Midwifery Care
for Immigrant and Refugee Women in Ontario

Prepared by the Equity Committee of the Interim Regulatory Council on Midwifery

Le Conseil intérimaire sur la réglementation de la profession de sage-femme est un groupe mandaté par le gouvernement de l'Ontario depuis 1989 pour réglementer la profession de sage-femme. Dans ce rapport, l'auteure documente les recherches sur les méthodes d'accouchement des femmes immigrantes et réfugiées ainsi que l'accès qu'elles ont aux services de sages-femmes en Ontario.

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Between 1989 and 1992, the Equity Committee of the Interim Regulatory Council on Midwifery (IRCM) met with immigrant women in different cities in Ontario to talk with them about their experiences with childbirth in their home countries and since coming to Canada. The Interim Regulatory Council was the organization set up by the provincial government to prepare the way for the eventual regulation of midwifery in Ontario. The Equity Committee was originally created to ensure equal access to midwifery services by all women in Ontario and to heighten cultural sensitivity amongst practicing midwives. The following is a report prepared by the Equity Committee reflecting the issues and concerns raised by immigrant and refugee women.

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To be an immigrant woman and to have a baby in Canada is a stressful experience. We are discriminated against because we are poor, because our skin colour is different, because our faces are shaped differently, because our customs and language are different. Many people have stereotyped us as passive, subservient, ignorant Third World women.

Because we do not speak English, we are forced to be silent—to accept the rules; to accept the methods doctors use during the birth; to be without power. Because of the language barrier we can't say no or ask questions. Because of the environment we are afraid to challenge what the doctors are saying and doing to us. We become the objects of medical intervention. (Melida Jimenez "Teniendo a Mi Hija (Having My Baby)" *Healthsharing*, Fall 1991.

Our meetings with immigrant and refugee women and those who work with them in Toronto, Ottawa, and Kingston were often charged with strong emotions about the unjust treatment of this group of women during pregnancy and childbirth at the hands of the Ontario health care system. Sentiments like those expressed by Melida Jimenez above were heard repeatedly. Melida practiced as a physician in Guatemala before emigrating to Canada where she has had extensive experience with the Canadian health care system.

Our consultations took place in Ottawa in April of 1990, in Toronto in March and April of 1992 and in Kingston in June of 1992. In January of 1992, we also met with a group of practicing community midwives in Toronto to discuss their experiences of working with immigrant and refugee women.

In each city, efforts were made to reach as many women as possible to join us in an informal discussion about their experiences. We contacted immigrant health and social service agencies and other immigrant and refugee organizations in each city in advance of our proposed meeting times. In Ottawa, we met with immigrant women working at OCISO (Ottawa Carleton Immigrant Services Organization); in Toronto with individuals from the Immigrant Women's Health Centre, Access Alliance Multicultural Community Health Centre, St. Joseph's Health Centre, the Birth Control and Venereal Disease Information Centre, York Community Services, the Coalition of Immigrant and Visible Minority Women, and Intercede (Toronto Organization for Domestic and Workers' Rights); and in Kingston with individuals from Kingston and District Immigrant Services, the Childbirth Education Association, individual nurses, and a community midwife working in the Kingston area.

Some women spoke of their own personal experiences while others spoke of the experiences of women with whom they have worked. Women from many parts of the world were represented in these discussions: Africa, Latin America, Southeast Asia, and the Caribbean.

It is important to emphasize that immigrant and refugee women must not be seen as a homogenous group. Every woman's experience is her own. It is affected by many factors including the country from which she comes; whether she has had to leave her country under duress and come here as a refugee or whether she has left it willingly; whether she has papers to be in Canada; the status of women in her culture; the role of midwifery in her country of origin; the colour of her skin; whether female circumci-

sion is practiced in her culture; her religious beliefs; her knowledge of English, and the length of time she has been in Canada. However, it was significant that there was a good deal of consistency in what we heard.

The women we spoke with expressed a high degree of dissatisfaction with the way they or others they know have been treated in the health care system and particularly in hospitals. Women spoke of the cultural bias in prenatal classes and in the written information distributed to them during their pregnancies. The issue is not just language, we were told over and over again; *it is cultural appropriateness.* For example, when the importance of exercise is stressed in a prenatal class, this may mean completely different things to a woman recently immigrated from Vietnam—where exercise is considered an essential part of a healthy pregnancy right up to the time of delivery—and a woman from Iran—where women are taught to eat large amounts of food and favour rest over activity.

The problem of language barriers is a major one for many immigrant and refugee women seeking maternity care. We were told that some will avoid seeking out care because they have already had the experience of not being understood by their doctor or other health care provider. Few services offer materials printed in other languages to help women understand the system. There are an increasing number of prenatal classes being offered in languages other than English in large urban centres like Toronto, but in Kingston, for example, we were told that "the numbers [of any one particular language group] aren't large enough to warrant it."

In describing the barriers that face immigrant women seeking health care, Ainalem Tebeje of OCISO in Ottawa stressed that new immigrants often find large institutions intimidating. Many immigrants come from small communities and may feel more comfortable with "health clinics rather then huge hospitals and one caregiver rather than several experts." In many cultures, people only go to a health care worker if they are very ill. Because pregnancy is seen as a normal part of life rather than an illness, many women do not seek out prenatal care. Pregnancy and birth are often not associated with doctors and medical care.

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In addition to the linguistic and cultural barriers which make it difficult for many immigrant women to use mainstream services, there can be major legal and financial barriers, particularly for refugee women. Son Doan, a Vietnamese trained midwife working as a nurse at Access Alliance Multicultural Health Centre in Toronto said that many women who come to her centre do not have a health card. Some do not come for care until they are seven months pregnant; they cannot afford hospitalization or a specialist. Melida Jimenez commented of the group without health cards, "They fall through the cracks, and the cracks are getting bigger and bigger."

In Ontario over the past ten years, many people have emigrated from countries where the practice of female circumcision is still prevalent. [See article, "No Words Can Express: Two Voices on Female Genital Mutilation" in this issue of *CWS.*] It is another example of a cultural practice which can have an impact on health services. Kowser Omer, a nurse and midwife from Somalia told us that in her country, a woman often weeps when she gives birth to a daughter because she knows what pain her daughter will have to go through with circumcision, usually performed at between five and eight years old. She told us, "There are certain things you don't even have words to express." The woman who comes to Canada from one of these countries often goes through even more pain when she faces unbelieving and judgmental health care workers. Women go from doctor to doctor until they find one who has some understanding of how to work with her in pregnancy, one who will not make her feel, as we were told, "like a freak." In one woman's experience, she felt that when she expressed her concerns to her obstetrician about the delivery of her baby as a circumcised woman, these concerns were not taken seriously and that she "had to put a lid on" talking about it.

Ainalem Tebeje also emphasized the importance of a strong cultural component in midwifery education because reproduction, pregnancy, and infant care are such culturally sensitive areas. She mentioned the role of men in birth as an example. Midwifery education and midwifery practices need to acknowledge that in some cultures, men are not involved in birth. The cultural norm may be that the female relatives in the woman's extended family are involved in the birth. Birth is seen as women's business and women may seek out midwives as female caregivers.

Lucya Spencer of OCISO saw continuity of care as essential to cross-cultural sensitivity. If midwives spend the time with women to get to know them and develop relationships with them, it is much more likely that the caregiver will be sensitive to that woman's needs.

Attitudes towards midwifery and place of birth varied amongst those women with whom we spoke. We were told that women who come from countries where midwifery is a strong and important part of their culture are often quite surprised to learn that midwives are not part of the health care system here. In meetings in both Toronto and Ottawa, participants felt that choice of birthplace would be important to many

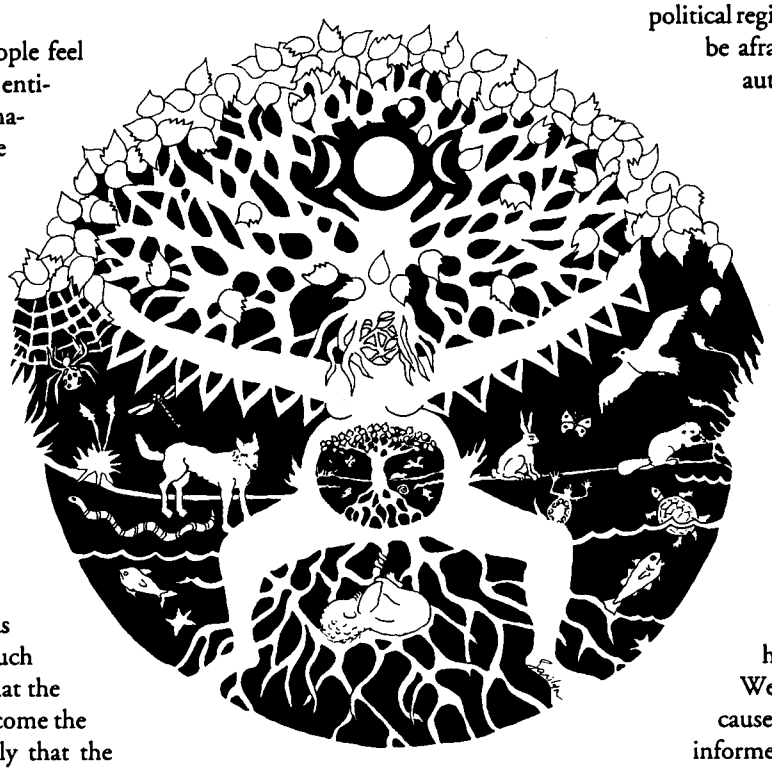
immigrant women. Many would have had home births in their country of origin and would feel most comfortable giving birth at home. It is often hard for women new to this country to be separated from the support of their families while in hospital. On the other hand, within every culture, some people feel the need to be "modern" and that part of being modern in this country is having an obstetrician and a hospital birth and rejecting more traditional practices like midwifery.

Similarly, some people feel strongly that they are entitled to what other Canadians have; since the majority of Canadians are having hospital births with obstetricians, they come to see this as the norm and something they, too, should have. The idea of a home birth may also be entirely out of the question if a woman is living in crowded quarters with various family members; in such cases, we were told that the woman may also welcome the break from the family that the hospital stay provides.

Fear may also play a role in the decisions an immigrant woman makes about her maternity care. Melida felt that some immigrant women who don't have their papers or have not been here a long time "may be afraid to have a midwife or a home birth...they don't want the responsibility" of what is still an unconventional choice.

The idea of a birthing centre for immigrant and refugee women, staffed by midwives of various cultures, was one which was warmly welcomed by most of the women with whom we met. Some mentioned that it would be particularly important for women without papers to be welcomed at such a centre. Auvriel O'Connor, a Jamaican midwife who works at a community health centre in Toronto, commented that her agency has been able to make arrangements with a local hospital for some women without papers to pay lesser fees. One woman said "a multicultural birth centre would be a dream."

Columbia Tarape-Diaz, who works for Intercede in Toronto, told us about the many women who come to Canada to work as domestics or nannies. Most are live-ins and work long hours. When a woman working as a domestic finds she is pregnant, it may be very hard for her to get or keep medical appointments because of her hours of work. Because of the frequent negative reaction of employers, the woman may try to hide her condition. Many are encouraged to have an abortion. We were told of one case in which the woman's employer arbitrarily booked an abortion with the family doctor. Women who choose to keep the baby may have to leave their employment and go to a shelter. They then find themselves "five months pregnant, out of a job, no permanent address, waiting for an OHIP [Ontario Health Insurance Plan] number, without money and subsequently not getting care pre- or postnatally." She told us that they network among themselves, but they sometimes are reluctant to give advice to others because they do not want to place themselves at risk with Immigration.



Sarilyn Zimmerman, Pen and Ink, 1993

Women who have had to leave their homeland because of oppressive political regimes may consequently be afraid of institutions and authority figures here. To many, the health care system appears to be rife with such authority figures. If they come from countries where the status of women is very low or where they have been victims of torture, they may additionally suffer from low self-esteem as they face health care providers. We were told that this may cause them to not demand informed choice or even to consent to a treatment or particular advice when they do not necessarily agree with it. Lucya Spencer of OCISO pointed out that it is frequently immigrant women who are victims of unnecessary procedures and surgery.

From the women we met with who are midwives trained in other jurisdictions, we learned a great deal about the profession and the practice in those countries. In places such as Vietnam and Jamaica, where physician resources are strained, midwives have a tremendous amount of responsibility for areas beyond the scope of practice proposed for Ontario midwives. In Vietnam, midwives call doctors only for cesarean sections; midwives are able to perform vacuum extractions and forceps deliveries. In

all of the countries we learned about, midwifery education is outside of the university system, usually in hospital-based programs.

Our discussions with immigrant and refugee women also brought out the need for public education about the health care system and about the arrival of midwifery as a regulated profession in Ontario. There was a suggestion that the IRCM could try to access more newsletters and publications of various cultural groups to get the message out about midwifery in as many languages as possible.

Conclusion

We only began the process of learning about the childbirth experiences of immigrant and refugee women through our meetings in Ottawa, Toronto, and Kingston. However, some clear issues and recommendations emerged from our discussions.

We learned that the experiences and expectations of new Canadians are as varied as the countries, cultures, and religious backgrounds from which they come. For many, their experience to date has been characterized as having to constantly struggle to even be heard by health care providers, let alone to be treated with respect. For some, the loneliness and isolation of being new to this country is only heightened when they go through the experience of pregnancy and childbirth in our current system.

In speaking with a number of health care providers who have been immigrants to this country, we also learned of the many ways in which they in particular are trying to make the experience of pregnancy and childbirth less frightening for women who are newcomers to Canada. Through prenatal courses offered in other languages, labour support from women who speak their language, and the translation of resource materials into other languages, women are being made to feel a little more comfortable with giving birth in a new country. But these efforts, we were told, are often few and far between and need to be considered more often by policy makers and health planners. As a new profession to Ontario, midwifery is in the fortunate position of being able to redress some of these inequities through the education and regulation of its professionals, and through its professional association.

While wanting to be respected for their unique experience and backgrounds, immigrant and refugee women also do not want to be treated as "other." Given the tremendous number of immigrants and refugees in Ontario, it is important that midwives practicing in this province who were born, raised, and educated here recognize that their own experience is only one of many. Currently practicing and new midwives to Ontario must make every effort possible to become aware of the wide range of experiences of immigrant and refugee women in pregnancy and childbirth, and ensure that the midwifery care they provide is both culturally sensitive to each individual woman's needs and empowers each woman to have control of her experience. Finally, the Ontario health care system must be prepared to support a culturally sensitive practice of midwifery.

Update

On December 31, 1994, midwifery legislation was officially proclaimed in Ontario, making it the first province in Canada to formally recognize midwives as a self-governing profession, funded by the Ministry of Health. Midwives can practice in hospitals, birth centres, and homes and must adhere to standards of practice developed by the College of Midwives. The College is currently working on a Prior Learning Assessment Project to integrate into the profession women who have been trained in other jurisdictions. This will hopefully open the doors for midwives trained in other countries who wish to practice in Ontario.

Members of the Equity Committee who prepared this report are: Anne Rochon Ford, a writer and policy advisor on women's health issues in Toronto; Pat Legault, a former nurse administrator active with the community health and birth centre movement in southwestern Ontario; Jesse Russell, a policy advisor on Native women's issues in Thunder Bay; and Vicki Van Wagner, a practicing midwife and director of the midwifery education program at Ryerson Polytechnic University in Toronto.

This report is one of a number which were written by the Equity Committee. Others are available for a small fee by calling the office of the College of Midwives at 416-327-0874. The mailing address for the College of Midwives is P.O. Box 2213, Station P, Suite 285, Toronto, Ontario, M5S 2T2.

CATHY STONEHOUSE

The second heart

Curl up your fingers
in the dark little one,
the light is out
no one is watching.
I can feel you
deep in my unclenched heart,
spiral breath
winds up your sorrow
like a cloth
wrung deep from a well.
On your rage I suck
of your grief I drink
till you grow strong enough
to be born.
Soft ear
placed upon my belly from the inside,
lips that unfold
into promises,
a way through.

Another poem by Cathy Stonehouse appears earlier in this issue.