beliefs. Participants were willing to give their clients as much autonomy in their beliefs and behaviours as possible, even when it may not have been clinically helpful—a difficult assessment to make, given the overall importance of building trust between healthcare practitioners and clients. It is important to recognize that the midwives were sometimes taking on extra work in order to make sure that their clients were still having good outcomes when their clinical care could not proceed in a normative manner due to their cultural beliefs. This finding aligns with Burton and Ariss' report that midwives do "extra-clinical" work in order to creatively meet the needs of their diverse clientele.[104]

One of the interesting tensions I identified in a couple of interviews was the question of how to balance the positions of racialized immigrant populations with the queer community, as they are typically conceived of having irreconcilable cultural differences. This issue came up in two specific instances. One midwife described asking her immigrant clients which pronouns they preferred and not assuming that they were in heterosexual relationships. It is interesting that she did this partially as a way of combatting the culture of homophobia she associated with her clients' home countries, which she was familiar with, having immigrated from that part of the world. This was the only instance in all of the interviews during which a participant explicitly

[104] Burton and Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," 268.

stated that she practiced a certain way in order to challenge an aspect of a client's cultural background. She noted that her clients had no way of knowing how their children might grow up, and that this was her way of planting "a little seed" for her clients to think about. Crucially, this midwife did not claim that her clients themselves were homophobic or transphobic, but rather that she believed she could challenge the very "macho culture" of their home country and create a different kind of space for her clients.

Another midwife identified a tension in the midwifery community between creating queer-friendly clinic spaces and still maintaining a sense of cultural safety for immigrant clients from the Global South. She pointed out that other midwives in the community had felt as though they could not display queer-friendly pregnancy guides in clinic spaces because of the religious beliefs of immigrant women from the Global South. This participant saw this as a problematic assumption that not only served to completely strip queer clients of their religious identities, but also serves to homogenize and vilify immigrant clients as homophobic—feeding into the narrative that immigrants are bringing "backwards values" into Canada. This participant felt that midwives could simply express a queer-friendly position and that immigrant clients would not make it an issue—assuming that they were even homophobic in the first place.

This participant was also an advocate for removing pictures of naked women from clinic spaces, because she felt that this would actually serve to make immigrant clients uncomfortable. She based this generalization on immigrant women she knew personally, who would be uncomfortable with pictures of nude women in waiting rooms that were mixed-gender. We can identify a tension in how this midwife speaks of her uninsured immigrant clients: on one hand, she was confident that her clients would be bothered by aspects of sexuality in some contexts (nudity); on the other, she was also willing to believe that they would not have difficulties when

faced with other potentially uncomfortable situations (non-heterosexual relationships). It may be that in addition to wanting to avoid propagating negative stereotypes about immigrants from the Global South, this midwife identifies imagined discomfort with queer relationships as an issue that could justify turning away uninsured immigrant clients.

II. Intracultural Differences

While all of the participants were able to identify instances of cultural differences in their relationship to their immigrant clients, not all of them discussed intracultural differences among the uninsured immigrant populations they served. Cioffi's study of midwives in America found that although midwives were able to clearly articulate and utilize knowledge of cultural difference, they were less capable of recognizing intracultural differences.[105] The participants who did recognize intracultural differences stressed the importance of not making assumptions about their clients, and ensuring that they were asking them questions rather than relying on stereotypes or previous experiences with other clients. To understand that "cultural norms may be highly relevant or totally irrelevant" depending on the client leads midwives to treat them as individuals rather than as members of a homogenous and predictable cultural group. One midwife noted that it is important to do this even when clients themselves behave in ways that reinforce stereotypical behaviours, such as preferring doctors to midwives. Another participant discussed the importance of understanding a client's expectation for birth in order to provide them with good care, but was careful not to homogenize cultural experiences. Her understanding of her clients' cultures comes from what they are telling her, not from outside sources.

However, even as midwives were explaining how they treated all their clients as individuals, there was still a tension that emerged between wanting to treat their clients as

[105] Cioffi, "Caring for Women from Culturally Diverse Backgrounds," 440.

individuals and drawing on past knowledge of cultural difference to help ease their clients into care. Midwives did not talk about whether making generalizations was ever helpful, but instead insisted on not only treating every client as an individual, but also on treating uninsured immigrant clients the same way they would treat Canadian-born or insured counterparts. This was a key tension that emerged in the interviews—an anxiety about treating clients equally and yet, also noting that uninsured immigrant clients often required extra work and specialized kinds of skills or care.

Midwives repeatedly noted that caring for their uninsured immigrant clients required an understanding not just of clinical skills, but also of social and settlement services. I found it striking that when I asked about culturally safe care, the responses that I got almost always found their way back to discussing finances and social supports. One midwife noted that she often felt that she was "a little bit the social worker, settlement worker, translator, and midwife." Another midwife explained that she thought the best advice she was best able to offer her team for working with uninsured immigrant clients was informed by her experience as a social worker. As mentioned before, these findings align with Burton and Ariss' interviews with 16 midwives in Ontario, which identified how midwives provide extra-clinical work in order to meet the needs of their "diverse" clientele. However, Burton and Ariss' interviews were focused on clinical birth spaces and saving late-to-care spots for marginalized clients, while participants in this study discussed a variety of other strategies that they use for navigating difficulties with language, families, and gender roles during hospital births and prenatal appointments.

Most of the participants identified the extra work that midwives had to perform as a major barrier to taking on uninsured immigrant clients. A few participants discussed the extra funds that practices could apply for, in order to offset the cost of providing extra care to clients.

However, midwives reported that these funds are extremely limited. Midwives also noted that uninsured immigrant clients were often at higher risk of medical complications, simply because they did not always undergo the required tests or see the specialists recommended to them. As one participant pointed out, midwives are less likely to take on higher-risk clients because they want to avoid the legal and personal ramifications of adverse health outcomes.

III. Conceptions of Agency

Perhaps the most interesting component of culturally safe care that came to light during these interviews was the participants' implicit and explicit discussion of the agency of their clients. The lack of agency that a few of the midwives ascribed to their uninsured immigrant clients was one of the more troubling details in their descriptions of caring for these women. Mohanty discusses the importance of not falling into the trap of a saviour complex in her canonical postcolonial critique of white feminism, in her "Under Western Eyes." She discusses how white feminists have a tendency to reduce "brown women" into figures who are in need of saving from "brown men."[106] In other words, white feminists assert their own agency by stripping it from the narratives they tell about women from the Global South. We can see instances of this happening very clearly in "Colonized Wombs," such as when women from the Global South have their agency erased in relation to the systems of colonialism and misogyny in their home country. Nonetheless, many of the participants engaged with issues of agency with varying degrees of complexity and demonstrated nuances in the narratives they told about their uninsured immigrant clients.

[106] Chandra Talpade Mohanty, "Under Western Eyes: Feminist Scholarship and Colonial Discourses," in *Third World Women and the Politics* of *Feminism*, eds. C. T. Mohanty, A. Russo and L. Torres. (Bloomington: Indiana University Press, 1991): 52.

Agency was central to almost all the challenges mentioned by midwives. The primary issue with language was that it hindered uninsured immigrant clients from being able to access informed choice to the same degree as their English-speaking clients. Midwives noted that this was especially tough during medical emergencies, as they felt they were taking away their client's bodily autonomy by making decisions without going through the process of consulting and discussing possibilities and repercussions with their clients. Participants pointed out, however, that this is something that applies to all clients, regardless of their language proficiency, simply because of the nature of medical emergencies during birth—sometimes consultation is not possible without endangering the life of the mother and child. One midwife offered a tentative solution to this challenge by pointing out that clients are trusting midwives to do what is best for them and their children, and therefore, making clinical decisions when it's not possible to consult with the client was actually honouring the client's wishes and her decision to place trust in the midwife's hands.

Similarly, midwives resolved the issue of agency in relation to the presence of spouses in one of two ways. Some midwives found ways to see clients on their own so they could try to speak with them one-on-one or with a professional interpreter, rather than with a family member present. This would suggest that there is some certainty on the part of midwives that clients cannot speak freely and express themselves unless they are separated from their families—that their agency is dependent on being away from their partners. Indeed, this is probably what most closely resembles Mohanty's idea of "white women saving brown women from brown men," except that sometimes the midwives themselves were also racialized. However, there was also another attitude that sometimes co-existed with the aforementioned belief, namely that midwives also attributed agency to their clients by pointing out that these women might be doing what was

more comfortable for them by having their partners present, and that doing so was actually resisting the North American norm of operating as an individual in the healthcare system. In the latter model of thought, agency is not something that is ascribed when immigrant women conform to a predetermined model of behaviour, but is instead read into their actions by decentering normative Western values in order to understand how women are navigating systems in ways that benefit themselves.

I do want to point out that the key difference between attributing agency to these clients and relegating their desires to a simple product of their "cultural background" is the emphasis that participants gave to the context in which these women are making decisions about their healthcare. Rather than acting as though one or two details of an uninsured immigrant client's background—usually their ethnicity or religion—would determine the entirety of their behaviour, midwives who were able to understand the context were making connections between race, class, migration, religion, gender, and sexuality, and explaining how they saw their clients navigating the various constraints imposed on them by each of these systems.

Some midwives were also thoughtful when reflecting on how some clients might have demeanors that are different from what the alternative birth movement would consider to be "empowered." One midwife discussed an instance in which she misjudged a woman's intelligence based on her accent and her quiet nature. The participant had assumed that a client who gave succinct answers was not really engaging with the care that the midwife was providing. However, during the interview she was able to unpack her assumptions about that client and explain how she learned from the experience—not all intelligent or savvy women speak in the same way. Conversely, one white midwife described staying with a client in a hospital because she thought that the client was not able to advocate for herself. When I asked if

the client spoke English, the midwife replied that she did, but that she was "Middle Eastern, very quiet, very subservient." These sort of comments present an interesting dilemma for me as a researcher and as an aspiring midwife, because even though it is clear that this participant had excellent intentions and provided an incredibly high level of service to her client, she still used essentialist explanations to describe her client's disposition, rather than understanding the nuanced ways in which people perform their identities in public spaces.

However, this participant was in the minority, as most of the other participants did not link women's dispositions or personalities to their cultural backgrounds. One racialized midwife cautioned against these sorts of simplistic readings, as she argued that the ways in which people behaved in public were different from how they behaved privately. At the end of another interview, a racialized midwife shared her feelings of unease that were caused by speaking about her uninsured immigrant clients as though they were a homogenous group. She pointed out that one could speak to ten different women from the same country and that while their stories might have similar elements, they would also be different in important ways, and part of her job is to pay attention to those differences. Agency and recognition of intracultural difference are linked, as understanding that women's decisions are not the sole product of their cultural background necessarily demands that healthcare practitioners take into account what the clients themselves desire.

Participants also discussed agency in relation to the informed choice that they tried to provide to their clients. They frequently expressed frustration over the fact that their clients' choices were so often restrained by finances, and pointed out that this was typically the factor that made the care more challenging than caring for insured clients. Multiple participants pointed out that during the initial visit, clients would barely pay attention to their description of the

midwifery model or any of the other information provided, waiting instead for the price tag of this care. In fact, a midwife who primarily works with uninsured clients told me that she starts the first appointment with the fact that clients will not have to pay for midwifery services in order to ease their mind and allow them to focus on the rest of the appointment. This midwife also pointed out that her discussion of informed choice was shaped by the fact that these clients did not have healthcare insurance—it would be somewhat ridiculous to act as though their choices were not more restricted than insured clients who might have sought out midwifery care on their own.

One of the central decisions midwives help their clients make is where to give birth. However, as Burton and Bennett have explored, this conversation is trickier when clients do not have health insurance.[107] Midwives revealed a variety of ways of seeing their clients' agency while discussing their choice of birth location. One midwife told me that regardless of whether her clients were planning on a home birth or a hospital birth, she encouraged them to speak with the finances department of the hospital to figure out what the potential fees could be. This functioned to make sure that the clients had more information and could use that knowledge to navigate a potential transfer of care. We can see the complex ways in which the concept of agency not only implicitly factors into midwifery services, but also informs the discussion midwives have with their clients. Their discussions are primarily structured as a way to introduce more agency into their clients' limited options.

Providing more information was not always viewed as providing better care or informed choice. One midwife talked about her choice to not overwhelm clients with too much information, as she felt that uninsured immigrant clients did not necessarily want to know as

[107] Burton and Bennett, "Meeting the Needs of Uninsured Women," 25.

many details as the wealthier white women who sought out midwives on their own (not coincidentally, the very clientele for whom the Ontario midwifery model was built). She argued that rather than overloading them information in which they are not interested, it is better to read their body language and determine if they want to leave the appointment early. She explained that visiting a healthcare professional was supposed to alleviate how much concern they needed to put into their pregnancies, not amplify it. And yet, this course of action was seen as an active choice, a sign of agency on the part of the clients—they did not conform to the Ontario midwifery model, as their values and lifestyles were different from the middle-class, white women who had been the majority of midwifery clients for such a long time. As Burton and Ariss point out, midwives accepting that their clients' values differ from their own means that midwifery in Ontario is becoming more diverse. This participant, in embracing her clients' deviations from the model, was demonstrating a complex reading of agency that did not reduce her uninsured immigrant clients to colonized subjects simply because they presented a challenge to the Ontario midwifery model.

Midwives also revealed their thoughts on agency through their discussion of authority. As Burton and Ariss have illustrated, it is important to midwives in Ontario to resist the hierarchy between healthcare practitioner and patient that pervades the medical model of childbirth. Midwives work to disrupt relationships such as these that reinforce the status quo of power relations.[108] A few of the participants explicitly mentioned how they struggled with communicating to their uninsured immigrant clients that the midwifery model did not encourage an authoritative relationship between practitioner and client. Midwives expressed discomfort at the idea that their clients would feel as though they were not equals in a partnership—one

[108] Burton and Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," 269

participant told me that she gave "recommendations" to her clients that they could choose to follow, but that she did not want to give orders the way a doctor might. This emphasis on a non-hierarchical relationship is consistent with the Ontario midwifery model, and seemed to be one of the most concrete ways in which participants conceptualized the agency of their clients. However, as a racialized midwife pointed out, the Ontario midwifery model was not necessarily shaped with the interests of immigrant clients in mind, as they do not all necessarily want their relationship with their healthcare practitioner to be one that puts the majority of decision-making back in their hands. Many uninsured immigrant clients were living in poverty and had other children to take care of, and understandably did not want to be repeatedly asked by their healthcare provider what course of care they should choose. As Benoit has observed, lower class, ethnic, and rural clients appeared to be accepting of a relationship whereby they would be medicated and managed by a healthcare practitioner, rather than engaging in micromanaging their childbirth.[109]

Despite wanting to distance themselves from the hierarchical medical model that created a distance between them and their uninsured clients, the midwives also wanted to be recognized as healthcare professionals, especially by hospital staff, but sometimes also by their clients.[110] There were multiple instances of midwives indicating that their uninsured immigrant clients were reassured by the professional setting of the clinic, or the formal training that the midwives received through the MEP (one client had initially believed it was a weekend course, to the dismay of a participant). One participant even mentioned wearing the stethoscope around her neck as a gesture that seemed to put her clients at ease, because they felt that they were with

[109] Benoit, "Uneasy Partners: Midwives and Their Clients," 278.
[110] I will not have time to discuss the relationships between midwives and hospital staff in this project, but it is an important site to explore, especially with regards to how uninsured immigrant clients become caught in the middle of the clash of two sets of values.

professional healthcare providers. Davis-Floyd has written about how midwives will strategically use medical technologies (often forced upon them by regulating bodies) in order to ease the minds of patients and their families, albeit sometimes in ways that those technologies are not originally intended.[111] We can see a similar tension that Ontario midwives must navigate with their uninsured immigrant clients—the desire to avoid a hierarchical relationships and still present themselves as trustworthy and experienced healthcare professionals.

IV. Positionality and Reflexivity

Understanding how midwives discussed their own positionality in relation to their clients is key to understanding how they provide culturally safe care and how they navigate the authority with which their position endows them. Almost all of the participants discussed their own race, and all but one of the white midwives engaged in a conversation about their racial privilege. White midwives mentioned that they were settlers on indigenous lands, and that they did not "understand all the implications" of immigrant clients' decisions regarding cultural practices. These statements indicate that they are not only aware of their own positionality, but that they are practising what Burton and Ariss call "cultural humility."[112] One participant pointed out that her whiteness established her as an authority to her uninsured immigrant clients, but did not necessarily make them trust her. The racialized midwives also discussed their race, and how thinking about issues of race and culture long before they entered the Midwifery Education Program enhanced their provision of culturally safe care. As Kennedy, Erickson-Owens, and Davis have pointed out, race and gender influence how midwives conceptualize the way they

[111] Davis-Floyd, and Davis, "Intuition as Authoritative Knowledge," 237.
[112] Burton and Ariss, "Diversity in Midwifery Care: Working Toward Social Justice," 281.

practice midwifery.[113] Similarly, it has been repeatedly noted that increasing diversity among midwives is necessary to improve its service towards its diverse clientele.[114]

What was consistent throughout the responses of white midwives and racialized midwives was an acknowledgement of the uncertainty and fear that surrounds providing culturally safe care to uninsured immigrant clients. Perhaps the most surprising discovery of all is that midwives identified these anxieties as a reason their colleagues might be reluctant to care for uninsured immigrant women. One racialized midwife described the "current moment of white guilt" that society is in, and explained that her white colleagues were so afraid of doing something that was potentially offensive that they ended up avoiding taking on clients who might require an extra degree of cultural sensitivity. As she pointed out, this resulted in the same barriers to access as racist attitudes towards clients. Certainly, even some of the white midwives who were providing care to uninsured immigrant clients mentioned that they felt unsure and nervous about doing or saying something insensitive.

While there is nothing wrong with feeling cautious about one's actions when interacting with vulnerable populations during challenging moments in their lives, I would like to suggest that over-cautiousness on the part of midwives is not helpful to either uninsured immigrant clients or midwives. Thoughtful and culturally safe care to clients should be seen as an on-going process that requires midwives to learn from their mistakes. One of the strategies a racialized midwife used was making sure that she had space to behave in a way that was less than ideal — that she could allow herself to acknowledge that she would occasionally judge a client for their decisions or get upset at the amount of extra work that uninsured clients needed. She explained

[113] Kennedy, Erickson-Owens, and Davis, "Voices of Diversity in Midwifery: A Qualitative Research Study," *Journal of Midwifery and Women's Health* 51, no. 2 (2006): 88.
[114] Wren Serbin, Jyesha and Elizabeth Donnelly, "The Impact of Racism and Midwifery's Lack of Racial Diversity: A Literature Review," *Journal of Midwifery & Women's Health* 61, no. 6 (2016): 694.

that making room in her practice for those thoughts and feelings meant that she could then address them and not carry them forward in her interactions with her clients. Another racialized midwife pointed out that much of what she had learned during the Midwifery Education Program (MEP) had taught her to view women from the Global South as lacking agency, and that this was something she had to consciously unlearn in order to provide culturally safe care for her clients. Her statements connected the MEP's vision of Third World Women to Mohanty's argument about white feminism's impulse to save brown women from brown men. Participants pointed out that the biases that they must unlearn in order to provide culturally safe care are sometimes ones that they pick up in the MEP itself.

The conversations on culturally safe care inevitably led back to the logistical difficulties of working with uninsured immigrant clients, as well as the fear that they could not adequately provide culturally safe care because of the nature of their work. One midwife who had undertaken graduate studies pointed out that it is much easier to think through the ethical implications of her actions and plan out the best way to approach issues in a culturally safe manner when she had the time and resources to reflect and organize herself. The midwives that I spoke with were doing their best to balance the clinical and social aspects of care, but they made it clear that clinical care was what they paid the most attention to. In order to discuss how they provided culturally safe care to their clients, they found it necessary to unpack the ways in which language, finances, hospital staff, and family all shaped the relationship between them and their clients. These factors led to a fear of being insensitive to the needs of their uninsured immigrant clients. It was this combination of factors that was consistently identified with being the reason that midwives in Ontario were often reluctant to take on uninsured immigrant clients. Thus, while the discussion on culturally safe care has evolved in the two decades since midwifery has

been legalized in Ontario, and midwives are learning to provide care to these clients in ways that are less essentialist, it is still important to understand that an overemphasis on the "safety" of these clients has also created a culture of anxiety within Ontario midwifery about serving this population.

Conclusion

What this project opened up is the tension between the goal of Ontario midwifery to include immigrant and uninsured populations, and the ways in which this clientele presents challenges to its model of care. The discussion that I had with participants emphasized the interrelated nature of logistical challenges and the importance of providing care that was specific to clients' needs and desires. Midwives incorporated critical thinking on race and class into their discussions of serving uninsured immigrant clients, offering a promising departure from the types of rhetoric found in the literature such as Patel and Al-Jazairi's "Colonized Wombs" and Johnson et al.'s work on healthcare professionals working with South Asian women. Their conception of culturally safe care was an aspect of their service that they valued highly, but it also presented a challenge to the established Ontario midwifery model.

While this research opened up this discussion, it is also clear from these conversations that there are numerous areas that require further exploration. The tension between serving immigrant clients and the queer clients, the role of the MEP in teaching culturally safe care, and the relationship between midwives and hospital staff were three major issues that came up in interviews but were not sufficiently explored as they did not fit into the limitations of this project.

Two findings unexpectedly emerged over the course of this research that both answered and challenged my initial research question. The first is about how the logistical barriers present in relationships with uninsured immigrant clients are inseparable from the challenges to providing these clients with culturally safe care. The second unexpected finding was that the anxiety surrounding culturally safe care and political correctness could sometimes act as a deterrent for midwives taking on uninsured immigrant clients. It seems that in order to properly engage with how Ontario midwives provide culturally safe care, it is useful to target both of

these issues. Addressing logistical issues and the broader culture of anxiety around political correctness offer ways for the Ontario midwifery community to move forward and recommit itself to providing culturally safe care.

What became evident over the course of this research are the ways in which Ontario midwives' conceptions of culturally safe care simultaneously disrupt the Ontario midwifery model while being informed by it. As demonstrated in the literature review, the Ontario midwifery model emphasizes choice of birthplace, agency of clients, informed choice, natural births, home as a place of comfort, and progressive politics. Serving uninsured immigrant clients forces midwives to reckon with the model's limitations and contradictions. How do midwives reimagine informed choice and agency when their clients have limited language skills, finances, and access to social services? How does the desirability of a home-birth change as clients experience conditions of hidden homelessness as they live in cramped and crowded spaces? Perhaps most interestingly, how do the political awareness and engagement valued so highly by the profession shift when the considerations are pushed beyond gender, and when midwives must grapple with other systems in which they are complicit, such as class, race, colonialism, and migration status?

In this project, I have shown some of the ways in which midwives navigate these challenges in order to retain the values of the Ontario midwifery model and provide culturally safe care. Yet it is important to note that navigating these tensions often results in midwives engaging with the limitations of a model that was designed with a specific, relatively privileged clientele in mind. Cultural safety is not achieved by simply inserting uninsured immigrant clients into the available model of care, but rather through a complex engagement with and reimagining

of the Ontario midwifery model and the ways in which it may be reworked in order to take the needs of these clients into account.

Appendix 1: Interview Guide

Before we begin, I just want to review your consent agreement. Do you have any questions about it? I also want to remind you that if at any point during this interview, you may choose not to answer a question or stop the interview.

Section 1: Basic information about the midwife:

How old are you?

How long have you been practicing midwifery?

How would you describe your ethnic/racial background?

Section 2: Context of working with uninsured clients

Can you tell me a bit about your work with uninsured clients?

PROMPTS:

- Do you serve many uninsured immigrant clients?
- What proportion of your practice is uninsured clients?
- Do you tend to see more uninsured or insured immigrant women?
- What is the socio-economic status of these women, usually?
- Are the clients from racialized groups?
- Do you normally experience a language barrier?
- What countries are the uninsured clients from?
- How do these clients feel about midwifery when they enter your care?
- How do they feel when they exit?

Section 3: Challenges of working with uninsured clients

Do you find that there are specific challenges in providing midwifery care to uninsured immigrant women? NB: IF NO, SKIP TO SECTION 4. IF YES, STOP AT END OF SECTION 3.

PROMPTS:

- What are the typical challenges are when you are serving this client population?
- How do you interpret/explain these challenges?
- Can you think of challenges regarding how both you and your uninsured client approach your relationship?
- How do you address/navigate these tensions when they arise?
- How do you conceptualize culturally safe care? Is it important to these relationships?
- What are challenges to providing culturally safe care?

- What strategies have you developed?
- Do you believe these strategies could be implemented by other healthcare professionals if they encounter similar issues with immigrant women?
- Is there anything specific to midwifery that would not be generalizable to other healthcare professionals when it comes to addressing the challenges that arise when serving immigrant women?
- Why do you think these challenges arise with this group (uninsured immigrant women) specifically?
- Do you attribute it to cultural difference?
- Do you think their experience of birth in their home countries makes a difference?

Section 4: Challenges of midwifery work in general:

Do you find there are challenges in working with uninsured clients that are typical of many populations that you serve? NB: IF NO, SKIP TO SECTION 5.

PROMPTS:

- How would you characterize these challenges?
- Are these challenges related to how both you and your client approaches your relationship?
- How do you navigate these tensions when they arise?
- What types of strategies have you developed?
- Do you believe these strategies could be implemented by other healthcare professionals when providing reproductive care to women?

Section 5:

Can you tell me more about your service for uninsured immigrants?

PROMPTS:

- What do you find rewarding about it?
- Can you take me through what you might have to specifically consider with this clientele that you normally wouldn't?
- Can you describe some past experiences of caring for uninsured immigrants?

Thank you for your time; I really appreciate your participation in this study.

Appendix 2: Consent Form

Ryerson University
Consent Agreement

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

Immigrant (M)others: Exploring Relationships Between Midwives and Uninsured Immigrant Women in Ontario

INVESTIGATORS: This research study is being conducted by Isuri Herath and Sedef Arat-Koç, from Immigration and Settlement Studies at Ryerson University. The primary research is Isuri Herath, who is conducting this research as part of the requirements for her MA. Sedef Arat-Koç is supervising this project.

If you have any questions or concerns about the research, please feel free to contact Isuri Herath (iherath@ryerson.ca) or Sedef Arat-Koç (saratkoc@ryerson.ca or (416) 979-5000 x 7338).

PURPOSE OF THE STUDY: This study will use interviews with midwives who serve immigrant clients to explore how midwives navigate potential tensions that might arise while providing care for immigrant women. There will be a maximum of 10 participants recruited for this study and only midwives who have received their training in Canada and have served uninsured immigrant clients will be recruited. This research will contribute to the primary investigator's major research paper for the completion of an MA in Immigration and Settlement Studies.

WHAT PARTICIPATION MEANS: If you volunteer to participate in this study, you will be asked to do the following things:

Partake in one to two interviews with the primary investigator. The interviews will be around an hour to an hour and half in length. The interviewer will collect information about your age, how long you have been practicing, and your ethnic identity. Here are some sample questions you may be asked.

I. Do you find that there are challenges in providing midwifery care that are particular to uninsured immigrant women?
II. How do you navigate these tensions when they arise? What types of strategies have you developed?

Once this research has been completed, findings will be available to you. If you wish to have an electronic copy sent to an email address, please indicate that at the bottom of this form.

POTENTIAL BENEFITS: My research will potentially benefit you by providing you, and other midwives, with a better understanding of strategies that can be used to navigate through tensions that might arise in providing reproductive care to uninsured immigrants. This may be beneficial to reproductive healthcare professionals more broadly, or perhaps even healthcare providers who work with immigrant clients. I believe it will also be beneficial to immigrant women more broadly, even those with health insurance, because I will be illustrating the strategies for providing culturally safe care that have been found to be useful by midwives.

WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT: You may recall moments of stress or discomfort that occurred during your time caring for uninsured immigrant women. If any questions make you uncomfortable, you are always able to skip the question, or stop the interview, either temporarily or permanently. You may also be at legal risk if you disclose criminal activity that you have participated in. I am obligated to report any criminal activity that you disclose to me to the police because of section 22 of the Criminal Code in Canada. I also have a duty to report any child abuse to the Children's Aid Society, as outlined in the *Child and Family Services Act*. I will maintain confidentiality throughout this study and afterwards, but this does not extend to protecting your confidentiality in the case of disclosure of illegal activity.

CONFIDENTIALITY: Confidentiality will be maintained during this project in several ways. I encourage you to select your own pseudonyms for this study, and I will only select pseudonyms for you if you are not interested in choosing one for yourself. The only paperwork that will have your identifying details will be this consent form. I will maintain confidentiality throughout this study and afterwards, but this does not extend to protecting confidentiality in the case of disclosure of illegal activity. These forms will be kept in a locked folder, along with the hard copies of the transcripts and any other sensitive information. The only person who will have access to this information other than me will be my supervisor. I will also make sure that I do not provide too many descriptive details of any one participant, so that the chances of you being recognized are reduced. For example, I might describe a participant as in their 20s or 30s, rather than give an exact age. I would also not combine descriptive details unless it was necessary to the analysis.

All the interviews will be kept confidential, and any recording equipment, tapes, transcriptions, files, and hard copies I use will be kept in my locked room. I will send you a summary of our interview so that you can review it and edit or add in any points that you wish. If you wish to no longer be included in the study, you will have two weeks from our interview to inform me that you wish to no longer have your data included. The only people who will have access to the tapes are me and my supervisor. The tapes will be destroyed immediately after transcription. The digital files will be kept solely on my password protected laptop, in an encrypted and password protected file. Data will be kept for seven years after the project, and the reason for this is so that it can be used in further academic research, such as publications and presentations.

INCENTIVES FOR PARTICIPATION: You will not be paid to participate in this study.

COSTS TO PARTICIPATION: You may have to pay for parking at Ryerson University. If this is the case, you may pay between $7.00 and $17.00. You will be fully reimbursed for this, in cash, after the interview.

VOLUNTARY PARTICIPATION AND WITHDRAWAL: Participation in this study is completely voluntary. You can choose whether to be in this study or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time and you will still be given the incentives and reimbursements described above. If you choose to stop participating, you may also choose to not have your data included in the study. You must contact the primary investigator within two weeks of your interview to have your data taken out of the study. Your choice of whether or not to participate will not influence your future relations with Ryerson University or the investigators, Isuri Herath and Dr. Sedef Arat-Koç, involved in the research.

QUESTIONS ABOUT THE STUDY: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Isuri Herath
iherath@ryerson.ca

Dr. Sedef Arat-Koç
saratkoc@ryerson.ca
(416) 979-5000 x 7338

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
rebchair@ryerson.ca

Immigrant (M)others: Exploring Relationships Between Midwives and Uninsured Immigrant Women in Ontario

CONFIRMATION OF AGREEMENT:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to participate in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement. You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____

Name of Participant (please print)

_____ _____

Signature of Participant Date

I agree to be audio recorded for the purposes of this study. I understand how these recordings will be stored and destroyed.

_____ _____

Signature of Participant Date

Do you wish to receive an electronic copy of the final research findings?

Yes ☐ No ☐

If yes, please specify which email you would like this sent to _____

Appendix 3: Recruitment Flyer

RYERSON UNIVERSITY

PARTICIPANTS NEEDED FOR RESEARCH ON MIDWIVES' RELATIONSHIPS WITH UNINSURED IMMIGRANT CLIENTS

Are You:

- A registered midwife who has served uninsured immigrant clients?
- A registered midwife who has received her midwifery training in Canada?
- A registered midwife who has practiced in Ontario?

If you answered "yes" to the above noted questions you are invited to participate in a study. The study aims to explore how midwives address potential tensions that might arise while providing care for uninsured immigrant women.

If you agree to volunteer, you will be asked to partake in an interview.

Your participation will involve one to two interviews of an hour to an hour and a half each.

If you are interested in participating in this study or for more information please contact:
Isuri Herath– MA Student
Immigration and Settlement Studies
Email: iherath@ryerson.ca
This research is being conducted as part of my MA research.
Supervisor: Sedef Arat-Koç

This research study has been reviewed and approved by the Ryerson University Research Ethics Board.

Isuri Herath
Email: iherath@ryerson.ca

Appendix 4: Email Script

Hello,

My name is Isuri Herath. I am a student at Ryerson University in the Masters of Immigration and Settlement Studies. I am contacting you to see if you might be interested in participating in a research study.

This research is being done as part of my Masters project and my supervisor's name is Dr. Sedef Arat-Koç. The focus of the research is to better understand how midwives navigate potential tensions that might arise while providing care for immigrant women.

To participate you need to be a midwife who has received her training in Canada, and who has worked with uninsured immigrant clients, and who has practiced in Ontario.

If you agree to volunteer you will be asked to partake in an interview.

Your participation will involve one to two interviews of an hour to an hour and a half each.

Your participation is completely voluntary and if you choose not to participate it will not impact our relationship, or your relationship with Ryerson University.

The research has been reviewed and approved by the Ryerson University Research Ethics Board.

If you are interested in more information about the study or would like to volunteer please email iherath@ryerson.ca or call 613-869-2237.

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