Student commentary.

Birth Where the Heart Is: Reflections on Broadening My Midwifery Learning in the Country I Call “Home”

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"In my split Grenada-Canada existence, I feel that this metaphorical third space is the one place I have always truly belonged to."

But underneath it all as I was growing up, home was still a sweet place somewhere else which they had not yet managed to capture yet on paper, nor to throttle and bind up between the pages of a schoolbook. It was our own, my truly private paradise of blugoe and breadfruit hanging from the trees, of nutmeg and lime and sapadilla, of tonka beans and red and yellow Paradise Plums.

Audre Lorde, Zami: *A New Spelling of My Name*[1]

I am a Canadian-born midwifery graduate of West Indian descent, lucky to have grown up both in Ontario, where I currently reside, and in Grenada, the place of my roots and the home of my heart. My identifying of myself as West Indian must invariably be followed by qualifiers. My Canadian accent signals that I am an imposter, and my mixed-race ancestry is masked by my desert-sand complexion and grey-blue eyes. Inevitably I find myself explaining that I completed primary and secondary school in Grenada but was born in Canada, to Grenadian parents. Yes, both parents. Yes, both were born in Grenada, as were my grandparents, great-grandparents, and most of my great-great grandparents; yes, both are fair-skinned like me and of mixed descent (Grenadians do come in a variety of shades); and yes, they still live in Grenada. I visit them as often as I am able–which is never frequently enough.

Where I live, confusion about my identity is not unique. More than one in four residents of Ontario were born outside of Canada, and in Toronto–where I reside–about 50% of the population is foreign born.[2] The offspring of these immigrants make up a further 22.5% of Ontario's population.[3] This ambiguous nationhood is central to the formation of second-generation identity. Migrants and their offspring are entrenched in a network of relationships that link birthplace, ancestral homeland, and the diaspora, to create a "third space" in which second- generation migrants are able to develop perceptions of identity, home, and belonging.[4] In my split Grenada-Canada existence, I feel that this metaphorical third space is the one place I have always truly belonged to.

The development of regulated midwifery practice in Ontario was in part a response to the need to increase access to care for the province's diverse population.[5] The profession's history is deeply steeped in social justice galvanized by a pursuit of equity, accessibility, and choice. The Ontario Midwifery Program (OMEP) developed a curriculum which includes cultural competence and humility to ensure care across the spectrum of social differences.[6] Midwives identify diversity as a significant aspect of their clinical practice and strive to provide client-centred care with a constantly evolving recognition of the wide range of cultures, needs, and values of the clients they serve.[6,7] It would seem to follow, then, that the population's diversity would be reflected within the midwifery profession; indeed, recruiting midwives of diverse backgrounds has been acknowledged as one way to embrace diversity within midwifery practice.7 Yet, entry into the midwifery profession was and continues to be weighted in favour of Canadian-educated white women.[8] In 2004, Sheryl Nestel wrote:

> Received notions of 'immigrant women'; the devaluing of non-European experience, credentials, and training; adherence to forms of feminist organizing that privilege the political skills and interests of white women; and acts of 'everyday racism'... have converged to create a predominantly white midwifery profession in a geographic space whose multiracial character is one of its most frequently invoked social signifiers.[8]

My self-identification as a West Indian and as a midwife of colour, then, is not insignificant.

I have grappled with my own identity confusion for as long as I can remember, and I imagine it will be ongoing throughout my midwifery career and beyond. My self-identification is relevant to the context in which I am pursuing this career and to my decision in January 2016 to embark on a 4-week international placement at St. George's General Hospital in Grenada as part of my formal, Ontario-based midwifery training. The learning

opportunities during this placement soared far beyond the clinical experience I had been hoping for.

Everybody in Grenada had a song for everything.[1]

At one point on my first day on the unit, I found myself alone in the labour room with a woman who at her previous check had been 5 centimetres dilated, in very active labour at term in her first pregnancy. I had scarcely introduced myself as a "midwifery student from Canada" before she announced (to the vacant beds beside her more than to me), "Ah want to mess." She closed her eyes, her voice low. "Oh lawd, ah want to mess. Ah want to meeeeeeesssss." I helped her climb back onto the bed and asked if she would be comfortable with the nurse-midwife coming back to assess her progress. The baby, I knew, was coming. In that moment, I was grateful that I was fluent in the local dialect. To "mess," in Grenadian vernacular, means to defecate. This woman was feeling the urge to push, and I was relieved that I did not miss a universal signal that transcends language and culture and that I did not have to ask a woman in transition for clarification on my first day on the job. There was little time for self-approbation, because in the next moment, it was transfer to the delivery room, my gloves on, the vertex crowning, and then—so quickly, so magically—a Grenadian baby was in my hands.

In health care, language matters. Communicating with clarity and precision is important not only for safety and efficiency but also for the client's experience. In pregnancy care, shared language between the care providers and the client is associated with an increased likelihood of establishing a connection and making the client feel comfortable asking questions and disclosing pertinent information.[9] The Ontario Midwifery Equity Committee established this during midwifery integration in the province through consultations with various groups whose members told the committee "rover and over again that language was the most important issue for many of them and that many would choose a caregiver who spoke their language over one who provides their preferred style of care."[6] In Grenada, the official language is English, so deficiencies in the vernacular would not have resulted in a complete breakdown in verbal communication for an English-speaking student. Yet there was an undeniable advantage to being familiar with local expressions and accents, and I found myself tapping into it every day of my placement.

Countless more times in the weeks that followed, I heard people in labour exclaim that they wanted to "mess," and I came to count on this as the herald of the second stage. I never used the expression myself, though; the phrase is common but is crude and unnatural when said with my Canadian accent. Instead, I asked the people I attended (as I asked those I attended in Canada) whether they needed to have a bowel movement. This distinguished me from the Grenadian staff, doctors and nurses alike, who without hesitation or awkwardness spoke the vernacular of the people they serve and then documented these exchanges in the "Queen's English."

My ability to understand and communicate effectively while being neither comfortable with nor welcome to participate in the local way of speaking marked me as both an insider and an outsider. It benefited me not to have to ask labouring people and fellow care providers to repeat or explain themselves. I imagine that for that reason my presence was felt as less imposing and burdensome. At the same time, the island's history of colonialism and the ubiquitous presence of St. George's University (the location of the American medical school on the island) made me especially self-conscious about my outsider status.

Once home was a far way off, a place I had never been to but knew well out of my mother's mouth.[1]

I was careful to identify myself as a visiting student midwife who was training in Canada. In a colonial setting, identifying oneself as such holds both positive (foreigner as expert) and negative (foreigner as intruder) implications, both of which made me uncomfortable.[10] The former was evidenced by my having to repeatedly correct staff and patients who continued to call me "doctor" even after I repeatedly stated my credentials. The latter, on the other hand, was only just discernable

through the subtle narrowing of eyes, the shutting down of facial expressions, and a retracting body language at almost every first encounter. I was certain I wasn't imagining it.

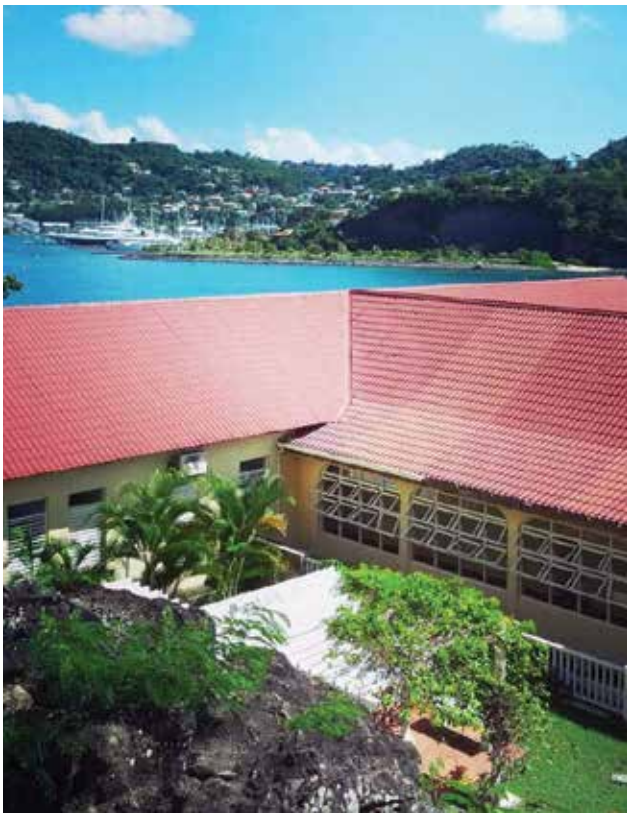
My confidence was bolstered, then, every time I was introduced to someone who recognized my family name as Grenadian. It worked to my advantage that at St. George's Hospital, staff are referred to by last name alone. On introduction, patients would frequently express surprise that my name was Grenadian, and I relished the opportunity to explain that yes, I am born to Grenadian parents (yes, both parents) and that I am an alumna of Westmorland Secondary School in St. George's. Sharing this information often brought perceptible relief to both myself and the patients, who instantly relaxed and became chattier with their foreign-accented student midwife. On occasion, during longer and slower labours or during rounds on the maternity ward, my revelation led to the retracing of family lines and to discoveries of mutual friendships or even kinships. On an island with a population of just over 100,000, one typically need only scratch the surface to find no more than a few degrees of separation.

My familial ties to Grenada and my time living there afforded me a certain amount of cultural capital. For example, one needs to know not only how to speak the local language (in this case, English) but also how to use it appropriately and in context–which would require an understanding of the Grenadian vernacular). In placement settings, cultural capital "may include such things as the ability to abide by unwritten workplace conventions, dress appropriately for the workplace, ask meaningful questions and engage in tearoom banter. Cultural capital can be accumulated over time, but because it operates at the 'taken-for-granted' level its acquisition is not necessarily straightforward or easy."[11]

The possession of cultural capital in an international placement can enrich the placement experience and enhance one's ability to meet the needs of clients there. I depended on it to help me develop professional and clinical relationships, navigate instances of patient advocacy, and provide culture- and resource-appropriate clinical care. As Audre Lorde wrote, "I thought, this is the country of my foremothers, my forebearing mothers, those Black island women who defined themselves by what they did."[1]

When my midwife supervisor walked out of the delivery room after the first birth I attended in Grenada, she clasped my shoulder and said, "Congratulations. You just delivered your first Grenadian." I beamed, my cheeks flushing with the magnitude of this privilege.

At every birth in the days and weeks that followed, I continued to marvel at my hands being the first hands to welcome new life and citizenship in this beautiful country. There was a transcendent quality to participating in and bearing witness to childbirth in the land where my grandmothers and great-grandmothers bore their own children, at the same hospital where my maternal grandmother, pregnant with her seventh baby, died from pre-eclampsia. Given the dangers of "voluntourism" inherent in all international placements, it is with humility that I have reflected on the valuable opportunities for learning that are afforded in a



low-resourced healthcare setting. I learned a great deal about resourcefulness and efficiency; about ensuring that every nonsterile step is complete and that everything you will need is ready before donning your sterile gloves (wasting a second pair would be unacceptable); and about managing care so that the one working blood pressure cuff in the unit can make it through the morning rounds in the ward and back to the labour room between the required assessments. I could write about the management of basic universal precautions in this context, or the nuanced meaning of the word "disposable," or the improvised use of items such as hospital gowns and sanitary pads with other supplies on hand when the items you want are in short supply. These experiences have elevated my appreciation for the abundance of resources and privileges available in Canada and have given me an understanding of the bare essentials needed for childbirth in unanticipated situations; I have no doubt that I will be in some capacity a better clinician because of them.

However, from my perspective, my greatest personal growth and learning developed from an increased awareness of and familiarity with birth in the context of my heritage and from the emotional impact of having such a heritage. In this placement, I witnessed Grenadian women become mothers for the first time (or sometimes the fifth time) and mirrored the congratulatory smiles that greeted them as I wheeled them from the delivery room back to the ward. I supported breastfeeding—with hands, words, gestures, and advocacy—and stood amidst circles of nursing mothers while they exchanged food recipes they knew to facilitate milk production. I helped new mothers give their babies their first baths, and I heard them express their anticipation of going home, where hot water comes from a kettle and their own mothers or aunts are waiting to share a bedroom and infant care. I groaned and rocked and roared with people in transition, because here there were no analgesics, no birth tubs or private showers, no music or heat packs or essential oils, and absolutely no space for a support person in the labour room. In this placement, I witnessed triumph, heartbreak, sisterhood, strength, resilience, and the beginning of new life on the island.

I aspired to make myself useful and to have a positive impact, however small, on the individuals with whom I came into contact. Yet I was acutely aware of how inconsequential my presence was, how the hospital would be staffed the same on that shift whether I was there or not, how soon I would be gone, and how births would continue in my absence. My time in Grenada was brief, but the value of the experience was its ability to disrupt my identity confusion.

> The other side of this argument must be understood to truly comprehend the dilemma that second-generation Canadians face. They may not always admit that they are Canadian, but in their parents' place of origin, they are not who they believe themselves to be.... What you identify as your home, and your identity, is a figment of your imagination. Bits and pieces of your parents' and family's history have influenced you, but it is not your history. [C. Stuart Taylor, *Marginalizing Identity: The I and the Other of a Second-Generation Canadian*].[12]

The four weeks I spent working with Grenadian midwives is now a part of my own history, affording me a sliver of material understanding, beyond my own imagination, of what it is to be a Grenadian midwife. This, layered with my cultural and ethnic background, is significant in legitimizing my claim to becoming a West Indian–identified midwife in Canada.

C. Stuart Taylor wrote, "We carry our traditions with us....Recreating in words the women who helped give me substance."1This sense of legitimacy matters a lot to me. Midwives of West Indian descent are a minority in Canada, and I feel that it is important—politically—to add to the representation of this marginalized group in professional spheres. The presence and participation of people of colour in professional midwifery groups are crucial for disrupting the white-dominated social geography of the midwifery profession.[8]

Apart from strengthening and diversifying the midwifery profession, West Indian representation among clinicians facilitates and caters to diversity among clients and potential clients of midwifery. Attending birth in Granada has given me a deeper

appreciation and understanding of what clients from similar backgrounds may expect when coming into care. The style of care I observed in Grenada was not unfamiliar to me; the typical caregiver-client relationship, though difficult to articulate, was reminiscent of relationships I have had with West Indian health professionals, teachers, and other care providers in my youth in Grenada. It stands in sharp contrast to the styles of care, communication, and relationships that I am now accustomed to in my metropolitan Canadian life. I was not shocked or surprised but was rather struck by my awareness that the interactions I witnessed would be perceived very differently by less familiar observers. As stated by Josephine Etowa in *Becoming a Mother: the Meaning of Childbirth for African-Canadian Women*:

> *As a cultural phenomenon, human childbirth is a unique process involving highly systematized patterns of care and diverse perspectives so that members of one culture might not recognize care in another culture as care. Thus, if one cultural group confronts the practices of another, they may be left wondering how women even survive the childbirth process. Culture not only specifies the perinatal care available to the perinatal family, but it also socializes and educates thereby eliciting the desire for a particular style of care.*[13]

As the midwifery profession grows across Canada, it may become easier to match clients' desires for particular styles of care with midwives who can provide them. Midwives who not only identify as belonging to a specific culture but are also familiar with that culture's pattern of care in pregnancy, during birth, and post partum can be assets to the care of members of that cultural community.

Midwifery students bring a diversity of cultures, ethnicities, racial identities, nationalities, educational backgrounds, socio-economic statuses, abilities, sexual orientations, gender identities, religions, family structures, experiences, and ways of knowing. We will all develop our own midwifery identities that are uniquely shaped by the histories we carry with us and the communities we belong to. My placement experience led me to wonder what it would be like if more students who identify with a particular culture or nationality could experience births in the place of their roots. The 4 weeks I spent in Grenada's main hospital will have a significant impact on my identity as a West Indian midwife in Canada, and I encourage midwifery students to consider pursuing a similar opportunity for themselves.

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