ARTICLE

Photo by Sherry Prenevost

Racialized Student Midwives' Exploration of Resilience in the Ontario Midwifery Education Program: A Qualitative Descriptive Study

Examen de la résilience des étudiantes racisées du programme ontarien d'enseignement de la pratique sage-femme : étude descriptive qualitative

Touka Shamkhi, Claire Ramlogan Salanga, BComm, BHSc, RM, and Elizabeth Kathleen Darling, RM, PhD

ABSTRACT

Background: Resilience is often positioned as a response that empowers midwives and midwifery students to cope with challenges and support professional longevity. However, formally documented understandings of resilience do not account for the unique and varying experiences of racialized midwifery students. In order to address this gap, we asked the following research question: "How do racialized midwifery students in Ontario experience resilience?"

Methods: We conducted a qualitative descriptive study using focus group interviews. We recruited current and past students who attended the midwifery education program in Ontario via email, social media, and word of mouth. We asked interested participants to complete an online demographic questionnaire via REDCap. Two investigators, a midwifery student and a midwife who both identify as racialized, co-facilitated focus groups that were held in person in Toronto and Hamilton and online. We used REDCap to generate descriptive statistics summarizing the demographic characteristics of participants. One investigator transcribed audio recordings of the focus groups. We managed and analyzed transcripts in NVivo. Two investigators conducted open coding of all the transcripts together. Coding results were then discussed with a third investigator to formulate categories and themes.

Key Findings: A total of 16 participants took part in four focus groups in August 2019. Racialized students understand and experience resilience in varying and complex ways. We identified five major themes pertaining to resilience: "defining" resilience, mental toll, active vs. passive coping, individual vs. collective resilience, and agency. Additional themes beyond resilience included systemic exclusion, whiteness, and midwifery culture in the Midwifery Education Program.

Implications: Our findings provide specific insights that should be used to guide efforts to improve the experiences of racialized midwifery students throughout their time in the Ontario Midwifery Education Program.

KEYWORDS

midwifery, racism, resilience, mental health, education, reproductive justice

This article has been peer reviewed.

RÉSUMÉ

Contexte : La résilience est souvent présentée comme une réaction qui donne aux sages-femmes et aux étudiantes de la pratique les moyens d'affronter les défis et de soutenir la longévité professionnelle. Cependant, les conceptions formellement documentées de la résilience ne tiennent pas compte des expériences uniques et diverses des étudiantes sages-femmes racisées. Afin de combler cet écart, nous avons posé la question de recherche suivante : « Comment les étudiantes sages-femmes ontariennes racisées vivent-elles la résilience? »

Méthodes : Nous avons réalisé une étude descriptive qualitative au moyen d'entrevues avec des groupes de discussion. Nous avons recruté des étudiantes anciennes et actuelles du programme ontarien d'enseignement de la pratique sage-femme par des courriels, les médias sociaux et le bouche à oreille. Nous avons demandé aux participantes intéressées de remplir un questionnaire démographique en ligne avec l'application REDCap. Deux enquêtrices, une étudiante en pratique sage-femme et une sage-femme qui s'identifient toutes deux comme personnes racisées, ont coanimé des groupes de discussion qui se sont déroulés en personne à Toronto et à Hamilton ainsi qu'en ligne. Nous avons utilisé REDCap pour produire des statistiques résumant les caractéristiques démographies des participantes. Une enquêtrice a transcrit les enregistrements sonores des groupes de discussion. Nous avons géré et analysé les transcriptions dans NVivo. Deux enquêtrices ont effectué le codage ouvert de toutes les transcriptions ensemble. Les résultats

du codage ont ensuite été discutés avec une troisième enquêtrice afin d'identifier les catégories et les thèmes.

Principales constatations : Seize personnes en tout ont participé aux quatre groupes de discussion en août 2019. Les étudiantes racisées comprennent et vivent la résilience de manières différentes et complexes. Nous avons dégagé cinq grands thèmes relatifs à la résilience : la « définition » de la résilience, le tribut émotionnel, les stratégies d'adaptation actives par opposition aux stratégies passives, la résilience individuelle par opposition à la résilience collective, et la capacité d'agir. Parmi les thèmes autres que la résilience, on trouve l'exclusion systématique, la blanchité et la culture des sages-femmes dans le programme d'enseignement de la pratique.

Répercussions : Nos constatations fournissent des renseignements précis dont on devrait se servir pour orienter les efforts visant à améliorer l'expérience des étudiantes racisées lorsqu'elles suivent le programme ontarien d'enseignement de la pratique sage-femme.

MOTS-CLÉS

pratique sage-femme, communauté, populations vulnérables, équité en santé

Cet article a été évalué par un comité de lecture.

INTRODUCTION

Several researchers have explored factors that contribute to the attrition of midwives and midwifery students in Ontario,[1–3] whereas others have explored factors that contribute to the retention of midwives.[4] In the context of midwifery attrition and retention, resilience has been described as an ability to endure and recover quickly from challenges and as a quality that empowers people and promotes professional longevity. One missing voice in the conversation about resilience is that of racialized midwives and midwifery students. Canadian studies that mention resilience in midwives and midwifery students are limited and do not account for racialized midwives or midwifery students.[4] Most non-Canadian studies on midwifery resilience also do not consider racialized midwives and midwifery students.[5–9] The ones that do are American[10] and thus do not account for different midwifery models as well as the overall context and nuances that are unique to Canada and, more specifically, Ontario. Moreover, the existing American research has focused on midwives and mention racialized midwifery students sparingly.

The "weathering hypothesis" put forth by Arline Geronimus and colleagues describes how racism and systemic white dominance operate to directly threaten the physical, mental, emotional, and psychological health of racialized persons.[11] McGee and Stovall explore how this phenomenon manifests in academia—namely, the negative health outcomes associated with the psychologically and emotionally taxing nature of enduring systemic and everyday racism in high-pressure academic work.[12] "Weathering" is a concept that racialized midwives and midwifery students in Ontario have been intimately familiar with since before the regulation of midwifery in 1994. In her research, Sheryl Nestel details the mechanisms by which racial exclusion occurred during the time of legislation of midwifery in Ontario. These mechanisms include exclusionary policies, bureaucracy, and superficial platitudes; the ongoing impacts of this can be seen in racialized students today.[13–15] White Ontario midwives' failure to appropriately address their racial privilege resulted in, as Nestel puts it, "midwifery activists [choosing] a political route that sustained rather than challenged systems that marginalized other women."[13–17] Wider literature shows that racialized academics and in-training health care providers experience unique factors that contribute to attrition.[16–20] This is reiterated in American studies on midwifery students and midwives.[21,22]

The need to retain students and increase the midwifery workforce has been echoed by several studies.[1–3,6,23,24] Racialized midwives are uniquely qualified to care for racialized populations, and

maternity care organizations and researchers are becoming increasingly aware of the necessity of diversifying the midwifery force.[10,15,16,21–25] Many studies have established that racial concordance between health care provider and client significantly improves care.[26–29] In order to achieve a high quality of care for all, we must increase the racial and ethnic makeup of the midwifery workforce, which requires that we invest in efforts that promote the well-being and retention of racialized midwifery students. Our objective was to understand students' experiences of resilience to determine how best to counter the conditions that produce the attrition of racialized midwifery students. Our long-term vision was to mitigate the risk of attrition and its consequences for health care system costs,[1] access to maternity care for clients,[1,21–23] and the ability to build and sustain a diverse midwifery force to meet the needs of an increasingly diverse population.[1,21–24]

METHODS

We conducted a qualitative descriptive study using semi-structured focus groups.[30,31] Ethics approval for the study was obtained from the Hamilton Integrated Research Ethics Board.

Participants, Setting, Recruitment

People were eligible to participate in the study if they identified as racialized and were currently or had ever been a student in the Ontario Midwifery Education Program (MEP). People who had left the program or profession were included. Indigenous MEP students–specifically, First Nations, Inuit, and Métis students–were not included in this study, as none of the research team members are Indigenous. We understand that settler research that "explores" Indigenous people has a long and harmful history that reproduces the colonial narrative of "discovery,"[32] and we recognize that Indigenous peoples are diverse in thought, experience, and practice, and that they have sole authority over their knowledge and history.

We distributed a recruitment poster via email to all current MEP students (at Ryerson, Laurentian, and McMaster Universities) and to all members of the Association of Ontario Midwives, as well as via social media platforms (Facebook, Instagram, and Twitter). We used social media and word of mouth to recruit individuals who have left the program or profession.

We sent people interested in the study a letter of information and a consent form. We offered the option of in-person focus groups in Toronto and Hamilton or online focus groups on the WebEx platform. Focus group participants were offered either a nominal Starbucks gift card or in-person refreshments.

Data Collection

Prior to the focus groups, participants were asked to complete a short demographic questionnaire, hosted on a secure server (REDCap), that included an open-ended question about race and ethnicity. The focus groups were conducted by a current racialized midwifery student and a racialized midwife. We used a semi-structured format; 11 questions were prepared as prompts for guidance if needed. The interviews explored how participants define resilience (if they do), facilitators and barriers to resilience; how they experience resilience; and what outcomes this experience has for participants. We audio-recorded and transcribed all focus group proceedings. We also included transcripts of the text chat from the online focus groups.

Analysis

Focus groups were transcribed by the co-investigators. The transcripts were analyzed and managed using NVivo 12 software (QSR International, Melbourne, Australia). We used inductive thematic analysis, beginning with primary open coding to summarize and describe the data, followed by secondary or focused coding to identify categories and themes.[33] The coding was done by the co-investigators who facilitated the focus groups, and the analysis strategy and process were reviewed and guided by an experienced qualitative research supervisor. We then held an online WebEx member-checking meeting where study participants, as well as individuals who were eligible to join the study but did not, were invited to review the preliminary results and offer feedback.

Table 1. Characteristics of Study Participants

Characteristic	*N = 16* n (%)
Age at time of study (yrs)	
18–29	10 (62.5)
30–47	6 (37.5)
Age at time of first year in the MEP (yrs)	
18–29	13 (81.2)
≥ 30	3 (18.8)
MEP site	
McMaster University	8 (50)
Ryerson University	7 (43.8)
Laurentian University	1 (6.2)
Current vs. former students	
Current	8 (50)
Former	8 (50)
Race and/or ethnicity*	9 (56.3)
Black	3 (18.8)
South Asian	2 (12.5)
Southeast Asian	1 (6.2)
Arab	1 (6.2)
Latin American	

MEP, Midwifery Education Program

* Race and ethnicity are social constructs with varying, and often contradictory, definitions. We deliberately left this question open-ended to avoid imposing categories and forcing participants into an identity "box," as well as to avoid inadvertent endorsement of deeply problematic and illegitimate race "science." [Angela Saini, *Superior: The Return of Race Science* [Boston: Beacon Press, 2019]].

Four people attended the member-checking meeting, three of whom were study participants. Descriptive statistics were used to summarize the findings from the demographic questionnaire.

Criteria for Rigour

We used various methods to achieve rigour in this study. Racialized individuals from within and outside the midwifery community were consulted to help contextualize this research project, limit researcher bias, and arrive at appropriate language choices.[34]

The researchers' historic and contemporary positions, roles, and identities, including race and ethnicity, cannot be divorced from the research process and results, and thus inevitably affects how information is received, interpreted, and disseminated.[31,35,36] In order to account for the investigators' positionality as it relates to the research, we have provided details regarding the investigators' racial and ethnic positions as they relate to the research.[23,24] The co-investigators engaged in reflexive practices such as taking field notes and having frequent debriefs following the focus groups to unpack meetings, promote transparency, and limit researcher bias.[37] We ensured that we remained close to the purpose of this research project by following the participants' priorities and encouraging the participants to share their own thoughts, feelings, and experiences regarding resilience during their time in the MEP. Having two racialized co-investigators facilitate the

Table 2. Summary of Themes and Subthemes

Theme	Subthemes
Defining resilience	• Description of resilience • The burden of resilience • Systemic whiteness of the MEP • White supremacy • "The program did damage they didn't want to recognize"
Mental toll	• Stresses of visibility • Stress and physical toll • "Resilience speaks to exhaustion" • Surviving "a sick social experiment"
Active vs. passive coping	• Mechanisms of coping • An intentional silence • Day-to-day coping
Individual vs. collective resilience	• Collective mindset • Resilience as community driven • Drawing on internal strength • Surviving together
Agency	• Agents of change • Self-determination and drive • Imagining racialized midwifery futures

focus group helped to create a safe, comfortable environment for participants to be candid about their experiences. Having the same two racialized co-investigators perform the analysis helped to ensure credibility. The credibility and integrity of the analysis and results were confirmed during the member-checking session, in which the participants affirmed the results and provided feedback that was incorporated in our presentation of the findings.

RESULTS

We conducted two in-person and three online focus groups in August 2019. Twenty-one people contacted the primary investigator to be included in the study, but only sixteen were able to participate in their original or rescheduled focus group. Table 1 summarizes the demographic characteristics of the participants. Of the former students, one had not graduated. Of the seven former students who did graduate, one is not practicing. Two of the participants who identified as Black also identified as biracial. Participants who specified ethnicity or nationality listed the following identities: Caribbean, Jamaican, Nigerian, Filipino, British, Canadian, Indo-Canadian, Ghanaian, Palestinian, Sri Lankan, Chinese, and Malaysian. Three participants indicated their religion in responding to the question about race and ethnicity. Two participants identified as Muslim and one participant identified as Christian. Although religion is not race, some religions, such as Islam, are racialized. Structuring the race and ethnicity question as open-ended allowed Muslim participants to include this aspect of their identity as it impacts their experiences in the MEP.

We identified five major themes related to resilience: defining resilience, mental toll, active versus passive coping, individual versus collective resilience, and agency. Each theme is discussed

in greater detail below with quotations from the focus groups, and sub-themes are described. The themes and sub-themes are summarized in Table 2.

Theme 1: Defining Resilience

This theme highlights the descriptive language study participants used to conceptualize their experience of resilience, as well as the experiences and circumstances in which their experiences of resilience are situated. Within this theme, participants spoke of the following sub-themes: describing resilience, the burden of resilience, systemic whiteness of the MEP, white supremacy, and "The program did damage they didn't want to recognize." Key to this theme is that experiences of systemic racism were a defining aspect of participants' experiences of resilience.

Describing Resilience

Participants had varying understandings and feelings towards resilience. For instance, while it was common for resilience to be described as "pushing through," "perseverance," and an "ebb and flow of adaptability," whether or not this had a positive or a negative connotation varied. While perseverance was seen as a strength for some, it was viewed as a weakness for others, as described by one participant:

> *My resilience became my weakness—it was like I was a dummy. Like you're repeating the same things that's happening to you and you can't do anything about it and then you look like the idiot for staying and getting up every single time. Because you keep feeling like you can do something, but you know at the end of it you're defeated already. Like there was no way you were gonna progress no matter how much you try, [tearing up] no matter how hard you try.*

Ultimately, many participants likened resilience to a "double-edged sword," given that resilience happens in response to the experiencing of harm: "There's a fine line between resiliency and burn out. And we have to be mindful that even though it can be positive, it can lead to destroying people."

The Burden of Resilience

In an already academically rigorous and financially challenging program, racialized students are subject to additional barriers and obstacles, seen and unseen, that result in their requiring more resilience.

> *I find that wherever you are a minority in a setting, you need to have bigger resiliency because everything is harder [because of] everything you deal with, you know, constant microaggressions—it takes a toll physically so you have to be tougher and it becomes your normal, and because of that, oftentimes we don't validate that we live in a constant mode of stress because of that….and then you add to that the MEP is a difficult program and also if you don't have peers to support you, it can be a very lonely place, because everything you experience you experience differently due to that barrier or that invisible barrier, however you want to name it, that colours your experience on a day-to-day basis.*

A common burden described by participants was the burden of "taking on a teacher role." Unlike their white counterparts, who can focus on learning, racialized students also have to educate others, often without consent or compensation, on topics tied to their humanity and basic human rights. This is especially common in the course "Working Across Differences" (previously known as "Social and Cultural Dimensions of Health"). Not only are racialized students expected to be teachers, they are expected to be gracious teachers even as they are being re-triggered while having their personal lives and experiences mined for "educational content."

> *…and there I am now, empathizing with them while we're re-triggering my own experiences… and somehow in "Working Across Differences," like you're expected to share and open your personal experiences and you're expected to share so that you are educating.*

Systemic Whiteness of the Midwifery Education Program

Institutionalized whiteness in the MEP

functions, through deliberate actions or inertias, to produce white supremacist conditions that necessitate racialized students' resilience. Participants described being excluded and ostracized within their cohorts. But before exclusion occurs interpersonally, it occurs at the systemic level within the MEP–from student recruitment to the processes within the MEP that decentre and push out racialized students. An example of this is the high cut-off average for admission to the MEP, which participants cited as failing to account for systemic barriers to high grades, offering no consideration for lived experience, and inevitably favouring a demographic of white women.

Systemic whiteness in the MEP is also deeply reflected in the power structures that are created and upheld by white solidarity. The following quotation is from a participant who described trying to access support from white faculty after experiencing racist abuse in placement and was instead met with faculty who stood firmly with the white preceptor responsible for the racist abuse.

> *This part this goes into the hierarchy within midwifery. So, when I decided I needed to leave [placement], I spoke with somebody in the office who is like, I don't know, the person I'm supposed to talk to about this. And I already knew when somebody told me "Talk to this person, maybe they'll hear the abuse that you're experiencing." I'm like, "Who's gonna be on my side? This person runs this clinic!"*

Several participants spoke about how racialized students are treated as expendable, while notoriously racist midwives and practices are protected, platformed, and offered opportunity for career growth within the MEP and in the profession. "Systemic whiteness" essentially refers to how the program is designed by white women and structured around whiteness, with the intention to serve white clients. This is particularly exemplified by the Working Across Differences (WAD) class.

> *I found that WAD taught me [nothing]as an Asian person.…You know, just everything I learned about here in this program was kind of the white woman's midwifery. And I think that's why in my experience, this might not be the same for you guys, in my experience that's why in NC [normal childbearing, a clinical placement] I saw no clients that were not white.*

White Supremacy

This category refers to the ways in which white supremacy manifests in interpersonal interactions, which often shows up as the midwifery community's white members' projecting their insecurities and perceived sense of inherent dominance onto racialized midwifery students. Two participants recounted the following:

> [Participant 1] *Yeah, and we were applying [to the MEP] on our first time, and she–this person that said that to me–was, I guess, disgruntled. It was probably her third or fourth time that she made it in and so she decided that I locked my spot because they were adding Black people.*
> [Participant 2] *So they feel incompetent and insecure and they take that out on you?*
> [Participant 1] *Oh, absolutely.*

Participants described how criticisms and observations about the MEP that challenged white dominance were perceived as a threat, and how white students, preceptors, and faculty respond to the perceived threat by labelling racialized students as unprofessional or aggressive. Being labelled unprofessional served to silence racialized students.

White supremacy also manifested as entitlement over personal and cultural boundaries of racialized students. For example, one participant described witnessing a white student imitating a dance from India as a part of her "diversity" presentation.

"The program did damage they didn't want to recognize"

This category refers to the actions and inactions of white faculty, staff, preceptors, and students that contributed to the lack of safety that racialized students experience. For example, one Black student approached a faculty member for support in regard to discrimination experienced in

placement. Instead of supporting the Black student, the faculty member sided with the preceptor and encouraged the student to pursue career choices outside midwifery, suggesting that the student "should consider something lower, like nursing." This student ended up leaving the program. A different participant shared the experience of not being protected, as follows:

> *I have been told so many times that just because I have melanin, basically I have to do 200% to make it look like 100%. I have to be more proper, I have to take more crap; I have to sit in clinic rooms where my clients are arguing about slavery…and my preceptors did nothing to protect me. We were there, and it's not right [cries].*

Theme 2: Mental Toll

This theme is made up of four categories: stresses of visibility, stress and physical toll, "resilience speaks to exhaustion," and surviving "a sick social experiment." It highlights the outcome of resilience as it affects participants' mental well-being.

Stresses of Visibility

This category refers to the ways in which racialized students' visibility, juxtaposed against the MEP's whiteness, produces many stresses for them. One such stress arises from dealing with being labelled "combative" or "unprofessional" by white peers and faculty if these students speak up after encountering racism in class or in placement. One participant recalled the experience of correcting misinformation and providing important context for a statistic regarding elevated rates of sudden infant death syndrome in Indigenous children as follows: "Just voicing that statistic in completeness makes you an enemy, like 'Oh wow, here she goes again, she wants to correct us.' You're blamed for trying to voice the reality."

Black students were especially villainized for speaking up. Several Black participants described experiencing hostility or bracing themselves for hostility when speaking up.

> *You don't wanna fight them back, because then they will get upset, and then you look like the monster or the "angry Black woman" stereotype.*

Stress and Physical Toll

This category refers to the impact that chronic exposure to the white supremacist culture in the MEP has on racialized students' mental and physical health. This chronic exposure to whiteness is difficult to "switch off."

> *I felt like I couldn't switch off, even during my off-call times. I felt like, for me, that wasn't allowed because for me… switching on would be like turning on [the] white person [version of me], who is able to talk to white people and understand where they're coming from and whatnot. And then switching off is becoming the person that I was raised to be. I can't do that. I find that after being in a situation where knowing that, at any moment, I can be called and I have to switch on to this professional white speaking person, I just…get so little time off as truly myself in this program that it's hard for me to leave work problems at work.*

Some students, particularly those who left the program or profession, described symptoms of posttraumatic stress disorder, anxiety, and depression, which they did not have prior to entering the program. One participant described this as follows:

> *I was still being mistreated, I was still… not encouraged, and [in tears] this was my dream[to be a midwife]! You know, like this is what I had wanted to do, and I've just been made to feel stupid and that I don't belong here… And I… went to faculty, to let them know that I had to leave the program and I had to leave for… I had to say like, mental health family emergency–I wasn't going to say me! They weren't gonna believe that! They're just gonna be like, "Oh yeah, everybody's going through mental health [struggles]"… and they're like, "Oh, maybe you need to see counselling, maybe you need to see someone," like whatever, fine. And I sat with the lady from here, and she said she spoke to many midwifery students who experience the same thing. And I was*

> Some students, particularly those who left the program or profession, described symptoms of posttraumatic stress disorder, anxiety, and depression.

like, "Okay, but…now what do I do? Now I have to recover from this. Now I'm in the state of depression. Now, I'm depressed for months. Now I have anxiety for months. Now I can't sleep. Now all I hear is the beeper. Now I can't have a healthy relationship with my parents, because they think I'm a failure. Now what? Now I'm broken for months and a year until I finally had the courage to go into [another profession].

Though some current and former students viewed graduation as the outcome of "resilience," this was not always the case. Those for whom resilience is indistinguishable from survival, resilience necessarily includes those who left the program or profession. While some students had to temporarily stop pushing by deferring a year to rest and recuperate, other students had to cease pushing entirely by leaving the program. As a former student relayed, "And for me, having been a person who had to leave the program, I had no choice. I had every resilient bone, everything I gave to this program, everything. Everything I gave." This participant's story shows that "pushing through" is how some experience resilience, and ceasing to push is how others reclaim their lives and move on. Regardless of whether resilience meant graduating and practicing or leaving the program or profession, participants described having emerged as different people from the people they were when they entered.

"Resilience speaks to exhaustion"

This category refers to the ways in which racism erodes the mental and emotional health and energy of racialized students. Although it takes immense strength to get through the program, one participant noted, "resilience speaks to strength, but it also speaks to exhaustion." Another participant said, "Our classmates [are] mentally and emotionally exhausted because of all the extra work it takes to exist in the MEP because we're the one [who] have to call people out, we also listen to their [white students'] problems and how hurt they were," to which another participant added, "And soothe them [white students]!"

Surviving a "sick social experiment"

This category refers to how racialized students described being depersonalized and treated as objects of their white counterparts' learning. This was especially evident in the Working Across Differences class, in which racialized students were used as specimens under the microscope of whiteness. One participant said of that class, "It's like a sick social experiment." Another stated the following:

Yeah, I personally feel like the discomfort has to do a lot with also the people of colour that are in the program that are just on display.…And there's so many intersections, so it's kind of like, "Okay, so you want me to talk about my immigrant parents? Okay, now you wanna talk about how I have no money. Now you wanna talk about OSAP [Ontario Student Assistance Program]? Now you wanna talk about sexual violence that has occurred," you know what I mean?

The necessity to be resilient was often described, within the context of the program, as being something that needed to be survived.

Resilience–one, the capacity to recover quickly from difficulties: toughness. Or two, the ability of a substance or object to spring back into shape: elasticity. Based on this I think I have resilience. I don't think I bounced back "quickly," and I may have sprung back into a different shape; but I'm HERE, despite my experiences in the MEP, despite so much. I feel like a

survivor. And like [another participant] said, it wasn't on my own. I have people in my corner who dragged me across the finish line because they knew my dream and wanted to help me realize it.

Theme 3: Active Versus Passive Coping

This theme is made up of three categories: mechanisms of coping, intentional silence, and day-to-day coping. Participants described varying and often intersecting methods used to "survive" the MEP.

Mechanisms of Coping

Participants used a variety of coping mechanisms that are commonly viewed as supporting resilience. They described self-care practices, such as sleeping, eating well, watching movies, going to the gym, and accessing counselling services as being helpful. At the same time, however, self-care was difficult for many people, due to the rigorous aspect of the program, as well as the additional barriers and discrimination that racialized students face. Although participants used these coping mechanisms, they were not sustainable on their own.

Participants described mechanisms for coping that were both active and passive. Sometimes self-protection meant fading into the background to attract less attention, and sometimes self-protection meant taking up space. For example, one former student recalls their experience in the MEP as follows:

When I look back at my experience in the MEP, I can see that I was resilient when I protected myself, whether it be taking time off when I needed it, whether it be standing up for myself, whether it be crying in the corner [laughter] for five minutes, then saying, "Okay, let's keep going."

Thus, resilience was less about active "versus" passive resilience, because most students oscillated between the two. Rarely was passiveness or activeness static. One participant detailed their experience with adjusting their method of self-protection as follows:

I think that the idea of activeness and passiveness is very strong. I think it about specific times for me, specifically in my last year in the MEP, about being mistreated really, not treated well at all. And the majority of that time, I just kind of took it–and that was, you know, to me at the time, I thought I was being weak, I thought I was not protecting myself. But the reason why I took it was because I wanted to get through, I didn't wanna make waves, I didn't want to–I didn't want any destruction. I wanted to let the people who thought they were authority and had head over me to not do anything worse to me, to not take matters further than what they were, so that I can get through. And then at the end, when I realized that power was gonna be what held me back, then I became more active! And I was like, "well, no." And my voice came out.

An Intentional Silence

This category refers to how racialized midwifery students choose to engage or not engage in speaking up or taking action. For instance, the following participant describes the mental process of choosing her battles:

Being patient, having to decide what conversations are worth having and what conversations are not worth having. And choosing where you can make your difference, because you're around, you're gonna be around these people for the next four years, right. So you have to approach things in a certain manner where you can still function and be civil with one another.

Day-to-Day Coping

One the most used mechanisms of day-to-day coping was code switching. Code switching refers to alterations in language, vernacular, mannerisms, and other physical and verbal forms of expression that racialized students take on–or, by way of whiteness, are forced to take on–in order to function in white spaces. Participants described code switching as the "work voice" or "white person voice." For example,

I know when to be the me that my friends

know, that my family knows, that my clients who have Caribbean background knows, and to not. I know that when I'm talking to certain OBs [obstetricians]at the hospital how much I can relax or not. I know how much respect that will or will not gain me.

Who defines professional? That's what I think. Who defines professional? Saying that "to be professional you must sound and look and talk [white], and if you can't look [white], at least sound [white]."

One participant pointed out the flaw in code-switching as the following:

I feel like there's only so much code switching that we can do; when I think back to some of my experiences, there are some people that no matter how much code switching you do, you are still that person of colour that walks in the room.…I'm still trying to present myself as this white whatever notion whatever, and I'm still that Black person in the room.

Theme 4: Individual Versus Collective Resilience

This theme includes four subthemes: collective mindset, resilience as community driven, drawing on internal strength, and surviving together.

Collective Mindset

Also described as a "for us, by us" mentality, collective mindset refers to the commitment that racialized students have not only to their individual success but also to racialized community members in and outside of midwifery. This mentality was the core of many participants' understanding of resilience.

I have a more of a "for us, by us" mentality. It is true that we have to go through this systemic mode of education. Once we get there and we get what we need and what we want, why don't we go back to our community and start our own and support our own and do our own? And this is where I'm saying that yes, a few of us could bite the bullet for the greater good of others, but if we go back and bring it back to our community and empower them to ask for more and to expect more…you know, come to the good people, the right people, and give them what they need. And you know, we could be agents of change in our different [fields]–and this is not just midwifery. This is in commerce, in banking, in social services–in everything. Because right now I feel that we have to save us.

Resilience As Community Driven

Community making is fundamental to many racialized students' experience of resilience in the MEP.

We have to remember that collective aspect of resilience. Things are rarely done alone; we are organizing together, doing research studies, we're thinking about ourselves but also about our peers and those who come after us who…can benefit from the work that we do. That's a big part of resilience…is the collective and community aspect of this kind of work.

The process of forming and nurturing connections within the racialized midwifery community can begin as early as the first day.

Being a part of our cohort, we were lucky enough to have people walking in the first day and being like, "Oh, they are two or three other people" or "there were five people in total" who look different. This is great. You do not even necessarily need to get along with all those people, but knowing that they exist was enough, and then we're lucky enough that we do get along. Because it's not like I see a Black person and I'm like, "we're best friends" automatically [laughter]. You obviously have different personalities, so being lucky enough to actually like those people, it's just an added layer. And I feel like I'm in a really good place compared to any of the other people who've gone through the program feeling that alone. I feel like I have that privilege of having those people who do look similar to me actually being my good friends.

Another way of engaging in community making happens online, whether via communication applications such as WhatsApp, or social media

> One of the most common suggestions for change was to develop a stream within the MEP specifically for Black and other racialized students.

platforms such as Facebook. Participants described using social media to connect across geographical distance, share information and resources, and provide emotional and peer support.

Drawing on Internal Strength

Individual resilience does not necessarily mean a resilience that is isolated from the collective; rather, it refers to how individual experiences inform any particular student's experience of agency and resilience and how that, in turn, is incorporated within the collective experience of resilience.

> *I had a choice, coming from a former career where tokenism was the key, I had a choice when I got into the MEP, I had a choice to either play the game–and I used to play it all the time, and it made me successful in my career–or just decide to be myself. And I hit forty and there was no way I was going to be somebody else again. I want to be me for a change. In the MEP my refusal to be tokenized has related, that's for sure, but also I feel much more at peace with myself, and once you see things for [what] they are, you cannot un-see them. And you cannot deny yourself anymore. In this light, I've also decided…I was willing to make sacrifices so that I only work with the people I want to work with. You know, like not being in an all-white clinic anymore [sighs]–I want to be myself and not be a number or a token or check mark or a convenience for someone. I'm done with that.*

Surviving Together

This category refers to the solidarity and mutual support within the racialized midwifery community. However, as participants point out, solidarity is complicated. In response to the question, "What does solidarity amongst racialized folk look like?" a participant said the following:

> *I don't even know if I have an answer or just what the problem is with that, because we have been divided, right? Through centuries and generations of colonization and etcetera, we have been divided to not have solidarity, right? To not bond with each other, to not trust each other in certain areas, and so in this realm of to break down systemic foundational issues that are affecting us negatively and affect our careers and affect our peers and our futures, for us to have solidarity, that means that we have to agree to kick against that wall and to kick against that, I don't know, again, that foundation. Like how do we have solidarity when we've been trained to not trust each other? We've been trained that what our ideas are can't be right, so therefore if one of us comes up with a good idea of how to break down that system–I feel like we would have to retrain our brains to have solidarity and just agree to trust each other. Agree [to] try our ideas. Agree to show up for stuff. Agree that we're worth it.*

Therefore, solidarity is not an inherent state of support within racialized communities; rather, it is an ongoing commitment and dedication to showing up for one another.

Theme 5: Agency

This theme is made up of three subthemes: agents of change, self-determination and drive, and imagining racialized midwifery futures.

Agents of Change

This category refers to the ways in which current and former students expressed shared motivation to create change in the MEP.

> *When I was in the program, a lot of the experiences that I had I didn't realize*

that they were related to…let's say, being a racialized midwife or a midwifery student at the time. And now that I'm a practicing midwife, I find that…some of the same things, just not in a student aspect, are coming around again, and I'm finding that a lot of my colleagues and/ or students that were either in the year below me or still currently in the program are experiencing similar things as I was, and I find that pretty problematic that there hasn't been much of a change. So I'm here to hopefully share my experience and be a part of a larger something that's moving towards creating a safer space for midwives of colour.

Self-Determination and Drive

This category refers to the racialized midwifery community's capacity to identify problems, challenge the status quo, suggest solutions, and determine courses of action.

It was more me…not accepting everything that was told to me, 'cause it didn't resonate with me.…So especially I found some of the readings in some of the classes, I just–in my reflections that I would have to hand in I would express that it didn't make any sense to me. What I was able to… not rebel but…to show my resilience by not accepting something just because somebody wrote it.…I realized that maybe that was my way of being resilient.

One of the most common suggestions for change was to develop a stream within the MEP specifically for Black and other racialized students.

"Even with what [other participant] is saying [about having a seat at the table]… we would still be the token on the panel. The only way I can see it is…a midwifery program for just POC."
[Facilitator] *"What would a BPOC stream look like?"*
"By and for BPOC people!"

Another key suggestion for change was the development and implementation of a zero-tolerance policy.

I think there just needs to be a zero tolerance. They kind of say it in the MMI [Multiple Mini Interview]…"how do you deal with bullying?" or online bullying or whatever. And, of course, everyone's gonna give the answer, "oh, you shouldn't bully people," but I think, I think there needs to be something more on race, and they need to ask. Because everyone has dealt with things that are offensive that, I would say, people can be kicked out of the program for and say "we don't tolerate this here."

Other suggestions for support and change included hiring a racialized person to teach the Working Across Difference class; having a BPOC-designated placement lottery system (i.e., pairing racialized students with racialized preceptors); opening up the catchment areas for racialized students; having a designated racialized person within the program faculty or staff to support racialized students; financial support for BIPOC student groups at each site; diversifying the student body, faculty, and staff; and cultural safety training for white students, faculty, and staff. Participants emphasized that these changes and supports are just steps to a larger goal of undoing over two decades of white supremacy in midwifery.

Diversifying the cohort and the faculty are necessary changes to be made, but I don't think they're changes that should be made as the solution, do you know what I mean? I think they are shortcomings that need to be fixed. They're not "above and beyond"…it's the bare minimum that needs to be met.…They shouldn't just make those changes and go, "Oh, look at us, we're diverse and we're done!"

Participants agreed that while midwifery is being made more diverse, the profession should work simultaneously to ensure that its racialized members are supported and set up for success.

Imagining Racialized Midwifery Futures

A racialized midwifery future–one in which racialized clients have access to an abundance

of racialized midwives–was the driving force behind many participants' understanding of resilience. Imagining a racialized midwifery future is indistinguishable from imagining racial-reproductive justice. Many former students participating in the study said that even though it may be too late for them to personally reap the benefits of change within the MEP, they want to be a part of changing the circumstances for future students.

> *"[…]identifying what are the barriers and supporting each other throughout the program and encouraging others to join and make it possible for them to join and finish it its valuable for each of our communities"*

DISCUSSION

Our research aimed to centre the experiential knowledge, expertise, and stories of racialized midwifery students, which scholars engaging in critical race theory describe as necessary in dismantling hegemonic forces in academia.[12,38] Our work expands and challenges notions of resilience within midwifery. Our findings describe the unique stresses and toll on mental health that racism creates for racialized midwifery students and reveals how white supremacy adds to the already notable challenges of being a midwifery student and how it shapes experiences of resilience. Further, our work supports a critique of the individual focus of the concept of resilience and points to how an overemphasis on individual characteristics that support "surviving" can be a dangerous way of absolving the MEP of responsibility of addressing systemic racism.

Our participants' descriptions of the ways in which they demonstrate resilience align with previous research about experiences of coping with racism. For instance, Joseph and Kuo described an ebb and flow between passive and active modes of coping based on context and classification of discrimination (i.e., systemic versus interpersonal).[39] There seems to be a stronger preference for passive coping skills for interpersonal discrimination and for active coping skills for systemic or institutional discrimination.[39,40] Passive coping trends towards dealing with day-to-day interactions and energy preservation, using strategies such as avoidance (choosing your battles) and withdrawal (silence).[12] Whereas McGee and Stovall argue that active coping methods (i.e., confronting racism) alleviate more stress than passive methods, we found that passiveness and activeness work synergistically to promote personal and professional longevity. Several studies echo our findings that racialized peer support, community support, and a sense of responsibility to serve racialized communities were integral to the experience of coping with resilience.[12,15,41,42] Emphasis on collectivity, a sense of community, and a strong understanding of race and racial identity have been shown to have a positive impact on the mental health of racialized people and to offset the anxiety and depression associated with discrimination.[12,15,43]

Our finding that white supremacy plays a predominant role in shaping the experiences of racialized midwifery students aligns with previous research. From white-centredness in classes such as Working Across Differences, to white maintenance of the status quo via gatekeeping of all channels leading to and within midwifery, white supremacy is the backbone of the Ontario MEP.[13–15,44] Aseffa and colleagues' study on racism in Ontario midwifery, as well as Husbands's study on the experiences of racialized students in the Ryerson MEP, documented similar experiences of racism and white-centeredness in MEP classrooms and placements.[14,15] Both Husbands and Nestel (whose work explores the pre-legislation and early legislation days of midwifery in Ontario) found that criticisms and observations that challenged white dominance were perceived as threats.[13,14] For instance, in the movement to legislate midwifery in Ontario, race and racialized midwives were treated as a threat to the unified front that white midwives had to show in the face of resistance from the medical community. As one white midwife stated, "There were these other forces that were too powerful, that were gonna get us if we weren't careful, if we didn't show solidarity and unity amongst ourselves."[13,42] This display of whiteness is representative of the centuries-old solidarity amongst white women that produced the white supremacist culture within the MEP that was described by participants in this study.

> Any meaningful solution to the attrition of racialized midwifery students and midwives must address systemic racism.

Our participants' observations about how the enforcement of "professionalism" was made to be exclusionary is congruent with the work of Bailey, who coined the term "misogynoir" (i.e., anti-Black misogyny), which explains how perceived "aggressiveness" is largely dictated by gendered anti-Blackness.[45] The exclusionary property of misogynoir is corroborated in Aseffa and colleagues' study, which highlights how negative perceptions of Black women affected a Black midwife's decision not to seek a leadership role.[15]

For many of our participants, resilience and coping were heavily based in varying modes of self-protection, one of the most common of which was code switching. Though code switching can be a useful tool for navigating white spaces, the unspoken pressure on racialized students to adopt a "white person voice"—as enforced by coded professionalism rules—has been shown to erase racialized students by rendering any markers of their humanity barren.[13,23] Given the white-supremacist roots and functions of professionalism, it cannot be argued that code switching is merely part of the necessary transition from student to professional.[23,46,47]

The common thread throughout the focus groups was the overemphasis on individualism in the MEP, which is a reflection of the neoliberal white feminist paradigm from which the MEP operates.[13,48,49] This individualistic perspective of resilience, forged and enforced through whiteness, creates pressure for racialized students to display individual resilience in response to institutionalized issues, thus absolving the MEP from the racism interwoven in its fabric while simultaneously failing to account for the impact of racism on student success. These critiques resonate with the work of McGee and Stovall, who challenge the expectation of "grit" from racialized students in academia. As they explain, this perspective "often leaves it up to individuals to rise above their challenges and roadblocks without recognizing the stress and strain associated with surviving [and even thriving] academically despite encounters with racism."[12] Therefore, though it is important to have an arsenal of self-care strategies, it is a disservice to racialized midwifery students to place the onus on them to engage in self-care without changing the racist and material conditions that cause them harm.[12] Our findings indicate that any meaningful solution to the attrition of racialized midwifery students and midwives must address systemic racism. As Aseffa et al. asserted, addressing racism in the MEP requires disrupting the systems upheld by white supremacy that exclude students who are racialized, deny their reality, and render them expendable.[15]

LIMITATIONS AND IMPLICATIONS

Our study is shaped by the worldview and lens of the research team: the primary investigator (Shamkhi), who is a refugee from the Shia-Muslim Iraqi diaspora; the co-investigator (Salanga), who is a first-generation Indo-Caribbean-Canadian; and the senior investigator (Darling), who is a first-generation white Canadian with parents of British and Scottish origin. We have reflected critically on our own social locations throughout the research process and have worked to remain true to the voices of our participants and to include perspectives that differ from our own. We acknowledge that our study is missing the varying and necessary perspectives of Indigenous current and former students and that any deeper exploration of the particular nuances of anti-Black and anti-Indigenous racism in the MEP must be led by Black scholars and Indigenous scholars.

Qualitative research of this nature sometimes draws concerns that its participation may be skewed towards people who have stronger views or more

Table 3. Summary of Participants' Recommendations

1. Develop a BPOC stream within the MEP that includes BPOC-designated placement lottery systems (i.e., pairing racialized students with racialized preceptors) that are not limited by site-specific catchment areas.
2. Implement a zero-tolerance-for-racism policy with the support and guidance of a racialized equity expert in consultation with racialized midwifery students and midwives under which offending parties may be expelled.
3. Hire a racialized person to teach "Working Across Difference," the first-year course that addresses social determinants of health.4.Hire a racialized equity expert within the program (faculty or staff) to support racialized students.
5. Provide financial support for racializedstudent groups at each site.
6. Diversify the student body, faculty and staff while simultaneously ensuring that racialized students and faculty are supported within the program.

BPOC, Black and people of colour; MEP, Midwifery Education Program

extreme experiences related to the research topic. The strong alignment of our identified themes (across all our participants and focus groups) with previous research on this topic make it unlikely that our findings represent only the experiences of a minority of racialized MEP students. Furthermore, even if our participants do represent those on whom racism within the MEP has had the most impact, these perspectives are the most important voices to hear if we genuinely want to build and support a more diverse midwifery workforce.

This study supports a paradigmatic shift, from supporting individual resilience to dismantling the fabric of institutionalized racism that necessitates resilience. Table 3 summarizes the recommendations for institutional-level change within the MEP as identified by our participants.

Our research also points to important areas for future research, including (1) exploring the diversity in experience, world view, and perspective among current and former Black, Indigenous, and racialized midwifery community members; (2) more deeply examining inter- and intracommunity solidarity, meaningful relationship building, and praxis; and (3) evaluating the impact of institutional changes within the MEP to counter systemic racism.

CONCLUSION

Racialized midwifery students' experiences of resilience are as much a celebration of longevity and capacity as they are an indictment of systemic racism in the MEP. However, our findings show that conversations about retention and diversification of the midwifery profession must move beyond a focus on individual resilience.

ACKNOWLEDGEMENTS

Thank you first and foremost to the participants for trusting us with your stories, and the racialized midwifery community for the constant love, support and motivation. I am endlessly grateful to be in community with you, extending to and beyond the midwifery world, and I am honoured to have witnessed to and documented our stories. Thank you to Priya Thomas, Gachi Issa, and Ayan Ali for helping me organize my thoughts to make this project possible. Thank you Claire for the countless hours you spend with me discussing our approach, then collecting, reviewing and analyzing the data–and the hours you spent grounding this project, debriefing at each step, and keeping me focused. And last but not least thank you Dr. Liz Darling for your supervision, this project would not have been possible with your continued guidance, support and resources.

REFERENCES

1. Wilson R, Eva K, Lobb DK. Student attrition in the Ontario midwifery education programme. Midwifery. 2013 Jun 1;29(6):579-84.
2. Wilson R, Neiterman E, Lobb DK. Student attrition in the Ontario Midwifery Education Student attrition in the Ontario Midwifery Education Program: a qualitative analysis–I. personal issues. Can J Midwifery Res Pract. 2013;12.
3. Cameron C. Becoming and being a midwife: a theoretical analysis of why midwives leave the profession [peer reviewed article]. Can J Midwifery Res Pract. 2011;10(2):22.
4. Versaevel N. Why do midwives stay? A descriptive study of retention in Ontario midwives [peer reviewed article]. Can J Midwifery Res Pract. 2011;10(2):29.
5. Hunter B, Warren L. Midwives' experiences of workplace resilience. Midwifery. 2014 Aug 1;30(8):926-34.
6. Clohessy N, McKellar L, Fleet J. Bounce back-bounce forward: midwifery students experience of resilience. Nurse Educ Pract. 2019 Apr 17.
7. Crowther S, Hunter B, McAra-Couper J, Warren L, Gilkison A, Hunter M, et al. Sustainability and resilience in midwifery: a discussion paper. Midwifery. 2016 Sep 1;40:40-8.
8. Hogan R, Orr F, Cummins A. Sustaining 'super' midwives: building resilience in midwifery students. Women Birth. 2015 Jan 1;28:S18.
9. McGowan JE, Murray K. Exploring resilience in nursing and midwifery students: a literature review. J Adv Nurs. 2016 Oct;72(10):2272-83.
10. Dawley K, Walsh LV. Creating a more diverse midwifery workforce in the United States: a historical reflection. J Midwifery Womens Health. 2016 Sep;61(5):578-85.
11. Geronimus AT, Hicken M, Keene D, Bound J. "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. Am J Public Health. 2006 May;96(5):826-33.
12. McGee EO, Stovall D. Reimagining critical race theory in education: mental health, healing, and the pathway to liberatory praxis. Educ Theory. 2015 Oct;65(5):491-511.
13. Nestel S. Obstructed labour: race and gender in the re-emergence of midwifery. Vancouver: UBC Press; 2011
14. Husbands K. Educating across difference: exploring race and representation in the Ryerson midwifery education program through the experiences of black and people of colour students and graduates. Toronto: RBC Immigrant, Diversity and Inclusion Project; 2017.
15. Aseffa F, Mehari L, Gure F, Wylie L. Racism in Ontario midwifery: BIPOC midwives and midwifery students unsilenced. Can J Midwifery Res Pract. 2021;20(2).
16. Ackerman-Barger K, Hummel F. Critical race theory as a lens for exploring inclusion and equity in nursing education. J Theory Constr Test [Internet]. 2015 Fall/ Winter [cited 2019 May 15];19(2):39-46. Available from: http://search.ebscohost.com/login.aspx?direct=true&db=asx&AN=110850781&site=eds-live&scope=site
17. Orom H, Semalulu T, Underwood III W. The social and learning environments experienced by underrepresented minority medical students: a narrative review. Acad Med. 2013 Nov 1;88(11):1765-77.
18. Loftin C, Newman SD, Dumas BP, Gilden G, Bond ML. Perceived barriers to success for minority nursing students: an integrative review. ISRN Nurs. 2012 May 30;2012.
19. McDonald C, McIntyre M. Realities of Canadian nursing: professional, practice, and power issues. Philadelphia: Lippincott Williams & Wilkins; 2017.
20. Graham CL, Phillips SM, Newman SD, Atz TW. Baccalaureate minority nursing students perceived barriers and facilitators to clinical education practices: an integrative review. Nurs Educ Perspects. 2016 May 1;37(3):130-7.
21. Wren Serbin J, Donnelly E. The impact of racism and midwifery's lack of racial diversity: a literature review. J Midwifery Womens Health. 2016 Nov;61(6):694-706.
22. Valentin'Welch M. Evaluation of a national e'mentoring program for ethnically diverse student nurse'midwives and student midwives. J Midwifery Womens Health. 2016 Nov;61(6):759-67.
23. Goode KL. Birthing, blackness, and the body: black midwives and experiential continuities of institutional racism. New York: City University of New York; 2014.
24. Yamasaki McLaughlin E. Increasing the racial and ethnic diversity of direct-entry midwives: exploratory interviews with black midwives and educators. [Masters thesis]. Kenmore (Washington, USA)]: Bastyr University; 2012.
25. Association of Ontario Midwives. BIPOC mentorship program [Internet]. 2019 [cited Mar 1 2019]. Available from: https://www.ontariomidwives.ca/racialized
26. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999 May 10;159(9):997-1004.
27. Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. Journal Racial Ethn Health Disparities. 2018 Feb 1;5(1):117-40.
28. Street RL, O'Malley KJ, Cooper LA, Haidet P. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med. 2008 May 1;6(3):198-205.
29. LaVeist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav. 2002 Sep 1:296-306.
30. Lambert VA, Lambert CE. Qualitative descriptive research: an acceptable design. Pac Rim Int J Nurs Res Thail. 2012;16(4):255-6.
31. Milner R. Race, culture, and researcher positionality: working through dangers seen, unseen, and unforeseen. Educ Res. 2007 Oct;36(7):388-400.
32. Ermine W, Sinclair R, Jeffery B. The ethics of research involving Indigenous peoples. Saskatoon: Indigenous Peoples' Health Research Centre; 2004 July:1-272. Available from: http://iphrc.ca/pub/documents/ethics_review_iphrc.pdf
33. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006 Jan 1;3(2):77-101.
34. Haberman M. Urban schools-day camps or custodial

centers?. Phi Delta Kappan. 2000 Nov 1;82(3):203.
35. Ladson-Billings G. Racialized discourses and ethnic epistemologies. Handbook Qual Res. 2000 Mar 18;2:257-77.
36. Stanley CA. When counter narratives meet master narratives in the journal editorial-review process. Educ Res. 2007 Jan;36(1):14-24.
37. Gentles SJ, Jack SM, Nicholas DB, McKibbon K. Critical approach to reflexivity in grounded theory. Qual Rep. 2014;19(44):1-4.
38. Allen M. The relevance of critical race theory: impact on students of color. Urban Educ Res Policy Annu. 2017;5(1).
39. Joseph J, Kuo BC. Black Canadians' coping responses to racial discrimination. J Black Psychol. 2009 Feb;35(1):78-101.
40. Utsey SO, Ponterotto JG, Reynolds AL, Cancelli AA. Racial discrimination, coping, life satisfaction, and self′esteem among African Americans. J Couns Dev. 2000 Jan;78(1):72-80.
41. Shavers VL, Bakos A, Sheppard VB. Race, ethnicity, and pain among the US adult population. J Health Care Poor Underserved. 2010;21(1):177-220.
42. Greer TM. Coping strategies as moderators of the relation between individual race-related stress and mental health symptoms for African American women. Psychol Women Q. 2011 Jun;35(2):215-26.
43. Pascoe EA, Smart Richman L. Perceived discrimination and health: a meta-analytic review. Psychol Bull. 2009 Jul;135(4):531.
44. Young J. Nineteenth-century nurses and midwives in three Canadian cities, 1861–1891. Can Bul Med Hist. 2013 Apr;30(1):189-208.
45. Bailey M. They aren't talking about me…. Crunk Feminist Collective. 2010 Mar 14;14.Marom L. Under the cloak of professionalism: covert racism in teacher education. Race Ethn Educ. 2019 May 4;22(3):319-37.
46. Allemang EM. Alegal midwives: oral history narratives of Ontario pre-legislation midwives [masters thesis]. Toronto: Ontario Institute for Studies in Education; 2013.
47. Moon DG, Holling MA. "White supremacy in heels": (white) feminism, white supremacy, and discursive violence. Commun Crit Cult Stud. 2020 Apr 2;17(2):253-60.
48. Gill R, Donaghue N. Resilience, apps and reluctant individualism: technologies of self in the neoliberal academy. Womens Stud Int Forum. 2016;54:91-9.

AUTHOR BIOGRAPHIES

Touka Shamkhi is currently finishing her Bachelor of Health Science in midwifery at McMaster University. Upon graduation she hopes to continue promoting equity in midwifery education, the midwifery workforce, and access to midwifery services.

Claire Ramlogan-Salanga is a Registered Midwife and the Chair of the Council at the College of Midwives of Ontario and a sessional instructor in the Midwifery Education Program at McMaster University. She has a Bachelor of Commerce degree (Ryerson) and a Bachelor of Health Science in Midwifery degree (Ryerson). She is currently in the Master of Science in Health Education program at McMaster. Her research focuses on social justice curriculum development, intersectional approached to research design and equitable access to midwifery services.

Dr. Liz Darling is a Registered Midwife and the Assistant Dean of Midwifery at McMaster University. She has a Masters degree in Health Research Methodology (McMaster) and a PhD in Population Health (Ottawa). Her research focuses on maternal-newborn health services, with particular areas of interest including midwifery services, health disparities, access to care, health policy, and perinatal health surveillance.