

GROWING MIDWIFERY IN MANITOBAⁱ

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THIS ARTICLE HAS BEEN PEER-REVIEWED

PREFACE

This is a personal narrative of the story of midwifery in Manitoba and of some recent events leading to regulation. I have been involved with midwifery in this province for nearly 15 years, first as a consumer advocate, then as a mother who chose midwifery care for the birth of her four children, and later as a member of the Midwifery Implementation Council. This is the first and second of a series of four papers that will document some of the events and decisions that shaped the practice and availability of midwifery in Manitoba, with a focus on the efforts made, and the challenges encountered, in keeping the process and results women-centred. Part 1 provides a brief overview and sets the context for the following three papers. Part 2 looks at steps and challenges in including equity and access principles in the regulation process. Parts 3 and 4 will tell the stories of the education and integration.

PART I: THE DEVELOPMENT OF A WOMAN-CENTRED APPROACH

Introduction

The development of midwifery as a regulated and autonomous profession in the province of Manitoba has a long history that is both similar to experiences in other parts of North America and different because of our specific history and geography. Manitoba has a small population (approximately one million people), half of whom live in the capital city, Winnipeg. The province covers 649,950 square km, much of which is sparsely populated and reached by seasonal roads or by air only. First Nations and Métis people represent the fastest growing population group. There were few midwives practicing prior to regulation in Manitoba.

Table 1 provides a summary of the crucial events through the years leading to midwifery regulation in Manitoba.

As in other provinces in Canada, the movement to reinstate and recognize midwifery as a valid profession for maternity care was inspired by social movements of the 1960s and 1970s. By the early to mid-1980s, a core group of dedicated women and families began to speak more openly about their own experiences as midwives and as women choosing midwifery care, and to organize politically. The activism was split somewhat between those with a "community focus" and nurse-midwives who had been trained in other jurisdictions and were not practicing at the time, but were lobbying for standardized care, the right to practice as midwives, and recognition of midwifery as an independent

profession. All who were advocating for midwifery by the late 1980s and 1990s were calling for greater access, availability and choices in maternity care for Manitoba women.

The Working Group

Although there were earlier submissions and proposals made to the provincial government, the first decisive step by the government began when the Manitoba government convened a Working Group on midwifery (1991) with Patricia Kaufert, PhD as Chair. Initially the group was primarily made up of doctors and nurses. With time a consumer advocate and two "lay" midwives joined.

The Working Group reviewed numerous academic, community and government documents, and studied regulation in other jurisdictions. In a report to Manitoba Health in 1993, the Working Group made 41 recommendations regarding regulation in Manitoba. Among the recommendations was a call for the provincial government's health ministry (Manitoba Health) to establish the Midwifery Implementation Council to advise the government and oversee the implementation of the other recommendations.

The Council

In May 1994, the Minister of Health announced the provincial government's commitment to midwifery as a regulated, autonomous and funded service for Manitoba women. The "Report from the Working Group" was released publicly and the Chair of the Midwifery Implementation Council (the Council) was announced.

Carol Scurfield, the Council Chair, is a family physician with an established practice at Winnipeg's Women's Health Clinic and experience in maternity care. Her training and practice had taken her to locations in northern Manitoba and her enthusiasm, determination and immense flexibility were, as it turned out, critical to the success of the Council's work.

The other members of the funded, 13-woman council were announced December of 1994. The Council members were chosen to represent and address the needs and issues of many of the women of Manitoba, as well as to provide a breadth of skills and expertise. Four women were named as council committee chairs and their original duties followed recommendations from the Working Group.ⁱⁱ The Council Chair participated in all the committees, which was important for the smooth flow of

TABLE 1: SIGNIFICANT RECENT EVENTS THAT LED TO REGULATED MIDWIFERY IN MANITOBA

(adapted from the College of Midwives of Manitoba 1999)

1981	• Social Planning Council report favours the use of trained midwives • Manitoba Homebirth Network is established
1982	• Manitoba Association for Childbirth and Family Education is established
1985	• Manitoba Traditional Midwives Collective established • Manitoba Action Committee on the Status of Women appoint sub-committee to address women's concerns about childbearing
1986	• Association for Parents & Professionals for Safe Alternatives in Childbirth, Manitoba Chapter is formed (MAPPSAC)
1987	• Manitoba Action Committee on the Status of Women publishes "Midwifery: A Discussion Paper"
1988	• Manitoba Action Committee on the Status of Women recommends the legalization of midwifery services in "Midwifery: Recommendations to the Manitoba Government" • The Nurse-Midwives Association of Manitoba is formed • The Manitoba Homebirth Network is incorporated
1990	• Manitoba College of Physicians and Surgeons and the Manitoba Association of Registered Nurses release a joint report recommending the legalization of nurse-midwifery
1991	• Minister of Health, the Hon. Don Orchard, establishes the Manitoba Working Group on Midwifery
1992	• Nurse-Midwives Association of Manitoba changes its name to the Association of Manitoba Midwives to reflect support for multiple routes of entry to midwifery
1993	• Midwifery Program is established at the Health Sciences Centre • Manitoba Health publishes the "Report and Recommendations of the Working Group on Midwifery"
1994	• The Midwifery Implementation Council is established by Hon. James C. McCrae, Minister of Health
1997	• The Midwifery and Consequential Amendments Act is passed
1998	• Midwives Association of Manitoba is formed • Midwifery Implementation Council becomes the Transitional Council of the College of Midwives of Manitoba
1999	• Manitoba government announces funding for midwifery services
June 12, 2000	• Midwifery and Consequential Amendments Act is proclaimed and 12 midwives are registered and begin employment

information among the committees and members, and for her role as spokeswoman. A full list of Council members is presented in Table 2, but many other women and men provided countless hours of work and support to the Council and the committees as our work progressed.

The Council was fortunate to have the assistance of a dedicated staff person ("Midwifery Coordinator") from Manitoba Health for the duration of the Council's existence. This gesture by the government was an illustration of their commitment to realizing regulated and funded midwifery in the province.

Creating a Woman-Centred Process

The Council was given enough resources to meet formally every month, with an initial mandate for two and half years. Committee work was on-going and Council meetings were used to make practical decisions guided by their over-arching philosophies. The Implementation Council was formally dissolved late in 2000.

From the outset, the Council agreed to use feminist principles and a consensus model of decision-making.ⁱⁱⁱ Because discussions about midwifery and midwifery care are fraught with emotion, we felt certain that it would not be possible to hear all arguments fairly and consider all possible solutions without this attention to process.

Learning to use consensus for meetings was not easy and a number of Council members (myself included) worried that valuable time was being tied up in "process" instead of "doing". However, later we were very glad of the protocols we had chosen and truly felt that we had considered virtually all options in making all decisions.

This women-centred, feminist approach was the foundation for all the work the Council undertook. The guiding question was "What is best for Manitoba women?" This often referred to women who would be receiving care, but just as frequently meant those women who would be giving care - the midwives themselves. We reviewed the evidence in research literature from Canada and internationally, and were very grateful for the wisdom and experience of our counterparts in other provinces. Based on the evidence we gathered, we then considered the implications of what we found for Manitoba women. Some of the questions that arose were: Would all clients be served well by a particular standard? What were the implications of a given model of care for a practicing midwife? Were her rights as a worker considered fairly? Finally and critically, Who was being left out?

The Yellow Papers

Building upon the work of the Working Group, the Council established a number of foundation documents that became key points of reference for the duration of the Council's work. These were "The Philosophy of Care", "The Definition and Scope of Practice", "The Model of Care" and "The Code of Ethics". The "yellow papers" were derived from the work already done by our counterparts in Alberta, British Columbia, Ontario and Quebec and from the recommendations of the Working Group. As each document was developed, the same questions of inclusion and exclusion were used to shape the final wording.

TABLE 2: ORIGINAL AND SUBSEQUENT MEMBERS OF THE MIDWIFERY IMPLEMENTATION COUNCIL

Original Member	Successor	Representation	Note
Carol Scurfield, Chair		Family medicine	
Gillian Andersson*	Alicia Read	Nurse-midwife	* Passed away August 1996
Anessa Maize	Marla Gross	Direct entry midwife	
Akaterini Zegey-Gebrehiwot	Eda Pangilinan	Recent immigrant midwife	
Kris Robinson†		Nurse-midwife	
Madeline Boscoe		Consumer advocate	
Margaret Haworth-Brockman†		Consumer	
Sheila Sanderson	Heather McKay*	Consumer	* Passed away August 2001.
Diane Tokar		Rural women	
Yvonne Peters†		Human rights lawyer	
Ina Bramadat		Nurse and university professor	
Joan McLaren†		University and community college educator	
Lorna Grant‡		Obstetrician	
In addition, these women were integral to the process of implementation and regulation:			
Laurel Garvie	Linda Barker	Manitoba Health Coordinator	
Florence Klassen		Manitoba Health Consultant	

†Committee Chairs

‡Lorna Grant was recently returned from Hamilton, where she had been part of the development of regulated midwifery in Ontario.

One additional founding document was the Council's "Midwifery Competency Chart". In the first month's of the Council's work, Joan McLaren, PhD, Chair of the Education Committee, led a two-day consultation with 12 midwives from diverse backgrounds. The result was a competency chart or template of over 163 skills and knowledge that a midwife must demonstrate to practice safely. The exercise of developing the Core Competencies served a number of purposes:

- It brought together six nurse-midwives and six non-nurse midwives who had not, until then, had opportunity to work as colleagues.
- The charting process established that there was enormous common ground among the participants about core competencies.
- The Core Competencies became a template against which the Assessment and Upgrading was developed.
- The competencies established a way of thinking about learning and training for midwifery candidates. The Council's focus in subsequent work was on how to meet the competencies, not necessarily on debating the merits of disparate forms of training. The competencies were kept as the desired outcome of any education and experience gained.
- The Core Competencies document was further used to develop the curriculum outlines for the education programs proposed by the Council and the College.

Although it was more difficult to articulate, (and so never quite made it to "yellow") the Council demonstrated a profound commitment to principles of equity. The by-laws of the College of Midwives of Manitoba, for instance, include a preamble that outlines four principles of equity and access, as do many of the

documents and standards of the College. These are:

Section 2.0 Commitment to Equity

2.1 The College is committed to the goal of equity in the practice of midwifery that includes:

- Providing service to women who historically have been under-represented or under-served by the health care system; and
- Recruiting midwives with diverse backgrounds, experience and knowledge. Such recruits may be drawn from groups including immigrants and newcomers to the province, visible minorities, Aboriginal persons, persons with disabilities, and persons who live in rural or remote communities.

2.2 The College shall strive to meet its commitment to equity by:

- Removing and preventing systemic barriers in the practice of midwifery; and
- Ensuring that groups that have experienced historical disadvantage such as immigrants and newcomers to the province, visible minorities, Aboriginal persons, persons with disabilities, and persons who live in rural or remote communities, are represented on the council and committees of the College.

On June 12, 2000 the Manitoba government proclaimed the Midwifery and Consequential Amendments Act that identifies midwives as autonomous primary health care providers. At the same time, the Manitoba government put in place the mechanisms to make midwifery care available as a funded service for women, including establishing payment to midwives and those they may consult or collaborate with. The first 12 midwives registered to practice were hired by Regional Health Authorities on that same day, June 12, 2000.

PART II: INCLUDING WOMEN IN A WOMEN-CENTRED MODEL

Introduction

The 13-member Council spent over five years laying the groundwork for the regulation of autonomous midwifery and its integration into the health care system. Within the Council, four committees undertook four pieces of very different work at the same time.^{iv} A real concern for all of these committees, however, was how to include as many midwives as possible in the process of registering competent practitioners. This paper examines the ways in which the Council endeavoured to include the widest range of midwives in the regulation process.

Including Nurses and Non-nurse Midwives

In Manitoba before regulation, nurse-midwives were unable to use their full range of skills as midwives, and frequently worked as labour and delivery nurses only. There were a few exceptions, particularly through some pilot projects in the early 1990s, but most of them chose not to practice outside the health care system. Ironically, many of these nurses were recruited to Manitoba in the 1960s and 1970s to provide comprehensive maternity care (including attending labour and delivery) in nursing stations and on reserves. As northern maternity care became more about transferring women away from their home communities, many of the British recruits moved to Winnipeg, Brandon and Thompson to work on labour and delivery wards, where their scope of practice was limited to only nursing activities. There were a number who became vocal advocates of regulated midwifery.

There were a few midwives (some were nurses, others had direct-entry training) in Manitoba who provided home birth care and had strong support from the community.^v One family in northern Manitoba, for instance, arranged over the years for a southern-based midwife to travel to their town and be available for the births of several babies among a group of mothers, who were sisters or sisters-in-law. Though there are no accurate statistics on the number of home births attended by midwives in northern and southern Manitoba, there were approximately 50 home births in southern Manitoba each year by the early 1990s. At this point the midwives who attended home births reported that they were no longer able to meet the growing demand for their services.

The few midwives who provided care and attended births at home before regulation had only infrequent working relationships with physicians. This is in contrast to many of the midwives in British Columbia, Ontario and Quebec who were in practice before regulation and had established on-going working relationships with local physicians.

Much of the early work of the Equity/Access Committee included consultation with women throughout the province. Wherever the Council members traveled in Manitoba to talk about the process for regulation, a number of nurses and (former) nurse-midwives would attend. Their reactions to the proposals are recorded as mixed. The issue of home births was especially contentious, creating ideological tensions between the two groups. By 1997 a split between nurse-midwives and other midwives seemed inevitable. The Council hired an independent facilitator who met with nurse-midwives to clarify why there was

such resistance to the proposed model of care.

For the first time the Council heard that it was not home birth per se that some nurses objected to, but rather that they did not want to be "forced" to provide care in a setting where they did not feel safe. Because it was critical not to lose the expertise and knowledge of these midwives from an already small number of potential registrants, the Council worked to include the concerns raised in the draft proposals for legislation. The result is a clause in the Act that allows midwives who register until 2003 to declare their preference not to practice in all settings. Their registration specifies the limits to their practice. They are required to attend and witness births in other settings and must be able to provide unbiased information to clients, but they do not have to provide primary care at births in all settings.^{vi}

Midwives Trained Outside Canada

The Midwifery Implementation Council was determined that midwifery in Manitoba would not become a resource relevant and available only to white, middle-class urban women. It seemed very likely that Manitoba's growing population of new immigrants would include women who had been trained as midwives in their home countries. Over the months and years we grappled with terms like "immigrant" and "new immigrant" but the Council came to recognize that "new" is a relative term and that most midwives trained in some other country. Ultimately, all qualified midwives who wished to register had to demonstrate their competency, unless they had already been assessed and were considered able to be registered within Canada.

Early attempts to meet with women from new immigrant communities were not well attended. A few women came forward to join committees to advise on how best to include foreign-trained midwives in the process. When the Assessment and Upgrading (A/U) was developed and we were able to provide the midwives with concrete information about the requirements for all applicants, over 60 percent of the women who attended an information meeting held by the Council were midwives who had come to Canada since 1980.

Foreign-trained midwifery applicants in Ontario and British Columbia had to declare English as their mother tongue or provide proof of completion of a TOEFL exam. After consulting with staff from Manitoba's Department of Heritage and Citizenship, Language and Training, the Council was advised that the standard tests of English were not necessarily a good measurement of someone's ability to function in a particular workplace where certain terminology would be more critical than "an understanding of Shakespearean English" (pers comm). The Council was enormously grateful to the Department for its commitment to develop an English-for-Midwives course. The Department agreed to do four things for the Council:

- To establish the benchmark of English needed for the job of midwifery;
- To test all applicants to that benchmark;
- To develop a curriculum for English-for-Midwives; and
- To teach the curriculum.

In the interests of equity, every applicant was required to go through the English language testing as a pre-requisite to getting into the Assessment and Upgrading.

Fifteen women took part in the English-for-Midwives classes over two years. In a few cases, the midwives took the course at the same time as proceeding through the Assessment and Upgrading. In other cases the women completed the English language training before formally being accepted to the A/U. The instructor included learning and studying techniques in the curriculum because it became apparent that there were substantial cultural differences in learning practices amongst those who attended.^{vii}

When the first group of midwives registered in 2000, eight of 20 of them had been trained in another country. This is a figure to be proud of, but there is a sadder side to the story. Many of the women who entered the A/U were not successful. There were a number of reasons for this. The A/U was a four-month full-time program. This meant that a woman not only had to pay her tuition, she usually had to give up her paying job to attend the classes. Secondly, it became apparent that there were profound cultural differences in learning styles, which could not be addressed in the short time frame. Thirdly, some women found there was too little time to learn about the Canadian medical system and hierarchies and how their midwifery knowledge would fit with the Manitoba competencies. It seems likely that these areas could have been addressed with some type of a longer-running refresher course.

Aboriginal Women

The "Working Group Report" recommended that the Council undertake greater consultation with Aboriginal Manitobans than had been possible during the Working Group's own mandate.^{viii} Although only one woman on the Council was of Aboriginal background, we were very grateful for the tremendous support we received from Aboriginal women throughout the province who provided advice, guidance and wisdom.

When the draft legislative proposals were first drawn up by the Council in the spring of 1996, the Council decided to suspend submission of the draft to the Legislature because we were not satisfied that we had consulted with enough Aboriginal women.

Consultation took a number of forms. To get the best response from the greatest number of women in northern Manitoba, the Council commissioned two northern women to organize small focus groups throughout the North (north of 53°).^{ix} In all, more than 200 women in over 20 communities met and contributed to those consultations. Similarly, Council members traveled to 10 southern communities to meet with women and health care providers on reserves, at healing lodges and at tribal meetings. The Council also commissioned separate consultations among Métis women in southern and central Manitoba. The results of the consultations were compiled and summarized.

In general, the Council found cautious acceptance of the idea of regulated midwifery among Aboriginal women. At a time when many people see only death and tragedy in their communities, the opportunity to "bring birth back" was welcomed. However, women did not want to be receiving any sort of "second-rate care" for themselves or their families. Aboriginal women we met with agreed that midwives who are able to bring current medical knowledge to a practice that also relies on more traditional, holistic and culturally appropriate care would be acceptable.

Communities differ in their plans to introduce regulated midwifery. Currently, at Nelson House, for instance, there is a new birthing centre waiting for midwives to begin practice and Berens River, a First Nations community on the east side of Lake Winnipeg, is looking for midwives to provide pre and postnatal care on reserve with no immediate plans for births to take place in the community.

To ensure that there were formal mechanisms for meaningful participation of Aboriginal women in the development and regulation of midwifery, the Midwifery and Consequential Amendments Act requires a Standing Committee on Issues Related to Midwifery Care for Aboriginal Women (named Kagike Danikobidan). The Committee was first convened in June 1997, following passage of the Bill. A continued emphasis on decisions made by consensus has helped to ensure that representatives from Kagike Danikobidan have equitable participation in all aspects of the College business.

Including Women in Rural and Remote Manitoba

Women's choices for maternity care in rural and remote communities of Manitoba have historically been limited. Many Manitoba women must travel vast distances to Winnipeg or Thompson because there is no obstetrical care available in their community. Those from northern and remote communities are transported by air to Winnipeg for childbirth because nurses employed by the (former) Medical Services Branch (MSB) or at other small clinics are not "qualified or permitted to provide care during labour and birth, except in emergencies" (MSB, pers comm). As mentioned before, this is ironic because until the late 1970s British nurse-midwives were actively recruited to northern Manitoba because they could provide maternity care. Rural women in the south have also had to travel further for childbirth, as fewer and fewer family physicians and hospitals provide obstetrical services.

Women have continually voiced their concern about having to leave their families, homes and communities for childbirth. Moving from one centre to another always leads to a certain fragmentation of care. For Aboriginal women from northern reserves it can mean being flown to Winnipeg as much as two to four weeks before the expected due date, to a city where both the medical staff and the language may be unfamiliar. The history for the current (and past) pregnancy must be re-told to each new nurse, technician or doctor. Social and community supports are largely unavailable for the mother.

Over two winters (1996 and 1997) evening meetings were held in 15 rural communities, reaching more than 200 women in all. Women who attended the gatherings spoke as consumers, and, in some cases, about what they wanted to be able to do as providers. Most women who attended had already had some form of midwifery care and were worried that their already tenuous access to care would be withdrawn with regulation. Stories mothers had heard from other provinces about new restrictions on midwives' practices caused them to be very clear that they did not want geographical restrictions placed on Manitoba midwives when the profession became regulated.

Including Women's Concerns in the Regulation of Midwifery

The Council was committed to incorporating the concerns raised by women throughout the province during the various consultations. The Standards for Care include consideration of what would be equitable, reasonable, and feasible for most Manitoba women. For instance the "Standard for Out-of-Hospital Birth" was developed with consideration of the geography and distances between communities in Manitoba. In the absence of conclusive evidence about what is acceptable for distance to a secondary or tertiary hospital or physician, the onus is on the midwife to assess the circumstances of a pregnancy and the proposed place of birth. The midwife has established guidelines for ensuring appropriate back-up, access to emergency assistance and providing information to the mother.

The Council felt that a requirement for two midwives at every birth would restrict the number of women who could receive midwifery care because there are so few midwives spread across rural Manitoba. So, the criteria for second attendants at births are more inclusive than in other provinces. In keeping with evidence in the literature and community standards, the second attendant may be another midwife, a nurse, emergency medical personnel, or a physician. The second attendant must have demonstrated competence to assist a midwife during neonatal or maternal obstetrical emergencies.

There is nothing under the regulation of midwifery in Manitoba preventing midwives from continuing their registration as nurses. In Manitoba it is possible for midwives to still earn income as nurses in remote and rural communities where a midwifery practice may be small.

Health care delivery in Manitoba became regionalized in 1996, when the Council was part way through its work. Regional Health Authorities (RHAs) are provided with a global budget that must be used to cover the costs of required health services. Because of its newness, most RHAs would not take advantage of midwifery services without a specific pot of money allocated to employ midwives. Indeed, initially, most RHAs were unfamiliar with the training and qualifications of midwives and with their scope of practice. Manitoba Health has a dedicated process to ensure RHAs can properly accommodate and integrate midwives into hospitals and health care systems. Nevertheless, only five RHAs have received funding for midwives. Of the 26 full-time midwifery positions allocated to RHAs in 2002, 16 are in Winnipeg and 10 are employed in rural and northern RHAs. There are not enough registered midwives to meet the ever-increasing demand and, for some women who live outside Winnipeg, regionalized health care currently prevents them from getting access to midwives at all.

CONCLUSION

For over two years now we have seen the fruition of the five and half years of work done before regulation. In many ways we have demonstrated that it is possible to build a women-centred policy and program. But it is clear that the work cannot be considered complete until midwifery is truly accessible to women throughout Manitoba. The challenge for Manitoba is to ensure there are adequate budgets and support for new midwives to receive training and experience that will be appropriate for the women they will serve.

AUTHOR'S BIOGRAPHY

Margaret Haworth-Brockman is the Executive Director at the Prairie Women's Health Centre of Excellence in Winnipeg. In 1994 Margaret was appointed Chair, Equity and Access Committee of the Midwifery Implementation Council, by the Manitoba government. She traveled throughout Manitoba, meeting with women and practitioners to consult them about the development of regulated midwifery in Manitoba. With the Implementation Council, Margaret co-wrote many of the documents, policies, procedures and strategic planning that are part of the operations of the College of Midwives of Manitoba and served on the Board of Assessors. Margaret was the first Registrar and Executive Director of the College of Midwives of Manitoba, from the time of its distinction as the professional body in 1999.

Margaret has written over 30 published papers, articles and presented papers, including a chapter in the 2000 National Guidelines for Family-Centre Maternity and Newborn Care. She is a member of the Board of Directors of Klinik in Winnipeg, and sits on numerous steering committees for women's health in Winnipeg concerning women and poverty and Aboriginal women's health issues.

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FOOTNOTES

ⁱ This is project #64 of the Prairie Women's Health Centre of Excellence.

ⁱⁱ The author was one of the "consumer" voices on the Council, having had midwifery care for her four births, both in hospital and at home. She was named Chair of the Equity and Access Committee.

ⁱⁱⁱ Williams RB. More than 50 ways to build team consensus. Arlington Heights, IL: IRI/Skylight Publications 1993. Scott J, Flanagan E. Achieving consensus: tools and techniques. Menlo Park, CA: Crisp Publications, 1996. Starhawk. Truth or dare: encounters with power, authority and mysteries. San Francisco CA: Harper & Row, 1987.

^{iv} The four original committees were Education, Practice, Legislation and Equity/Access. In time, new committees were formed as needed.

^v There were, at various times, five to eight midwives who attended home births in the 1980s and 1990s. These were the women who were "known" in the home birth community. There were very likely other women who attended home births, particularly in remote communities.

^{vi} There are further restrictions within the profession for these registrants, which limit the decisions made in College business, standards or education related to a setting in which the midwife does not provide care.

^{vii} These differences in learning styles bear further analysis, which is beyond the scope of this narrative.

^{viii} See Part I of this series.

^{ix} Ms. Freda Albert of Norway House and Ms. Freda Lepine of Thompson.

^x College of Midwives of Manitoba. Integrating Midwifery Services: Implementation Manual, 1999.