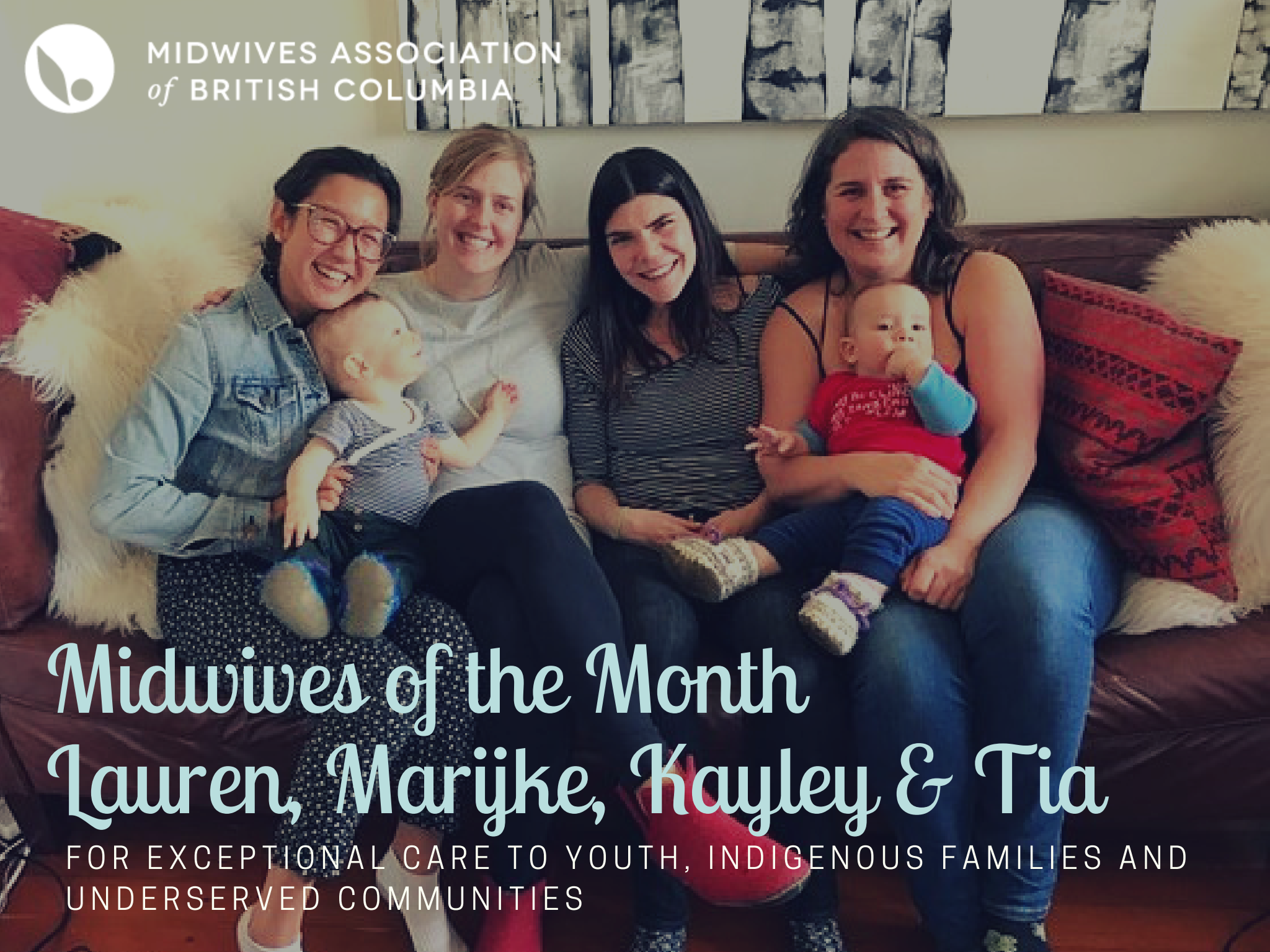
MIDWIVES ASSOCIATION
of BRITISH COLUMBIA
Midwives of the Month
Lauren, Marijke, Kayley & Tia
FOR EXCEPTIONAL CARE TO YOUTH, INDIGENOUS FAMILIES AND UNDERSERVED COMMUNITIES

When I asked Marijke de Zwager to be our Midwife of the Month for March I wasn't surprised when she said that she'd like to share the role with her practice partner Lauren Redman, Kayley Redgers who has taken over Lauren and Marijke's caseload while they are both on mat leave, and student midwife Tia Felix. Marijke, Tia and Lauren are active members of MABC's Committee for Indigenous Birthing lead by Evelyn George. Our interview took place in Kayley's east van home over homemade lentil soup and tea in the company of Marijke's baby Shay, Lauren's baby Ronan and Kayley's good natured black dog. Learn more about these social justice-minded midwives and the communities they serve through our conversation—it's a long and fascinating one so you might want to make your own pot of tea first!

MABC: How did you all begin working together?

Marijke: I started working in Vancouver as a midwife 6.5 years ago. I have a background in child and youth care and community development. When I began practicing as a midwife I started out taking clients that were a bit more marginalized, younger and/or higher risk on the side of my regular practice at *Pomegranate Midwives.* Lauren Redman was going into fourth year then and she became my student 3.5 years ago. With Lauren as my student we were able to start working more and more in this population because I had a supportive partner that eventually went from being my student to becoming my practice partner. Before that I had a variety of different practice partners. **One of the hardest things about serving a high barrier low resourced client base is that you don't make extra money for doing extra work.** Some midwives and midwifery students are really interested and curious about this type of work but they're not able to do the extra work for no extra money so it was hard to keep a practice partner. Lauren's been my practice partner for the last 3 years.

As practice partners we were able to expand what we did through a connection that we had at the *Urban Native Youth Association (UNYA)*. We cared for the executive director of UNYA and afterwards she approached us about being the midwives at a new clinic there called the *Native Youth Health & Wellness Centre.* Last year when we started the project at UNYA Tia Felix was a student at *Strathcona Midwifery Collective* and because we were working with a young Indigenous population and because Tia is Indigenous we wanted to involve her in the project and provide her with an opportunity to learn and to work with folks that she's quite close to and wants to work with.

Tia: Yes, and I continued to work as a doula for some of the clients to help with the continuity of their care and it was as much care for me as it was for them. I found it to be really grounding work. **I really appreciated midwives like Marijke and Lauren who started those connections and that as a student midwife I was able to express my identity and my culture.** At the birth that I attended with Kayley Redgers there was a prayer that was said in Thompson and I was able to pick up some words from that and have a conversation around it. The experience was really warming and grounding and I couldn't have asked for a better support. It's great to learn how to do the clinical skills and the documentation but the work I do with these midwives is a whole other skill. Like Marijke said, even though we don't get paid for those extra things we do, for me it's a big part of job satisfaction.

Kayley: I worked at Pomegranate alongside Marijke and Lauren. I was also really interested in working with marginalized populations. It worked well time-wise because they both got pregnant and were in need of a locum so I made the move to work with them. So thanks for getting pregnant! I am currently working solo which has been conducive for the caseload that I have. **After making such a strong relationship with my clients it's really important to be there with them for their birth, the postpartum period and to be available to them.**

MABC: How difficult has it been to find practice partners that share your values?

Marijke: Lots of people don't want to do the work, students and midwives alike. A lot of people are intrigued by the work and they think it's really interesting but when you can make the same amount of money caring for a middle class mainstream population that tends to not have a lot of social issues, or things that are going on, or need extra help with forms then people just choose what is easier.

For me, I became a midwife because I really love working with this population of people and I think that midwifery is so perfectly suited to being able to support people well in the childbearing year and help them build a community of supports so they can be successful in their family building and parenting. **I've had clients that have been able to keep their children with them because of the extra support that we've been able to offer and I have clients who sometimes choose not to keep their children right now because they're not at a place where they can make those tough decisions.** Our whole client-base isn't always facing barriers. Sometimes we have clients that have a lot of challenges outside of pregnancy and sometimes we have really straight forward multips who are very easy to care for. It's also about balancing out and not having a full caseload of clients that need extra support.

Lauren: Something that Marijke taught me early on as her student was connecting our clients that are less marginalized and have more resources with our clients who have less. I think that's one of the things that we can do without doing all the work ourselves. It means finding ways of using the community resources in a good way.

Lauren Redman, RM with client and baby

It’s hard politically because there is so many program cuts and the midwife ends up taking on the brunt of some of that work when we need a lot more hands on deck. **I think burnout is a huge issue. Because midwifery is already a hard profession and midwives are pulled in so many directions, once you add in any complexities it becomes a lot harder.**

Marijke: It's also so rewarding to see people be able to access things they wouldn’t have access to before. One of the examples that Lauren was talking about in terms of connecting clients is we had a client who lives on the second floor of a public housing unit that doesn’t have a functional elevator and at the time she had two babies under age two and no way of getting down the stairs with both of her kids. She was trapped at home because she didn’t have a stroller that would fit both of them. We wrote a letter to BC Housing hoping that she could get a better situated apartment for her and her children because this place was not going to be practical in the long run. In the meantime, we were able to access resources though some of our other clients and within a day we had two double strollers for her to choose between—the side by side or the front to back one. **When you don’t have a lot of resources you’re often taking whatever you can get but when you get to actually choose because you have options it’s a much more empowering experience.** And then she was not trapped at home. She got this new stroller and was able to take her kids out and go to the park, activities that were helping her engage more in the community. So that’s one example of the ways we leverage the access to resources from one client to the next and people are really excited about doing that.

We also have a past client that approached us wanting to help out with food. She made a project of getting together with some other moms who had been in midwifery care making food to keep the freezer at Strathcona stocked so that when someone has a baby you can take some food from the freezer to their house if they don’t have a big social circle of people who can bring them extra food and extra support.

Kayley: **Strathcona itself is a great hub for facilitating that kind of help. There is a whole wall full of clothes and blankets and baby stuff and it has been incredible to see how generous people have been in giving all of their fancy baby stuff.**

Lauren: And all the workshops are free or sliding scale in the clinic. So everything that is held there is accessible for people.

Marijke: The UNYA project is different than regular midwifery in that we don't set appointments, instead we have a drop-in schedule. People can set appointments if they want and sometimes they come to their appointments and sometimes they don't. But there is also just the opportunity for people to drop in and see a midwife.

Strathcona Midwifery Collective

UNYA is a big organization with lots of different resources. There's a nurse practitioner, alcohol and drug counsellors, Elders associated with the program—there's ways to connect people with resources beyond what we're able to do on our own at our midwifery practice. The drop-in hours make all the difference. Some days we will be at UNYA for 3 hours and we won't necessarily have any clients come in to see us, there is always work to be done figuring out cases that we're already working on or getting more resources for someone, etc., but we're not paid for those hours unless we actually have clients come and see us. If so, we're paid in the same way that all midwives are paid in terms of course of care as opposed to being paid for the amount of time you spend with someone. It actually works a lot better for our clients because we find that they're able to access us more easily and we're able to see them more regularly because they can come when it works for them in that time period.

Kayley: Yeah, I think the drop-in works super well for our clients. I do see lots of youth at UNYA but also see some UNYA youth other places in the community for visits.

For example, right now there are youth in care who are homeless and aren't comfortable in a clinical setting but feel really happy to come to UNYA because they can also access other services like seeing an Elder while they are there.

Marijke: We still go to meet our clients, some people can't come into the clinic for a variety of reasons—lack of childcare, no bus tickets, etc. So often we will meet people at their homes like all midwives do postpartum but sometimes antenatally as well. Or at a coffee shop, or at school, or wherever makes sense for us to meet with them.

Kayley: A McDonalds, a food court, a park.

Tia: Or pow wow. **Meeting clients where they're at makes a big difference in their care**. I'm thinking of our client who was able to have a homebirth and we gave them that option. And they felt empowered being able to keep their loved ones and little ones at home and still make it work.

Marijke: And have as many people as they want in the room. Or as few people as they want in the room. Be as loud as they want to be. Or play drums right when the baby is born and not have anybody tell you that they have to do something different. One family that were having their 9th baby between them and had never had a birth that they had felt entirely in control of in the sense that they could have as many people as they wanted there, they drummed a welcome to the baby just as they were born, and they were just so happy to stay home and be in their own environment. **Systemic racism is still a really big problem in the healthcare system that I don't feel we talk about enough. And some people are really scared to go to the hospital or access a midwife or a doctor at all.**

Lauren: **With that same client she had a preterm labour scare and we were in the hospital and I remember the OB saying, "does she understand when to come back to the hospital? I'm not sure she understands." And I said, "it's her 6th baby. Of course she understands." The assumptions are rampant. The assumption is that she's not going to care for herself in the way that you think she should care for herself.**

MABC: Is there some way the profession could be improved to encourage and allow midwives to better serve clients who may be facing barriers to care?

Lauren: Sometimes it's challenging to have balance in our lives. Salaried midwifery would help midwives to do this challenging work while maintaining balance in their lives.

Kayley: There needs to be some kind of shift. I don't know exactly how but **having some kind of billing system in place that is not reliant on your caseload and you're not having to subsidize your life by taking the lower risk more straightforward clients. Being able to spend that time with the people who need it.**

Marijke: Salary midwifery works really well for that model. There's some places like remote communities such as Seabird Island and Haida Gwaii that have salary midwifery models because their caseload numbers are quite low but that also acknowledges the amount of work that they're doing to serve those populations. **There's no urban example of a salary midwife yet at this point but with the project at UNYA and with our ongoing relationship with the *First Nations Health Authority* we're really hopeful that within the next few years it might be a possibility. It would mean that if you spent a long time with a client or a little bit of time your income would still be maintained the same and it would be more sustainable in the long run.** There's a fee in Ontario for extra care that you offer that can be used for clients that have a lot of extra needs, but it's only two per clinic per year. So it's very minimal. Not every community is going to manage to have a salary midwife either. It is something to look at in terms of having an extra billing code for extra meetings you are attending and taking people to ultrasounds and stuff like that.

Kayley: Or going to find housing with them, or filling their birth certificate out with them, or going to meet with the Ministry to discuss a plan—there's so many things. Which are so wonderful to be able to be a part of and to advocate for our clients, but it's a lot. It's definitely not like a 20 min prenatal visit.

Marijke: In the long run the idea is to get an outreach worker at Strathcona who really understands midwifery that can also develop a trusting relationship with the client. Maybe they are a doula too and it can be a combined role.

Lauren: I'm thinking of the Kwiyo:s (respected Auntie/doula) worker who works at Seabird Island with midwife Amelia Doran. She does those kinds of things in the community so that Amelia is not doing it all.

Marijke: Some things makes sense—you're doing a postpartum visit and it's easy to fill out the birth certificate form when you're at their house. It takes extra time in your postpartum visit but that makes sense for the midwife to help with that. Sometimes we do extra things and it makes all the difference for the client. Back to the client that was having her 6th baby, she was really anemic and we were wanting her to get an iron infusion and they made the appointment for like 8:30 in the morning.

Lauren: No 7:30. And she had 3 little ones at home and lives far from the hospital and didn't have a vehicle so it was impossible for her to make it there on her own.

Marijke & Lauren at Strathcona Midwifery Collective

Marijke: But Lauren took her. She picked her up, they stopped at McDonald's and got some breakfast. She went to the hospital and got her iron infusion. Then when she was there she was able to make the appointment at a time that worked better for her in the future.

Lauren: I worked hard to try to get her another one. But it was a miracle we got the 7:30 appointment in the first place.

MABC: What would your advice be to midwives who are interested in caring for patients who might be marginalized and have less access to services?

Marijke: There is lots of room for ways in which we can support each other doing this work. There is a lot of passion sitting around this table. **Midwives working in Vancouver, and across the province for that matter, I strongly encourage them to take on clients that may seem a little more complicated and if they want to give us a call we can talk about some of the strategies we use.** We've done that a few times with other midwives. Sometimes we get calls and midwives say this might be a better client for you but If I do all of that work it's not going to spread and it's not going to be evened out. It's good for all midwives and if they need help I've had calls from midwives as far away as Creston where a midwife who hasn't interacted with the Ministry of Children and Families before and wanted to ask some questions about when to report. An important part of our work is encouraging other midwives to take this kind of work. Not necessarily take on doing this clientele full time if they don't want to, but taking a client here or there because their clinic is closer to where that person lives, they have a relationship with them already or because it is just good practice.

Lauren: And good community building as well. **It's a weird thing to think that because you're marginalized you have to go to these one or two clinics that will accept you or that will know how to care for you. That seems ludicrous to me. I feel like every midwifery clinic should be for everyone to some degree.**

Marijke: We do the outreach so we look for these clients and we've made a name for ourselves so people want to come to us. But not every person pees on a stick and calls a midwife. **A lot of people don't even know that there are midwife opportunities still or they don't know until later in their pregnancy.** One of the things we try to do is keep spots open later in pregnancy if people want to come into care later. Some midwifery clinics fill up right away and don't have that flexibility to take on clients later on in their pregnancy. Everybody's different a). when they figure out their pregnant and b). knowing what their options are. **I think it's so important that we continue to do this work because it's important for people to know they have options.** Midwifery care isn't for everybody—some people work better with an OB, with family doctors that have known them for their whole lives. But I want to be sure that people who might not be treated as well in those contexts, and may not make it to their appointments on time, and may have extra stuff going on in their lives and need a little extra time and support, that they can come find a midwife who has the time and energy to spend with them.

Marijke: That's the balance that we're trying to strike. For example, if every clinic in Vancouver took one client a month that couldn't pay then we would all be spreading out the pro bono work. We are trying to support midwives to be able to care for those clients themselves. Spread out the resources as well. UNYA is really specific in that we care for any young Indigenous identifying person who wants to be cared for by us.

Tia: Whereas the placement I was just coming from in Kamloops was a lot less accessible and rich in resources compared to Vancouver. A lot of reserves are located an hour or two hours down a dusty dirt road. Somehow there has to be a meeting in the middle. **Many midwives in more rural communities are having to do a lot of extra work without pay and trying to come up with systems on their own.** It sparks creativity but when you're running on a 24 hour shift it can be dangerous even.

Kayley: It's also fascinating to see how much extra midwives will put into their work.

Marijke: It is so great that the *MABC has an Aboriginal lead now (Evelyn George)* because before Evelyn got the job and was able to work on our behalf we were doing committee stuff as well off the side of our desks. It's good that MABC has made it permanent and long term and hopefully one day we can make it a full time job eventually partnered with the FNHA.

MABC: How does midwifery's model of care allow you to address the unique needs of your clients?

Kayley: The continuity we can provide. And length and frequency of appointments is a huge benefit to our clients.

Lauren: To be able to sit and chat with clients for longer than a few minutes. The holistic aspect of the care we provide. **Midwives are really good at discussing the spiritual, emotional and mental aspects of health and not just treating the pregnancy as a disease or as a physical experience.** In the work that we do, we expand upon that even further—we try to at least.

Marijke: We can set our schedules. When we're on call we can go to peoples houses if that works better for them or meet them at a coffee shop and be really flexible about our time spent with them. And **we are flexible with people about how often they want to see us.** There is a standard in midwifery that you see clients once a month for the first 6 months and we can make visits more frequent than that. Some clients want to see us more often right from the start and some clients don't want to see us as often and we can keep in touch by texting or messenger. Building a network of support as a care provider. When you call the Ministry of Children and Families or social workers and say I'm a registered midwife and I'm advocating for this person there is a level of professional respect that occurs.

Lauren: I think most midwives are advocates already so it's a natural progression.

Tia: Choice of birthplace.

Marijke: Continuity of care and the relationship is what allows us to come to the next level with folks. I had a client that I was under the impression had 2 previous pregnancies—one where she had a baby and one where she had an abortion. At about 34 weeks, she said, I feel a little nervous to tell you this but I actually had another baby that I didn't tell you about before that was adopted out at birth and I didn't want you to judge me. And I responded by telling her that I was glad she told me and felt safe enough to tell me. **She was very worried about the perception a care provider might have** about that and I said it's better that you tell me from an obstetrical perspective but it's also good that I know in case any of the previous birth experiences are coming up for her.

If that person didn't have that kind of care in her pregnancy and she was already feeling ashamed about that she probably wasn't going to reveal that she had in fact had another child. And it was nice, I think, for her to finally be able to talk about it. To say that she was really wanting to do it differently this time and wanting to parent this baby and be ready for that. And not wanting those past experiences to dictate who she is now. **That's one of the frustrating things about people who've been involved with the foster care system and the Ministry of Children and Families is that if you were in foster care yourself they are more likely to look more closely at you. It's really sad because that means that a). they are acknowledging that they probably didn't do a very good job when you were in foster care and b). you're already set up with a disadvantage. It's not your fault you were in foster care and now you're trying to break a cycle and change things in your own life and it's really hard when people in authority are focused on the fact that you had a difficult upbringing. The assumption is that you're not going to be able to parent your kids. I feel strongly about advocating for people to have a chance to parent their kids and get a chance to be judged based on their actual actions as opposed to their history or their parent's history.**

Marijke: The effects of colonization, of residential school—people are breaking cycles. I really like to name it when people are ready and open for that. We can offer people extra support if they need it. **Being able to offer someone free counselling because they had a parent who was in residential school and acknowledging that that is impacting them and how they are living their life today is so important.** For some people it's the first time they have made those connections. They obviously know best because it's their lived experience but it's also making the connections between what's happened in their life and the politics that came to influence those things. We want to be able to offer resources and suggestions and opportunities to connect either with people in a similar situation or with a counsellor or an Elder.

We also believe in harm reduction. I made Tia go buy cigarettes for one of our clients once.

Tia: I'd never bought cigarettes in my life before. It was what our client needed at that time and it was for the best outcome. Obviously the care shows because you have clients traveling from Surrey and other communities just to access this care. They're making the multiple bus trips and SkyTrain trips because they value the care they're getting from midwives like Lauren, Kayley and Marijke.

Marijke: With our expanded scope Kayley can do IUDs and I can do birth control prescriptions. There's one client I have that I've been doing her depo shot for 3 years. I know that we're only supposed to do them for the first 6 weeks postpartum, but some people don't have consistent care in their lives and I feel they should be able to call me every couple of months or a year down the road if they don't have any other care. **This way if they don't want to have any more babies and they want birth control I think it's really appropriate that they come to us and they feel safe doing that as opposed to having to go to a different walk in clinic every time. Expanded scope practice and then possibly being able to take care of people for a year to two years postpartum is important.** I'm not a pediatrician and I'm not going to be able to diagnose any kind of complex things with babies but we have a good sense of what's a normal healthy thriving baby postpartum up to a year and same with the questions and issues that might happen for moms. I think especially around postpartum depression and anxiety that often occurs much later than our care period. It's really important for us to be accessible for women. When we end our care with clients we always say it is an ending of a chapter but if they need something or are struggling down the road please don't hesitate to call and we will help them try to find the resources they may need. If we had that as part of our scope that we were technically paid for we could offer care in a much more continuous way.

Not everybody wants to keep their babies or pregnancies or their babies later on and we do counselling to help people make those decisions. I've had clients that I've cared for in between pregnancies and we've been able to connect around getting an abortion or helping them though a miscarriage or supporting them in the decision about what they want to do about a pregnancy that wasn't planned. That's really important. Not all people will contact a midwife for that because, I think, there's an assumption that because you are a midwife you're maybe only focused on babies and people having "successful" pregnancies, and not necessarily wanting women to have choice and have good reproductive health care.

And that's what's really important. It's more important to establish if it's the right time and place for this person to have a baby. And if it's not, I'm also going to help you determine which way you can go with this unwanted pregnancy.

MABC: Do you feel that you're supported financially and emotionally or otherwise by our practice or your practice partners in working with folks with barriers?

Kayley: Absolutely. I think it's a really really hard job to hand off to someone else. Kind of impossible. And **the practice that I work at is a practice full of incredible midwives, but it's hard to develop that strong relationship with clients and then take time off for example.** Working supported solo like I do is not a situation where that's feasible.

Marijke: Yes. Even if we have two people in labour and we really want to be there we have people at our practice that we feel confident being able to call as back up.

UNYA asked us to come and work with them. They obviously would have loved to be able to pay us and we're not there yet and this is just the start of that project. And we feel supported there in accessing the things that we need to make sure that we can do our jobs.

Kayley Redgers and her client and baby

It's a balancing act. Supported solo is the hardest way to do this work but in a partnership of two it is better because you can trust your practice partner which is why it is so great that Lauren was able to do this work with me. And then I was able to go away for the weekend and not worry that my client isn't going to get the kind of care that I want her to get because it's just another midwife filling in that I don't work as closely with or that doesn't have a relationship with the client. And there's a benefit to supported solo because you have a really unique and intimate relationship with each of your clients. **I think one of things that I shy away from in this work is really big teams because it's not good for our clients.**

Kayley: Even two people can be difficult and overwhelming for my clients. It's a lot to hand off to someone else. I think it's hugely beneficial to be solo but it also has drawbacks to not be able to leave your work.

Marijke: The great thing about having a student is that there is sometimes even more continuity for clients. With Tia for example there were times where I had to leave her at the hospital with a client whom she had a relationship with and call another midwife to help her out because the other birth that was happening was say in a different language and I couldn't find another midwife to help so I had to go. **Having a student involved with the care allows almost more continuity sometimes than the actual midwife because the midwives are switching on and off and the student is able to be around for that.** Obviously students need to take their protected time off too. It was such an amazing thing that Tia was able to come to some of the births of folks that she met over and over again regardless of which midwife it was managing the birth.

Tia: And often it was those relationships that felt really important to me. And at the same time I felt like I was bridging for the second midwife that was coming into their care. Being a student and being respected and having a supportive role, not just being an observer but also helping navigate those relationships, was also important. And the clients respected and appreciated that.

Marijke: **Ultimately as a settler and as a white person I do this work because I feel there is evidence of poor outcomes for Indigenous families in general across the health care spectrum. But particularly in pregnancy and childbirth: low birth weight babies, preterm labour, even mortality in the Indigenous population is higher in general. It's very important that this work gets done but ultimately the goal is for Indigenous midwives to be able to care for Indigenous clients.** Kayley and I are here to continue to do the work until there's more midwives like Tia and Lauren to be able to do that work too. Tia's ability to make cultural connections was such a great part of having her be our student last year. In fact, she makes family connections.

Tia: It's really a big family. I love serving clients especially that come from similar backgrounds or communities or share similar history experiences with me. The clients and I are able to open up those conversations. If there was something they were afraid of that was coming up in their birth or their care I could relate. Not just because of my skin colour but because of the experiences that I've had as well. And I was able to help others understand that. **Cultural connections are just as important as doing exams and is something that isn't often discussed or recognized in healthcare.**

Marijke: That's part of a good clinical outcome. **Somebody can't be safe if they're not safe culturally as well.** We do our best and obviously sometimes we probably make mistakes and hopefully people will help us learn from that. Everybody needs something different in their care so we try to be aware of that. I recently heard of a term called cultural agility and I am really intrigued by that.

MABC: What initially brought you to midwifery and why is it important for you to serve the population that you do?

Lauren: I became interested in midwifery because I wanted to be of service and to blend my desire for social change and health and wellness. I originally wanted to become a social worker like my grandmother, but after attending a birth I was hooked. **My roots are both mixed European descent and Métis, and this has led me to want to increase access to midwifery care for Indigenous families and also for families to know this time as an important ceremony.**

Marijke: I did an earlier degree in international development and went overseas and realized I was just a white punk from Canada who wanted to change the world and I really had no idea what I was doing. So when I came back, I had to do a retake on the situation. I started working in a housing program for young moms and I was blown away at that stage of my life to find these young people having C-sections for what seemed like little to no reason. So I started out by becoming a doula and going to births with people. **And I witnessed that it was a constant battle for some people to be seen and heard in the healthcare system.**

And I realized that a doula can only do a certain amount, but a care provider can do a whole lot more and that's when I went into midwifery. I was consciously choosing registered midwifery because I wanted to be accessible to everybody. I didn't want to choose something where people had to pay for the service. There's a lot of midwives in the province caring for all kinds of people but for me working with the Indigenous community is one of my focuses because the health disparities are obvious. My parents were immigrants and I am a first generation Canadian. **I was born here and I am a settler on unceded territory and I feel like it's my responsibility to give back because of where I live and what I do. It's similar for me in the immigrant population because I speak French and Spanish I want to be able to offer safe care to people in those languages.**

Tia: It started for me when I was 4 years old and I got to attend the birth of my sibling. I'm from a family of 7 siblings with a single mom and when I was at my brother's birth a random lady who was one of the moms of a woman in labour across the hall cam up to me and covered my ears and told me I shouldn't be there. I thought, why not? This is normal and totally exciting. Years later my sister had pneumonia shortly after she was born. **My mom is Indigenous and the nurse was asking questions that weren't related to pneumonia, like did she have FASD, and it just wasn't appropriate. I started piecing things together—why does this happen to my family and not others? I'm fluent in Secwepemc and one of the things I do is translate for my Elders and they have a fear health care because of past experiences and history.** I wondered why? It started coming together for me when I was pursuing my science degree taking classes in environmental science and psychology and I was thinking I might be a doctor when I grew up. **I went to my sister's birth and she had a midwife and all the pieces fit together—my background in traditional medicine, my background in science, and the work with Elders in my family and how I kept seeing cycles and cycles of judgement and mistreatment and discrimination. I thought I could pursue all of those things through midwifery.** I also did doula work in the background.

Right now there is a lot of work around culture and expressing diversity and being inclusive and what kind of work we can do to help support those things and what that means. The more people that become allies and recognize where they sit on that spectrum and what they want to do and pursue that. Any support is good to start off and build on that community. Because **right now Indigenous midwifery is lacking and there are tons of communities that need support and care.**

MABC: Are you able to integrate traditional Indigenous midwives into the care that you're providing?

Tia: Sometimes being a registered midwife does come with it's own drawbacks but I feel like there is a future. That the care is going to somehow come together, I don't know exactly how but I think as a registered midwife we can definitely support that.

Lauren: **BC is so far behind. Ontario had a clause since the inception of midwifery that midwives can practice traditionally and not have to be registered, and we don't have that here.** It's something that the committees that most of us are on have been working on already for 5 or 6 years. Regulation is a huge barrier.

Tia: Those midwives that are outside the system are being framed as bad guys or rogue and I don't think that's the right term to use. We need to create space for that type of care.

Marijke: People should have a right to choose and the idea would be that if people wanted to choose a traditional midwife and needed to transfer back into the healthcare system that they would be able to transfer to us and not to the hospital so there could be continuity. Having relationships with traditional community midwives is really important. But it's very scary for them right now. It's important that as we grow as a profession we continue to make those connections with community midwives because we can be a bridge.

Tia: **I feel like we also have a lot to learn from them and for them to feel scared to share that is a big barrier. There is a lot that the university programs don't offer.**

Lauren: **I think that there's places across the land like *Six Nations* that have their own training program. Indigenous midwives lead the program and are exempt from the clause and yet they have a training program and it's amazing. It is the gold standard. The *Manitoba Indigenous Doula Initiative* is another group that's paving the way for Indigenous doula work and we still have a long way to go here in BC with that. There's many examples of things that are happening and it's really exciting. We have a lot to look to for examples of progress being made in a positive way.**

A lot of people would consider the way that registered midwives are trained really colonial. There needs to be different training options. Training that's collaborative and closer to peoples homes. It's a huge deal.

Tia: Using a western medical point of view. In some cultures that's not how we learned.

My journey to come to the UBC Midwifery Program was a big deal. **I come from a rural community in the Interior. My band is called Splatsin of the Secwepemc Nation and for me to leave my mom and my siblings, who I financially support, and move to Vancouver, one of the most expensive cities on my own, has been a big barrier.** When I go back home and I tell my community what I'm doing people want me at their births and I tell them I'm only a student I will be there as a doula. That's my way of meeting them in the middle but even then they say, can't we just have you? **I'm already seeing midwifery care being reintroduced here.**

At home people are talking about grandmas and sisters and Elders and partners and what we traditionally did and it's an exciting revitalization that I get to be a part of as well encourage for more people. But coming to Vancouver for school is a really big barrier. **Accessibility to midwifery care and accessibility to midwifery education is so important.**

Lauren: A lot of people see the university as a colonial tool and the midwifery program is no exception to that. The fact that it's only offered at UBC in the south in one of the most expensive cities is a huge barrier.

Tia: **Currently right now the UBC Midwifery Program, I'm just going to name it, is very white. There are very few midwives that are minorities. And I think there's a reason for that. Affordability is one**. **Making the program accessible is not just holding two spots in the program for Indigenous students, it takes more than that.**

MABC: What is the best part of being a midwife?

Kayley: I did my first undergrad in Women Studies and was really interested in women's health and more specifically, women's (peoples) choice in health care. **Midwifery spoke to me on many levels because it was an opportunity to provide choice to my clients during an incredibly important time in their lives.**

When I did my first undergrad, I also worked as a volunteer doula with 'vulnerable' populations. It most definitely sparked my love for birth and desire to become a midwife and do the work that I do.

Lauren: **The best part of being a midwife is being present at one of the biggest transitions in life. We're so lucky that we get to guide families during such a remarkable time. It is also so satisfying watching people get excited about their health and their family's health.**

For some people it's the first time they've thought about their bodies in a positive or holistic way and we get to help with that.

From left to right - Baby Ronan, Tia, Kayley, Lauren, Marijke & Baby Shay

BC Midwife of the Month is a monthly profile series presented by the Midwives Association of BC. This series honours practicing midwives for their extraordinary contributions to current issues facing the profession and serves to introduce the public to a broad spectrum of midwives working in BC.