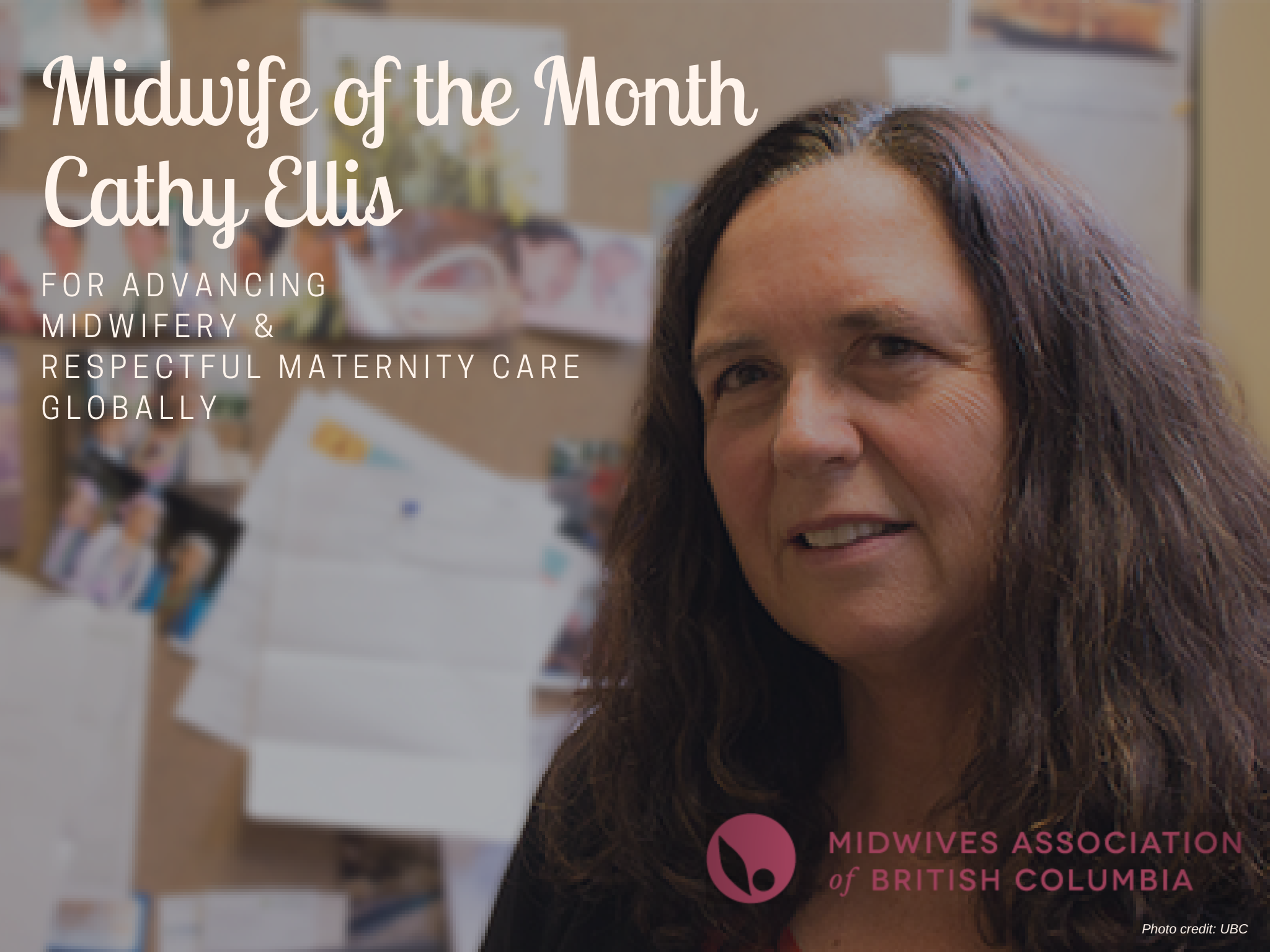

Midwife of the Month
Cathy Ellis
FOR ADVANCING
MIDWIFERY &
RESPECTFUL MATERNITY CARE
GLOBALLY
MIDWIVES ASSOCIATION
of BRITISH COLUMBIA
Photo credit: UBC

UBC Midwifery Senior Instructor and founder of the Citizens for Global Midwifery Program Cathy Ellis describes herself as, “just an ordinary Saskatchewan person who was lucky enough to become a midwife.” But her accomplishments are far from ordinary. Cathy has spent her career supporting safe and respectful birth and pregnancy care in low resourced countries around the world. Learn more about this high energy global midwifery educator and her upcoming "midwifery marathon" to Nepal and Uganda.

MABC: What sparked your interest in global midwifery?

CE: I started my midwifery career when I was in my twenties in Mexico where I worked with Dr. Mickey Rostoker who became my partner. Mickey was working in a very rural community and I worked alongside him and a Mexican nurse to provide prenatal care, childbirth and postnatal care to local mothers. And I was pregnant at the time. **So my story isn’t so different from many young midwives whose journey into midwifery started with a personal experience of giving birth in a way that felt very respectful and empowering and that’s what happened to me.**

I worked for several years in the community of Apaxtla de Castrejon in Mexico and I became “the midwife” together with a nurse, who was called “the nurse” and I also worked with two traditional midwives, but we were the team who worked outside of the clinic. There was congeniality there but not much of an overlap. We attended births in a 3-bed clinic where running water was carried to us on a donkey. We did have electricity. And, I attended the home births of those who wanted to deliver at home.

That’s where I got my start. And then when I came back to Canada people knew I had been attending many births with Mickey. They knew Mickey because he had done his internship in Regina, Saskatchewan. We had no midwife in the comunity so I fulfilled that role the same as many other midwives did across Canada and I learned more and more as I went along. Then later on we went to Nicaragua to work as civilian medical people within the health system during the Sandinista revolution and the Contra war from 1983 – 1985. And then I went back several times for short contracts. All of that was with CUSO International.

And by that time we had a family of three little boys that we took with us. Yes, I was very energetic.

MABC: When did you start the global midwifery program at UBC?

CE: I started a global midwifery program for students at UBC in 2005. And we started off by going to quite a few different countries including Mexico. We didn't accompany all of them; they had one of the local preceptors.

One of our students went to Pakistan with some other international preceptors. I went with two students to Zambia. We also included the Netherlands as one of the placements.

Then as the years passed we evolved to concentrate more on Uganda and then Uganda and Nepal. Those are the two countries we're working on now as we find that in order to secure our place in the country as a foreign university carrying out bi-lateral learning projects with their midwives and students and our midwives, physicians and students we need to go to the same place every year. Otherwise other midwifery programs would like to be in these countries.

For Uganda we were invited by the Chief Obstetrician of one of the rural hospitals in 2005. I met him when I was teaching ALARM International in Zambia. We were the teachers and he wanted me to come there with my students. For Nepal, we got invited to come and help them get midwifery going specifically for the rural and remote areas. We got invited in the fall of 2006, the day they signed the peace accord for the war in Nepal, the Maoist insurgency.

They are both very excellent countries in which to learn about and practice respectful childbirth and midwifery skills in low resource settings and share some skills with others.

In both countries we work in both urban and rural hospitals. Particularly in Nepal, we specialize in going to rural and remote areas to try to work with the local auxiliary nurse midwives who have had eighteen months of training and basically do a full scope of midwifery care and who can certainly use the support. For us, we receive the knowledge and ways of working in low resource settings. We learn a lot from them as we have learned many things from our Ugandan colleagues.

We work in mostly regional referral hospitals with the entire team from obstetricians to intern physicians to midwives. We work side by side with the local team and learn to work in difficult situations where there isn't much equipment or technology and it's difficult to get the obstetrician to come and help because they're so busy. And in turn we teach some Canadian ways of working and offer some updates. Notably we have brought methods for delayed cord clamping to all the places we've worked, including the somersault manoeuvre as well as techniques for managing breech, which are globally used. The same ones that I have taught with the ALARM international program in many countries. ALARM is the international program of the Society of Obstetricians and Gynaecologists of Canada (SOGC). That is the same technique we teach at UBC Midwifery and in British Columbia through the ALARM course. We teach the same technique overseas because it is the easiest technique to do, and it is the method accepted by their training centers as well. And we also teach them how to manage shoulder dysplasia, which is quite a rare occurrence in these countries, but when it happens they need to know how to handle it using a safe method.

Apparently when they are using some of our methods they call to each other, "Come and help, we are going to use the Canadian method for this problem, for this stuck shoulder." The method used is the hands and knees method because that would have been new for them but it really works. That's what most of us use, we ask the mother to go on hands and knees and we remove the posterior arm.

I really like the fact that there is bi-lateral learning. The best thing we did I think, the most influential move we made in Uganda was to bring a Ugandan midwife Prossy Musoke to Canada in 2008 for a month and train her in methods of neonatal resuscitation and show her how we practice midwifery in our province.

Midwife Prossy Musoke shows student midwives how to check a newborn at Masaka hospital. Photograph: Tadej Znidarcic for the Guardian

Prossy went to many different settings. When she went back to Uganda she first updated all the people in her hospital and then in her district on what she had learned. **Between 2008 and now she has become one of the most sought after international trainers, not only for neonatal resuscitation because now they have a Helping Babies Breathe program and Helping Babies Breathe Plus program that she is the national trainer for, but also for emergency skills and the proper use of, and day-to-day maintenance of hospital equipment.** She and other people we have trained have become national trainers. She can reach so many more people than we can when we are only there for four to six weeks every summer.

MABC: Is there plans to have more people from Uganda come back to Canada for more training?

CE: What we have done since Prossy came is financially facilitate midwives to attend ICMs (International Confederation of Midwives' congresses around the world). The UBC Midwifery Program went to the congress in Durban and Prague with the Ugandan midwives and we co-presented and published articles with them through participation in ICM. This year we have also facilitated a Nepali midwife to attend the congress in Toronto. We didn't sponsor a Ugandan midwife this year because we've already taken them to several conferences.

We will continue doing the same thing and our ongoing plan is to bring a Nepali midwife to Canada who is involved with an educational program for professional midwives in Canada to see how we teach and practice**. In Nepal midwifery is a beginning profession the same way that we were 20-years ago and in some ways we're still a new profession in Canada.** It does take a lot of time and organization to facilitate bringing somebody to Canada.

MABC: Yes, I would imagine. How many people do you have working on this team with you?

CE: Dr. Mickey and myself were the original people and then Grace Brinkman, RM has been coming for quite a number of years to Uganda, as has Angela Spencer, RM. Angela has been coming every year, Grace has been coming every two years and she may start coming more often.

We have started training junior instructors and so far we have BC midwives Alix Bacon and Joanne Gillies. **Next year we will be bringing several more junior instructors so that by the time the older midwives and physicians are not able to go and do the work we will have a whole team of younger ones who are ready and happy to carry on what we are doing.**

In early years when our program was small we had more than half of the students participating in the global placements. Now we have a bit fewer than that but it's still close to 40% of the students every year who do a global placement and it is still quite a large number.

Over the years we have been able to secure some competitive and non-competitive bursaries for students. They do quite a bit of work getting ready to go in terms of packing and preparing materials.

We have a full team of packers who pick up things that arrive from our volunteers who knit and sew. **We give every mother who we attend her birth a baby hat or other knitted or sewn things, maybe a blanket. It just shows the love from Canadian grandmothers and other people who have time and energy to make these things for them.** We're doing that quite a bit both in Uganda and Nepal. We take as much as we can. This year we have become one of the organizations that are able to get an extra bag on our flight to Nepal.

There's a lot of work that goes on behind the scenes to get materials and the team here. We get a lot of donations from local midwives. The Victoria midwives always give us money to buy neonatal resuscitation equipment, and we take donations from other people.

UBC Midwifery student Jacquelyn Thorne packs bags for Nepal and Uganda. Photo credit: UBC.

We have a fund through UBC midwifery to raise money. As money goes in, money comes out to support our partners in Nepal and Uganda. If they ask us for a bag and mask for resuscitation, we bring that. They asked for a computer for continuing education so they can put on presentations and this year we are taking new laptops that are already loaded with educational material in their language.

We always try to give them what they ask for. For instance, when they asked for a vacuum for vacuum assisted delivery we took that.

We are not big, we are small but we just keep going and I think our partners in Nepal and Uganda appreciate that. Many large projects are on for 3-years full tilt and then they are done while ours doesn't have an ending, hopefully.

MABC: Are you working on any other global projects?

CE: Other projects I have enjoyed working on is the UBC Centre for International Child Health project in Bangladesh. That was funded by the former CIDA, by the Canadian government. It was called “Interrupting Pathways to Maternal Neonatal and Child Sepsis.”

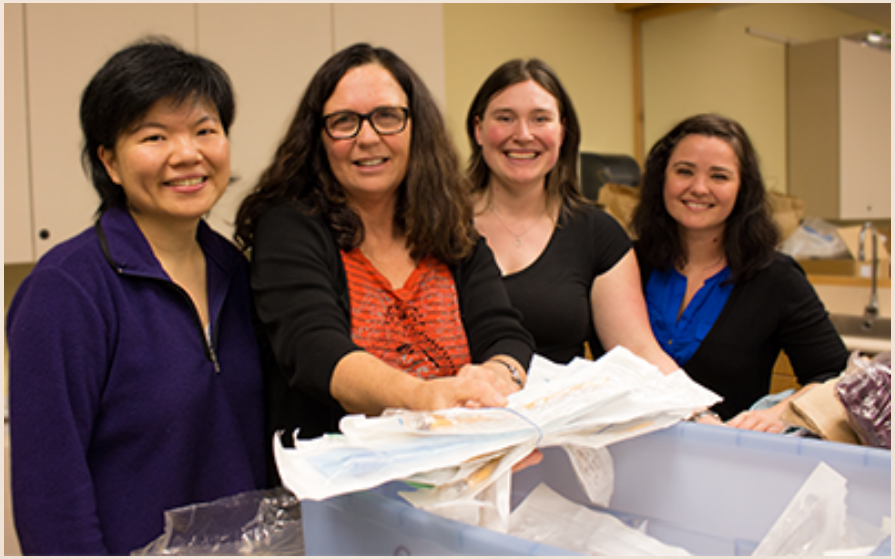
I really enjoyed working with other members of the UBC team, mostly physicians and with my counterparts, both physicians and midwives, in Bangladesh, in a rural area called Tangail. **I think we really helped to get these rural hospitals on track to attend more normal births in a way that was more evidence based and to detect and treat sepsis among mothers, newborns and children much sooner.** I’ve also enjoyed the work that I’ve done teaching the ALARM international program with SOGC. I’ve gone to quite a few countries to do that including Zambia, Kenya, Guyana and others.

One of the things I’m most proud of is mentoring newer midwives and maybe inspiring them that even though the situation globally might seem very, very difficult and hard to change sometimes because of attitudes of people, and the power imbalances between obstetricians, midwives and mothers, there are some ways that we can work, such as the partnership model and bi-lateral learning, that do seem to make a difference, albeit slowly.

When we started in Uganda, in the first two years, there were only two changes we were able to make alongside a local midwife whom we hired to carry on there with Prossy Musoke the midwife we brought to Canada. The two changes were:

- Having oxytocin regularly available on the ward to prevent and treat haemorrhage, and
- Giving the injection of oxytocin to prevent haemorrhage

We tried to do more things than that but it takes a long time to make change. I think it’s a good thing we did make those changes because they might possibly be the biggest changes you could make to save mothers’ lives since most mothers who die at birth, die of post partum haemorrhage.



Cathy Ellis flanked by 2015 cohort of UBC Midwifery students Nancy Hsiao-Lan Tsao (far left), Jacquelyn Thorne and Rachelle Fulford (far right). Photo credit: UBC.

Now that maternal mortality has been reduced within facility based births in both Uganda and Nepal the conversation and the aims of some of our work together with our partners has been changing to more of a systems look at the facilities. We look at how to make parts of the system work a little bit better and to make sure that respectful childbirth is carried out as much as possible in these facilities with the urging of our partners who also see that as a very important step forward.

Once mothers aren't dying as much then the next step is to make sure the institutions and facilities try to improve their work, their methods, their communication so that women have a better childbirth experience.

MABC: How would you define respectful childbirth?

CE: We actually use the White Ribbon Campaign material and there are quite a few different aspects to it. It has to do with the sharing of information with people; respecting mothers' wishes; allowing them to birth in the way that they want to birth; maintaining confidentiality; kind words rather than disrespectful treatments and attitudes towards them.

MABC: Does the UBC global midwifery program help make students better global citizens?

CE: Well, the feedback I've got from some students is that they feel more comfortable and confident working at home births as a result of working in a low resource setting where you cannot call an obstetrician for help right away and you don't have all the technology like the ultra sound machine at your fingertips. I think our students get more and better hands on clinical skills.

But maybe, even more importantly, I feel that some of them are inspired to work in low resource areas of Canada and feel more comfortable and confident as a result of this program to extend their skills and expertise to other areas of the province, particularly rural and remote areas where they don't have as many obstetricians, ultra sounds and all the help that you do get as a midwife in the larger urban centres.

And I think it makes people more aware of the disparity between the rich and the poor, which is something that in our busy lives we can forget about and not think about inequities in our own back yard as much. Whereas when we have experienced them and have studied them we are more aware and are more prompted to take action at home.

MABC: Next month I know you and the group will be going to Nepal.

CE: Actually next week! In one week I will be going with two students to Nepal and we will be in the city a little bit to meet the partners there, including the president of Midwifery Society of Nepal Kiran Bajracharya and they will have a chance to visit the national referral hospital where all the difficult cases that can be referred in come to and it is free for mothers. We will also go to one rural area and one very remote area in the Solukhumbo District. We're in the south part of that district which is an area of food insecurity and it is an area of great poverty. That is where I did my doctoral data collection. When I was there last fall, four mothers actually died, three at home of PPH and one in a health facility with an ectopic pregnancy.

It's quite a scarce population, too; it's not a very big area and they will see for themselves and feel for themselves that distance when they are walking up and down those mountains that the people themselves call hills (I call them mountains). The passes that I had to go over (some of them more than 3500 meters) just to get to the study sites. It is quite rugged walking and of course, I walk slowly but we get there and sleep in tents and eat the local food and purify the water and sit in people's homes to eat their traditional foods. I think it will be a big eye-opener for them. We will travel and work with our Nepalese midwife colleague Pema Sherpa.

Where we go to see the birthing centres the young local midwives will be happy to see students who are in an educational program (almost practicing midwives). Our students will have something in common with them because most of the midwives in these rural birthing centers are just out of school for a few years. It will be a really nice transition for them and we will travel with Pema who can translate so they can talk with the local midwives as much as they want.

And they will also be involved in teaching. They will be able to teach some of the things that are involved in respectful childbirth, like choice of birthing position and comfort positions during labour and those kinds of things. As well, they will learn how the Nepali midwives handle birth in a very low resource setting. Some of the settings have to have water hauled in by bucket at the birthing center; it's really quite difficult. And all of them have sporadic electricity.

Cathy Ellis with Bangladesh Midwives with UBC Center for International Child Health Project on "Interrupting Pathways to Maternal, Newborn and Child Sepsis."

The students who went the last couple of years really loved it in Nepal. The year of the earthquake I was in Nepal with my students and we were in an area that wasn't affected so much by the earthquake but it shook very hard. It was very frightening. We stayed working in the hospital; they were on emergency mode. The births all took place on the main floor in little private areas on the main floor of the hospital. Birth carries on regardless.

There were quite a few deliveries; babies were maybe shaken out as a result of the extreme shaking of the earth. We worked there for a while and then after a week the students returned home and I stayed working in the relief camps with Mickey who arrived on a plane when the rest of the foreigners were leaving. We joined our local colleagues in inter-professional relief camps providing thick tarps for shelter, basic food items (large sacks of rice and lentils and cooking oil) and the medical and women's reproductive health tent. That was my role together with a member of our partner there, the Midwifery Society of Nepal; for one of the camps I took Pema Sherpa and the others I took Rashmi Rajopadhyaya with me to work together in the reproductive health area. There was a lot of work to do and it was very sad.

MABC: How long did you and Mickey stay?

CE: We stayed for a month. And Mickey did a fundraising activity and the students who were there also helped with that and we raised quite a bit of money. Some of which we used for the relief camps and some we used to support an orphanage that we're connected with, not so much through the UBC program, but through our family. We were supporting the orphanage because they needed to move because of the cracks in the building.

I think our local partners there were very glad that we were able to stay and work with them. In terms of my partnership with the Midwifery Society of Nepal, I developed and taught a short course with the Midwifery Society of Nepal, for nurses to go to the earthquake-affected areas and work in the childbirth area (antenatal care, childbirth and post partum) and UNICEF sponsored that. Because of our partnership with the Midwifery Society of Nepal, I was able to help out in that way. Again, that multiplies the effect we can have in a country. The whole thing was pretty scary, especially the outreach camps but I'm glad I did it.

MABC: What is the most rewarding aspect of student midwives teaching and spending time in under resourced countries like Nepal and Uganda?

CE: I think it might be different for me than for the students. For me, **it's seeing the replication of our skills and our attitude of being with women in the midwives in these countries.** Mostly they have been trained in the medical midwifery model and we are able to share some of the updating and refresher courses so that when they are in their midwifery practice their skills are more up to date. For instance, the avoidance of episiotomy is really important to me so when I see fewer episiotomies I'm really happy about that.

The change in practice and attitude is what makes me the happiest. We have other trainers in Uganda from the different tribal goups so that they can always put in some phrases or discussion in their own language as well when they teach neonatal resuscitation and other topics.

Former UBC Citizens for Global Midwifery Program participants Natalie Amran and Quinn Metcalfe celebrate with a new mother of twins in Uganda in 2012.

When I see our partners in Nepal and Uganda presenting the topic, and they're basically sharing that information better than I would have done, but it is because we introduced it to them. So you see your work being replicated in a way that is even better than we would have done ourselves.

And, also the friendships we have built over the years. We have so many good friends in these countries that it's really nice to see them year after year. Even keeping in touch throughout the year, we do that now that people have internet. It's really nice and our students and other instructors also make friends and keep in touch. It's really nice having friendships across borders.

MABC: What are your hopes and dreams for the UBC Global Midwifery Program?

CE: I don't like to think too much into the future because we can only do what we can in the present. We are doing as much as possible trying to move to a system where we give our graduates a chance to take a leadership role and whether it be in this program or other programs such as the CAM program, Red Cross, Doctors Without Borders, or any other organization. That's what I hope we do. Help to develop and inspire future midwifery leaders and practitioners.

MABC: What does International Day of the Midwife mean to you?

CE: When I have been in other countries for International Day of the Midwife (and that has been specifically Kosovo and Nepal because that's where I've been in the springtime other than Canada) it's really been a big celebration of what has been accomplished. It seems like Nepal celebrates it even more than we do in Canada even though they are just in the process of regulating legalization and getting the educational programs going (some of them have started but they're really just taking baby steps).

It's really great to see how they stop and give each other a pat on the back as if saying, it's really a long road but let us give ourselves congratulations and feel happy about how far we have come on this journey to make childbirth safer for mothers and newborns and as well, to bring the midwifery profession to all areas of our country.

MABC: Are there quite a few areas not served by midwives currently in Nepal?

They don't have a profession of midwifery where they have educated anybody. This is the first year Nepal has been recognized by the ICM as having a midwifery profession. This ICM coming up I will be standing with them. I won't be walking across the room with them because I'm not Nepali. But I'm standing with them. Before that nurses offered midwifery services, so did doctors and so did auxiliary nurse midwives but that kind of education didn't meet the level of the ICM to be counted as a midwife.

That's why I think we can say that most of Nepal isn't served by the kind of midwifery profession as envisioned by the ICM but other professionals are trying their best to provide and develop skilled birth attendants by nurses and doctors in the rural areas. That's the term they've been using in Nepal for the last 10-years.

MABC: A lot of what you are describing sounds like successful collaboration between health professionals.

CE: **Collaborative care is the only way to have safe care in rural and remote areas. I also feel that it is the same for urban areas as well.**

When the childbirth is normal in the urban centres, midwives can work in birthing centers and at home births and in their own practices very successfully and use the consultancy system, which we've developed to work. Nobody works alone. The smaller the community the more important the team work.

Especially in rural and remote areas where they can't refer clients out to anywhere. The only place the mother and her family can be is the smaller birthing centers, primary health centres or the small rural hospitals.

I had such a powerful experience last fall when I was in Nepal collecting my data with the local people in their homes for three and a half months.

MABC: Could you please describe what an example of a day would have been like for you there?

CE: Often we stayed in our tents in somebody's yard or near the house of the people that were our contacts, for example, a school teacher. We would sleep in our tents and in the morning we would get up early because villages wake up very early. We would go into the house and they would give us buffalo milk to drink while we sat on little stools by the fire. They had an open fire pit and that was their kitchen inside. It was a little bit cool because it was the end of fall, almost winter, but not quite.

We had made arrangements to interview mothers and female community health volunteers about the experiences in childbirth and their customs and their needs for safer childbirth. People would wander over to the yard outside the house and we would sit and interview them with my translator.

Cathy Ellis with student midwife Emma Butt with mother and family members after birth in Nepal after the earthquake.

My co-researcher and translator Bimala Rai brought her baby Nina with her. She was a local woman who had grown up in the district right next door to the district where I was working so she was very well accepted because she was the same ethnic group as many of the people there. We also brought her baby sitter who was a family member of hers. The baby Nina was seven months and when we left the baby was 10 months. The babysitter would take the baby and walk her around while we interviewed the mothers.

Some of the rural places we would have lunch around 1:30 or 2:00 p.m. Some places they only ate twice a day; once around 9:00 a.m. and once around 7:00 p.m. at night. We would do our interviews during the day and after supper we wouldn't interview anymore because people don't move around much at night and there isn't any outside electricity. Once it got dark we would go to bed very early in our tents.

After we finished our time in the rural/remote birthing centres our porters would return and pack up everything and we would walk to the next site or a combination of walk and rough jeep, which was very, very bumpy and we would go very, very slowly to the next site. We would start all over again with the contacts we had made through the district public health nurse.

I just felt so privileged to be able to hear the stories of the women and one of them in particular stays in my mind. She just said so wistfully, "I just wish I could have had the help of other women for my childbirth. The women in my family were away and I was alone."

That's what midwifery provides. We are with women. We have to find ways to get pregnant women to where the midwives are and the midwives' practices; and, for the facilities to be easy enough to access and culturally appropriate enough to access so that people ae very happy to go there.

MABC: Are there traditional midwives working there as well?

CE: Yes, in some parts of Nepal but not in this particular area (Solu). When we started working in Nepal in 2007/08 we still met with whole groups of traditional birth attendants and did some teaching and learning with them. The government is not working to have any teaching or learning [for traditional midwives] any more and instead most of the responsibility goes to female community health volunteers to work with the mothers around the educational piece and try to get the mothers to go to the local birthing center for delivery. Sometimes the community health volunteers do go to the births but they do not necessarily have the expertise; sometimes they do, sometimes they don't.

When I ask them “who is your midwife?" they answer, “it’s my mother-in-law.” So it’s the mother-in-law and the local ladies who know how to help their daughter-in-law because they have done it themselves.

And that’s usually how it is, some women go to their mother’s home. There is no fixed rule. In the area I was working in it would be very much the mother-in-law because they go to live at their husband’s home. So then the mother-in-law is there.

It is really a community kind of knowledge about birth that is the important thing there. And a lot of their practices are quite evidence based. The problem is not having anyone to help when they have a problem and this business about delivering outside because it is really quite cold there during the fall, winter and spring.

MABC: Do you have thoughts on ways in which regulated midwives here in BC could work together with traditional Indigenous midwives?

If that were the case in places in British Columbia where traditional midwives are doing the work, it would be very beneficial for them to work with registered midwives. And I think supporting each other could only be positive. I would definitely support that. The more collaboration the better and the closer people are to their mothers and their families the better. **The more we can work together and not protect our turf but share in ways to support the mother with what she wants and her comfort and cultural safety is the best thing to do from my point of view.**

Now in Nepal many mothers would like to deliver at home and so would they in Uganda. And they do deliver at home. They would like to have the skilled birth attendants go to their home.

Sometimes they do but more and more often they don’t. Part of it has to do with government policy but part of it also has to do with the logistics and the distance. They get out there and there’s a problem and they still have hours that the mother has to be carried or somehow brought to a facility.

I wish that there were more skilled birth attendants in rural areas of Nepal and Uganda so they could also attend the women in their communities but that doesn't seem to be happening. If it was happening I would support that as well, but I think women delivering in a place close to their home that has safe practices and skilled midwives is also a good alternative if it does provide cultural safety to them.

Or, alternatively when they know about birth preparedness programs and there is a whole theory and practice around that where they learn about how to prepare for birth in a little more organized way than many people do now. And they know the danger signs for mother and baby and plan a way to transfer to hospital. That's also something that is very beneficial that we have been doing in a different project I'm working on in Mugu, Nepal where I took one of our UBC students last year.

That place was so remote that when we had to leave there were no planes. There were forest fires and too much dust in the air so we had to go by jeep. It was 21-hours with an average of 8-kilometers an hour. There wer no public transports on the road because it was not a real road; it was just a rough track.

The people really benefit by having birth preparedness programs and community based misoprostol, which they don't have at this point. Misoprostol could be distributed either through community health workers or through the auxiliary nurse midwives at antenatal care and that has proved successful in some areas of Nepal but it hasn't been brought in there yet and mothers are still dying because they can't get to any help there, and they do die of PPH. **Working with the people who are close to the mothers is always a good thing to do.**

In the regional referral hospitals in Uganda we're a little bit removed from that just because there's so much work to do on a facility basis. But we are going out to those rural areas to see how midwives are working in small health care centres and very small primary care centres to see how they are managing and what kind of births they can attend when they don't have caesarean capability in the centers.

MABC: Can you tell me a little about your family?

Yes. I have a partner, Mickey Rostoker, he's a family doctor and we've worked together since I became a midwife when I studied with him and the local nurse in Mexico. We've worked together our whole careers basically.

We have three children who are grown up, three boys and two have partners (so far) and each of the two in partnership have two little children. That's really fun as well.

MABC: Do you have activities or things that you enjoy doing outside of this work?

Oh no, no, no. I do other things too! Hiking and backpacking, and cross-country skiing, cycling, snowshoeing; those kind of things. I travel to the Yukon whenever I can. That is where one of my sons lives. And I'm a swimmer. Even in cold mountain lakes; I swim in the Yukon in the lakes. When I'm backpacking I jump in the lakes, too; I don't like to miss anything. I go back to Saskatchewan, where I'm from, every summer.

When I came to BC people welcomed me which was very nice and I'm grateful for that, but I'm just an ordinary Saskatchewan person who was lucky enough to become a midwife. Just by chance! What are the odds that I would ever be able to do this?

MABC: Can you describe to me what you have coming up?

Every spring I go away for about 3-months. I don't return between Nepal and Uganda because it would be more expensive, more time on planes and more jet lag. So I go to Nepal and work there between four and seven weeks. But I'm teaching, travelling or clinically working because I have my temporary license in both countries. I'm working with midwives or with birthing mothers pretty well the whole time for 3-months.

We do take a little bit of time off, but we're very, very busy for those 3-months. When I leave Nepal and go to Uganda this year we're applying for our permanent licenses because they said we overstayed as temporary. We had been getting a license there for 11 or 12-years but now we have to get the permanent license and that will take a few days.

Once we get the license we will be on the wards or teaching 5 or 6-days the whole time and it involves over 100-births every summer between Uganda and Nepal and maybe even more because we're also supervising local students. The births are some normal, some breech, some twins, some miscarriages, some women who are sick with different problems or some women who come in with labour dystocia so we're just very, very busy.

We put ourselves in very, very busy situations and it's my midwifery marathon. It's fun, we are energetic and we do get a little bit tired when we get home and rest up a little bit. After I return home for a few days I usually head to Saskatchewan.

We're really enjoying both the challenges and the rewards of weeks working with our colleagues in other countries.