

**SOCIAL DETERMINANTS OF PERINATAL HEALTH:
PERSPECTIVES ON THE ROLE OF MIDWIFERY**

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Abstract

There exists an abundance of literature that connects adverse perinatal outcomes to certain social and structural determinants of health. Midwives, like many other community-based primary healthcare providers, are often aware of various social determinants of health (SDH). Ontario midwives champion continuity of care and building trusting relationships with clients as significant aspects of their philosophy of care. Some midwives are committed to working with vulnerable populations in their communities and believe that midwifery's model places the profession in a unique position to offer personalized and comprehensive care to those in marginalized social locations, with the goal of producing the best health outcomes for women and newborns. This original qualitative research paper aims to explore if there exists a lack of knowledge or understanding among Ontario midwives regarding SDH and how they produce inequitable health outcomes; what epistemological barriers midwives may experience regarding health inequities; and what role (if any) midwives believe they have in addressing the issues faced by marginalized clients to mitigate adverse health outcomes.

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Introduction

Adverse perinatal outcomes (encompassing the prenatal, intrapartum, and postpartum periods), most significantly preterm birth, low birth weight, intrauterine growth restriction/small for gestational age, neonatal abstinence syndrome, and neonatal/infant mortality contribute to public policy concerns due to their high costs for health, social, and educational systems. In addition to high rates of mortality, there are long-term sequelae for infants born preterm or small for gestational age (Bushnik et al., 2017; Campbell et al., 2018; CIHI, 2009; Joseph et al., 2007; Kramer et al., 2000; Kramer et al., 2001; Liu et al., 2010; WHO, 2012).

Attempts to understand the complex phenomena of adverse maternal, fetal, and neonatal health outcomes have led to a growing body of research demonstrating their relationships to inadequate perinatal care (INPC), predominantly examining the barriers that marginalized pregnant women¹ face in accessing care (Angus et al., 2012; Darling et al. 2020; Downe et al., 2009; Heaman et al. 2007; Nussey et al. 2020; Sword, 2003). The barriers often discussed include lack of awareness of services, geographic distance or transportation costs, lack of childcare, precarious employment/unemployment, previous negative experiences with the healthcare system (including discrimination from providers, overt racism, and stigmatization of poverty), lack of culturally appropriate care, and fear of child apprehension. Most literature emphasizes equity of access to health services rather than health equity as a function of social determinants of health (SDH).

¹ The terms ‘pregnant woman/women’ and ‘mother’ will be used throughout this paper for consistency with references cited. However, it is acknowledged that not all those who experience pregnancy and mothering identify as women.

For the purposes of this study, marginalization is understood as a product of inequitable social relations. There is a need to identify the root of oppression in inequitable social relations, understand the lived experiences of those occupying certain social locations, as well as analyze the interaction between dominant groups and those on the ‘margins’ (Roberts, 2017). What is of particular interest here is how the social and structural relations of power in perinatal healthcare serve to undermine the experiences and health outcomes of marginalized pregnant women and their infants.

This research aims to explore the complexities of perinatal care provision for marginalized populations within the Ontario midwifery profession, focusing on SDH. The central questions are: what knowledge and perceptions of SDH do midwives in Ontario possess, and how do they view their role in addressing adverse perinatal outcomes for marginalized clients? Through interviews and focus groups, this qualitative study aims to determine if midwives experience epistemological barriers that impact their understanding of SDH and their approach to practice. Although no specific hypothesis guides this qualitative inquiry, the assumption is that midwives’ perceptions and clinical strategies are likely to be shaped by who they are, the training they have received, and the institutions that employ them. It is also expected that many participants will reference the opinion that midwives in Ontario are ‘well-positioned’ to care for marginalized groups due to their comprehensive and personalized care, and their emphasis on relationship-building and community health.

Participants’ knowledge and awareness of SDH and their perspectives on improving perinatal outcomes for marginalized populations are considered to be the

sensitizing concepts for this qualitative study. This inquiry is expected to reveal how midwives' care philosophies are constructed; how their training and work environments shape their knowledge of SDH; how their care for marginalized populations is organized and delivered; and how this impacts perinatal health outcomes.

Background

Biomedicalism in Perinatal Care

The biomedical approach to understanding and mitigating adverse perinatal outcomes predominantly focuses on a pregnant woman's lifestyle habits rather than on social and structural determinants of health (e.g. class, gender, race, disability, housing, employment, education, and food security). This focus reflects a neoliberal rhetoric of individual responsibility and blame (Mykitiuk & Scott, 2011). Recommendations for a healthy pregnancy typically focus on attending regular appointments, eating healthy food, ensuring adequate rest, exercising, maintaining a healthy weight, avoiding smoking and the use of other substances, taking vitamins or supplements, managing stress, and minimizing exposure to environmental or workplace hazards. Such recommendations do little to contextualize or address social and structural determinants of health. Labelling pregnant women as 'high-risk' due to lifestyle factors ignores structural issues and psychosocial stressors that may limit their ability to present to care, implement changes, and follow recommendations.

Psychosocial stress caused by material deprivation and social exclusion can contribute to mental health issues and lead to the adoption of 'unhealthy' or 'risky'

behaviours. Associations between area income, immigrant density, income inequality, and preterm birth were described in a 2009 Canadian study by Auger et al., illustrating that these associations were mediated by maternal birthplace and education. The study further elucidated “the ‘neo-materialist’ pathway, which posits that underinvestment in material capital in less equal communities translates into lost opportunities and possible adoption of harmful health behaviours”, as well as the psychosocial pathways that contribute to stress and subsequent adverse biological outcomes (Auger et al., 2009, pp. 8-9).

The neoliberal, individualistic rhetoric fails to situate a pregnant woman’s circumstances within broader social, political, and economic contexts; and ignores health inequities caused by systemic oppression. The ideology of biomedical risk management dominates in perinatal care compared to other domains of medicine and is “mediated by class considerations, as working-class women are less able to conform or to appear to conform to the high standards of behaviour expected of a potential mother” (Mykitiuk & Scott, 2011, p.319). The emphasis on risk and individual responsibility in perinatal care, as well as the tendency for healthcare providers to increase management and surveillance for those deemed to be higher risk, disproportionately targets and blames those who are racialized, living in poverty, and experiencing mental health concerns and/or addiction.

Research from the past decade has demonstrated that self-reported experiences of racism in prenatal care have been associated with up to three-fold increases in adverse birth outcomes, with some studies finding evidence of socioeconomic position mediating the association between racism and poor outcomes (Nuru-Jeter et al., 2009). Experiences

of racism contribute to psychosocial stress, and “awareness of the ever-present possibility of discriminatory treatment may itself be a chronic stressor for people of color” (Nuru-Jeter et al., 2009, p.31). Psychosocial stress in pregnancy has been associated with preterm birth, low birth weight, risk of infection, and increased neonatal morbidity and mortality (Zachariah, 2009). Several studies have demonstrated that Indigenous women, particularly, report harms caused by their interactions with healthcare professionals, ranging from stigmatization and neglect to gross mistreatment (Roberts, 2017). Woven through the literature on discrimination experienced by impoverished and racialized women in perinatal care are themes of power imbalances, oppression, and structural violence, all of which contribute to significant stress and health inequities for marginalized pregnant women and their infants (Nuru-Jeter et al., 2009; Roberts, 2017; Young, 2001; Zachariah, 2009).

Social Determinants of Perinatal Health and Health Policy

In a retrospective cohort study on inadequate prenatal care (INPC), Nussey et al. (2020) found that women without access to regular prenatal care were 20 times more likely to lose custody of their newborns at the time of hospital discharge; and their newborns were more than twice as likely to be small for gestational age (SGA), with neonatal intensive care unit (NICU) admission rates nearly three times higher. This study also found that data on important social determinants of health (e.g. income and education) were poorly reported: “INPC is associated with lower rates of identification and documentation of clinical and social risk factors” and that “INPC is a risk factor in

and of itself that should be identified and should inform the plan of care”. The authors concluded that reducing adverse perinatal health outcomes associated with inadequate care requires addressing the underlying determinants of health “not just at the level of clinical service, but also at a policy level” (Nussey et al., 2020, p. 599).

Socioeconomic position is a multifactorial and complex measure. In their research on socioeconomic status (SES) and preterm birth, Kramer et al. (2001) suggest that “socioeconomic disadvantage is unlikely to be a direct, independent determinant of preterm birth; instead, it probably leads to unhealthy behaviours, exposure to stress, and psychological reactions to stress that shorten gestation” (p.105). This statement sheds light on a more critical awareness of adverse perinatal outcomes mediated by the psychosocial stress caused by living in poverty.

Psychosocial stressors are the mediating variables in Kramer’s research, and the methodology uses hypotheses based on these variables and causal pathways instead of associations between risk factors (such as smoking) and preterm birth. Measurements in their hypothesized causal pathways include chronic and acute stressors, perceived stress, personal resilience, low social support, biological markers, and unhealthy behaviours which result from low SES, ultimately causing or increasing the risk of preterm birth (Kramer et al., 2001). The results demonstrate that spontaneous preterm birth is significantly and independently associated with maternal mental health issues (Kramer et al., 2009). This information is relevant for maternity care providers and those attempting to address the complex psychosocial factors affecting adverse birth outcomes, particularly among marginalized populations living in poverty.

Knowledge of mediating factors may help reduce certain risks, but the researchers state it is unlikely that a reduction in adverse perinatal outcomes will occur without eliminating poverty itself (Kramer et al., 2000). Such a conclusion speaks to the need for political will to enact policy change and intervention at broader systemic levels.

Despite persistent associations between SDH and adverse health outcomes, public health discourse and policies in Ontario continue to focus on individual lifestyle and behavioral changes, rooted in a neoliberal rhetoric of self-improvement (Brassolotto et al., 2014; Hallstrom, 2016; Langille, 2016; Raphael, 2008). How and why has this emphasis on modifying behavior gained so much traction, rather than addressing underlying psychosocial, economic, and structural factors? “This focus on lifestyle concerns escalates in spite of emerging evidence that these factors count for little against the importance of developing health promoting public policy and strengthening the ability of the citizenry to influence the determinants of health” (Raphael, 2008, p. 490). One could argue that it is more tangible and less costly for healthcare providers and policy makers in Ontario to focus on lifestyle interventions than to enhance public policy on health promotion, but it has become increasingly evident that these interventions are not improving health outcomes (Bryant & Raphael, 2020; Hallstrom, 2016).

The behavioral modification approach that is particularly emphasized during pregnancy is fixated on self-improvement, personal responsibility, and individual blame (Mykitiuk & Scott, 2011). In the cases of preterm birth and SGA infants, the consistent focus on behavioral modification in pregnancy concerning smoking, drug and alcohol use, regular attendance at prenatal visits, and healthy eating is not improving rates of

adverse outcomes. Preterm birth is the leading cause of neonatal and infant mortality in Canada and its rates have been steadily increasing in Canada and other industrialized nations (Association of Public Health Epidemiologists in Ontario, 2013). From 2006 to 2013, the preterm birth rate remained steady at just above 8% in the province of Ontario (Toronto Public Health, 2017).

A 2009 report by the Canadian Institute for Health Information (CIHI) demonstrated that the obstetric complications of maternal hypertension and diabetes are most strongly associated with preterm birth; and whether these conditions are pre-existing or pregnancy-induced, they are both generally attributed to lifestyle factors and therefore considered amenable to behavioral modification (CIHI, 2009). A 2022 report by Statistics Canada shows that from 2000 to 2016 the mean birth weight for all births decreased, while rates of SGA infants increased by 12%, with the most pronounced upward trend noted between 2008 and 2016. The report suggests that this trend is likely to have been “influenced by larger underlying economic factors” and that “the negative effects of an economic recession on maternal health has been well documented” (El Adam et al., 2022, p. 8). This report also identified that key factors connected to adverse perinatal outcomes during an economic recession are “unemployment, income, stress and psychosocial wellbeing” (El Adam et al., 2022, p. 9).

Given the well documented relationships between socioeconomic inequalities and adverse perinatal outcomes, we are at a critical juncture where strategies to reduce income and other inequalities related to SDH among women of childbearing age must not only be researched and discussed, but actively implemented at the policy level. This is

particularly critical because the relationship between poverty and healthcare access is “persistently salient for Canadian women as a whole”, in addition to the intersections of poverty, sexism/genderism, and racism (McGibbon, 2016, p. 496). There is a significant amount of government agency literature and declared action in Canada that pays lip service to the importance of addressing SDH, including a Health Inequalities Data Tool by the Canadian government, the development of the Canadian Council on Social Determinants of Health, and Canadian commitments to the Rio Political Declaration on Social Determinants of Health; but no improvement is apparent across many perinatal measures, including obstetric complications, preterm birth, and infant mortality (Bushnik et al., 2017; Campbell et al., 2018; Nussey, 2020; Public Health Agency of Canada, 2023; Sword, 2003).

How is it possible for significant perinatal health inequities to persist in a nation that boasts universal access to healthcare, and a national healthcare expenditure of approximately 11% of its GDP (CIHI, 2018)? There is a strong relationship between welfare regime type and the poor socioeconomic conditions that lead to adverse perinatal outcomes. In the case of infant mortality, “the social democratic nations (Austria, Sweden, Denmark, Norway, and Finland) show better infant mortality rates than do the liberal nations (the U.S., the U.K., Canada, and Ireland) for all decades from 1960 to 2000” (Coburn, 2010, p. 79), a trend that continues to the present (Bryant & Raphael, 2020). Reducing economic inequalities and committing resources to social infrastructure must be prioritized to improve health outcomes (Langille, 2016; Raphael, 2008; Raphael & Curry-Stevens, 2016). To ameliorate adverse perinatal outcomes, maternal and infant

healthcare providers and researchers have a significant role to play in advocating for policies that directly address SDH: improved working conditions, support for a living wage, improved food and housing security, anti-racist and trauma-informed frameworks, and the de-commodification of post-secondary education, mental healthcare, dental care, pharmacare, and child care.

In a 2014 study that drew on the concept of epistemological barriers, Brassolotto et al. discuss the challenges Ontario public healthcare providers face in addressing SDH. Their work describes epistemological barriers as “past worldviews and thinking patterns that can serve as obstacles to future progress and knowledge production” (Brassolotto et al., 2014, p. 322). There are significant variations how conceptions of SDH are approached, and this study highlights that the primary discourse in health professions is not only biomedical and focused on the individual but also depoliticized:

The decontextualized and depoliticized view of health does not question social and political structures; it takes them as a given and deals with issues within these preexisting structures. This approach ignores the presence and intersections of structural phenomena...and other forms of inequity – or treats them as irrelevant or marginal to health (Brassolotto et al., 2014, p. 322).

Their qualitative study is based on interviews with Medical Officers of Health and staff from Ontario Public Health Units. It concludes that inaction on SDH likely stems from epistemological barriers caused by “internalized discourses and traditions” that continue decontextualizing health from the sociopolitical environment (Brassolotto et al., 2014, p. 333). The researchers’ suggestions for overcoming such barriers include changes at the Ministry level regarding decision-making and training; new research tools that

address health policy; emphasizing SDH leadership; and meaningful accountability to track activity and progress on SDH activities (Brassolotto et al., 2014).

Some literature has suggested that healthcare providers' privilege and social status can produce a limited understanding and depoliticized view of the social and structural contexts of pregnant women living in poverty. This limited understanding and depoliticized approach often lead to judgment, the medicalization of poverty, and pressure on pregnant women to conform to socially and medically acceptable standards (Roberts, 2017).

In addition to depoliticized views and their playing out in specific approaches to health practice, the research on health inequities (specifically adverse perinatal outcomes) and their relationship to SDH generally lacks a political economy lens. Such a perspective would place these complex relationships within the broader context of how the Canadian liberal welfare state and the resurgence of neoliberal approaches to governance affect health policy and the distribution of resources that can create inequities in perinatal health. Liberal welfare states like Canada create greater income and health inequities, ultimately resulting from power inequalities than other forms of the welfare state (Bryant & Raphael, 2020). This power inequality is a product of neoliberal and capitalist ideologies emphasizing the market which give more power to those who own and control the means of production while undermining the social and political institutions that might help alleviate income and health inequalities (Coburn, 2004).

Liberal welfare regimes typically offer modest benefits, and entitlement to such benefits (such as social assistance) is strict, encouraging the market to fill the gaps

(Esping-Andersen, 1990). Canada's health insurance system may be universal because all citizens can ostensibly access basic needs, but it is far from comprehensive or equitable. Ontario's rather high healthcare spending does not mean it is adequately invested in health or health promotion. Public health policies are needed that address the quality and distribution of SDH and take account of the politics of health.

Bambra et al. (2005) explain that health is political for three reasons: health is a commodity in a neoliberal economic system, therefore some groups have more than others; the social determinants of health are amenable to political interventions; and the right to conditions that support health and well-being should be considered a human right. Increased public awareness (particularly among healthcare providers) that recognizes health and its determinants as political issues is greatly needed. This may be particularly important for the midwifery profession.

Midwifery in Ontario

The social and feminist movement which advocated for access to midwifery services in Canada throughout the 1970s and 1980s was “made up largely of white, educated, middle-class women in both urban and rural communities who were seeking alternatives to mainstream obstetrical care” and who were critical of biomedicine as ‘consumers’ of perinatal healthcare (MacDonald, 2018, p. 281). Over the past several decades, the re-emergence of midwifery in many Canadian provinces and territories was founded on a movement that sought to address the male appropriation and medicalization of pregnancy and childbirth, and is celebrated as a victory for women's health.

The midwifery movement has used “the rhetorically powerful symbols of tradition and nature which help to construct biomedicine as the ‘other’ against which midwifery identity has, in part, been formulated” (MacDonald & Bourgeault, 2009, p. 91). However, the advent of a ‘new midwifery’ was established predominantly by white, affluent, educated and able-bodied midwives (Nestel, 2006); and since midwifery became regulated in Ontario in 1994, its practice has operated within a biomedical risk-based discourse similar to that of obstetrics, as regulation necessitated cooperation with the medical establishment (Paterson, 2010).

Despite midwifery’s suggested alternative to obstetrics, its biomedical approach to perinatal care is now firmly rooted in a discourse of illness (with a vocabulary often including ‘diagnosis’ and ‘symptoms’ to describe the state of pregnancy itself), and an emphasis on the need for clinical management and surveillance. Perinatal care has become increasingly risk-based, with pregnant bodies as objects of analysis, management, and governance.

Informed choice is a founding tenet of care in Ontario’s midwifery philosophy (AOM, 2023). The development of informed choice in the ‘new midwifery’ as a social movement was inspired by the women’s movement of the 1960s and 1970s (MacDonald, 2018). In particular, the women’s health movement and sexual/reproductive liberation “introduced several new ideas into public discourse on health that were revolutionary at the time: that one can and should learn about and be responsible for one’s body and health, and that with access to information and a sense of responsibility would come

personal strength, autonomy, and a more critical stance towards health providers and institutions” (MacDonald, 2018, p. 280).

With its emphasis on informed choice, the practice of midwifery attempts to challenge power imbalances that are inherent in health encounters. Feminist politics and the resistance to male and medical colonization of women’s bodies that drove the early midwifery movement led to legalization and regulation in most Canadian provinces and territories, but it has been argued this once radical stance against modern obstetrics and the medicalization of pregnancy has “been replaced by a ‘new midwifery’ that is seemingly complicit in the perpetuation of a hierarchical, ‘expert centered’ healthcare experience” (Paterson, 2010, p, 128). This hierarchical experience is further complicated for marginalized women and their families by a profession that remains predominantly represented by white, educated, affluent practitioners.

The common use of the term ‘non-compliant’ in perinatal care for those who fail to follow recommendations or adhere to clinical management plans is problematic. Compliance highlights the power relationship between practitioners and pregnant women, and reflects an ideology that women should be passive recipients of perinatal healthcare. As discussed, the practice of midwifery attempts to challenge this power imbalance with its emphasis on informed choice and respect for a client’s autonomous decision making; but midwives in Ontario are simultaneously beholden to regulatory and hospital guidelines, as well as expected cooperation with community standards typically established by obstetricians (Paterson, 2010).

As such, midwives may respect a client's informed choice but are required to discuss and document when a choice falls outside of clinical recommendations or guidelines. Non-compliance challenges professional expectations and can result in a pregnant woman's behaviour being construed as irrational, deviant, or culpable; and "this emphasizes the principle of beneficence invoked by the paternalistic professional rather than promoting the autonomy of the patient" (Playle & Keeley, 1998, p. 306). The concept of non-compliance presumes that not following clinical recommendations is a 'choice', but this fails to acknowledge that the choices for marginalized women are often conditioned and constrained by social and structural inequities.

Due to midwifery's model of care that enables longer visits and focused, personalized care, as well as its philosophy that espouses building respectful relationships and supporting clients to make their own informed choices, the profession in Ontario champions its unique position to address inequities for marginalized women and their families. The Association of Ontario Midwives has stated that midwives are "well positioned" to address the issues facing clients living in poverty and to "improve outcomes due to their close relationships with both clients and broader community service providers" (Nelson et al., 2014). The 2014 clinical practice guideline provides tangible recommendations regarding nutrition, reducing barriers to care, and navigating social assistance; however, it fails to situate the reality of poverty within larger social, political, and economic contexts. As mentioned, recent studies that have examined midwifery care for marginalized populations and inadequate prenatal care help to identify strategies to improve perinatal health outcomes but remain significantly focused on

removing barriers to midwifery care. These barriers are either largely professional or are rooted in social determinants of health, with little mention of the need for political engagement and advocacy from healthcare providers or broader policy change (Darling et al., 2019; Darling et al., 2020; Nussey et al., 2020). Therefore, the purpose of this research is to explore if there exists a lack of knowledge or understanding among Ontario midwives regarding SDH and how they produce inequitable health outcomes; what epistemological barriers midwives may experience regarding health inequities; and what political role (if any) midwives believe they have in addressing the issues faced by marginalized clients to mitigate adverse health outcomes.

Methods

This qualitative inquiry operated within a naturalist paradigm, acknowledging that realities are varied, socially constructed, and holistic (Lincoln & Guba, 1985). A naturalistic approach enables an understanding of how a particular situation has come to be, and this form of inquiry allows for the complexities of phenomena to be investigated by interviewing human subjects to gather data.

Thirteen registered midwives in Ontario participated in this research study, with clinical experience ranging from one to over 15 years. Individual key informant interviews with three midwives in leadership and/or research positions were conducted. Four focus groups were also carried out with each consisting of two to three participants who were actively practicing registered midwives from both urban and rural communities.

The separate methods of key informant interviews and focus groups were utilized to allow for potentially diverse discussions to emerge. Key informant interviews with one individual at a time in positions of leadership and/or research, all of whom had many years of clinical experience, were more comprehensive due to the time and privacy these interviews afforded. Focus groups provided the opportunity for thought-provoking discussion among participants where ideas could be shared, and participants could draw from one another's anecdotes and experiences.

Participants were recruited by email using purposive sampling that involved criteria to ensure varied representation in terms of both urban and rural work; years of clinical experience; race/ethnicity; gender identity; and sexual orientation. Of the 13 participants: three practiced in rural communities; four had less than 5 years of experience, seven had 5+ years, and two had 10+ years; four identified as racialized; five identified as members of LGBTQ+ community; and two identified their gender as non-binary (with the remaining being cis-gender women).

The purposive sampling approach increases “the likelihood that the full array of multiple realities will be uncovered” (Lincoln & Guba, 1985, p. 40). Since the researcher is a member of the midwifery profession, purposive sampling was accomplished by identifying peers for small focus groups in addition to three key informants from the profession, involving a selection process that attempted to recruit participants with diverse practice locations, years of experience, race/ethnicity, etc. as discussed above. Ethics approval was obtained from York University's Ethics Review Board, and written informed consent was obtained from participants before each interview and focus group.

All interviews and focus groups were conducted over the Zoom platform, and participants chose whether or not to have their video cameras turned on.

A semi-structured interview guide with open-ended questions explored the participants' perspectives and knowledge of social determinants of health and their views on the role of midwifery in caring for marginalized populations (see Appendix). Utilizing open-ended interview questions allowed for a range of perspectives to be discovered. This research approach allowed the exploration of connections between social situations, professional practice, and policy-making in the institution of midwifery by studying shared patterns of behaviours, languages, and actions (Creswell & Creswell, 2018). The questioning techniques encouraged respondents to communicate their underlying attitudes, beliefs, and values.

Following the guidelines for naturalistic inquiry, there was also an emphasis on pacing the interviews and keeping them productive by maintaining flexibility and an easy rhythm. Rather than initiating the research with a particular theory, a constructivist and qualitative approach allowed theories to be inductively developed based on the findings from interview data.

Interviews and focus groups were recorded and transcribed verbatim by the Zoom software, and the researcher also took notes. The discussions ranged in length from 60-120 minutes. Transcripts were initially reviewed along with the recordings for errors made by the software and organized with any notes taken. The researcher then reviewed all transcripts for thematic analysis of the data, noting and coding the themes and patterns of meaning that emerged across the interviews.

Once an initial reading was complete, the data were analyzed using the constant comparison method to develop a grounded theory. This method is accomplished by (1) comparing incidents applicable to each theme; (2) integrating themes and their properties; (3) delimiting the theory; and (4) writing the theory (Glaser & Strauss, 1967). In such an application, the ‘theory’ was limited to identifying the main categories and themes expressed by midwife participants in a manner that retained the integrity of their constructions but which allowed for the identification of concepts by the researcher. The constant comparison method required that as an incident was coded for a particular theme, it was compared with previous incidents. As a result, two themes emerge – those that the researcher constructed and those that emerged from participants’ responses. Therefore, this process stimulated thought, leading to descriptive and explanatory themes (Lincoln & Guba, 1985). Digitally coloured highlighting was used to identify and associate repeated ideas and themes. The themes were substantiated by re-reading the transcripts to ensure the data captured the central ideas appropriately.

As a member of the midwifery profession in Ontario, the researcher acknowledges both the benefits of clinical experience and access to information, as well as the potential for bias. Having the ability to communicate with participants during interviews using the same clinical language, common comprehension, and shared experiences enabled effortless interpretation of study data. The researcher also has direct experience working in outreach midwifery with marginalized populations. This experience assisted and informed the study, but also meant the data was sometimes viewed through the lens of the researcher’s own experiences, some of which have been

personally and professionally challenging. Bias was minimized by member checking, as well as having the final paper peer reviewed.

Of note, these interviews took place during the COVID-19 pandemic. It is now well understood that healthcare workers continue to experience significant levels of burnout from the increased demands and chronic stress of working through a pandemic. This burnout can lead to diminished capacity, pessimism toward one’s profession, reduced quality of care, high attrition rates, and decreased self-esteem (Sharifi et al., 2021). Although the effects of working through a pandemic added to participants’ experiences of burnout and frustration with their profession, many of the issues and professional barriers discussed existed for midwives before the COVID-19 pandemic.

Results

The findings from key informant and focus group interviews revealed three major categories illustrating midwives’ perspectives on the following: 1) complex effects of social determinants of health on perinatal care; 2) professional barriers; and 3) recommendations for change at multiple levels (see Table 1).

Table 1. Summary of Key Findings

Category	Themes
Complex effects of SDH	<ul style="list-style-type: none"> • Intersectionality and compounding effects of various SDH on perinatal health outcomes • Fear and mistrust of systems • Experiences of racism
Professional barriers	<ul style="list-style-type: none"> • Midwives’ experiences of burnout; feeling overworked/undervalued

	<ul style="list-style-type: none"> • Lack of support from midwifery practice groups • Strained hospital and interprofessional relationships • Lack of relevant education/ongoing training
Recommendations for change	<ul style="list-style-type: none"> • Expanded scope of practice • Reformed model of care and funding structure • Increased diversity within profession • Improved intersectoral collaboration • Changes in data collection • Enhanced midwifery leadership and political advocacy

1) Complex effects of social determinants of health on perinatal care

When participants were asked to describe their knowledge and perceptions of the SDH that most impact perinatal care for marginalized populations, they discussed various interconnected issues. These included income insecurity, food insecurity, lack of affordable housing or homelessness, precarious work and unemployment, lack of transportation, lack of affordable childcare, immigration status, lack of health insurance, language barriers, lack of education, child welfare system involvement, limited social support/isolation, racism, past and present trauma/mental health concerns, substance use/addiction, violence; as well as the disproportionate ways in which Indigenous, racialized, and new immigrant clients experience these many issues.

Participants explained that these interconnected issues often prevent clients from accessing perinatal care or even prioritizing their care, as there are too many barriers and competing demands. The overarching concern expressed by many participants was the

perpetual state of stress and chaos in which many marginalized clients exist and their need to focus on simply surviving each day. One participant with many years of clinical experience stated, “The social factors make life unendingly difficult and unjust and insurmountable. I think that people just don’t appreciate how difficult a day-to-day existence is when you have nothing. And I think the more you work with people, the more you see that and understand that.”

Participants were able to articulate that the circumstances created by overall stress, trauma, scarcity, and insecurity can lead to negative health outcomes for both clients and their newborns. Nearly all participants described that more vulnerable or marginalized clients are often late in presenting to prenatal care (if at all), unable to consistently attend prenatal and postpartum appointments, lack social and emotional support during labour and childbirth, have newborns with higher rates of NICU admission, are more likely to experience mental health complications (particularly postpartum), and are less likely to breastfeed. The following statement illustrates the interconnectedness of these complex issues and the cascade of negative effects that can occur:

Not having dedicated support can impact things like labour and birth outcomes and some clients are alone during labour because their partner has to stay home with other children, or they can’t afford other labour support. Then all these things lead to higher risks of postpartum mood issues and struggling with breast- or chestfeeding just because you can’t make it work or there are too many other things happening. You can’t sit around and work on feeding or hire a lactation consultant because you can’t afford to and you need to get on with the rest of your life.

Another participant expressed their frustration about the effects of material deprivation on perinatal mental health and a perceived lack of solutions:

I see [colleagues] refer to [urban mental health resource] and I just think, their sadness right now, in my non-psychiatric opinion, is due to lack of material fulfillment. That they can't have a basic human existence with stable housing and finances. And it has nothing to do with CBT [cognitive behavioural therapy]. And nothing that I do or say can actually change that situation and no referral is going to change that situation.

The interrelated issues of precarious employment, lack of transportation, and lack of childcare were discussed by several participants as creating significant barriers. These affect attendance at midwifery appointments and recommended consultations with specialists and/or appointments for ultrasounds and laboratory work. Participants highlighted that many clients with precarious employment could not afford to be absent from work, and those without access to transportation or childcare are often unable to travel to appointments or manage the time away:

If there are any other clinical issues, like they need extra ultrasounds for something or they need to have an MFM [maternal fetal medicine] consult, that makes things much more complicated. Because with any sort of consult appointment, your entire day is gone, which is hard when you can't miss work. Not to mention, the cost to get to the hospital to then turn around and wait hours for your appointment.

Nearly all participants were able to link their understanding from research and practice of how these interrelated factors can lead to significant adverse health outcomes, including undiagnosed or poorly managed obstetrical conditions, higher rates of untreated infections, low birth weight, small for gestational age infants, and preterm birth (along with its associated sequelae).

In general, the participants with more years of experience in clinical practice, as well as the key informants in roles of leadership and research, were better able to describe the challenges and complexities of caring for marginalized clients. They articulated a more nuanced understanding of the compounding effects of SDH on perinatal health outcomes. It was also noteworthy that the few participants who were able to identify the need for broader systemic change and more political involvement and/or advocacy from midwives for policy change were those who themselves occupied marginalized social locations.

Fear and mistrust of systems

One of the significant topics that surfaced throughout all interviews about social determinants of perinatal health was the fear that marginalized clients can experience when accessing care, particularly due to heightened surveillance from the child welfare system, as well as stigma and discrimination from service providers. Participants described that living in poverty, struggling with mental health and/or substance use, and being racialized are all major risk factors for increased surveillance from the healthcare system, as well as other service providers and agencies, which can lead to investigation from child protective services.

Nearly all participants discussed the overwhelming stress and pain for clients who must navigate the threat or reality of child apprehension, especially if they had involvement in their youth with the child welfare system. Midwives acknowledged that they have a duty to report if there is a legitimate risk to a child's safety, but the profound

concern that came up in most interviews focused on the trauma created by child welfare system involvement:

Sometimes CAS [Children's Aid Society] is called when there are no child protection concerns and this interference and surveillance are profoundly traumatic and disruptive. But anytime somebody sort of falls outside of that tranquil compliance, you run the risk of this. The ways in which in the name of protecting children, we destroy women. And it's not to say that children shouldn't be protected, it's to say that you could protect children by protecting their mothers.

One participant distinctly articulated how the trauma caused by child welfare involvement can keep families in cycles of poverty and oppression:

There's this loop that people in poverty get into, right? They have a baby and they live in poverty. And so, social work at the hospital identifies that they live in poverty. And because of that or because of a lack of social support, a history of drug use, or history of apprehension, suddenly now they're forced back into that loop of being questioned as parents and being questioned as people. From day one of a child's life, not only is that determining their health outcomes through potentially being separated from their parents and being forced into a foster system where we know there are higher rates of child abuse. It's just so complicated and so vastly oppressive...They can't escape it.

A few participants witnessed first-hand the discrimination that clients can experience from other healthcare providers in hospitals when marginalized or involved with the child welfare system, noting the stress that clients feel when they cannot meet the expectations of socially acceptable parenting. Other participants discussed the challenges marginalized clients face when they are 'flagged' within the hospital system for meeting certain criteria that necessitate social work involvement, emphasizing that many marginalized clients avoid the hospital due to fear of judgment, surveillance, and mistreatment.

Another participant, who identified as racialized, shared an experience about what they viewed as inequitable treatment and over-surveillance of a racialized client by their midwifery practice group:

There was a young Black mom who had disclosed a history of cannabis use, but it was significantly reduced during pregnancy. And then I had this very affluent client with a prestigious job, who actively and knowingly drank [alcohol] throughout her whole pregnancy. Yet, my clinic wanted to flag the young Black person. It's fine if you want to be like, hey, I want to advise on this substance use, for whatever reason, racial or not. That's one thing. But when you have two people that are engaged in risky things and you only worry about the young person of colour, while the White mom could get away with it and no one put a red flag towards her. It's really, really [*expletive*] upsetting.

One participant explained, "Certain situations automatically red-flag someone for a social work consult and this can feel intrusive and unjust. It's a very fine line between, will this actually be supportive, or will this be a risk to my client?" A few participants sometimes felt compelled to protect clients, especially those who are racialized, from the child welfare system that seems unjustly interfering with their lives, leaving women and families vulnerable to pain and ongoing trauma.

Participants highlighted a lack of trust in the healthcare system and other intersecting services due to stigma, mistreatment, and over-surveillance. This lack of trust can cause marginalized clients to refuse recommended consultations in the hospital because of negative past experiences or trauma or refuse to follow up due to discriminatory treatment. The risk of child apprehension and the fear of judgment and discrimination often prevent clients from accessing perinatal care. The interviews revealed an understanding that race and class are important in determining how people

are treated within systems, especially the healthcare system and that for many, the pain of experiencing certain types of discrimination is not worth accessing healthcare.

The few participants who were able to articulate a connection between the issue of over-surveillance and discrimination by the child welfare system and the need to address broader socioeconomic inequities, white supremacist culture in healthcare, and how the privilege and dominant whiteness of the midwifery profession can contribute to classist and racist perceptions of marginalized clients were those who themselves identified as racialized and/or occupied marginalized social locations.

Experiences of racism

A second significant topic revealed throughout all interviews when examining social determinants of perinatal health was the experience of racism for marginalized clients and its profound effects on the care they access and receive. In addition to the over-surveillance of racialized and Indigenous clients previously discussed, nearly all participants mentioned instances of overt racism in the hospital, from other healthcare providers, and at times from midwifery colleagues. Several anecdotes were shared describing first-hand witnesses of racist conduct from healthcare providers, including blatant remarks, discriminatory assumptions, and a lack of awareness or appreciation of cultural differences. One participant explained:

I've seen not honouring what a woman of colour is saying as proof, particularly related to pain. I've actually heard people talk about, oh, you know, she's acting this way because it's cultural. As opposed to a woman of whatever other culture experiencing pain and it being perceived differently. And therefore, care being provided differently, right? Like hopping to get them pain relief versus it not being a priority.

Although much discussion focused on discriminatory treatment from other care providers and within institutions, several participants were willing to acknowledge that these issues also exist within midwifery: “I think midwives have this sense that we are more socially advanced and critical, and so a lot of us are ignorant to the fact that our practices and colleagues could be and are so racist sometimes.”

Many participants also discussed what they perceived to be a lack of culturally safe care, particularly in hospitals, and how this serves as a significant barrier to care:

I had a situation where I had a client who felt they were treated disrespectfully due to their race, and used the words feeling traumatized, not wanting to return to the hospital for care...I think that is one of the more recent kind of glaring examples of how it impacted both her emotional well-being, but also that it had a potential to cause an adverse outcome.

Several participants highlighted the need for considerable advocacy for their racialized and Indigenous clients, especially around normalizing cultural practices within hospitals (e.g. smudging in labour rooms), but particularly calling attention to discriminatory treatment.

The majority of participants spoke about the unique barriers for racialized immigrant clients, particularly a lack of culturally safe care in hospitals and from care providers, as well as language barriers made more complicated by difficulties with translation services. It was mentioned that many midwifery practices utilize translation services during clinical encounters, but during consultations with other care providers or interactions with other programs and agencies, this is often lacking or altogether absent.

The intersecting and compounding effects of class, race/Indigeneity, newcomer status, language barriers, and social isolation create challenges for system navigation and experiences of culturally unsafe care. These can prevent clients from consistently accessing perinatal care, placing them at risk for pregnancy and birth complications and poor birth and postpartum outcomes.

2) Professional barriers

Participants were asked about their belief that midwifery is well-positioned to care for marginalized clients and asked what this looks like for them in practice. They were then questioned about the professional barriers they face when providing this care. One participant spoke passionately about their opinion on midwifery's role in care provision for vulnerable populations:

I think our role as part clinician, part social worker, part professional friend is really unique, and I think it has a lot of potential. If midwives are truly practicing to uphold the principles of informed decision-making, we can show people a different way to interact with the health system. Our jobs are an important point of intervention for healing trauma for people sometimes simply by offering choice, and our care hopefully fosters trust and collaboration.

The demanding on-call schedule, long hours attending births, time spent travelling for home visits, compassion fatigue, lack of support from other healthcare providers or actual interprofessional conflict are some factors contributing to high rates of burnout and attrition in midwifery. Many participants spoke at length about their belief that midwifery is well-positioned to care for marginalized clients from a philosophical perspective. However, implementing care for higher needs clients is an enormous difficulty when so

many midwives already feel overworked and undervalued. One participant stated, “our model of care is problematic in terms of sustainability, with midwives being very tired and burnt out.” Another participant highlighted how challenging burnout can be for midwives and the clients they are trying to care for: “burnout leads to a reduction in quality of care and increasing disrespectful care. Midwives just lose capacity when they’re burnt out and are struggling themselves emotionally and mentally to be able to give that thoughtful care to others.”

Some participants discussed that midwives in Ontario disproportionately care for white, affluent clients, who typically do not have high needs and therefore demand less work for an already over-burdened and often burnt-out group of professionals. Several participants spoke of the care required for more marginalized clients, including extra case management, considerable advocacy, intersectoral collaboration, translation services, extra time building trusting relationships, trauma-informed care, missed appointments, more home visits (due to lack of transportation or childcare), arranging referrals, and child welfare system navigation. One participant addressed that this extra work is often a significant barrier in a profession that does not have the structure to make it a priority:

Often the work looks like trying to connect people with lots of resources when they come into care, definitely offering more home visits. It’s often more important to really try to meet people where they’re at, especially if they’re missing lots of appointments and trying to get creative with how we can provide care. It’s a lot of extra work. I sometimes hear people say ‘we can’t care more than they do’ but actually we can. We have more time and privilege to care about certain things and that’s our job that we get paid for.

Some participants also commented on the profession of midwifery not reflecting the communities in which they work, the need for more diversity within the profession,

and the position of privilege midwives occupy serving as a barrier to caring for marginalized populations since it is easier to maintain the status quo of the profession.

One participant spoke of how this privilege creates barriers:

The way we practice is limited by the fact that we were created in the same system that creates social inequities. That in and of itself is something that we should constantly acknowledge. And that has to do with our education, who is admitted to our program, who can afford our program, who has access to university education. And then it plays into who passes their placements, who gets a job, and who maintains a job.

Several participants spoke of a lack of support from midwifery practice groups creating a significant barrier to caring for marginalized clients. Without the commitment from practice owners and colleagues, or a clear mandate to provide care to particular populations, midwives interested in doing this type of work in their communities do not feel encouraged or well-supported. A few participants felt that there could be an ideological stance among midwives that caring for marginalized populations is outside of the definition of 'healthy and low risk' midwifery and, therefore, outside the profession's scope of practice. Others felt that some colleagues were not interested in the extra time and challenge this work demands. Some participants addressed the additional stress and exhaustion a midwife can experience when their practice is unsupportive of their initiatives or how they would prefer to provide care. One participant stated, "We need support from our practices because not all practices support marginalized clients as well as other practices do, or support the midwives who are caring for marginalized people as much as it could be done." Another participant added, "I think the work of midwifery just fills up, so you've got to actually decide to do something different. You have to have a

mandate. It requires really stretching the boundaries of the model.” Many participants felt this support from practice groups is particularly critical when working in more racialized communities and those with higher poverty rates.

An additional professional barrier that nearly all participants discussed was a lack of education, ongoing training, and an overall lack of understanding about caring for marginalized clients. One participant stated matter-of-factly, “The major barrier that we have professionally would be unknowledgeable or ignorant care providers.” Participants’ concerns included a lack of adequate curriculum in the Ontario Midwifery Education Program that teaches social and structural determinants of health; a lack of mandatory continuing education that covers topics related to culturally safe care, anti-oppression, and trauma-informed care; and building knowledge and skills for system navigation (e.g. social assistance, child welfare). One participant had a thoughtful summary of this issue:

The other barrier is just a real lack of knowledge and education and therefore lack of ability. To do the kind of deep advocacy work that is required when caring for vulnerable or marginalized populations takes an enormous amount of savvy and learning. Meeting people where they’re at is really important. Not deciding that because people don’t come to you that they don’t want care. But in fact, people do want care. It’s just difficult sometimes for people to get it and they have many reasons for avoiding it. I think it requires a skill set to both care for people in a way that’s respectful and acknowledges their history and past and present. And it also requires a skill set to understand the systems and advocate for people to be supported by the systems. And it also takes skill set and ethic to think that you should.

A focus group participant with several years’ experience, exclusively in rural midwifery work, described the personal challenges of caring predominantly for ‘higher needs’ clients who are living in poverty, Indigenous/racialized, and/or using substances;

as well as there being no financial incentive to take on the extra work often associated with such clients:

I think the biggest professional barrier that I experience is that I am working what I feel to be more than full time with 31 BCCs [billable courses of care] a year. My clients are almost all some degree of high needs, and I have to do some degree of social work coordination for a majority of them. So, the BCC model is one of my structural barriers. And if I could bill for service, or you know, have some kind of salaried structure...

Most participants acknowledged that midwifery is well suited to provide perinatal care to marginalized clients but advocated for an expanded scope of practice, alternative care models, and/or different funding and pay structures that would better support this. Many believed this care could help improve maternal and newborn health outcomes, and a minority expressed personal interest or ongoing commitment to this type of work.

3) Recommendations for change

Participants spoke of various solutions and recommendations for change in response to questions about surmounting the previously discussed barriers. These changes might improve the health and birth outcomes for marginalized clients and their newborns and midwifery's role in reducing health inequities.

Provider level

Most participants spoke at length about the need for changes within the midwifery profession itself regarding its model of care, scope of practice, education, and funding and pay structures. Participants felt that midwives would be better able to address barriers

for themselves and their most marginalized clients by expanding midwifery's scope of practice, allowing for greater flexibility and creativity in the profession's care model, and creating more sustainable call schedules to address burnout.

Several participants spoke of the benefits of expanding midwifery care beyond six weeks postpartum to offer longer-term and broader spectrum maternal and newborn care, such as sexual and reproductive health, abortion services, contraception counselling and prescribing, well-baby checkups, and infant vaccination.

As discussed earlier, nearly all participants called for changes to the curriculum in the Ontario Midwifery Education Program and mandatory, ongoing continuing education to address non-clinical facets of midwifery that would enhance care for marginalized clients. However, one participant also spoke of the need for midwives to be invested in this type of education truly:

Midwives are often ignorant of their own racism and privilege. Midwives are often not invested in continuing anti-racist or culturally safe training, nor was it included in training curriculum. Many midwives are not invested in BIPOC/queer-inclusive language or clinic materials. There is a need to be openly anti-racist and inclusive in all aspects of practice, not just something performative.

A few participants highlighted the importance of more support for Indigenous midwives and midwives of colour wanting to access education. Some participants mentioned that the Ministry of Health, the Ontario Midwifery Education Program, and the Association of Ontario Midwives all have a significant role to play in creating necessary changes to training access, curriculum, and continuing education, but also

acknowledged that it is midwives themselves that must advocate for these changes within their profession.

Some participants also discussed the lack of substantial advocacy for change among members of the profession due to its lack of diversity and position of privilege. One participant stated: “We are still a very white profession, so I think some of our clients are not seeing themselves represented in the midwifery groups that are caring for them. We all need to support having a well-educated but a diverse midwife population as well, with many languages and races represented.” One participant, in particular, viewed the lack of advocacy for change as a symptom of privilege:

Of all the people who should be arguing for a decrease in economic disparities in society and an end to racism and an end to colonialism, it's healthcare providers. But in fact, they're entrenched in those systems and benefit from those systems. And so it's hard for them to argue against them in any meaningful way. And I think midwives have allied themselves to those kinds of entrenchments, broadly speaking.

Healthcare system level

Most participants spoke of the need for improved intersectoral collaboration, especially when so many of the programs and services aimed at assisting those with higher needs lack funding, and are often fragmented, inadequate, or simply unaffordable (e.g., mental health services). A few spoke of the need for clear goals and mandates for marginalized populations within midwifery practice groups and among the various care providers, services, and institutions they intersect with. One participant strongly advocated for the creation of interdisciplinary teams with such mandates:

I'm thinking of institutional teambuilding or to work intentionally at getting to know each other and the people we care for. Building a business model so that everyone is on the same page, dedicated to a particular population. In the best-case scenario, it would be providing a framework for other professions to follow.

Some participants also discussed the need for greater support from the Ministry of Health and hospital and university institutions for midwives to engage in equity and diversity work. One participant stated: "I think if big organizations and businesses like hospitals and healthcare actually worked from an anti-oppressive and anti-racist standpoint, that would be our number one change for things to then trickle down for our marginalized groups to feel safer and to improve their access to care."

A small number of participants addressed what they viewed as significant issues with the data collected by Ontario's perinatal and newborn care system, BORN (Better Outcomes Registry and Network). These participants spoke of the need for changes and additions to the data since the measured research and health outcomes can only be as meaningful as the data collected. One participant stated, "I think it is really important to be collecting class and race-based data and addressing those outcomes which are very real." Another participant summarized the issue by stating:

We need to challenge the BORN database to create data sets that are actually useful and beneficial for marginalized communities. What we are doing right now in terms of research in midwifery in Ontario is we are providing more ample research to support those populations already benefitting. Those who are actually in research are the ones that can call for certain data sets to be placed in the BORN system. So, if you don't have researchers interested in that, you're not going to change the data.

Political level

A few participants discussed the need for greater midwifery engagement at different levels of the healthcare system, particularly those that could lead to policy change. Some participants felt this could be accomplished by stronger midwifery leadership within hospitals and community health centres, and some saw a need for stronger midwifery presence and decision-making within other institutions, such as the Ministry of Health and regulatory bodies. One participant stated:

We need policy and development changes and changes to access to care. Midwives should be seated at different places within our [healthcare] system. But midwives need to want these changes rather than maintaining the status quo of low risk and higher income clients. We could play a role in providing a framework for other professions and we could be a powerful example. We do have a role to play in challenging our colleagues and our institutions.

Another participant echoed the sentiment of the need for midwives in positions of leadership, advocacy, and policy change but spoke of the limitations of the profession itself:

We can work to try to dismantle racism within our communities and our own profession, increase the diversity and number of midwives, and call for more midwife-led research. We have a strong role to play as advocates. Our work is political, but we are often too busy to address larger issues at systemic levels.

A small minority of participants spoke of changes that were not health care system or provider related, which included addressing racism and colonialism, the need for living wages or a universal basic income, comprehensive universal health care (especially for newcomers), free childcare, and stable, affordable housing. There was also some acknowledgement that these changes require a commitment to political advocacy

from healthcare providers themselves. One participant expressed, “If there was political will to improve health outcomes, it would happen not through the healthcare system, it would happen through income and housing.” Another participant spoke of what was needed within the midwifery profession:

I think there’s an enormous potential for midwifery to reduce health inequities both in practice and in an advocacy role, but I think that needs to be developed. I think the conversation needs to be had. It’s as though we are perpetually paying ourselves to not solve the problem if we invest in perinatal and mental health without investing in housing and income for people. It’s futile... I think that if you build a class of professionals whose allegiance is to that upper echelon of wealth, you can’t be surprised when they’re not interested in dismantling it.

One racialized participant in particular spoke passionately about what they believed to be a critical solution for change: “I would say as far as our community goes, the Truth and Reconciliation [Commission] report, the Missing and Murdered Indigenous Woman and Girls report, there’s just a million [*expletive*] recommendations – do them. They’re already there, just do them”.

Overall, only a small minority of participants, most of whom occupy marginalized social locations themselves, articulated in some way that health and healthcare are political, and that midwives could have a more significant role to play in political advocacy and policy change. One participant addressed what they viewed as an ideological dilemma preventing meaningful improvements in perinatal health outcomes: “I have been really surprised in my own work to realize that people, healthcare providers, really do view the social determinants of health as lifestyle choices, but also I would say attributes of individual people. And I think that is really, ideologically, a key point that needs to be teased out”.

The trustworthiness of these qualitative research findings was accomplished by verifying the credibility of the findings through member checking (Lincoln & Guba, 1985). To further verify the data analysis process, brief written narratives of key categories and their sub-themes were provided to participants by email for review and correction. Of those that responded, there was agreement of the researcher's interpretations, and respondents agreed that the ideas expressed had been adequately captured.

Of note, although the two separate methods of key informant interviews and focus groups were used, the findings were remarkably similar across all discussions conducted. The data from each individual interview and focus group reflected the key categories and themes established by the researcher during analysis.

Discussion

This research provides valuable insight into the knowledge, perceptions, and opinions of midwives in Ontario regarding perinatal care for marginalized clients and SDH. The findings from this study add to the growing literature about the effects of poverty, race, and other interrelated factors on perinatal health, but also offer an original and unique perspective from registered midwives.

Most participants were well aware of and able to describe in detail the effects of SDH on maternal and newborn health outcomes. This theme of complex and compounding effects is a powerful example of intersectionality. The framework of intersectionality contributes to “an understanding of human beings as shaped by

interacting social locations and identities” (Crenshaw, 1989; Hunting et al., 2015, p.103). These interactions exist within structures of power which (re)produce forms of privilege and oppression influenced by classism, racism, sexism, colonialism, neoliberalism, and biomedicalism. Using intersectionality as an analytic tool to explain disparities in perinatal health outcomes, the complex interactions between social location, structural disadvantage, and multiple axes of oppression reveal how power contributes to health inequities.

Most participants were strongly focused on individualized clinical changes and support, but advocacy and change at the policy level were not strongly identified as a priority in the role of midwifery. This reflects the dominant neoliberal paradigm of healthcare, where the focus is on individual responsibility, lifestyle changes, and clinical interventions rather than addressing the broader social and structural issues that create and perpetuate health inequities. Most participants demonstrated an overall lack of political awareness regarding how midwives could meaningfully participate in demanding policy changes that could impact health and social inequities. These findings are also reflected in a 2011 study on type 2 diabetes in vulnerable populations which found that “without political advocacy, community health care providers may become complicit in managing poverty rather than promoting health” (Pilkington et al., 2011).

It was well understood among participants, especially those with more years of experience, that the effects of SDH complicate or prevent regular access to care, particularly prenatal care. This expressed understanding among midwives about the implications for perinatal health outcomes from lack of access to care is reflected in

recent midwifery-led research on inadequate prenatal care, but these studies also lack thorough discussion about the political advocacy roles that midwifery could play in reducing adverse perinatal outcomes (Darling et al., 2019; Darling et al., 2020; Nussey et al., 2020).

Many participants were able to articulate their experiences and concerns regarding over-surveillance and child welfare system involvement for marginalized women. The focus on monitoring and investigating pregnant marginalized women has remained resistant to change, and there has been an increasing emphasis on the ideology of ‘intensive mothering’ which is viewed as socially acceptable child rearing. This ideology “fits within neoliberal notions of individual responsibility and risk management and is based on middle-class ideals”, often leaving marginalized women vulnerable to surveillance and viewed as lacking in their ability to parent (Romagnoli & Wall, 2012, pp. 273-274).

The child welfare system serves a well-intentioned function in our society, aiming to protect children from abuse and neglect. However, there remain common discriminatory perceptions that women who are poor, racialized, single, and/or experiencing mental health and addiction issues are more at risk of mistreating their children or failing to protect them from harm (Brown, 2006). An understanding of the intersectionalities of inequities in child apprehension is gaining traction. Studies have demonstrated that child custody loss among women with mental illness is more likely to occur for women of colour, those who have never been employed or have low employment history, those using substances, and those with limited social support and

fewer social services (Hollingsworth, 2004). A critical report by the Ontario Human Rights Commission (2018) stated that in addition to addressing systemic racism in the child welfare system, “the broader social and economic issues that contribute to over-representation of Indigenous and Black children in child welfare also need to be addressed”. The over-representation of Indigenous/racialized children in Ontario’s child welfare system continues “because there is a false assumption among Child Welfare Agencies that Child Protection legislations are culturally and racially universal, yet hidden in this rhetoric is a blatant, White-favoured standard of parenting that puts Black and Indigenous families at risk” (Adjei & Minka, 2018, p. 511). While many participants could speak to their concerns or direct experiences with discrimination in the child welfare system, most were unable to connect these issues with the need to address broader socioeconomic inequities, or how their own privilege and the dominant whiteness of the midwifery profession might contribute to discriminatory perceptions of Indigenous and racialized women and their parenting practices.

One of the more unexpected findings from this study, however, was the extent to which midwives experience the burden of their professional barriers and how they described these barriers as preventing them from providing care to marginalized populations. Nearly all participants expressed frustration about demanding hours and call schedules, compassion fatigue, and burnout creating challenges for providing the higher level of care that is often required. Many participants also described the burnout that results from feeling undervalued and unsupported – by their practice groups, other healthcare providers, hospitals, and the healthcare system in general. The consensus was

that it is incredibly difficult to care for marginalized clients when midwives themselves feel marginalized and overworked by the systems within which they operate. These findings are echoed by a 2020 qualitative study which investigated how midwives make their care more accessible to clients of low SES and the barriers they face in doing so (Darling et al., 2020). The researchers found that midwives expressed feeling limited by the demanding nature of their work; their scope of practice, model of care and funding arrangements; unsupportive practice group culture; difficult hospital and interprofessional relationships; and inadequate curriculum in the Ontario Midwifery Education Program (Darling et al., 2020).

The history of whiteness in the establishment of a ‘new midwifery’ in Ontario, as well as an examination of experiences of racism among Indigenous, Black, and racialized midwives and midwifery students are discussed in a 2019 online survey by the Association of Ontario Midwives (Aseffa et al., 2021). This research highlights “the pervasive and insidious nature of racism within Ontario midwifery” and the ways in which professional burnout is exacerbated for racialized practicing midwives and those training to enter the profession (Aseffa et al., 2021, p. 20). Racialized participants in the present study echoed similar experiences of racism with colleagues, practice groups, other healthcare professionals, and hospital institutions; and the ways in which such experiences amplify their burnout.

Addressing (inter)professional, organizational, and regulatory barriers and discrimination would certainly assist in increasing access and quality of care for marginalized populations while also reducing professional burnout for midwives.

However, these solutions do little to address the root causes of poverty and racism as significant determinants of perinatal health outcomes, and continue to position midwives and their work as depoliticized.

A recurring theme in the limitations of studies on preterm birth in Canada is the lack of adequate socioeconomic information from perinatal data collection (Bushnik et al., 2017; Campbell et al., 2018). A few participants spoke of the need to change the perinatal data collected by the BORN information system (BIS) and the Ministry of Health and Long-Term Care (MOHLTC). In Ontario, the paucity of this data stems from a lack of information in the Ontario Perinatal Record (OPR), a standardized form for perinatal care developed by the Provincial Council for Maternal and Child Health designed and mandated to be used widely by maternity care providers in the province. The OPR requests information about parental education and occupation. However, there is no explicit request for information about annual income, income range, or use of social assistance; rather, there is simply a qualitative check box for “financial/housing issues”, which might warrant a narrative note in the client/patient chart at the practitioner’s discretion (Ministry of Health and Long-Term Care, 2017, p.1). The utility of this type of information when extracting data for research purposes is significantly lacking. The OPR affects what is available in the BIS, the database for BORN Ontario (though it is worth noting that the previously mentioned information about education and occupation does not enter the BIS). BORN Ontario boasts a rigorous collection and interpretation of data to contribute to maternal and newborn health and the health of all citizens of Ontario. However, Public Health Ontario has criticized the BIS for its complete lack of

socioeconomic information at the individual and family levels (Ontario Agency for Health Protection and Promotion, 2016).

Based on what is known about the effects of psychosocial stress caused by poverty and the resulting relationship with adverse perinatal outcomes, it should be viewed as unacceptable that socioeconomic data is not collected or easily accessible, which forces health agencies, clinicians, and scholars to find this data by other (potentially less reliable) means, typically using the Canadian census and/or assigning area-based measures of socioeconomic status to an individual based on location information (Ontario Agency for Health Protection and Promotion, 2016). This issue raises more critical questions about the motivation behind this lack of data and the agenda of Ontario's MOHLTC as the funding source for BORN Ontario. Without adequate information on socioeconomic factors concerning perinatal outcomes, how can recommendations be made or changes implemented at the healthcare provider or policy level? Those in power at the policy level and the MOHLTC in Ontario can maintain the status quo by failing to implement strategies that adequately address SDH. Alternatively, they could develop radical policy change through a commitment to recognizing that poverty in Ontario is unquestionably associated with increased obstetric complications, as well as neonatal and infant morbidity and mortality. Midwives, other maternity care providers, and perinatal researchers could play a significant role in demanding that changes be made to the OPR and the resulting data that is collected by the province.

Overall, the findings from this study reflect that certain epistemological obstacles exist for midwives. Although most participants demonstrated an understanding of the

concepts of SDH and their effects on perinatal outcomes, their approach in practice remains predominantly focused on reducing barriers to care that these SDH create with individualized advocacy, support, and clinical interventions, as well as how their professional barriers further complicate the care they can provide. Although there were few exceptions, what was lacking for most participants regarding how they conceptualize SDH and their role in promoting health and minimizing adverse outcomes was an acknowledgement that healthcare providers can and must challenge social and political structures. Participants largely demonstrated a conceptual disconnect from the SDH that leads to adverse perinatal outcomes and the broader, macro-level policy changes that would reduce social inequities leading to improved health outcomes.

Of interest, some participants were able to identify strategies that could help overcome such epistemological obstacles. These included diversifying the profession by addressing the dominance of white, affluent members (a sentiment that was expressed by nearly all participants, regardless of their own race); acknowledging the history of exclusion of racialized midwives from practice; and creating task groups or committees to address racism within hospital institutions, all of which could help to confront race and racism as significant determinants of perinatal health. In her book *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery* (2006), Nestel critiques Ontario's 'new midwifery' and its reproduction of racial inequities by excluding midwives of colour. She discusses what she describes as 'white knowledge' – largely available within and through communities of white women. She writes, "Women of colour struggled for access to these forms of knowledge, not always successfully, and their absence from an

otherwise sound repertoire of midwifery competencies affected these women's abilities to successfully negotiate assessments and a variety of other interactions with white midwives and with the Ontario midwifery bureaucracy" (Nestel, 2006, p.147). Some participants, mostly those who were racialized, acknowledged that the lack of diversity and the position of privilege occupied by most midwives in Ontario prohibits understanding and, therefore, meaningful change.

Participants also advocated for curriculum reform in the Ontario Midwifery Education Program (MEP) and continuing professional education to include topics that address SDH, anti-oppression, trauma-informed care, advocacy initiatives, and policy advising, all of which could address intellectual hurdles and gaps in knowledge and broaden midwives' worldviews. A 2005 study on political involvement in the nursing profession found that implementing a more politicized role to address health inequities requires increased political awareness and incorporating a curriculum that teaches and encourages involvement in advocacy, activism, and policy change (Boswell et al., 2005). The findings from discussions with participants around curriculum issues and ongoing training speak to the need for improved education and enhanced skills, as well as the belief that it is important. This requires that midwives feel motivated to improve their knowledge and understanding, and that the Ontario MEP and the Association of Ontario Midwives (AOM) implement necessary changes to make this an ongoing priority. Since the interviews took place, the AOM has continued to create non-mandatory professional education webinars, which now include topics such as Indigenous, Black, People of Colour (IBPOC) leadership in the profession to address actively deconstructing white

supremacy culture and building anti-racist organizations; Ontario midwifery race data; and access to midwifery care for people of low SES (AOM, 2023). With financial support from the Government of Canada, the AOM has also recently developed a “Racial Equity Toolkit to support midwives on their journeys towards achieving racial justice in the profession” (AOM, 2023). These resources are available online to all provincial association members, but participation is not mandated.

Conclusion

Due to midwifery’s model of care that enables longer appointments, care in clients’ homes or unconventional clinical spaces, personalized practice, and its philosophy that espouses informed choice and respectful relationships, midwifery in Ontario maintains that it is uniquely positioned to address health inequities for marginalized women. However, this study has elucidated that midwives, as well as their interprofessional colleagues and institutions, are not immune to demonstrating authoritative, discriminatory, and depoliticized practices. This study’s findings also indicate that in order to adequately address inequities in perinatal outcomes, midwives in Ontario must overcome certain epistemological barriers. This will require a more evolved comprehension of social and structural determinants of health, a diversification of the profession, a commitment to midwifery-led health equity data collection and research, and a politicized approach to midwifery practice with strong advocacy for policy changes that will impact SDH.

The findings from this research have important implications for perinatal health

policy and the need for maternity care providers to strongly advocate for policy changes that will directly improve the lives and health outcomes of their clients/patients. This research also has relevant implications for members of Ontario's midwifery profession, as well as its regulatory bodies, provincial association, training curriculum, and research objectives.

There is an increasing demand for healthcare that utilizes a conceptual awareness of social justice consistent with addressing the conditions that influence health inequities. Sexism/genderism, racism, classism, and neoliberalism are oppressive social and political conditions and significant determinants of poor health (Pauly et al., 2009). Awareness of discriminatory healthcare practices and conditions that create barriers for women identified as vulnerable or marginalized are crucial for increasing our understanding of perinatal health inequities and developing equitable perinatal health policies. Recognition of the neoliberal structures and processes that favour corporate power and influence and how these shape the welfare state in Canada has also become critical for understanding the public policies that have eroded the programs and institutions necessary for addressing SDH.

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APPENDIX

INTERVIEW GUIDE

Introduction

Thank you again for taking the time to participate in this study. [*For focus groups: I am very grateful to have you all involved, and I look forward to the discussion we will generate here today*].

My name is Sarah Anderson. I became a Registered Midwife in Ontario in 2015 and am currently completing the Master's program in Health Policy & Equity at York University. This study is my major research project, which will fulfill the requirements of my degree.

As a brief introduction, there is literature that demonstrates relationships between marginalized social and economic positions, and adverse perinatal health and birth outcomes in Canada. For example, there are documented associations between race, poverty, and birth outcomes, including preterm birth, low birth weight, intrauterine growth restriction, and infant mortality. However, much of the emphasis (particularly in epidemiological and clinical research) remains focused on so-called “lifestyle choices” as risk factors (such as inadequate nutrition, substance use, lack of exercise), rather than discussing underlying causes or understanding these behaviors in the broader context of an individual's life circumstances and social location.

Disparities in perinatal health and birth outcomes remain a significant issue for both health equity and policy in Canada. The premise of this research is the understanding that midwifery is well positioned to provide care for marginalized clients; often attributed to longer visits, more personalized care, continuity of care, and the ability to visit clients in their home environments. The purpose of this study is to explore midwives' knowledge and perceptions of social and structural determinants of health, and to examine perinatal care for marginalized clients within the context of the midwifery profession and its philosophy of care.

Finally, to reiterate what was outlined in the informed consent document that you signed: participation in this study is completely voluntary, and you may choose to stop participating at any time or decline to answer particular questions. Your participation will remain completely anonymous and your name will not appear in any report or publication. During the interview, you may choose to remain anonymous to the other participants and leave your camera turned off. The interview will be recorded. It is expected that the interview will take approximately one hour and will involve a series of open-ended questions intended to generate discussion. I will give ample space after asking questions to allow time for reflection. When possible, I encourage you to use personal stories or experiences in your responses, as this can provide rich and meaningful information. Because your comments will remain anonymous, I want everyone to feel comfortable being as open as possible about personal experiences or opinions.

[For focus groups: And if someone has shared an opinion or perspective that echoes your own, I also encourage you to share that. Please don't feel as though you can't repeat a response – this is actually very valuable information!]

Are there any questions or concerns before we begin? Once we start, please feel free to interrupt and ask questions at any time.

[Begin recording. State date & time. Indicate whether focus group or individual interview.]

Interview/Focus Group Questions for Registered Midwives

Social & Structural Determinants of Health

Can you identify the most important or visible social determinants of health in your clients' lives?

[Explore a variety of social/structural determinants of health such as income, housing, food, transportation, childcare and support, employment/unemployment, education, social exclusion/isolation, racism, classism, sexism/genderism, homophobia, etc.]

How do you think these factors affect your clients? Affect their health?

How do these factors influence the ways in which you provide midwifery care?

Caring for Marginalized Clients

****Provide a clear definition of the term 'marginalized'**

"Marginalized populations are groups or communities that experience discrimination and exclusion (social, political, and economic) because of unequal power relationships across economic, political, social, and cultural dimensions" (from the National Collaborating Centre for Determinants of Health)

Do marginalized clients make up a portion of your client base?

What are some of the particular issues that marginalized clients face?

How do these issues affect the pregnancies, birth outcomes, and/or postpartum periods of
a) marginalized individuals in general? and b) your marginalized clients?

What kinds of services and supports are available in the community for marginalized clients?

How adequate are these services? How easy are they to navigate/access?

Midwifery is considered to be ‘well positioned’ to care for marginalized clients due to more personalized care, longer visits, home visits, etc. In your experience, how true do you find this to be? What does this look like for you in practice?

What changes do you think might improve the health of your clients and their birth outcomes?

Barriers

What are the barriers that marginalized clients face in accessing care and/or meeting their health needs during the perinatal period?

What personal and professional barriers do you face in providing care for marginalized clients?

[Explore midwives’ positionality, barriers within practice groups, interprofessional, within hospitals and other institutions]

How could these barriers be surmounted?

How aware are you of marginalized clients experiencing stigma and discrimination?
What are your experiences with this?

Role of Midwifery

What role does midwifery have in reducing health inequities?

How could midwives advocate for the health and well-being of marginalized clients and their families?