IN PURSUIT OF THE CANADIAN DREAM

EQUITY AND THE CANADIAN CERTIFICATION OF INTERNATIONALLY EDUCATED MIDWIVES

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Abstract

Labor market projections indicate a shortage of health care workers across Canada and around the world. The shortage of healthcare workers is more acute in developing nations, which grapple with weak health systems unable to address high disease burdens. This situation is made worse by the movement of health personnel in search of a better standard of living, access to advanced technology and more stable political conditions in developed countries such as Canada - a process known as ‘brain drain’. Brain drain has been described as ‘a perverse subsidy’ by scholars and identified as disconcerting by the World Health Organization, which calls for the ethical recruitment of internationally educated health professionals.

Significant research on the migration and recertification experiences of internationally trained physicians and nurses exists but very little has been written on internationally educated midwives (IEMs). This study uses a social equity framework and insights from Foucauldian and post-colonial feminist research to explore practices of assessment and bridging programs for IEMs; the factors that impede IEM recertification; and the ways Canadian midwifery stakeholders mitigate international migration (brain drain) and poor labor integration (brain waste) of IEMs. Data collection was primarily through key informant interviews and document analysis. The study data - gathered and analyzed in 2011/12 – is reflective of the situation of midwifery during that period.

Findings from the study indicate several inequities in the recertification process of IEMs, primarily in the application process to assessment and bridging programs and in financial and geographical constraints. The study also suggests a lack of discernment by midwifery stakeholders between active and passive recruitment, and tacit support of the passive recruitment of IEMs. Questions are also raised regarding the inclusivity of the Canadian midwifery model of practice and illustrate that further research is needed.
Acknowledgements

This thesis was only possible with the support and guidance of Dr. Lori Hanson, Dr. Debbie Mpofu and all of the amazing women who participated in the study and shared with me their personal stories and insights.

Without the patience of Dr. Hanson and Dr. Mpofu and their passion for midwifery I would not have had the honor of learning about this great profession. I am also indebted to them for giving me the time I needed to overcome personal challenges and complete this thesis. In their example as remarkable human beings and academics, I have been fortunate to gain many academic skills and life lessons that will undoubtedly help me in the next stage of my life.

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Chapter 1. Introduction

1.1 Background

According to the World Health Organization (1), the global shortage of health-care workers is approximately 4.3 million doctors, midwives, nurses and support workers. Although developed nations such as Canada, the United States and Australia are experiencing a shortage of health care professionals, the shortage is most extreme in developing nations such as Malawi. The situation is made worse when there is an intentional migration of health care professionals from developing nations to developed nations, a phenomenon known in academic literature as *brain drain*. According to Misau, Al-Sadat and Bakari (2), brain drain is the movement of health personnel in search of a better standard of living and life quality and access to advanced technology and more stable political conditions in different places worldwide. Brain drain may be within country but in most cases refers to cross-border or international migration and often from developing countries to developed ones.

Research shows that between 23% and 28% of physicians in the United States, Canada, the United Kingdom and Australia are international medical graduates and that 40% to 75% of the physicians migrated from low-to middle-income countries. Furthermore, migration from Asian, Arab and African countries has significantly increased, where 30% of Chinese doctors migrate to Australia and 54% of health workers educated in Arab and African universities work in Europe and North America. According to the literature, the major source countries of health workers are India, South Africa, Pakistan and the Philippines. Major source countries in Africa are South Africa, Algeria, Egypt, Kenya and Nigeria (3).
Despite immigrating to developed nations to improve life quality, access advanced technology and increase opportunities for career advancement, many health professionals from developing nations are finding it difficult to obtain certification and positions in destination countries. Significant amounts of them are finding survival jobs or moving on to other fields. Moreover, it is now well recognized that immigrant incomes do not converge with native born incomes and that in fact the reverse is occurring, where the gap between immigrant and native born incomes (after taking education and language into account) is set to increase (4-7).

As troubling as the above finding is, the majority of the literature on labour integration is on the experience of a select group of internationally educated health professionals, in particular physicians and nurses. There is very little on internationally educated midwives (IEMs). When IEMs are mentioned in the literature, in most cases it is in the context of nurse migration. The limited literature on the certification of IEMs and on their experience of Canadian certification is problematic. Scarce literature on the Canadian certification of IEMs not only limits the evaluation of the three Canadian programs in terms of accessibility and training but can also perpetuate a system that is exclusionary or imposes an added burden for the significant number of IEHPs that experience a devaluing of their skills and eventual deskilling in the Canadian labour market (4-7).

1.2 Purpose and Objectives of the Study

The aim of the study is three fold. The first objective is to use a public administration social equity framework to describe the practices of two Canadian bridging programs and one assessment process for IEMs in equity terms. The second objective is to use the findings of the above line of inquiry to elucidate the factors that influence the Canadian certification of IEMs. The final aim is to illuminate the ways in which the midwifery community (i.e. regulators,
administrators, associations) mitigate the brain drain and brain waste of IEMs. Similar to internationally educated nurses or physicians, IEMs undergo deskilling and devaluing in the Canadian market and too often watch their skills go to waste (8). In addition to understanding the ways in which brain drain and brain waste are mitigated, the study will also situate the position of Canadian midwifery on brain drain within the wider brain drain discourse.

All of the collected data has been analyzed through the use of the aforementioned social equity framework and the application of both a post-colonial feminist perspective and a Foucauldian post-structuralist perspective. The social equity framework is useful in understanding equitable practices along four dimensions: procedural fairness, access, quality and outcomes (12). The post-colonial feminist and Foucauldian post-structuralist perspectives are both critical social theories that investigate the issues of power and justice and the manner(s) in which the economy, issues of race, gender, class, discourses, ideologies, education, religion and other sociocultural dynamics and institutions interact to create social systems (9).

Post-colonial feminism like post-colonialism critiques western centered understanding(s) of gender, class, race, sexuality and religion bringing to light the impact and challenges that colonial legacies have had and created in the relationships between developed and developing world peoples. The perspective also provides innovative ways of understanding transnational difference (9-10). Foucauldian post-structuralism sheds light on the interrelationships between discourse, knowledge and power. Through understanding how discourse is created and maintained in society, a Foucauldian analysis allows for a deeper understanding of the structure and language of social institutions and organizations (11).

It is my hope that the findings from the aforementioned equity framework and theoretical perspectives will not only assist in meeting the above aims but will also add nuance to the
understanding of the IEM certification process and the experience of IEMs as they pursue Canadian certification.

1.3 Research Questions
The study’s guiding research questions are:

1) How equitable are assessment and bridging programs in terms of procedural fairness, equitable access, quality and outcome in midwifery practice?

2) What factors impede the successful initiation and/or completion of midwifery certification?

3) In what ways does the midwifery community mitigate brain drain and brain waste?
Chapter 2. Literature Review

In order to better understand the equitable practices of Canadian midwifery bridging and assessment programs, it is important to understand the history of Canadian midwifery and its influences, in particular the regulation and professionalization project of Canadian midwifery, the influence of feminism and counterculture movements, the education and training structure for Canadian born midwives and IEMs and the relevance of equity in general. Additionally, pertinent to this study will be understanding the migration of internationally educated health professionals from developing nations to developed nations (brain drain) with a secondary discussion on the Canadian contribution to brain drain and the role of ethical recruitment. All of the above will be presented in the literature review below.

2.1 History of Canadian Midwifery

Until the late 1800s, midwifery was the primary and preferential mode of health care delivery to pregnant women across Canada. Up to the 1870s, midwives were teaching medical students’ obstetrics at the University Lying In Hospital in Montreal and the Burnside Hospital in Toronto. However, soon after the near demise of the midwifery profession began, starting in Nova Scotia but closely followed by other provinces across Canada. Physicians began to intrude on midwifery territory as they started to recognize the financial market of managing labour and delivery. This is evident in a letter sent to the Canadian journal *The Lancet* in 1873, where it is quoted “that deliveries are, to many of us country doctors a very remunerative part of our practice” with evident frustration regarding the loss of income to “old bodies and quacks” (p. 50). The fight between physicians and midwives for monopoly over labour and delivery continued on for several decades - before physicians with their collective organization and legal prowess gained the upper hand - an easy win over the very scattered and disorganized midwifery body.
The physician monopoly inevitably caused a change in the predominant labour and delivery paradigm with a shift from home birth and women centered care to hospital deliveries and pregnancies managed by physicians. The most fatal blow to Canadian midwifery was in 1947 when the Canadian Medical Association openly stated that labour and delivery should be the full responsibility of physicians, a move that ensured that even in remote regions that lacked proper medical facilities, midwifery was to be discouraged and devalued. As stated by a journalist at the time “there is no better index of the political power of the medical profession, than the fact that it put midwives out of business, even where there was no doctor to provide service” (p. 50). Apart from surviving elements in Newfoundland, where midwives continued to practice until 1960, midwifery was non-existent in all other Canadian provinces.

It wasn’t until the 1970s that midwifery remerged and started to enter public consciousness. The emergence of the new midwife during the 70s is in large part due to the socio-cultural movement at the time. Parent consciousness and birth activism started to rise in North American society as a response to the ‘knock ‘em out and drag ‘em out’ (p. 51) mentality of medical deliveries (15). Successful experiences of home birth attended midwives and the uncooperative nature of the medical establishment at the time, created space for midwives to practice and flourish. By 1984, more than one hundred midwives were catching babies across Canada and were openly challenging the dominant medical paradigm and monopoly on labour and delivery. Additionally, despite being few in number, the new midwives were very organized, politically savvy and engaged in public discourse on labour and delivery - a distinct difference from the ‘granny midwives’ of the past (15-16).
2.1.1 Professionalization

Influenced by the Home Birth Movement, the new midwifery movement aimed to empower women by placing the control of the birthing process back into their hands. This women centered approach advocated not only for women to choose the place and manner in which their child was born but that knowledge, responsibility and power be redistributed in an egalitarian manner creating a therapeutic alliance. This ‘taking back control’ over the reproductive process appealed and garnered support from the Women’s Health Movement and by extension many feminist activists of the time. Despite the growing support for midwifery, midwives during the 70s and 80s did not consider themselves to be birth experts or professionals. Midwifery at the time slowly rose as a working alternative to medicalized maternity. In response to charges of practicing medicine without a license, criminal negligence and homicide charges due to the death of a baby, midwives and their allies were motivated to pursue political activities and started to organize and lobby for the integration of midwifery into the Canadian health care system. Integration would come with legal protection, legitimization and financial security (16-17). Professionalization of midwifery started out with a professional association led by a select group of women tasked with garnering public support and leading the integration process. This move along with state sponsorship led to the successful integration of midwifery into the Canadian health care system. Due to the cost-effectiveness of midwifery and the positive public image of supporting women’s health, state support for midwifery was strong and supportive of professional self-regulation. Shortly thereafter, with state support, the first direct entry undergraduate midwifery program was established in Ontario (16-17).

Although integration has been positive on the whole, the midwifery professionalization project has not succeeded unscathed. As noted by one researcher (16), throughout the process,
changes occurred in the egalitarian philosophy of midwifery, where the role of women using midwifery care became less pronounced. She and others suggest that as professionalization continued for Canadian midwifery, the relationship between midwives and their clients became more structured and detached, creating a new bureaucratized midwifery with established guidelines and professional standards (16).

2.1.2 Influences of Feminism in Midwifery

The resurgence of midwifery after targeted removal by physicians was accomplished by the support of the Women’s Health Movement and in particular feminist activists. Up against a hegemonic medical model, lay midwifery redefined the reproductive process encouraging a woman centered and holistic approach. Consisting mostly of middle-class white women, midwives developed the training necessary for providing reproductive services that included informed choice, the acknowledgement of birth as a psycho-social-physiological process and the right use of technology. Influenced by feminism, the women’s health movement, counterculture lifestyles, and British midwives working to be recognized in the health care system, the new midwifery gained momentum and successfully acquired state sponsorship and integration (8, 16-17).

According to Nestel (8), the growing success of the new midwifery was accomplished with the use of a particularly powerful political subjectivity. This was in response to the negative portrayal of midwives (oftentimes racialized) in North America as primitive and dirty. In response, midwifery activists had to reconfigure the new midwife as respectable, knowledgeable, modern, educated and Canadian/white. This was ironic since many of the first midwives wishing to practice after integration went to the American-Mexican border to gain state required clinical experience (8).
Nestel’s analysis shows how, using the narrative of global sisterhood, many Canadian midwives were educated by midwives that would fit the very stereotype they worked hard to shred when pursuing legitimacy. Undoubtedly, unexamined notions of global sisterhood that create power differences among women have had a negative impact on IEMs, especially IEMs of color. Along with inferiorizing notions of immigrant women and the devaluation of non-Western education, western forms of feminism using an unexamined narrative of global sisterhood strengthened normative whiteness and everyday racism and created a mainly white midwifery profession (8). The intersection of western feminism, midwifery and IEMs will be revisited in subsequent chapters of this thesis.

2.1.3 Current Education of Midwives in Canada

As midwifery gained ground in the 1970s, the training profiles of practicing midwives varied from apprenticeship to vocational to university based education. Many of the midwives advocating for professional recognition learned midwifery through self-directed reading of reproductive health care literature accompanied by practicing midwifery with supportive clients. Others attained midwifery training abroad before immigrating to Canada or left Canada for the United States in order to acquire midwifery training. As the number of practising experienced midwives increased so did requests for apprenticeships that involved a few years of clinical experience, observing and participating in births bundled with the reading of reproductive health care literature and the completion of relevant courses (16).

However, as is characteristic of many technocratic developed nations, attaining professional success and status in Canada required achieving at least an undergraduate university based education. The midwifery profession was not exempt and once integrated into the healthcare system, university education at the undergraduate level became a requirement for
practice within Canada (18). The midwifery community at the time was divided on the issue, many believing that midwifery education should primarily remain experiential and apprenticeship based. The argument against standardization emphasized that a university based education model would not be aligned with midwifery philosophy, which is a holistic philosophy that requires a personalized path to learning and doing midwifery that respected each individual’s way of learning and approaching pregnancy and birth (16,20).

Recognizing the legitimacy of the above argument, the Midwifery Coalition\(^1\) at the time proposed a compromise, agreeing to include an internship requirement into midwifery education incorporating direct hands-on experience and mentorship. Despite the compromise, however, the opinion that a university undergraduate model rejects the non-medical birth culture of midwifery still exists. In particular, some midwifery stakeholders held the position that a university model establishes a midwifery curriculum with elements that are arguably indistinguishable from other forward thinking medical curriculums. Nevertheless, the Coalition’s compromise stands and across Canada a university based undergraduate degree is required to practice midwifery (16, 20).

To date there are seven midwifery undergraduate programs in Canada: three programs through a consortium at McMaster, Ryerson and Laurentian universities; one at the University of British Columbia; one at the Université du Québec à Trois Rivières; one at Mount Royal University in Alberta; and one at the University College of the North in Manitoba (19). The four-year undergraduate curriculum includes health and biological science courses, social science courses and midwifery care courses that comprise academic and clinical components.

\(^1\) The Midwifery Coalition includes the Ontario-Nurse Midwives Association, the Ontario Association of Midwives and the Midwifery Task Force of Ontario (MTFO).
Clinical classes are combined with practice in midwifery settings to allow students to acquire clinical skills in prenatal, intrapartum, postnatal and newborn care while being supervised by midwifery preceptors. Placements may be five to six semesters with the option(s) of experience in interdisciplinary and international settings and/or an internship in the last year of studies. In order to complete the undergraduate program, a student is required to successfully complete all academic courses, examinations and a minimum of 60 births (40 as a primary care provider) in the hospital and/or out of hospital. In addition to the aforementioned, the student is also required in many provinces and territories to write the Canadian Midwifery Registration Examination (CMRE) prior to becoming a registered midwife (19). The following table provides an overview (with data available only to 2009) of midwifery education programs in Canada.

<table>
<thead>
<tr>
<th>Midwifery Education Program</th>
<th>Funded seats (per year)</th>
<th>Enrolment (all 4 years)</th>
<th>Graduates (to 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>McMaster</td>
<td>30</td>
<td>103</td>
<td>163</td>
</tr>
<tr>
<td>Laurentian</td>
<td>30</td>
<td>98</td>
<td>115</td>
</tr>
<tr>
<td>Ryerson</td>
<td>30</td>
<td>126</td>
<td>162</td>
</tr>
<tr>
<td>UBC</td>
<td>10</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>UQTR</td>
<td>24</td>
<td>74</td>
<td>52</td>
</tr>
<tr>
<td>UCN</td>
<td>14</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>138</td>
<td>458</td>
<td>549</td>
</tr>
</tbody>
</table>

Table 1: Midwifery Education Programs: Seats, Enrollment and Graduates (27)
2.1.4 Bridging Programs: Internationally Educated Midwives

In 2003, the Canadian Midwifery Regulators Consortium (CMRC) initiated a research project that aimed to facilitate information and resource sharing, determine profession-wide best practices and develop and pilot assessment tools for IEMs. The project also aimed to standardize professional requirements, assist provincial regulators and increase access to bridging programs for IEMs. According to the findings of the study, written as a report titled the National Midwifery Assessment Strategy (21), the following comprises the current Canadian IEM assessment strategy:

1) All provinces use paper-based assessments for midwifery education, clinical experience, and language competency in addition to written and clinical competency based exams.

2) Every province mandates a period of supervised practice giving midwives time to fill knowledge and/or competency gaps (Quebec uses this period as an assessment period).

3) The Ontario International Midwifery Pre-registration Program (IMPP) and the Multi-Jurisdictional Midwifery Bridging Project (MMBP) are the two Canadian bridging programs in Canada. Clinical placements are incorporated into both bridging programs. Graduates from both programs are not required to undergo further assessments except the aforementioned supervision period. In Alberta, midwives with experience can also apply to the Prior Learning and Experience Assessment Program (PLEA).

4) Most provinces have a College of Midwives that regulates midwifery practice in agreement with The Midwifery Act, Midwifery Regulations, the Regulatory Bylaws and other relevant legislation. The goal of each College is to ensure that qualified, competent midwives are delivering safe, high quality care to women and their families. One way Colleges’ ensure safe, high quality care to women and families is through the creation of
guideline documents like a Code of Ethics (see appendix 2 for Saskatchewan’s Code of Ethics).

Outlined in the above report and indicated below are the principles of the pan-Canadian Midwifery Assessment Strategy: (1) transparency, where the process of becoming an IEM must be comprehensive with all information regarding it being easily accessible, clear, and have a provincial and national outlook, in an effort to help IEMs have an understanding of the model of practice, have enough information to decide which province to live in and determine whether they have the financial and personal resources needed to undertake Canadian certification; (2) fairness, meaning that all the tools and processes used to evaluate IEMs should be fair, adhere or surpass industry benchmarks and be carried out in a manner that is respectful and culturally competent; (3) consistency, where provinces should aim to harmonize and make consistent IEM evaluation processes, policies, procedures and tools wherever possible; (4) flexibility, where evaluation processes of IEMs should be individualized, available in multiple locations and be offered as frequently as possible; (5) effectiveness, in that evaluation tools and processes effectively select IEMs who are able to work safely in Canada and (6) collaboration, whereby all jurisdictions collaborate to maintain the best evaluation of IEMs through (but not limited to) the sharing of information, co-offering and/or harmonizing assessments, policies and procedures while ensuring industry benchmarks (21).

In addition to the above, the report also outlines national and international IEM certification strategies and their associated challenges. The findings show that the main areas of assessment for internationally educated professionals are the professional education of the applicant, the applicant’s language ability and the applicant’s clinical background. The findings also show that regulators use more than one evaluation tool, usually a written exam, clinical
evaluation and/or an internship. Moreover, across the board regulators agree that language competence is necessary for success, followed by cultural competency, currency of practice and the similarity of education and training to the education and training of the source country. Other challenges to certification noted by the report are financial constraints (high costs), the difficulty in attaining information from abroad, limited suitable professional language exams, better evaluation tools and gap training programs. The report also touches on the view of midwifery stakeholders (IEMs included) which agree that cost and time factors are key challenges for IEMs, that integration into the Canadian model of practice is necessary for the success of IEMs, that evaluation processes are resource intensive and that in principle a national assessment strategy incorporating provincial and territorial consultation be offered both in English and French (21).

Central to integrating IEMs into the Canadian health care system are bridging programs. The programs are designed for IEMs with experience in antepartum, intrapartum and postpartum care and who have the skill-set to successfully complete registration requirements. The primary purpose of bridging is to identify and address gaps in education and competency, facilitate the transition into professional culture, support applicants in their path to registration and work with midwives as they search for employment. All of the Canadian programs are comprised of modules that address common gaps in knowledge, education and experience while also incorporating clinical, didactic and model of practice components (21, 22,26). Information on the three Canadian programs, the IMPP, the PLEA and the MMBP are presented below. All of the information on the programs reflect the time period (2011/2012) in which the study took place.

The IMPP is based at Ryerson University G. Raymond Chan School of Continuing Education in Toronto. It is a nine-month bridging program with an accelerated 6-month option for
IEMs who have been educated and registered in a jurisdiction that recognizes and regulates midwifery, who are fluent in English and who have been working as a midwife in the last five years. The program also requires that interested IEMs hold an Ontario G1 drivers license, have at least 40 births as a primary midwife or 30 births as a primary midwife and 20 births as an assistant or second midwife. Although the program is designed to bridge IEMs who will be working in Ontario, it has accepted applicants from other Canadian provinces. Midwives interested in working in other Canadian provinces will need to independently meet all additional requirements of the province they wish to work. For midwives who plan to work in Ontario, the IMPP will assesses them, provide information on midwifery practice in Ontario, provide clinical placements, mentoring opportunities and limited knowledge and skills enhancement (22).

The Prior Learning and Experience Assessment process is a portfolio based assessment for IEMs and for midwives trained by apprenticeship and/or self-study. The purpose of the program is to provide a medium in which midwives establish their knowledge, skills and experience demonstrating their ability to practice midwifery safely in Canada. The PLEA process consists of a portfolio assessment, a national written exam and clinical and/or objective structured clinical evaluations (OSCEs). Similar to bridging programs, applicants must also be fluent in English and have a good understanding of the Canadian midwifery model of practice (23). With the exception of Alberta, by 2011, many Canadian provinces had phased out the PLEA process in place for the MMBP. Saskatchewan, however, still recognizes midwives who have successfully completed the program (24-25).

It was in the aforementioned NAS report (2006), that the need of and call for the creation of the MMBP was outlined. At the time the IMPP and the PLEA were the only available programs
in Canada for IEMs. The MMBP was launched as an effort to provide greater access to bridging while also addressing the limits of the PLEA. Instead of having to move to participate in the IMPP, IEMs in Western and Atlantic Canada would be able to attend a bridging program closer to home and unlike with the PLEA would have access to instructors and guidance as they proceed through the certification process. The innovative design of the program incorporates distance education technologies, rotating assessment locations held in a participating province every year and assessment and orientation for IEMs who wish to work in Western and Atlantic Canada (British Columbia, Alberta, Saskatchewan, Manitoba, Northwest Territories, Nunavut and Nova Scotia). The purpose of the program is to validate IEM midwifery experience and education, preparing IEMs for successful integration into the Canadian health care system and successful application of the Canadian midwifery model of practice in addition to qualifying IEMs to sit the Canadian Midwifery Registration Examination (CMRE) (27-28).

Moreover, the MMBP includes a pre-assessment model of prior learning and experience to determine areas of weakness as a means to screen-in and wherever possible to tailor the MMBP to each IEM. Similar to the PLEA and the IMPP, the MMBP also includes OSCES and in the curriculum of the program uses IMPP courses as a baseline. Other features noted in the NAS report regarding the MMBP is that it emphasizes efficiency, effectiveness, flexibility, harmonization and cross cultural training for educators and clinical instructors. Moreover, due to the collaborative nature of the MMBP, the program acknowledges relevant courses from other institutions (e.g. evidence-based practice and introduction to the Canadian health care system) and accepts funding from participating provinces to maintain the program (21).
As of 2011, the MMBP had completed its pilot phase (with 14 graduates) while the IMPP is an established program that upgrades 20 to 25 IEMs a year. Due to a lack of funding, the MMBP was temporarily suspended in 2012 with midwifery regulatory and educational partners claiming a possibility the program will reopen as soon as the fall of 2014. The pilot of the MMBP received funding from the federal government, with subsequent funding to be expected from participating provincial governments. All IEMs wishing to become certified in Canada have been routed by regulatory bodies to the IMPP and in the case of Alberta also to the PLEA. While negotiations between MMBP midwifery education and regulatory partners continue with provincial governments, Manitoba (one of the MMBP provinces) is developing a provincial bridging program. The following table shows the available data for the IMPP and the MMBP in 2010.

<table>
<thead>
<tr>
<th>Program (initiated)</th>
<th>Cost*</th>
<th>Location</th>
<th>Duration</th>
<th>Funded seats</th>
<th>Enrolment (2010)</th>
<th>Graduates (to 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPP (2001)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accelerated Stream ($4,500)</td>
<td>Ontario (Toronto)</td>
<td>Accelerated Stream (6 months)</td>
<td>20</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Normal Stream ($5,700)</td>
<td></td>
<td>Normal Stream (9 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMBP (2007)</td>
<td></td>
<td>Mostly online</td>
<td>Accelerated Stream (3 months)</td>
<td>24</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Accelerated Stream ($7,500)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal Stream ($9,500)</td>
<td>Rotates the location of assessments</td>
<td>Normal Stream (7 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>44</td>
<td>41</td>
<td>107</td>
</tr>
</tbody>
</table>

*Cost of completing the program (does not include cost of relocation)
Table 2: Assessment and Bridging Programs (April 2010) (27)
Once midwifery achieved self-regulation and integration in Ontario, hundreds of women looked to get their prior midwifery training recognized, nearly half of which were immigrant midwives of color with significant experience, professional skills and credentials. Yet, despite their impressive background, immigrant midwives of color currently comprise only 12 percent of registered midwives in Ontario (8). This study is the first one to look at the three programs and the reasons they seem to produce a small number of graduates and particularly small numbers of immigrant midwives of color. The following table shows the number of midwives registered and practicing in Canada in 2010.

<table>
<thead>
<tr>
<th>Province or Territory</th>
<th>Registered Midwives</th>
<th>Practicing Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>184</td>
<td>157</td>
</tr>
<tr>
<td>AB</td>
<td>50</td>
<td>48</td>
</tr>
<tr>
<td>SK</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>MB</td>
<td>51</td>
<td>40</td>
</tr>
<tr>
<td>ON</td>
<td>487</td>
<td>435</td>
</tr>
<tr>
<td>QC</td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>NB</td>
<td>4 (pending)</td>
<td>1</td>
</tr>
<tr>
<td>NS</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>PEI</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NL</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NWT</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
The literature review above presents a historical and contemporary overview of Canadian midwifery and midwifery education. In reviewing midwifery literature, there was very little on the experiences of IEMs and even less on matters of equity in relation to the education and certification of IEMs. Despite this, midwifery research similar to research on IEHPs, shows that overall IEMs find certification and bridging processes expensive, have language difficulties and find it difficult to integrate into the socio-cultural elements of Canadian healthcare. The process and the low numbers of certified and integrated IEMs are then exacerbated in the case of midwifery with the limited availability of bridging programs (20,21, 29,30).

### 2.2 Global Brain Drain and Source Country Consequences

As mentioned in the background, brain drain is the flight of individuals with technical, entrepreneurial and managerial skills, from the developing world to the developed world (i.e. North America and Western Europe) (31). The term is usually tied to emigration of health care workers, which according to the World Health Organization, has worsened access to basic health care for many people in the developing world (32).

The disparity in access to basic healthcare becomes even more prominent when it is understood through the lens of disease burden. North and South America combined have 14% of the world's population, 10% of the global disease burden but employ 37% of the global health workforce and contribute over 50% of the pool of global health expenditure (33). On the other
end, Sub-Saharan Africa, a region facing immense population health challenges, has 11% of the world's population, 25% of the global disease burden, 3% of the global health workforce and spends less than 1% of health expenditures worldwide (34).

Therefore, the most worrisome aspect of brain drain is when an economically vulnerable source nation such as Malawi with its significantly higher burden of disease cannot provide health care to its population because of limited healthcare worker capacity. Adding to the adverse impact on health care systems, brain drain has also been found to limit the overall economic productivity of a nation as well as negatively impact its ‘academic reproduction’ that is the passing on of skills and knowledge by academics to new generations of health professionals. For example, major migration of Ghanian doctors to the Middle East in the 1980s has been found to severely deplete academia in the country despite policy initiatives to undo the damage (33,39).

In addition to a loss of investment, secondary losses are also evident in the quality and output of health care, ability to battle or manage negative health outcomes, tax revenues and in overall source country economic growth (3). One proposed solution to brain drain has been partnerships between the diaspora and developing nation institutions in order to improve health capacity and innovation in developing nations. Other suggestions include putting in place ethical recruiting practices and restitution by developed countries to developing nations in line with the amount lost due to the emigration of skilled workers (40). Despite the type of solution proposed, a combined effort of multi-level stakeholders with a specific commitment to support the development of health systems in low-and middle-income countries is necessary. An example of such an effort has been undertaken by the Pan American Health Organization (PAHO) and the Office of the Caribbean Program Coordination (PAHO/CPC) in the form of Managed Migration Program of the Caribbean (MMPC) (41).
The MMPC is a “multilateral, cross-sector, multi-interventional, long-term strategy for developing and maintaining an adequate supply of nurses for the Caribbean region” (41). Critical to the success of the program is its partnership with countries outside the region such as Canada, the United Kingdom and the United States, international organizations and agencies such as the World Health Organization, International Council of Nurses, Health Canada, educational partners such as the University of Alberta, University of Toronto, University of Michigan and the strong participation of Caribbean nurses (educated abroad) who have returned to further nursing in the region. The MMPC and participating governments and stakeholders share the common perspective that migration from the region needs to be managed and moderated in order to maximize benefits and minimize costs. The aim is to capitalize on potential points of collaboration in the areas of trade and multilateral agreements involving nursing service and education. Some examples of this joint effort to manage and moderate regional brain drain are:

1) The government of St. Vincent in collaboration with U.S. partners has established an agreement whereby U.S. partners will pay the St. Vincent government training costs for each Vincentian nurse employed in a partner organization on the condition that the reimbursed amount is reinvested in nursing education and training.

2) A joint agreement with the Jamaican Nursing Council and U.S. partners allows Jamaican nurses to work in the U.S. two weeks every month, where nurses can attain additional training and/or more money. This agreement allows Jamaica to offset the loss that would be felt if the nurses left permanently for the states.

3) A Caribbean - Canadian proposal that encourages temporary migration of Caribbean nurses to Canada. Both countries have incorporated migration of nurses
into their regional and national plans and have instituted incentives for nurses to
return to the Caribbean and disincentives for them to overstay in Canada. The
proposal also incorporates the understanding that although nursing is an
independent service profession it is also a vital element of the realization of an
effective health care system.

An analysis of the MMPC has not been published, however mentioned in a PAHO/CAP
2003 report on the program are two early achievements (1) the successful cooperation of national,
regional and global stakeholders and (2) program specific achievements in areas such as
recruitment, education and retention, management practices and policy development and health
science research (41, 42).

2.2.1 Push & Pull factors
The emigration of health professionals from developing nations can be categorized
according to three levels: those who go to developed nations for advanced training and never
return, those who go for advanced training, return to work for a period of time and then emigrate
and those who train locally and emigrate once they have completed their studies or after having
worked a bit following their studies (35). Various reasons designated as push and pull factors are
cited in the literature for the intentional migration of health professionals.

Push Factors include a lack of funding for research, a lack of research facilities, limited
opportunity for advancement, lack of intellectual stimulation, violence and social turmoil, absence
of good education for children, low salary and poor work and living conditions. Pull factors are
the direct opposite of push factors and are (but not limited to) better remuneration, better working
conditions, safe and stable living conditions, opportunity for intellectual stimulation and most
importantly targeted recruitment of the West as an attempt to address its shortage of health care professionals (33, 36-38).

2.2.2 Current Global Situation

The brain drain literature is extremely polarized and can be viewed as a battleground for competing interests and emotional arguments. The proponents of brain drain state that skilled workers will waste their talent in their source countries and that migration to developed nations (with supportive research and practice environments) leads to global innovation. This school of thought argues that some gains will flow back to the source country through the import of improved technology, partnership networks or the return of migrants with enhanced skills, personal connections and ideas for innovation that will enhance the health and research capacity of source countries. Additionally, this position argues that the emigration of health workers improves the economy of a country by reducing demand on the government to provide employment, opportunities for advanced learning and proper access to health care. Finally, the proponents make an argument that the prevention of international migration of health workers is unethical in that it is preventing choice and the pursuit of better work and living conditions (43-45).

The opposing school of thought puts emphasis on domestic technology innovators which are not only believed to develop technology appropriate for developing countries but are also innovators that can play a vital role in enhancing source country capacity and development. This argument states that despite the significant distance from the hubs of technological innovation, domestic innovators are able to facilitate diffusion of technology in their countries in addition to preparing the landscape (i.e. domestic knowledge production) necessary to absorb foreign
technology. Additionally, this group states that outflow of health workers from fragile economies and health systems exacerbate global health issues, especially since many of the major source countries have a high burden of disease and scarce health infrastructure and workers able to battle the high burden of disease. This position also argues that financial flow back from the diaspora through partnerships, mentoring or money sent to family in source countries is not sustainable and sufficient to balance the human capital loss associated with the emigration of skilled health workers. Simply put, the opponents believe that the migration of health workers from developing nations benefits destination countries and negatively impacts the development and capacity of source countries (46-48).

Iredale (49) suggests that the migration of skilled workers from developing nations to developed nations will not diminish in the near future. The author further suggests that destination and source country punitive or restrictive actions will in all likelihood fail because oftentimes they are not put into relevant social and economic context(s) and not framed through inclusive (international and regional) discussions. Discussions which some scholars feel must make clear the historically privileged position of the developed world and the necessary ethical work needed to address the brain drain phenomenon (44).

### 2.3 Canadian – Saskatchewan Contribution to Brain Drain

According to the World Health Organization (50), there is a shortage of 4.3 million health human resources (HHR) worldwide (HHR including doctors, nurses and midwives). Canada, like many countries included in the above statistic also experiences a shortage of health care workers, primarily due to misdistribution and underutilization of HHR (51). Much of this shortage is not in metropolitan centers but in rural areas in provinces such as British Columbia, Saskatchewan and
New Foundland and Labrador. Yet, despite the efforts to fill health care worker vacancies, the country is slated for significant labour force shortages in the near future (52). For instance, the Canadian Nurses Association (2013) estimates that Canada will face a shortage of 60,000 registered nurses by 2022 (108). Similar shortages are predicted for physicians, midwives and allied health care professionals such as radiology technicians. In addition to inefficiency in HHR, other factors such as the age structure of the healthcare workforce and a lack of interest by medical students in family medicine play a role (53).

To meet health care demand, Saskatchewan Health (like many provinces) actively recruited physicians and nurses, mostly from South Africa and the Philippines (58), sometimes offering up to $25,000 for practice establishment. In 2011, foreign educated physicians working in the province were estimated to be 49% of all practising physicians. Moving forward, however, latest health care worker projections show upcoming provincial shortages of nurses (registered nurses, registered practical nurses, nurse practitioners and licensed practical nurses), home care/special care aides, medical laboratory technologists (MLTs), addictions counselors, occupational therapists, respiratory therapists, speech language pathologists, audiologists and public health inspectors (54-55). On the national front, current data show that 7% of nurses and 22% of physicians are foreign educated and that health professional migrants that come to Canada have considerable experience and training. Many of the health professional migrants come without pre-arranged employment although several (~400 every year) come to Canada with pre-arranged employment (56). Below is a brief discussion of cost.

Proponents of the brain drain phenomenon state that the international migration of health workers benefits both destination and source countries. The main argument is that from a financial
perspective, it is more cost-effective for developed countries to recruit educated health professionals from other parts of the world. Using the UK as an example, instead of training a physician for six years at the minimum of approximately 225,000 euros or a nurse at 12,500 euros, a migrant health worker will be able to practice at little to no investment by the state (3). Since 1998, the UK has saved 65 million in training costs alone for the nurses it has gained from Ghana. While some have stated that there may be a negative effect of migration on unemployment in developed nations there is research to suggest that any effect migrants may have is minimal and offset by the higher taxes they pay relative to what they receive in social security (3).

2.4 Ethical Recruitment

As in many developed countries, Canada’s continued recruitment of internationally educated health professions raises questions of fairness and health equity. Active recruitment of health professionals from source countries that have very little health workers to begin with exacerbates health disparities and facilitates the continued dysfunction of health systems. This is disconcerting since many of the source countries’ functioning health systems bear significant disease burdens including but not limited to the co-epidemics of TB and HIV/AIDS, high incidence of neonatal and maternal mortality and high incidence of diarrheal diseases (2, 3, 34, 40, 57).

Various authors discuss the ethical need for restitution, using varied definitions of the term. Pervati (44) makes a strong case for understanding restitution not just as a financial response to brain drain but also as one that includes repair, restoration and the righting of ethical wrongs. Her perspective encourages pushing past neo-colonial models of restitution that further notions of
charity and moving into a redistributive justice framework that aims to undo the perverse subsidy created by health worker migration to the developed world. Bell (107) concurs and explains that:

Thinking about postcolonial responsibility for medical migration invokes a shared responsibility to care about medical provision. It also leaves us at a doubling moment in which one’s ethically disposed subjectivity must also become the object of one’s genealogical scrutiny; and this without losing the sense of the irreducibility of the other. Ethics is exhausting, and never exhausted. It is infinite responsibility. (p.169).

Some of the proposed solutions to brain drain have include remittances sent by developed nations to developing nations to cover the loss of health workers, continued support in capacity building through partnership programs and cycling of health workers from developed to developing countries (58). In addition to the aforementioned suggestions, a strong case has also been made for the presence and implementation at the national level, of policies and commitments to international guidelines such as the Commonwealth Code of Practice for International Recruitment of Health Workers and the adoption of the WHO global Code of Practice on the International Recruitment of Health Personnel by the World Health Assembly (58).

At the moment a Canadian definition or understanding of ethical recruitment is absent from both academic and policy literature on HHR. However, health recruiters across Canada agree on the need for crosscutting expectations and guidelines that can serve as a common ground for the ethical recruitment of IEHPs across the country. Such guidelines will serve as ethical instruments that balance the interests of the Canadian health care system with the needs and interests of developing nations. An example of a guideline can be that sovereign states and their people have the right to determine immigration requirements and/or have the right to create
contractual obligations that professionals educated with taxpayer money fulfil before they emigrate (56).

Ethical recruitment discourse is divided along two lines: active versus passive recruitment. Active recruitment is generally understood to be the active recruitment of health professionals from developing countries that might not have emigrated otherwise. An example of active recruitment would be a developed country’s regional health authority advertising in a developing country’s newsletter or attending a job fair. Passive recruitment is much less obvious in that it requires the individual to independently relocate to Canada. In reality, however, passive recruitment can be complicated since individuals do not decide to relocate in isolation. An example of passive recruitment can be the contact of colleagues in Canada or the interaction with a recruitment agency that facilitates contact with employers in the developed world. Some research even suggests that the Canadian immigration point system and immigration and relocation support for international educated professionals is passive recruitment. Various authors suggest that despite the general understanding of active versus passive recruitment among Canadian recruiters and health institutions, there is a lack of federal and/or provincial ethical instruments that can delineate the two forms of recruitment creating a standard of ethical recruitment (51,56, 59-61). In the absence of such instruments and critical discussion on ethical recruitment, Canada’s reliance on IEHPs (as demonstrated by Prime Minister Harper’s statement that Canada is in a global war for talent (62)) will continue to raise concern and international condemnation.
2.5 Barriers to Canadian Certification (Brain Waste)

Internationally educated health professionals (IEHPs) face numerous obstacles on the path to Canadian certification. Anecdotal evidence like foreign doctors working as taxi drivers speak to the difficulty of becoming certified in Canada. Research on the matter identifies common barriers to certification such as the lack of Canadian job experience and references, challenges in credential recognition, misinformation regarding certification, communication skills and a lengthy, strict and expensive recertification process (63-64). Such organizational barriers to certification can be conceived to be associated with social equity. Social equity as a concept includes fairness, justice and equitable distribution. Social equity issues arise when individuals are systematically denied rights due to characteristics outside their control such as gender, income, ethnicity or race (12). Using International Medical Graduates (IMGs) as an example, the Government of Ontario noted in a report the use of an inherently unfair registration process to assess IMGs. The registration entailed a built-in process that expected all medical graduates to meet the same criteria and education requirements - a problematic notion since IMGs and Canadian medical graduates varied significantly in training and experience. In the effort to level the process, Canadian medical graduates who matched the requirements were implicitly favored and IMGs who differed in their training and experience were assessed unfairly and excluded (63).

Since there is very little research on IEHPs from an equity perspective, it is difficult to generalize the above findings for IMGs to other health professions such as nursing and midwifery. However, the aforementioned barriers to certification are shared across professions, where nursing and midwifery research both show that a lack of Canadian experience, misinformation regarding certification processes, poor communication skills and the lack of bridging programs and financial resources impede IEHPs from attaining Canadian certification (20, 21, 65).
The literature review above spans the historical development of Canadian midwifery including the movements that assisted its reemergence, the professionalization process of Canadian midwifery and the educational and clinical requirements to practice midwifery in Canada. The review also covers the detrimental effect of the international migration of health workers (brain drain) on source countries, the Canadian and Saskatchewan contribution to brain drain, the ethical recruitment strategies and ethical codes mitigating the negative effects of brain drain and the common challenges and barriers that impede IEHPs from pursuing Canadian certification (brain waste). Although useful in contextualizing Canadian midwifery, the literature review confirmed a lack of research on Canadian midwifery from an equity perspective. In particular, there was very little written from an equity perspective on the IEM certification process with even less on IEM bridging programs. This thesis aims to add to the literature by using an equity framework and insights from Foucauldian post-structuralism and post-colonial feminism to study the experience of IEMs as they apply to and participate in two Canadian IEM bridging programs and one IEM assessment process.
Chapter 3. Methodology & Method

The primary aim of this study was to examine the equitable practices of IEM bridging and assessment programs using a social equity framework, with additional insights drawn from two critical theoretical perspectives. The following sections detail the approach used and outline the public administration social equity framework. Subsequent sections describe the study design, data collection tools and the analytical framework used to analyze collected data.

3.1 Conceptual Framework

3.1.1 Social Equity

Classic equity theory emphasizes workplace equity and the balancing of people and profit. Contemporary literature has a broader perspective and although multidisciplinary has a heavy inclination towards theory. Reviewing the literature, one form of equity stood out due its practical applicability. Rooted in public administration (in fact being one of the three pillars of public administration) social equity is defined as “the fair, just and equitable management of all institutions serving the public directly or by contract, and the fair, just and equitable distribution of public services, and implementation of public policy, and the commitment to promote fairness, justice, and equity in the formation of public policy” (81, p.2). Fairness, justice and equitable distribution are at the core of social equity where for example unjustly denying benefits to someone who qualifies for said benefits is a breech of social equity. Extrapolating the above example, denying any individual their right(s) due to characteristics outside their control such as race, ethnicity and income becomes antithetical to social equity (80-81).

Yet, defining social equity does not go far enough to ensuring it in the public space. For social equity to mean anything it must become measurable. This is accomplished in public
administration through the use of a social equity framework (80-81) comprised of the following four pillars: procedural fairness, access, quality and outcomes. Each element of the framework is defined in more detail below:

1) Procedural fairness is a synonym for due process and it involves fairness in management practices, equity in eligibility criteria and equality in procedure. In the context of the study, this dimension is relevant in that it allows for the examination of the manifestations of the words fair and equity.

2) Access (also known as distributional equity) promotes the evaluation of policies, services and practices to measure the level of accessibility to said services and benefits. It includes an analysis of unequal access, where it sheds light on who receives benefits and services. In the context of the study, this dimension of the social equity theory will be useful in determining who gets accepted into the program and more importantly who gets rejected.

3) Quality (also known as process equity) promotes consistency in the quality of services to all involved groups or individuals. The assumption is that a commitment to equity will manifest in the provision of consistent and equal service to all involved groups. In the context of the study, this dimension will shed light on why some students fail to succeed in the bridging programs.

4) Outcomes is a dimension of equity that evaluates if policies and programs have the same impact for all involved individuals and groups. “This proxy for equity examines social and economic factors and then asks why different outcomes occur. A critical consideration of equity is how much inequality is acceptable and to what extent should interventions be made” (80, p.2).
3.2 Research Design

3.2.1 Case study

Case study methodology has been argued to be the central methodology for understanding “complex unstructured problems” (82). As a methodology it is most useful when wanting to study a phenomenon in detail and within a real-life context and when the boundary between the phenomenon of interest and the context of the study are not clearly demarcated (14). The methodology allows for the use of multiple sources that can be abstract or detailed some of which are interviews, observations, document and record analysis, sample analysis etc. (84). In the traditional sense, a case can be defined as a single unit of analysis under in depth study but it is worth noting that this single unit can be an individual, a policy or an organization. A simple 2x2 matrix has been proposed to categorize case studies into four types along the axes of single and multiple designs and holistic and embedded designs. The following figure illustrates the 2x2 case study matrix.

Figure 1. Case Study Matrix
In the single-case/embedded design researchers “disaggregate context and situations into more discrete carefully defined chunks and then reintegrate these parts with an explicit analysis of their context” (85). Moreover, the single-case embedded design is built on four pillars: triangulation, theoretical sampling, analytic pattern matching logic and analytic generalization. All four pillars are to be authenticated through the use of juxtaposition and iteration (82-83). For the purposes of this study, the single-case embedded design will be implemented with the case under study being Canadian bridging and assessment and the embedded units under study being the Canadian bridging and assessment programs: the IMPP, the MMBP and the PLEA, respectively.

3.2.2 Purposive and Snowball Sampling

Purposive sampling is when the researcher actively selects a sample that will be useful (86). The researcher may use prior knowledge, literature or practical knowledge to select participants. There are many forms of purposive sampling, where the aim of the researcher may be to study a broad range of participants (maximum variation sampling), extremes or outliers (deviant sample), participants with specific experiences (critical case sampling) or participants with expertise (key informant sampling). Moreover, participants may be able to recommend other participants that will be useful to the study, a process known as snowball sampling (86). The study used a mix of purposeful sampling and snowball sampling to interview key informant interviews. Access to the initial group of key informants was through the Canadian Association of Midwives and the Saskatchewan College of Midwives; with subsequent interviews made possible by key informants indicating eligible participants (i.e. snowballing). All interviews were conducted over speakerphone and were recorded to supplement note taking.
3.2.3 Data Collection

Data collection was from multiple sources as a way to gather as much information as possible in order to conduct a comprehensive analysis. This approach was necessity considering the scarce literature on IEMs. Additionally, wide-ranging sources can ensure the data is as representative as possible, so as to capture institutional dynamics and polices that affect the Canadian certification of IEMs. Besides the use of key informant interviews (see below), document analysis on position papers and policy documents was also conducted. Documents came from the websites of the bridging programs and from key informants and provincial midwifery association and regulatory websites.

3.2.4 Key Stakeholder Interviews

Overall, fourteen participants were interviewed as key informants. Nine of the participants were IEMs, which applied to, completed or failed to complete an IEM assessment or bridging program. The IEMs interviewed for the study were either from the IMPP (3), the PLEA (3), or the MMBP (3). Interviewing IEMs was paramount to understanding the experience of IEMs who pursue Canadian certification.

Interviews were also conducted with an academic, an administrator of a bridging program, and with members of the midwifery regulatory community. The academic interviewed was particularly useful in understanding the historical and current developments in midwifery both on the international migration (i.e. brain drain and related brain waste) front as well as on the process of IEM Canadian certification. The administrator interviewed provided valuable information on the progression, structure and ongoing challenges of one of the bridging programs. The three regulators that were interviewed were from three different provincial jurisdictions. Interviewing
regulators from different provinces was useful in providing a comprehensive understanding of the certification process for IEMs.

All interviews were semi-structured in design and were conducted using an interview script. Semi-structured interviews provide more flexibility than structured interviews since they give room for ‘rich’ and in-depth answers (87). The interview scripts varied with a different script for members of the regulatory bodies, the bridging program administrator, and the midwifery academic and participating IEMs. Among IEM participants, two scripts were used, one for IEMs who have successfully completed a program and have attained Canadian certification and one for IEMs who were unable to gain access or were unable to successfully complete a program (see appendix 3 for interview scripts).

3.3 Data Analysis

All data was organized and analyzed using the qualitative software NVivo. The method of analysis used was thematic analysis. The analysis was rooted in a social equity framework in order to identify recurring patterns (i.e. themes) in the data that appear at the latent level of analysis (i.e. discourse) and that showcase underlying assumptions and ideologies (88). After reading and re-reading the data, the framework was applied to the data and following a reflexive interpretative stage the themes were mapped (i.e. coded) onto the data. Themes were determined not only by quantity but also by quality in relation to research questions. The themes rooted in the framework give a nuanced understanding of the data. They were further examined using both a post-colonial feminist and Foucauldian post-structuralist perspective. Presented below are the phases of the analysis stage (88).
Figure 2. Phases of Thematic Analysis

### 3.4 Ethics

This study has received ethical approval by the University of Saskatchewan Behavioral Research Ethics Board on April 4, 2012 (see appendix). In order to participate, all participants were asked to sign a consent form that described in detail the required level of participation, any risks involved in participating in the study and the level of confidentiality they will be afforded as participants.

### 3.5 Reflexivity

All research originates from a particular place, making it imperative that researchers locate their experiences and culture in their work (89). As a Somali-Canadian brought up by a single mother who came to Canada as a refugee from war-torn Somalia, I grew up in a low-income community that consisted primarily of refugees or immigrants coming to Canada from the Global Social Equity Framework (initial Codes).
South. Whether it was from everyday experiences or working and volunteering with immigrants and refugees, I came to learn of the immense challenges they face, primarily poverty from unemployment or underemployment, discrimination and acculturation difficulties. The above ‘story’ and the experiences in it shaped my identity and continue to draw me to social justice work, particularly in advocacy for affordable housing and for the end to poverty via pro-poor policies and programs. The study’s research questions on equity, migration and labor integration for internationally educated professionals fits in the purview of topics that interest me but more importantly speak to the historical and present struggles of immigrants all across Canada - some of them in my family and others living in my community. While ensuring my experiences don’t bias the research process, I drew insight from them as I listened to and learned from IEMs who are in the process of or have achieved Canadian certification.
Chapter 4. Results

The aim of this study was to determine whether Canadian assessment and bridging programs are equitable, what factors impede successful IEM access and/or completion of assessment or bridging programs and what the position of the midwifery community is regarding brain drain and brain waste. In order to achieve the above, IEMs, regulators, an administrator and an academic were interviewed. This chapter will present the findings from the above interviews. It will be divided according to the research questions of the study; with the findings for the first and second research questions presented together as they both relate to the social equity framework. Relevant excerpts of the interviews will be divided along the delineated themes where each theme will be presented below the framework pillar it is affiliated with.

4.1 Social Equity Framework

(1) How equitable are assessment and bridging programs in terms of procedural fairness, equitable access, quality and outcome in midwifery practice? And (2) what factors impede the successful initiation and/or completion of midwifery certification?

As mentioned before, the social equity framework consists of four pillars: procedural fairness, access, quality and outcome. Procedural fairness was defined as fairness in management practices and equity in eligibility criteria. Access includes the evaluation of policies, services and practices to determine level of accessibility and the analysis of unequal access. Quality was defined as consistency in quality of services to all including an analysis of unequal access. Finally, Outcomes was defined as the evaluation of whether policy and programs have the same impact on all individuals and if not an analysis of why different outcomes occur and to what extent interventions should be made. The framework was used to measure the equitable practices of Canadian assessment and bridging programs the PLEA, the MMBP and the IMPP programs.
In applying the framework to the interview data, six themes emerged: service delivery equity, eligibility criteria equity, financial barriers, geographical barriers, support/accommodation and equitable training. The figure below shows each theme’s relationship to the framework.

![Figure 3: Social equity framework (pillars and related themes)](image)

The following will present an overview of each theme, presenting a description of it, the data that support its emergence and in section 4.3 a general discussion of how each theme answers the study’s research questions.

**Pillar: Procedural Fairness (fairness in management and equity in eligibility criteria)**

**Theme 1: Service Delivery Equity**

This theme is defined as the equitable roll out of assessment and bridging programs. The theme emerged from the interviews in two distinct patterns, one that speaks to the challenges that IEMs face in the application process in their effort to access the programs and another that is
supportive of the presence of equity in the programs. In describing the challenges they face, several IEMs stated that the main challenge they face was what they considered a cumbersome, time consuming and resource intensive application process. Noting that it was difficult to attain documents from abroad, many felt that they were not given clear instructions regarding required documents in addition to what they felt was a lack of consistency regarding what was required to enter the programs.

Although some recognized the difficulty administrators were faced with in validating prior learning and experience, at times they felt that the continuous and inconsistent requests by program staff was demoralizing. Many of the participants shared with me stories of IEMs who have decided not to pursue Canadian certification because of the process, some of them making the decision in the midst of an application process and others after hearing about the process from fellow IEMs. Others noted challenges were the cancelation of the MMBP in the midst of an application process despite assurances of the roll out of the program for one participant, and the lack of support and guidance in the self-directed PLEA program. It is important to note that the comments relevant to this theme were made in reference to the PLEA and MMBP programs with no mention of the IMPP.

Below are two excerpts from the interviews that articulate the primary frustration of IEMs:

[…] currently I do have friends who have had enough and they just don't want to carry on because they ask you for one thing, you provide, and the next thing, oh it's not enough and you bring this. No, you have to write this essay. No, you have to go through this OSCES and no. Those kinds of things really makes one ask a question that, what is different about Canadian midwifery? And not to say that just bring any Tom, Dick and Harry in, but the same time, one feels like you are striped naked and you are deemed not qualified enough to practice in Canada.

[…] I don't know them but I heard midwives in [...] speak to me about other people that found the process too longwinded to go through it. So I do know other people
in my situation who've got degrees in midwifery but who are choosing to not do it because of you know the whole process.

On a more positive light, one of the IEMs stated that bridging programs were meeting a need by providing needed orientation and revision in preparation for supervised practice:

[...] supervising midwives needed to be with new midwives but couldn't know ahead of time how much time it was going to take to be with the midwife who was being supervised. [...] so the bridging program seems like a good idea, that there would be consistency in terms of classes and things that should be done online. So that by the time the midwives were ready to be placed with the supervising midwives in a practice, they would need to spend less amount of time.

Another positive was mentioned by a bridging program administrator, which indicated that despite inconsistencies, program management staff aimed to standardize the application process as much as possible:

[...] because most likely for the sake of fairness, we try to keep our policies the same for the whole cycle but sometimes they need adjusting because sometimes it can be something that compromises the fairness of the process [...] but at the same time its really important for standardization to have policies and procedures that are binding.

Moreover, acknowledging that some changes (adding an interview component) have been made to the application process in light of IEM and bridging management experience:

[...] When we did this the first time in our pilot phase we could be better first of all at gathering information at our assessment phase and having individuals be able to share and tell us [...] what they know how to do [...] having that opportunity to speak is being enhanced now [...] and so when we first did the pilot we weren't very good at coordinating that and now I think we are much better and we tested it in our new mechanism and we tested it a few months ago at the end of the last pilot and the results were great even people were happier at being able to have an interview to delve and kinda be an additional component to the application they sent and so far it seems to be working.
Theme 2: Eligibility Criteria Equity

This theme is defined as the presence of eligibility criteria that is systematic and non-discriminatory (i.e. allowing for equitable access). This theme emerged from the interviews in three distinct patterns, in an overall discussion on general eligibility criteria of the programs such as numbers of births, language capacity, type of experience etc., as another discussion on the Canadian midwifery model of practice and lastly as a third discussion on the possibility of moving the model forward to increase access to midwifery for IEMs and the general population.

The following interview excerpts by IEMs show the general opinion and pride displayed for the Canadian midwifery model of practice and its place as a requirement for entry into bridging programs for IEMs:

[…] They sort of tell you that whatever you have been doing where you come from you have to learn to do midwifery the Canadian way. There are midwives who come from Iran, Morocco, and Nigeria and so sometimes they feel that they don’t want to spend time going backward and that they need to go forward. And so they say so we know you all come with different experiences but now you have to learn the Canadian model, this is what you hear all the time.

[…] I don’t think I agree with that like really if you’re going to be a midwife you need to really manage the entire scope of practice and if you happen to find a job that is flexible like a hospital that wants to hire you for midwifery shift work or a prenatal or postnatal clinic that wants to hire you as a shift work and you can tap more into aspects then more power to you but I think that if you are going to be certified you need to do all the aspects of the job.

[…] philosophical and cultural wrapping your head around and embodying of some of the principles of the Canadian model is important if an individual comes from a model that is really hierarchal and that is really disempowering both to the midwife and her client then and for some people they are just craving for a different way of doing it and they say great I have been looking for this all my life in being respected in my role as a midwife and be able to freely empower the women I work with and not be pressured to push them etc. and thats kinda a personal thing but the other folks they are stuck in this is the way you do it you know and so for those individuals the model of practice in Canada is not the right thing for them.
The second pattern emerges from the interviews as an acknowledgement and appreciation by midwifery stakeholders for the Canadian midwifery model in addition to considerations on whether it is time to revisit the model in order to increase access for IEMs:

[…] I know of one midwife who didn’t do that successfully and our Canadian model of practice is something that a person needs to embrace. […] our Canadian midwifery is embedded in choice. Women’s choice of birthplace that all midwives practicing in all settings and that is the strength of the Canadian model of midwifery practice. […] Is it necessary now that the midwifery profession is well established? I mean it's an issue possibly for debate but when a person really, to the core of there being, feels like everybody should have their babies in the hospital, no matter how good of a hospital midwife they are, that’s not what it means to be a Canadian midwife. And you can’t make a person embrace that model if that’s not what their hearts believe.

The third pattern of discussion in the interview data takes the above discussion on revisiting the model a step further to introduce different types of arrangements in the model as a means not only to increase access for IEMs but also to diversify Canadian midwifery:

[…] I think that we need to explore a variety of health human resource models and first and foremost I think we need more midwives and I don’t want to dilute the midwifery model of practice but I am wondering whether we could expand or enhance it.

[…] I think that there is a lot we can do and continue to do both in terms of always challenging our own cultural biases, challenging biases in the model and when I said to you that there are really fruitful dialogues that happen at the national level and even at the local levels between midwives regarding the model of care and midwifery care. […] and sometimes the model doesn't allow some individuals to participate if they don’t believe in the model so some midwives say I want to work on call I just wanna go in do my shift and go home and so that in itself you may not get some midwives from some countries but is that a good thing or not a good thing? If the model is so great for the women it serves and its very holistic in supporting the whole family, extended family, friends, should we not strive for that? Then how can we learn from all of the various cultural groups, how can they help inform how the model can help support them better that’s when the dialogue happens at the professional level and we can work to get feedback from people who apply and then decide not to apply.
**Access:** (evaluation of policies, services and practices to determine level of accessibility).

**Theme 1: Financial barriers**

In the study, financial barriers is defined as the financial constraints that inhibit the certification of IEMs. The theme emerges from the data in primarily two patterns, the first demonstrating the financial difficulties IEMs face and the second in the form of possible solutions to alleviate the financial burden of pursuing Canadian certification.

The excerpts below show the financial difficulties IEMs experience in trying to become certified in Canada, primarily in document costs during the application phase, program costs, relocation costs and overall lack of income.

[…] its not easy cause you need to get documents from all over the place and any place you have been you have to get a criminal record and those are all costs.

…I had to take four months off to do the practical aspect of things and that was the hardest part because your not working […] the program itself costs $5000 […] and the cost of flying back and forth also cost much […] and for my visits to BC so I think those things were the most difficult for me.

[…] it’s the length of time that it takes, separation from family, lack of income. It’s not just money you’re putting out, but also a lack of income.

The second pattern in the data presented solutions proposed by IEMs, regulators and the interviewed academic. Solutions ranged from the need for more bursaries by midwifery Colleges with return for service arrangements to public funding for IEMs to reducing cost through innovative program development.

[…] I think they should provide reasonable access and financial support wherever possible and I think they should also consider whether or not they could make arrangements for a return for service arrangement, where if you put them through a bridging program they would agree to work in an underserviced area for say 12 months.
whether the Colleges could somehow and I know they are there for the protection of the public we come by this all the time whether they can give out more bursaries and more availability across Canada.

[...] I think public funding to retrain, re-socialize and integrate [...] I think that is wholly appropriate because we can’t rely on the ITMs to fund all of this I think that is a lot to ask. If we wanted to do it in a loan model fine but I am not as crazy about that because I think we are creating a public good by integrating ITMs.

[...] I think that our biggest contribution really is in devising a model that would alleviate costs [...] a comprehensive online first term and we are developing a Canadian midwifery simulated practice called CAMsim were still developing it but its going to help people stay in their home communities whether they are abroad or living here [...] second component which is the in person one, so you still need to travel but we try to make it short, the first time around it was six weeks we cut it down to five weeks and in the future it may be down to as little as four weeks and for the accelerated stream its even less [...] the third part is the internship and we have created a network of preceptors and trained the preceptors and established the network to have internationally educated midwives be able to practice wherever they are.

**Theme 2: Geographical barriers**

This theme is defined as the geographical factors that impact the certification of IEMs. The theme emerged from the data in two patterns; the first details the geographical difficulties IEMs face and the second indicates solutions to reducing geographical limitations.

Here are excerpts showing the geographical difficulties IEMs face:

[...] so when I came into Canada I got to know about the PLEA and that was through the College of Midwives. So then I decided to use the PLEA instead of going to the IMPP because I had younger kids and I wasn't going to leave them and go to Ontario for 9 months.

[...] I know a couple, she was going through the bridging program but she felt being away from her family was too much and there were some family issues and she didn’t feel like there was any way to come back to the program or any way for her to complete it from a distance.

Here are other excerpts showing solutions to the geographical limitations IEMs face:

[...] the other thing is that the MMBP is portable, the first two intensives were offered at UBC but the design of the program is that it could be offered at any
educational institution so it could be offered at Dalhousie or the University of Manitoba the other year and the idea is to maintain the accessibility in having the intensives be portable and then so much of the program is online.

[...] the IMPP can only take so many students and the IMPP is only based out of Ontario which means you have to relocate for at least one term if your fast-tracked. We need more options, we need a bridging program in each province or a joint bridging program like something for Manitoba and Saskatchewan like there needs to be more choices, there needs to be many more ways because requiring these women to leave their families or to uproot their families or have their partner support them to go through school in a different province is unreasonable.

Quality (consistency in quality of services to all)

Theme: Equitable Training

This theme is defined as the provision of high quality, relevant and consistent training. The following excerpts show the various areas of concern for IEMs as they participated in the programs, mainly the lack of instructional consistency during the program, lack of preparation for the practicum and the absence of a standardized instruction or assessment by preceptors during the practicum.

There were some pieces I think that we were kind of lacking in the program, like there was a syllabus but it didn’t always flow the way it needed to [...] I think more structure might not have been a bad idea especially for some of the international students who are coming from a distance, I also think one of the things that might have been helpful was a little more consistency with the didactic portion of the classes or getting people a little more prepared for what clerkship would be like, cause it really was a jump into and figure out it was going to be like kind of a thing [...] where we were all commuting in the class and the scheduled professor wasn’t available that day and we were kinda left there to do work in the lab and self teach and that wasn’t always the easiest use of time for people.

[...] I would have expected that because I am a midwife with my experience and everything the practicum would have been the easiest part, that’s what I thought but for me it was challenging because of all the midwives supervising you and testing you not on the core midwifery stuff but on their experience. I would say the way they do things not to say that they way they do things are wrong, you could be trained one way but you know still do things a little differently and is still the correct way it should be done but when you are doing your practicum and you are being supervised and [...] your proctors are the ones with the final decision well
not final but a big part of the decision its emotionally draining and very taxing. I find because you are dealing with different humans it makes things a little harder so I find that part was the most challenging part for me.

Outcomes (evaluation of whether policy and programs have the same impact on all individuals)

Theme: Support/Accommodation

This theme is defined as the provision of support and/or accommodation to IEMs as they participate in assessment or bridging programs. Many of the IEMs felt there was adequate support in the programs and that the programs were overall well structured. Yet, some in their interview have requested more instructional support, more clinical experience and more time spent in understanding the Canadian model. Relevant excerpts from the interview data are below:

[…]I don't remember there being a lot of outside support offered to us during our didactic portion of the class.

[…] there needs to be time. It isn't just about numbers. It is about time to absorb the philosophy and model of care that comes with continuity and home birth practice.

[…]I think that providing more clinical experiences would be nice […] I think the programs can be self-paced […] more teaching would be really helpful for people coming from different models with this is how we do things in Canada, can you repeat this or do that.

What would’ve been nice would have been to spend a weekend in the intensive care unit or week with a pediatrician or those kinds of things. The way that the PLEA was set up you spend your time with the midwives and so we couldn’t have arranged that.

4.2 Brain Drain/Brain Waste

(1) In what ways does the midwifery community mitigate brain drain and brain waste?

The interview data suggested a lack of awareness of the ethical implications of passive recruitment for both IEMs and regulators and with respect to IEMs (possibly) an uninformed support of active recruitment.
The following are relevant excerpts:

[…] well I guess that would be each province, I think that they should be advertising about midwifery in Canada internationally, I am not Canadian so I cant speak to whether they should recruit midwives but they should certainly advertise it.

[…] support IEMs right from the get go whether here or abroad in assessing their prior learning and assessment and helping them upgrade to the Canadian competencies for midwives […] we are also developing a Canadian midwifery simulated practice called CAMsim […] It’s gonna help people stay in their home communities whether they are abroad or living here.

The thing is I want to pull that back, I do believe that yes they should recruit more midwives because the demand is really high but where I would say from wherever they can get midwives from but of course they should allow them to bridge because bridging is important it puts you in a better place.

Yeah it mitigates brain waste absolutely but mostly the programs are about re-socialization into the new model of practice […] I think brain waste is not utilizing skills that are here and so its partly a numerical issue and so if we don’t get people through the programs and through them quickly and by quickly they should get into the program quickly upon arrival […] there should be this you know throughput.
4.3 Summary

Although midwifery assessment and bridging program administrators have made efforts to ensure IEM success, several areas of concern remain in IEM access to and participation in Canadian midwifery programs. In answer to the study’s first two questions, six major themes (i.e. areas of concern) emerged from the interview data upon application of the social equity framework: service delivery equity, eligibility criteria equity, financial barriers, geographical barriers, equitable training and support/accommodation.

In reference to the service delivery equity theme, IEMs share their frustration with what they consider to be a cumbersome, time consuming and resource intensive application process. In eligibility criteria equity, IEMs not only reflect on the importance and uniqueness of the Canadian model of midwifery, but also wonder whether its time to revisit the model and incorporate different health human resource arrangements to diversify IEM access to Canadian midwifery. Respondents also suggested several financial difficulties associated with document costs (i.e. police checks, transcripts from abroad etc.) when applying to midwifery programs in addition to the cost of assessment or bridging programs, relocation costs and lack of income while participating in a program. The geographical barrier theme illuminates the relocation difficulties IEMs face when participating in bridging programs. In the equitable training theme, IEMs share the difficulties they face within bridging programs such as a lack of instructional consistency, lack of preparation for their practicums and the overall lack of preceptor assessment standardization during practicums.

In the support/accommodation theme, IEMs request more clinical experience, instructional support and time in absorbing the Canadian midwifery model of care. Lastly, in the third research question, a passive recruitment and uninformed support theme emerged from the data illuminating
a general lack of awareness of the ethical implications of passive and active recruitment. Additionally, the theme indicated the positive role assessment and bridging programs play in mitigating brain waste among IEMs with the stipulation that more work needs to be done to increase the number of IEMs completing programs and attaining Canadian certification.

Finally, in reference to the study’s single-embedded case design, a comparative analysis of the three programs (IMPP, PLEA and MMBP) along the aforementioned six themes, establishes a high level of coherence between the themes in all of the programs with one notable exception. In particular, the service delivery equity theme that primarily notes inequity in the application process does not materialize from the interviews of participants who applied to and/or participated in the IMPP.
Chapter 5. Discussion

Labor market projections indicate a shortage of health care workers across Canada and around the world (54-55, 89). To maintain a sustainable workforce, the capability of current health professionals needs to be maximized and future recruits must be retained through effective integration into the workforce. In the past, the stability of the health care workforce was achieved in part through migration, as health workers comprised a considerable proportion of professionals who migrated to Canada. Yet, it has proven difficult to replace losses from the retirees of an aging workforce. It is this reality, which has directed the attention of policy makers to support and facilitate IEHPs to re-enter and remain in their chosen professions (89). Whether they come as a result of active/passive recruitment or as immigrants/refugees, it is imperative to understand the challenges IEHPs face when pursuing Canadian certification, not only to grow the health care workforce but to also meet current and future demand.

This study aimed to learn from and understand the experiences and challenges one group of IEHPs face when pursuing Canadian certification, that is the experience of IEMs as they apply for, participate in and complete midwifery assessment or bridging programs. Having used an equity framework and insights from Foucauldian post-structuralism and post-colonial feminism, the study’s findings elucidate the particular challenges faced by IEMs with assessment and bridging as they pursue Canadian certification.

To broaden the scope and contextualize the study, I have included a discussion on international migration, integration and Canadian midwifery. The following sections discuss the research findings in light of that literature. Research findings related to questions #1 and #2 are discussed in section 5.1 and 5.2. Research question #3 is discussed in section 5.3, which situates
the discussion on migration and integration of Canadian midwives in a broader discourse on ethics, migration and the integration of IEHPs in Canada and around the world.

5.1 Social Equity and Canadian IEM Certification

For the purpose of this study social equity was defined as “the fair, just and equitable management of all institutions serving the public directly or by contract, and the fair, just and equitable distribution of public services, and implementation of public policy, and the commitment to promote fairness, justice, and equity in the formation of public policy” (81). To apply the above definition in understanding the equitable practices of midwifery assessment and bridging programs, I employed a social equity framework with four pillars: procedural fairness, access, quality and outcome. The use of the framework in analysing interview data produced six themes: service delivery equity, eligibility criteria equity, financial barriers, geographical barriers, equitable training and support/accommodation. Each of the themes indicated an area or areas of concern that call for further work to improve equity in the policies and practices of midwifery stakeholders. With the exception of the eligibility criteria equity (to be discussed in-depth in section 5.2) each of the themes will be discussed below.

Service delivery equity, defined as the equitable roll out of assessment and bridging programs surfaced from the data as the frustration of IEMs with a demoralizing, lengthy, inconsistent and resource consuming application process to midwifery assessment and bridging programs. It is important to note that the IEMs acknowledged that the application process is a work in progress, with changes being made to the process in response to IEM grievances. However, the changes indicated did not seem to address the heart of the concerns, which was the overall frustration with the application process as cumbersome, expensive and filled with inconsistencies. Literature on IEHPs shows that this is not specific to IEMs but also experienced
by IEHPs in general, where access to complete and timely information on how to re-enter their chosen professions has been difficult (89, 90-91). Research on Internationally Educated Nurses (IENs) also concurs with the frustration of IEMs, resulting in a collective call in the nursing community for “greater transparency and clarity within the licensure processes” (91-92). The call was answered in the form of a three-year research study by the Mount Royal College in Calgary, which incorporated enhanced transparency and clarity into a Prior Learning and Recognition Program (PLAR). The PLAR significantly reduced discriminatory practices and provided applicants with detailed information on the standards of practice that will be used to measure their performance, what is considered a successful performance and the manner in which assessment decisions will be made (92). Similar actions by midwifery stakeholders would be useful to IEMs as they navigate the application to midwifery assessment and bridging programs.

IEMs highlighted various financial and geographical challenges they face when pursuing Canadian certification. Financial difficulties such as costs associated with document (e.g. transcripts, police checks) preparation and authentication, relocation costs or assessment/bridging program costs. Geography was also an obstacle IEMs noted in almost all of the interviews, suggesting that the limited assessment and bridging opportunities available were inhibitory to IEM certification. With the MMBP suspended due to lack of funding, the only available options for IEMs are the PLEA in Alberta and the IMPP in Ontario, both with limited capacity. Again, both of the aforementioned financial and geographical challenges were not unique to IEMs. Aside from program costs, estimates of the cost of attaining Canadian certification typically leave out lost income, childcare and cost of language upgrading. The same estimates also rarely capture family circumstances such as an immigrant family living on low-income or cultural or gender factors that place priority on the upgrading of male family members when allocating family
resources, delaying the entrance of female family members into the professional workforce (92). Additionally, similar to IEMs many IEHPs also face a shortage of assessment and bridging programs (89). Recent initiatives by the federal government such as the Foreign Credential Recognition Loans Pilot and the Immigrant Access Fund (IAF) were launched to help IEHPs attain Canadian certification. The Foreign Credential Recognition Loans Pilot supports non-for profit or non-governmental organizations that help IEHPs acquire Canadian certification and the IAF helps reduce the financial burden on IEHPs as they pursue Canadian certification by providing loans of up to $10,000 to help with qualification assessment, course materials, tuition fees etc. (93). Other funding opportunities such as a bursary program by the Saskatchewan Ministry of Health (94) also exist to help IEMs pursue Canadian certification. Still, as noted in the interview data a need remains for more support from regulatory bodies and the federal government to help IEMs and all IEHPs acquire Canadian certification and enter the healthcare workforce, particularly given all the personal expenses incurred that are not part of the estimated program costs.

Lastly, equitable training and support/accommodation emerged from the interview data as the absence of relevant and consistent training and support and/or accommodation for IEMs. Equitable training emerged as a general concern by some IEMs and was expressed as the lack of instructional consistency during the program, lack of preparation for the practicum and the absence of a standardized instruction or assessment by preceptors during the practicum. Support/accommodation emerged as a need by IEMs for more instructional support, clinical experience and time spent in understanding the Canadian model. Although the above concerns are specific to IEMs, an overall recognition in the literature of the complex issues assessment and bridging
programs face in discovering ways to integrate curricula and assessment while also addressing the learning needs of IEHPs from a variety of cultures, countries and contexts exists (95).

In summary, the above discussion on the social equity framework and the themes resulting from the application of the framework, demonstrate that although midwifery assessment and bridging programs have been able to assess, fill gaps and reorient IEMs in preparation for successful integration into the professional workforce, the process has not been without challenges both for IEMs and for assessment and bridging program management. The application of the social equity framework explicated several areas of inequity that impede IEM access to and/or completion of assessment or bridging programs. Yet, it appears that the biggest challenge to IEM certification at the moment is the availability of assessment or bridging programs, with only two remaining after the suspension of the MMBP. In addition to lobbying by midwifery stakeholders for more stable financing, a case has been made in HHR literature for post-secondary institutions to formally recognize assessment and bridging programs and lead the development of such programs in the college or university sector (95). With no experiences of this to date, it is difficult to tell if this would be more equitable and effective.

5.2 The Canadian Model of Midwifery Practice

Using the equity framework, procedural fairness was expressed in two ways, one of which was eligibility criteria equity. Eligibility criteria equity emerged from the interviews in three distinct patterns: as an overall discussion on the standard eligibility criteria of the programs such as numbers of births, language capacity, type of experience etc.; as a discussion on the Canadian model of midwifery practice; and lastly as a discussion on reforming the model to increase access to Canadian midwifery. For the purpose of the ensuing discussion, standard eligibility criteria is not included as it remains in line with information presented in the literature review and does not
raise any equity concerns. All participants were in agreement with the core competencies required in the standard eligibility criteria and believed they were necessary prerequisites to enter bridging.

Although legislated and practiced differently in provinces and territories across Canada, the Canadian midwifery model of practice consists of six pillars: health and wellbeing, informed choice, autonomous care provision, continuity of care, choice of birth setting and evidence based practice (96). Health and wellbeing emphasizes that midwifery practice in Canada promotes the wellbeing of women, babies and families and respects pregnancy and childbirth as a normal physiological process, a process influenced by a women’s emotional, social, cultural and physical experiences. Informed choice manifests as the active non-authoritarian encouragement of women by midwives to make informed decisions about their care. Autonomous care highlights the independent and full provision of primary health care services by midwives to women within the Canadian midwifery scope of practice, including ongoing support by midwives to women referred to other care providers for conditions outside the scope of practice. Continuity of care is a commitment of partnership made by midwives to women where a midwife is available on call throughout pregnancy, labor, birth, and up to six weeks of postpartum. Choice of birth setting is the right of woman to make an informed choice of the setting of her childbirth, whether it is in her home, a birth center or at a hospital. Finally, evidence-based practice is a pillar that outlines that a midwife’s care must be up-to-date with and incorporative of the latest maternity research and care issues (96).

Considered to be a feminist profession (79), the Canadian model of midwifery emphasizes women centered care that is holistic and that “recognizes and celebrates the transition to motherhood for women and their families” (97). A product of the ‘rebirth’ of midwifery at the height of a time when women felt marginalized by overt medicalization of birth, the model
manifested the demands of women for control over their bodies, choice of birth setting and choice of birth attendants (97). The acceptance of the model and its holistic women centered care approach echoes in all of the interviews I conducted. Indeed, the strong adherence to the model is indisputable. Nevertheless, there may be room for improvement.

5.3 Canadian Midwifery, International Migration and IEM Integration

Similar to countries around the world, Canada faces a shortage of health care professionals, midwives included (1, 54-55, 85). However, unlike other health professions, Canada does not internationally recruit midwives (60). That is midwives are not among the health professions a Canadian regional health authority might advertise for in the newsletter of a developing country (51). In fact, the Canadian Midwifery Regulatory Consortium (CMRC) (106), which consists of all of the provincial and territorial midwifery regulatory bodies in Canada, holds the following position on the international recruitment of midwives (i.e. brain drain):

The CMRC will endorse policies and practices around recruitment that do not intentionally contribute to the depletion of the number of practicing midwives in countries where this will have serious implications for the standards of healthcare for women and their babies.

The position statement acknowledges the ethical implications of actively recruiting individuals with technical, entrepreneurial and managerial skills from the developing world to the developed world (i.e. North America and Western Europe) (31). A process of emigration by health care workers that the World Health Organization (WHO) (32) believes has worsened access to basic health care for many people in the developing world, especially in developing countries with a high disease burden and a weak health system unable to meet healthcare demand. It is this unjust balance of health care between the developed and developing world that has international
bodies such as the WHO, developing world leaders, academics and civil society bodies around the world calling for not only remittances for lost labour but “repair, restoration and the righting of ethical wrongs” (44, p.5). This form of restitution pushes past neo-colonial models of restitution that further notions of charity and moves into a redistributive justice framework that aims to undo the perverse subsidy created by health worker migration to the developed world (1,34-35, 39, 44).

A perverse subsidy that is not acknowledged by IEMs in the interviews I conducted demonstrated an overall lack of understanding of the ethical implications of active recruitment. Whether this lack of acknowledgement is a result of a lack of awareness or is due to poor question design is unknown. Further research is required to understand the true position of IEMs on brain drain. It should be noted, however, that all efforts proposed in this thesis to reduce brain drain are aimed at the systemic level of developing and developed world governments and not at the individuals who emigrate for a better life. One positive effort launched by the Canadian Association of Midwives (CAM) has been the associations 2011 ‘twinning’ project with the Tanzania Registered Midwives Association (TAMA). The collaborative venture between CAM and TAMA has included the sharing of ideas and resources in addition to peer-to-peer mentoring and collaboration on midwifery research, education and practice (109).

Passive recruitment is a less obvious as a form of recruitment than active recruitment since it requires the individual to independently relocate to Canada. Still, individuals do not decide to relocate in isolation. An example of passive recruitment can be the contact of colleagues in Canada or the interaction with a recruitment agency that facilitates contact with employers in Canada. Some research even go as far as suggesting that the Canadian immigration point system and immigration and relocation support for international educated professionals can be considered
passive recruitment (51,56, 59-61). The tacit presence of passive recruitment at the structural level was discernable in a few of the interviews I conducted, where bridging programs supported IEMs with immigration issues, translated application requirements to support accreditation of international credentials and produced simulated education programs for IEMs in Canada and abroad.

McIntosh, Torgerson and Klassen (51) suggest that attempting to discern between active and passive recruiting to determine when passive recruiting becomes unethical may be counterproductive. Instead they suggest that the goal should be creating guidelines that differentiate when recruitment of IEHPs is acceptable or unacceptable, for the distinction does not “eliminate the ethical dilemma that faces developed countries when it comes to the migration of IEHPs. Indeed, it is hoped that by moving past the attempts to categorize one can actually begin to think about the kinds of policy responses needed to respond to the very real concerns raised by developing countries that Canada is depleting their health workforce” (51, p.7).

Such policy responses have been suggested in the HHR literature, which outlines the need for crosscutting expectations and guidelines that serve as common ground for the ethical recruitment of IEHPs that balance the interests of the Canadian health care system with the needs and interests of developing nations. Yet, despite research and international codes (such as the WHO Global Code of Practice on the International Recruitment of Health Personnel) to ground and support the establishment of policy responses to brain drain, there continues to be a lack of federal and/or provincial ethical instruments that form a standard on ethical recruitment (51,56, 59-61). In addition to Canadian midwifery’s commendable position on active recruitment, midwifery stakeholders need to establish policy that clearly discerns between active and passive
recruitment in addition to establishing expectations, standards and practices that promote the ethical recruitment of internationally educated midwives.

Moreover, Canadian midwifery stakeholders can mitigate poor labour outcomes and deskilling (i.e. brain waste) of IEMs in Canada by addressing the challenges they face when pursuing Canadian certification, and thus averting a loss of education and capability that represents the loss of capital and labour of developing nations struggling to meet the health care demands of their people (46-48). This would be an approach that has been suggested by several interviewees and that has support in CMRC’s position statement on brain drain where the consortium promises to “support the continued growth and development of domestic midwifery training programs” (106, p.2).

5.4 Researcher Journey and Theoretical Insights

All research originates from a particular place, making it imperative that researchers locate their experiences and culture in their work (89). As noted in the methodology chapter, I am a Somali Muslim Canadian who came to Canada with my mother as a refugee fleeing the civil war in Somalia. I grew up in a low-income neighborhood that consisted primarily of other refugees and immigrants from the Global South. I share the above story to locate my research, this thesis and myself geographically and historically to show how my outlook, identity and research have been shaped by my experience as a minority Canadian living, volunteering and working with racialized, migrant and low-income communities. Looking at the data from this lens, I could not help but notice a troubling universalization of the maternal and childbirth experiences of women and the good versus bad construction of Western versus non-Western midwifery, respectively. Having familiarity with critical social theories such as post-colonial feminism and Foucauldian
post-structuralism, I felt a need to read literature in both of these critical areas of research to better understand the troubling nuances I was observing during my analysis of the interviews. Ruth (89) states that:

Active intellectual work is needed to develop worldviews that differ from the prevailing worldviews of Western academia. For researchers of color this means having to become epistemologically bi-cultural. An ‘outsider within’ position is developed by minority groups who are required to have fluency with practices of the dominant group in order to survive but also have knowledge of their own contexts. The ‘outsider-within’ position describes the ability to be both inside and outside of what is being researched so as to understand both. This position provides a platform for critically examining the limits of dominant approaches when attempting to understand the experiences of marginalized groups” (p.470).

As I was analyzing the data, I experienced the ‘outsider-within’ position, where I understood the dominant perception of the maternal experiences of women supported by the midwifery model of practice but I also recognized limitations. The particular conceptualization of choice and empowerment in the model and in the interviews in addition to the persistent emphasis on the mother first and then the family I felt was problematic since I see choice, empowerment and the maternal experience of women to be conceptualized, structured and experienced differently from culture to culture. Pulling from post-colonial feminist and Foucauldian post-structuralist research helped me describe and explain the problematic nuances I was observing in the data. I should note, however, that pulling in theoretical perspectives to understand the data late in the research process has its limitations. Although I was able to make a case for the nuances I
observed in the data, it is glaringly salient that aside from a few examples in the interviews, the data does not conclusively support my observations. To be able to problematize the conceptualizations and constructions I observed in the data and to determine the prevailing understanding among participants, I would have needed to introduce one or both of the critical theories at the start of the research process. The following sections introduce both critical theories followed with a discussion that ties my reading of the critical theories with my analysis of the data.

5.4.1 Foucauldian Post-Structuralism

It is difficult to define post-structuralism since it consists of a diversity of ideas that vary significantly in their conceptualization of the ‘subject’. Despite their differences, a common mode of questioning and fixation with the concept of the subject unites them. Questions such as “what does it mean for a subject to be constructed according to certain presuppositions rather than others? Or what, moreover, are the philosophical and political effects (and costs) of the constructions of a subject?” (67, p.35) are lines of post-structuralist inquiry. For many post-structuralists, the view of “a fundamentally static totality is an incorrect understanding of language and cannot constitute a basis from which to explain the relational between language and society or the symbolic order” (67, p.38). Thus, instead of wondering about the stability of a social system or how to keep it stable, post-structuralists wonder about how a stable social system becomes or can be undone. An analysis that helps to uncover the elements that make up a social system is referred to as deconstruction. Michele Foucault’s concepts of discourse, govermentality, and normalization are of interest in this study and are the focus of this discussion.
Michele Foucault was a post-structuralist whose interest lied in understanding the forces and interactions that constitute a subject (for e.g. how discourse constructs a subject). In his *Archeology of Knowledge* (67-68) Foucault evaluates the impact of discourse and its rules on the positioning, conceptualization and assertion of individuals relative to it and of it (discourse) to truth. For Foucault, a particular discourse will contain all of the possible positioning and all that can be known, written and said about a subject. Discourse produces objects, subjects and statements with spokespeople who assert discourse specific speaking positions. Statements then become highly effective and functional in that they do not only create speaking positions but according to Foucault can be techniques that produce objects, subjects and become essential to the functioning of institutions all within a framework of relational power. Statement and concepts are constrained by rules that determine what is known and what can be considered truth therefore regulating what can be known, thought and said of a subject or circumstance. Both concepts and statements then are entrenched in the discourse and are made legitimate based on conditions set out in said discourse (70).

In Foucault’s later writing *Discipline and Punish* (67,69), he discusses power that creates subjectivity and controls the subject through normalization. Thus, Foucault’s conceptualization of power is one that is not owned by subjects (as is suggested by liberalism) but one that is relational between subjects and that is always “out there caught up in a matrix of forces which create lines of division, relations of oppression and exclusion, codes of discipline and sites of subjection (67).” For Foucault, examining discourse is useful in understanding the relationship between power and knowledge as it manifests in language. In other words, examining discourse can give insight into what words and statements can’t be made and what statements will be denounced as false (69-70).
Foucault also examined the manner in which individuals were controlled and disciplined by experts and/or regulatory bodies, a mode of analysis he referred to as problematizing governmentality. He aimed to understand how experts and authority influenced the positions and capabilities of individuals. Through further examination, he concluded that experts and authorities influence behavior and perception by becoming the gold standard of knowledge and what is considered to be normal and/or moral - creating a scope of influence and determining the makeup of populations and individual subjectivities (70).

Foucauldian analysis of power, knowledge and discourse can be very useful in understanding the relationship between the language of regulators, educators, administrators and midwives with Canadian midwifery discourse. In particular, the aforementioned Foucauldian concepts of discourse, governmentality and normalization have been useful in teasing out nuance in the data that lay the groundwork for further research on midwifery’s professional claims and the outcomes of such claims on the equitable access of IEMs to Canadian certification, a rationale of which is presented in section 5.2 in the discussion chapter.

5.4.2 Post-Colonial Feminism

Founded on the contributions of Fanon in The Wretched of the Earth (1963) and Black Skin, White Masks (1967), Said’s Orientalism (1979) and the works of Bhabha (1994), Hall (1996) and Spivak (1998, 1999), post-colonial theory interrogates the impact of empire (i.e. colonialism). According to Ato Quayson (71), post-colonialism “involves a studied engagement of colonialism and its past and present effects, both at the local level of ex-colonial societies as well as at the level of more general global developments thought to be the after effects of empire” (p.20). Quayson also states “postcolonial analysis promotes the ability to look away from the phenomenon of interest in such a way as to disclose its complex expression of the
interrelationship between the after effects of colonialism and dominant contemporary experience” (p.21). That is, post-colonial analysis places emphasis on societal, institutional and cultural modes of racism such as Eurocentrism and ethnocentrism that span over multiple points of concern such as class, race, ethnicity, gender and language when examining difference and social injustice (71-72). The impact and benefit of post-colonial theory is the theories insistent rejection of binaries that create a rhetoric that locate non-Europeans as an inferior subordinate ‘Other’ (72). Deconstructing the ‘Other’, Bhabha (73) emphasizes that “cultures are never unitary in themselves, nor simply dualistic in relation of Self to ‘Other’ ” making the case that culture can be ambiguous, partial and fluid and the need for the inclusion of historical and political developments to the understanding of culture in order to prevent a simplistic understanding with fixed cultural characteristics (72).

Looking for interrelationships between the after effects of colonialism and contemporary experience, the postcolonial analyst aims to expose and deconstruct persistent colonial assumptions as a means to remove their power. The act of deconstruction is paramount to post-colonialism, where attention is paid to the various features of text and/or language uncovering unquestioned assumptions and/or inconsistencies (74). Assumptions can have widespread consequences and help to maintain global inequity and are thus of importance to the postcolonial analyst who aims to clear space for multiple voices in an effort to ensure voices of the so called ‘Other’ are not suppressed by prevailing ideologies (10, 75,77).

A main criticism of post-colonialism has been the absence of gendered lens when studying the after-effects of empire. Taking a gendered analysis when examining racial and ethnic exclusion is part and parcel of dismantling binaries of understanding and creating complex understandings of social relations - a main interest of post-colonial studies (72). Bringing a
gendered perspective to post-colonial studies (i.e. post-colonial feminism), scholars converged post-colonial studies with black feminist discourse. Black Feminism brings to the forefront the simultaneous and intersecting nature of race, class and gender, an intersection described as ‘simultaneous oppression’ (76). The addition of a gendered lens infused with a race and class based analysis furthers postcolonial analysis by including all historically silenced voices, both the men and women who constitute the ‘Other’ (72).

Prevailing discourses about women have the power to create subject positions, influence subjectivities and reinforce or confront existing gendered relations. Post-colonial feminism is a much-needed analytic tool and voice in a backdrop of discourses that produce types of knowledge about various women that position them in networks of power and project them as particular subjects (72). Implementing post-colonial feminism as an analytical methodology not only necessitates reflexivity and reciprocity but also requires the analytical elements described below:

1) The application of a conceptual framework that allows for a simultaneous oppression perspective between race, class, gender, culture and history.

2) An inductive analytical progression from specific to general moving from micro to macro levels of analysis.

3) A grassroots creation of knowledge where the views of the historically silenced are paramount.

4) The dissemination and use of knowledge to transform and remove inequities and injustice.
Thus, the aim of a post-colonial analyst is not just to illuminate inequity and injustice but to transform, bringing into policy and practice the social, political, economic and everyday experience of injustice by the marginalized (71). Discussions on ethnicity, migration and recognition of foreign certification can be fully understood if they are “seen in tandem with realities of struggles in real postcolonial societies, precisely because some of these topics are actually the effects of global population and cultural flows after colonialism” (71). A post-colonial feminist lens can also be useful in problematizing notions of global sisterhood in addition to the epistemological claims of midwives to knowledge(s) on ‘women’ and ‘midwifery’ which some midwifery researchers believe have not been critically examined (78-79) due to midwifery’s branding as a feminist profession thought to be established by “feminisms authorizing signature” (79). Moreover, post-colonial feminism’s emphasis on simultaneous and intersecting oppressions of race and ethnicity, the righting of inequities and the theory’s transformative agenda of giving voice to the historically silenced is useful when examining the implementation of equity in Canadian midwifery bridging programs.

5.5 Critical Considerations and Directions for Future Research

The following discussion represents a more abstract consideration of the meaning of equity as it relates to the Canadian model of midwifery practice. It is important to note that although grounded in the data, the following reflection goes beyond what was said, to reflect my own concerns. This rumination is not meant to be conclusive but to make a case for further research to promote a theoretically informed re-examination of the Canadian model of midwifery practice. Returning to two Foucauldian concepts, discourse and governmentality, I reflect on nuances I observed in all of the interviews that suggest a particular and problematic form of construction of the Canadian midwifery model of practice.
Foucault’s insight on discourse and its rules on the positioning, conceptualization and assertions of individuals is particularly useful in understanding many of the interviewees unwavering support of the model of practice. By controlling positioning and statements and producing objects and subjects, discourse according to Foucault becomes highly effective in the functioning of institutions (70). Using Foucault’s reasoning then the interviewees self-positioning for example in partnership with women and assertions of empowerment and choice is on par with the end products of a powerful discourse on the Canadian midwifery model of practice.

Foucault’s problematizing of governmentality, that is the manner in which individuals are controlled and disciplined by experts and/or regulatory bodies, reveals that a profession’s claim to ‘gold standard’ knowledge and what is considered normal and moral are techniques to influence and determine the makeup of populations and individual subjectivities (70). The above Foucauldian concepts are useful in understanding the unequivocal assertions by all the interviewees (some more pronounced than others) of the Canadian model of practice as the ‘gold standard’ of maternity care. This was a model of care referred to by one interviewee as a ‘philosophical and cultural’ approach to maternity that all IEMs must ‘wrap’ their head around in order to access Canadian midwifery. Such opinions were shared and reiterated by almost all of the interviewees – and are in line with midwifery academic literature (15-18, 20) and the position of regulatory bodies (21, 25, 27, 28).

Yet, using Foucault’s understanding of discourse, power and governmentality, as well as feminist questioning of categorical acceptance of labels such as “women” I began to question whether midwifery’s universalizing claim to empowering ‘women’ and to ‘gold standard’ knowledge of maternity may be creating positions of subjugation or exclusion of those who don’t subscribe to the particular vision of midwifery’s feminist project. Expanding the boundaries of
feminism and questioning the discourse led me back to the writing in post-colonial feminist works.

Post-colonial feminism is a theoretical field founded in response to the absence of a gendered perspective in post-colonialism and Western feminism’s inclination to define gender and women as distinct and universal constructs. Tackling Western colonial discourse depicting certain peoples as subjugated through constructs such as the ‘Third World’ or ‘Third World Women’ (synonymous to the Global South in this thesis) post-colonial feminism interrogates the homogeneity of the above constructs and argues against the unitary assumption that all western and non-western women have the same interests (98, 99). Post-colonial feminist Mohanty (100) asserts that ‘Third World Women’ is constructed in Western feminist writing as “sexually constrained” and “ignorant, poor, un-educated, tradition bound, religious, domesticated, family-oriented, victimized” a direct opposite of the “educated, modern, as having control over their own bodies and sexualities, and the freedom to make their own decisions” Western women. This is in parallel to the subtle and at times overt distinction between empowered Western midwifery and Western women, and the tradition-bound ‘Third World Women’ and ‘Third World’ midwifery that was present in a few of the interviews I conducted. At times it seemed that where ‘Third World’ midwifery was mentioned, it was constructed as being hierarchical, disempowering and devoid of choice for ‘Third World Women’ in contrast to a Western midwifery that is empowering and rooted in the freedom to choose.

Post-colonial feminists go on to also examine the privileged subject of feminism (the middle-class heterosexual women) and calls for a feminism that not only critiques patriarchy and medicalization in maternity but also questions its inherent biases (102). These are purported to be perpetuated and maintained by hegemony. Hegemony ensues when “dominant groups are able to
gain control of culture with the consent of the majority of the population so that it appears natural and commonsensical” (105). Commonsensical ways of knowing however, can be challenged and changed when competing and subordinate groups work to shift taken for granted knowledge paradigms. At times such shifts occur with the inclusion of new or different historical, cultural, social and economic nuances (103,105). Indeed it is the decentering of hegemonic discourses that postcolonial feminists advocate and that seems to be paramount to decentering Canadian midwifery and its liberal insistence on individual rights to a place where it reflexively engages with other forms of “political and religious freedom, choice and self-determination” (101,104).

Perhaps by expanding the model, questions of difference can become nuanced and mindful of power relations structured along race and ethnicity.

Sheryl Nestle’s critical work is one of the only Canadian studies problematizing midwifery in this way. In her work, she (8) documented the systematic exclusion of immigrant midwives of color in the initial phases of legalization in Ontario. Despite their numbers, and the commensurate amount of education and skills to be brought into the legalization process, she illustrates how they were systematically excluded from the image and practice of Ontario midwifery in the early years. Similar to the aforementioned postcolonial feminists, Nestle asserts the exclusion of immigrant midwives of color to an insistent adherence to a western feminist perspective that reinforces normative whiteness and perpetuates inferiorizing discourses of immigrant women, the outcome of which was a largely monoracial midwifery profession in Ontario.

In an effort to bring attention to the Western feminist epistemic limitations of the Canadian midwifery model of practice and the unequivocal unquestioned support of the model by IEMs and regulators in the interviews I conducted, I have drawn on the aforementioned Foucauldian concepts and postcolonial feminist research. Using such insights, I propose that the interviewees’
strong assertions in support of the model of practice may not necessarily be a result of the model's effectiveness for all women, but can instead represent the end products of a powerful and hegemonic discourse – the women-centered empowering Western feminist discourse of Canadian midwifery. Sheryl Nestle’s work on immigrant women of color and their exclusion from midwifery in Ontario perhaps highlights the exclusionary and discriminatory impact of this unquestioned Western feminist model of care.

My suggestion to deconstruct the model of practice and move it forward to meet the needs of all Canadian women has support in two of the interviews I conducted, which suggest that it might be time for the midwifery community to revisit the model to “enhance it with different human resource arrangements” and to “challenge any inherent biases”. The first suggestion of incorporating varied human resource arrangements was proposed by an interviewee as a means to increase access to IEMs and Canadian trained midwives who (also noted in other studies) may have difficulty with elements of the model of practice such as continuity of care for cultural or socioeconomic reasons (29-30).

Future research may open up the discussion to enhance the model to be more inclusive to IEMs who for socio-economic, personal or cultural reasons require a more flexible model of practice. Moreover, a critical examination of the model may confirm the need to include maternal experiences and knowledge paradigms of women outside Western epistemological perspectives. As a profession with a history of challenging hegemonic knowledge systems, producing alternative knowledge and empowering women, Canadian midwifery may now be in a position to re-examine its past and build on its present in order to continue to empower Canadian women and their families.
Chapter 6. Study Conclusions, Limitations and Future Directions

I began this thesis with many questions regarding equity and the Canadian certification of internationally educated midwives (IEMs). I expected to do a thesis primarily on international migration and related labor integration, and was relatively pessimistic about what I would find given the dismal situation of HHR brain drain globally. Thus, learning that for the most part, that Canadian midwifery regulators agree on the ethical implications of brain drain and brain waste and have produced position statements on brain drain was a pleasant surprise. Moreover, coming to learn that midwifery regulators and assessment and bridging administrators diligently work to ensure IEM success in assessment and bridging to Canadian standards was informative.

Still, despite the very informed and meticulous efforts by regulators and administrators, several policies and practices remain somewhat inequitable, primarily in regard to what IEMs have described as a cumbersome, lengthy, expensive and demoralizing application process. In addition to high program fees, relocation costs due to limited availability of assessment and bridging programs, concerns regarding the lack of supportive and consistent didactic training, unsystematic preceptor assessment, lack of time to orient to the model of practice, inadequate preparation for practicums and the possibly uninformed support of passive recruitment of IEMs. The study also indicates a need for further elucidation and analysis of a systemic bias that I suggest may come from the common interpretations of the Canadian midwifery model. In my discussion, I offer some initial thoughts on what could be viewed as Western feminist epistemic limitations of the Canadian midwifery model of practice, using insights from Foucauldian and post-colonial feminism.
Future research would also benefit from interviewing IEMs who were unable to gain access or complete assessment or bridging programs, as well as key informants from the IMPP program in order to gain a more nuanced view of the history, structure and development of the program. The few IEMs that graduated from the IMPP that I interviewed are from Western Canada and may have different experiences of the IMPP than IEMs who reside in and practice in Ontario. Another limitation of this study is that the literature review and findings from the key informant interviews and the review of key documents are limited to the 2011-2012 year. All of the conclusions of this study reflect this time period and may not reflect the contemporary situation of the examined programs and/or Canadian midwifery.

Finally, the findings of this study and the questions it raises regarding the equitable practices of assessment and bridging programs suggest that perhaps a full program evaluation on IEM recertification is called for. I would suggest it include, particularly the study of the application process to assessment and bridging programs, a study of the Canadian midwifery model of practice from an equitable prospective and interventions to reduce the financial burden and geographical challenges faced by IEMs when they pursue Canadian certification. All of these considerations are crucial to establishing an equitable recertification process that certifies IEMs so that they, in turn can empower and promote the wellbeing of all Canadian women, babies and families.
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Appendix 1. Acronyms

IMPP: International Midwifery Pre-Registration Program
MMBP: Multi-Jurisdictional Midwifery Bridging Project
PLEA: Prior Learning and Experience Assessment
MEP: Midwifery Education Program
IEM: Internationally Educated Midwife
IEHP: Internationally Educated Health Professional
CMRC: Canadian Midwifery Regulators Consortium
OSCE: Objective Structured Clinical Exam
HHR: Health Human Resources
IMG: International Medical Graduate
PAHO: Pan American Health Organization
PAHO/CPC: Pan American Health Organization and the Office of the Caribbean Program
MMPC: Managed Migration Program of the Caribbean
Appendix 2. Code of Ethics

CODE OF ETHICS FOR MIDWIVES IN SASKATCHEWAN

Whereas, The Saskatchewan College of Midwives has been established to protect the public by ensuring safe, accountable midwifery in Saskatchewan, the adoption of a code of ethics is one way of achieving that goal.

Whereas, the observance of ethical standards increases respect and trust for midwifery, by both current and future practitioners as well as the community served.

1. Midwives shall practice midwifery in accordance with The Midwifery Act, regulations pursuant to The Midwifery Act, the regulatory bylaws and policies of the Saskatchewan College of Midwives and other relevant laws and regulations.
2. Each registered midwife shall at all times act in a manner that enhances the reputation of the profession.
3. Midwives shall respect birth as a normal life process.
4. Midwives shall maintain current competency in their midwifery practice.
5. Midwives shall maintain their own well-being and remain fit to practice.
6. Midwives shall provide midwifery care without discriminating on the basis of the prohibitions set out in the Saskatchewan Human Rights Code.
7. Midwives shall respect a woman's right to informed choice.
8. Midwives shall inform their clients of the scope of midwifery practice and any limitations to the individual midwife’s scope of practice.
9. Midwives shall maintain client privacy and confidentiality subject to health privacy legislation as it relates to midwifery and so inform the client.
10. Midwives shall not abandon care of a client in labour or in an emergency, but will make all reasonable efforts not to be in a situation requiring deviation from accepted standards of care.
11. Midwives shall interact professionally, collaboratively, respectfully and honestly with the people with whom they work and practice.
12. Midwives shall not accept any gift, favour or hospitality for a professional endorsement of a commercial product for participation as a registrant at continuing education events.
13. Midwives will not accept any gift, favour or hospitality from a client that could be interpreted as an inducement to provide preferential treatment to them.
14. Midwives shall actively promote equal access to health care that meets the needs of childbearing women.
15. Midwives shall make known to the appropriate person or authority the practice of a colleague that appears not to maintain standards of practice in their profession.
16. Midwives shall provide the best possible care within the midwifery scope of practice in all circumstances. When a midwife is unable to provide care, the midwife shall make all reasonable attempts to find alternative care for the client.
Appendix 3. Interview Scripts
Registrar Interview Protocol

General Questions
- Can you tell me a bit about your role as the registrar for the College of (insert name)?
- Are you in frequent contact with internationally trained midwives (IEMs)?
  - If yes, follow-up questions: how do you address inquiries made by IEMs? (probe: do you keep a record of all of the inquiries? What sources of information do you direct IEMs to?)
- Can you tell me a bit about your professional relationship with the MMBP and PLEA bridging programs? (probe: how often do you speak with the administrators and what do you often discuss?)
- As a regulator, what are the challenges you feel IEMs face? Does your college regularly discuss IEM certification, in the form of policies, working groups, research etc?

Procedural fairness
- Would you say that most IEMs can easily access the MMBP or the PLEA bridging programs?
- Do you think that the MMBP and PLEA ensure access to varied groups of women? (prompts: advertising and promotion, eligibility criteria, language, answering requests for information, websites, etc.)? Please explain.
- Would you say that the structure (education and evaluation components) of both the MMBP and PLEA programs will facilitate IEM success (both in the program and in access to the program)? Please explain.

Access (also known as distributional equity)
- What factors should a fair bridging program for internationally trained midwives include?
- What do you think is the aim of the bridging programs?
- Do you feel that the bridging programs are certifying enough IEMs? If not, why do you think this is the case?

Quality (also known as process equity)
- How do you think the bridging programs balance HHR demand, available internationally trained midwives and quality of training?

Outcomes
- In what ways do you think socioeconomic status impacts IEMs who are interested in Canadian certification, both before and during the bridging program?
- How far do you think a bridging program should go to accommodate internationally trained midwives?
Interview Protocol for Academics

General Questions
- Why did you choose to do your research on midwifery?
- Can you tell me about your research on midwifery and on internationally trained midwives?
- In your research on internationally trained midwives, what type of challenges do IEMs experience when pursuing Canadian certification?

Procedural fairness
- Would you say that most IEMs can easily access the MMBP or the PLEA bridging programs?
- Do you think that the MMBP and PLEA ensure access to varied groups of women? (prompts: advertising and promotion, eligibility criteria, language, answering requests for information, websites, etc.)? Please explain.

Access (also known as distributional equity)
- What factors should a fair bridging program for internationally trained midwives include?
- What do you think is the aim of the bridging programs?
- Do you feel that the bridging programs are certifying enough IEMs? If not, why do you think this is the case?

Quality (also known as process equity)
- How do you think the bridging programs balance HHR demand, available internationally trained midwives and quality of training?

Outcomes
- In what ways do you think socioeconomic status impacts IEMs who are interested in Canadian certification, both before and during the bridging program?
- How far do you think a bridging program should go to accommodate internationally trained midwives?

Brain Waste & Brain Drain
- In what ways does the Canadian certification of IEMs mitigate or affect brain waste and brain drain?
- Do you feel think that as a profession, Canadian midwifery will follow the same path as the Canadian medical profession when dealing with ethical issues concerning the certification of internationally trained professionals, brain waste and brain drain? Please explain.
- What suggestions would you make to regulators and/or administrators who are determining how Canadian midwifery will address ethical issues around equity, brain waste and brain drain?
- What are the challenges you foresee midwifery will be facing?
Interview Protocol for Uncertified Internationally Educated Midwives

General Questions

➢ Why did you choose to be a midwife?
➢ Where did you initially get trained as a midwife?
  ▪ What was the role of a midwife in your country of origin? Is this similar to what you know is the role of a midwife in Canada?
➢ Why did you choose to come to Canada?
  ▪ What information did you have about certification when you first came to Canada?
  ▪ Was that information accurate?

Procedural fairness

➢ How did you access or hear about the bridging programs? How was your overall experience with the programs (Prompts (if applicable) – inquiring about registration, registration, clinical components, English tests etc.)
➢ Would you say that most IEMs can easily access the MMBP or the PLEA bridging programs? Please explain.
➢ Do you think that the MMBP and PLEA ensure access to varied groups of women? (prompts: advertising and promotion, eligibility criteria, language, answering requests for information, websites, etc.)? Please explain.
➢ Would you say that the structure (education and evaluation components) of both the MMBP and PLEA programs will facilitate IEM success (both in the program and in access to the program)? Please explain.
➢ If applicable: were the instructors aware of what midwifery was like in your country of origin? If they were, did they use their awareness in teaching you the Canadian model of practice?

Access (also known as distributional equity)

➢ What factors should a fair bridging program for internationally trained midwives include?
➢ What do you think is the aim of the bridging programs?
➢ How do you define unequal access?
➢ Do you feel that fairness and sensitivity was included into policies, services and practices? Please explain.
➢ Do you feel that the bridging programs are certifying enough IEMs? Are they certifying a wide variety of IEMs? If not, why not? Please explain.

Quality (also known as process equity)

➢ How do you think the bridging programs balance HHR demand, available internationally trained midwives and quality of training?

Outcomes

➢ Do you feel that your socioeconomic status affected your access to the certification program in any negative or positive way? If so, in what ways?
➢ Do you think that language capacity impacts your ability to gain certification? Please Explain.
Do you feel that your cultural background impacts your ability to gain certification? Please explain.

In what ways do you think socioeconomic status impacts ITMs who are interested in Canadian certification, both before and during the bridging program?

How far do you think a bridging program should go to accommodate internationally trained midwives?
Interview Protocol for Certified Internationally Educated Midwives

General Questions
- Why did you choose to be a midwife?
- Where did you initially get trained as a midwife?
  - What was the role of a midwife in your country of origin? Is this similar to what you know is the role of a midwife in Canada?
- Why did you choose to come to Canada?
  - What information did you have about certification when you first came to Canada?
  - Was that information accurate?

Procedural fairness
- How did you access the bridging program? What was your experience of the different parts of the program? (Prompts – registration, clinical components, English tests etc.)
- Would you say that most ITMs can easily access the MMBP or the PLEA bridging programs? Please explain.
- Do you think that the MMBP and PLEA ensure access to varied groups of women? (prompts: advertising and promotion, eligibility criteria, language, answering requests for information, websites, etc.)? Please explain.
- Would you say that the structure (education and evaluation components) of both the MMBP and PLEA programs will facilitate IEM success (both in the program and in access to the program)? Please explain.
- Were the instructors aware of what midwifery was like in your country of origin? If they were, did they use their awareness in teaching you the Canadian model of practice?

Access (also known as distributional equity)
- What factors should a fair bridging program for internationally trained midwives include?
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- Do you feel that the bridging programs are certifying enough IEMs? Are they certifying a wide variety of IEMs? If not, why not? Please explain.

Quality (also known as process equity)
- How do you think the bridging programs balance HHR demand, available internationally trained midwives and quality of training?

Outcomes
- Do you feel that your socioeconomic status affected your access to the certification program in any negative or positive way? If so, in what ways?
- Do you think that language capacity affected your certification? Please Explain.
- Do you feel that your cultural background affected your certification? Please Explain.
- How far do you think a bridging program should go to accommodate internationally trained midwives?