"We're Trying Really Hard, but I Don't Think We're Getting it Right": Understanding the Role of the Midwives' Association and Midwifery in the Province of Alberta, Canada: A Single-Case Study

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ABSTRACT

Problem: There is a critical shortage of midwives in Canada. Midwives' associations are a possible solution to sustain the profession. However, many provincial and territorial organizations are smaller, with minimal funding. Our study aimed to understand the role of the Alberta Association of Midwives (AAM), a smaller association, and the status of midwifery in the province of Alberta.
Methods: We used a single case study design grounded in feminist intersectionality and transformative theories. A theoretical framework for strengthening midwives' associations informed the data collection and analysis.
Findings: We reviewed nine documents related to AAM and midwifery in Alberta, eight podcasts released by AAM, and conducted 17 interviews with midwives and health system collaborators in Alberta. Findings showed that while increased membership strengthened the AAM governance and advocacy capacity, leaders lacked support to develop expertise. The profession was not enabling for racialized midwives, or Indigenous midwives. Participants identified AAM's role as dismantling systemic racism, advancing Indigenous midwifery, and addressing sustainability challenges in rural and remote practice.

Conclusion: The study highlights both organizational growth and persistent inequities, calling for anti-racist practices, transparent governance, leadership development, and urgent recognition of racialized midwives and Indigenous midwifery within Canada's truth and reconciliation efforts.

RÉSUMÉ

Problème : Il existe une pénurie critique de sages-femmes au Canada. Les associations de sages-femmes constituent une solution possible pour pérenniser la profession. Cependant, de nombreuses organisations provinciales et territoriales sont de petite taille et disposent d'un financement minimal. Notre étude visait à comprendre le rôle de l'Alberta Association of Midwives (AAM), une association de petite taille, et la situation de la profession de sage-femme dans la province de l'Alberta.
Méthodes : Nous avons utilisé un modèle d'étude de cas unique fondé sur l'intersectionnalité féministe et les théories transformatrices. Un cadre théorique visant à renforcer les associations de sages-femmes a guidé la collecte et l'analyse des données.
Résultats : Nous avons examiné neuf documents liés à l'AAM et à la profession de sage-femme en Alberta, huit podcasts publiés par l'AAM, et mené 17 entretiens avec des sages-femmes et des collaborateurs du système de santé en Alberta. Les résultats ont montré que, si l'augmentation du nombre de membres a renforcé la gouvernance et la capacité de défense des intérêts de l'AAM, les dirigeants manquaient de soutien pour développer leur expertise. La profession n'était pas favorable aux sages-femmes racialisées ou autochtones. Les participants ont identifié le rôle de l'AAM comme étant de démanteler le racisme systémique, de faire progresser la profession de sage-femme autochtone et de relever les défis de la durabilité dans les zones rurales et isolées.
Conclusion : L'étude met en évidence à la fois la croissance organisationnelle et les inégalités persistantes, appelant à des pratiques antiracistes, à une gouvernance transparente, au développement du leadership et à la reconnaissance urgente des sages-femmes racialisées et de la profession de sage-femme autochtone dans le cadre des efforts de vérité et de réconciliation du Canada.

KEYWORDS
midwifery, midwifery leadership, midwives' associations, Indigenous midwives, racism, anti-racism, capacity-building, intersectional research

BACKGROUND

Canada is experiencing a critical shortage of midwives. The 2021 State of the World's Midwifery Report estimates that implementing a midwife-led perinatal health system could yield the equivalent of 9000 additional midwives by 2030.[1] Yet, numerous structural barriers continue to impede the growth and sustainability of the profession. Insufficient provincial and territorial funding, limited availability of midwifery education programs, and restrictive health-service arrangements constrain the entry of new practitioners and intensify the workload of those currently in practice. Moreover, midwifery in Canada, predominantly comprising cisgender females alongside non-binary and trans-identified practitioners, remains undervalued within the broader health system, resulting in persistent pay equity gaps. Underrepresentation in leadership positions at both national and subnational levels further restricts midwives' participation in policy development and decision-making processes. For instance, the marginalization of midwifery perspectives during the COVID-19 pandemic and recent Canadian wildland fire events contributed to emergency responses that were neither adequately supportive nor responsive to midwives' safety and practice needs. Collectively, these intersecting factors place considerable strain on the midwifery workforce, jeopardizing practitioners' well-being and the long-term sustainability of the profession.[2]

Critical to the sustainability of midwifery in Canada are the intersecting impacts of racism and colonialism for racialized and Indigenous midwives. Racialized and Indigenous midwives experience racism regularly within their work as midwives.[3] Racism and colonialism in midwifery lead to higher incidences of burnout and attrition, which are detrimental to their mental health and well-being.[4] Specifically, for midwives, internal responses to racism cause "allostatic overload" and can lead to serious "illness and disability."[4] Overall, racism negatively impacts midwives' relationships, well-being, job satisfaction, and careers.[3]

Indigenous midwives provide healing and culturally safe care through prenatal, birth, and postpartum.[5] However, the white western focus of colonized Canada has created a system that delegitimizes and erases them and their knowledge.[6] Despite certain governance exemptions to support the practice of Indigenous (including First Nations, Inuit, and Métis) midwifery, only those who are trained through a recognized university program are eligible for registration in most jurisdictions, and there are geographical, legal, and financial barriers for Indigenous midwives who want to access these programs and practice Indigenous midwifery.[6]

Jurisdictions within the country face unique challenges to the growth and sustainability of midwifery. Alberta, the second province in Canada to legalize midwifery in 1992, only began funding and subsidizing midwifery services in 2009 and was officially included in the *Health Professions Act* in 2019.[7] The resulting disjointed integration severely impacted the growth of midwifery in the province; as of 2021, midwives attended 10.5% of births in Alberta compared to 20% and 25% of births in Ontario and British Columbia, respectively.[8] Difficulties for midwives in Alberta include growing pay equity gaps, insufficient pay raises, ableist working conditions, professional stigma, and lack of midwifery education pathways.[9]

Rural and remote midwifery practice in Alberta faces escalating challenges. Since the COVID-19 pandemic, many rural communities have experienced a growing crisis in health–human–resource recruitment and retention, thus increasing the demand for midwifery services in these settings.[10] Expanding the rural midwifery workforce and supporting practitioners to remain in these communities would improve access to perinatal care and reduce the need for people to travel long distances to give birth. This issue disproportionately affects Indigenous people, who are often forced to leave their communities to deliver in tertiary care centers.[11] The routine displacement of Indigenous birthing people is rooted in a colonial framework that prioritizes western biomedical knowledge and technological risk mitigation over the social, cultural, and emotional harms of birthing away from one's community.[12] In contrast, the rematriation of birth led by Indigenous midwives is widely recognized as a critical pathway toward culturally and clinically safe reproductive care.[13]

Midwives' associations play a critical role in integrating anti-oppressive policies and practices that support the sustainability of midwives across diverse geographical locations and communities.[14] Fulfilling this responsibility requires centring the voices of Indigenous and racialized midwives, who have clearly articulated what meaningful change must entail. Indigenous and racialized midwives and midwifery students emphasize that dismantling colonialism and racism demands actionable and sustained efforts from within the profession and must be led by midwives' associations.[3]

Despite their potential pivotal role, midwives' associations often operate as small organizations, relying on volunteers, and consequently require support, funding, and capacity-building initiatives to support the profession properly.[15] Since 2019, the Canadian Association of Midwives (CAM) has been undergoing a systematic and evidence-informed process to better support Canada's midwives' associations in capacity-building and impact. In their outcomes-focused 2021–2025 strategic plan, CAM has committed to strengthening regional midwives' associations "to develop robust internal structures, organizational effectiveness, anti-oppressive frameworks, and financial capacity to lead and advocate for the profession."[16] CAM's long-standing and recent bilateral relationships include, for example: (1) the National Indigenous Council of Midwives (NCIM), which advocates for and supports the needs of Indigenous midwives, (2) the Canadian Association of Racialized Midwives (CARM), and (3) the Canadian Caucus for Queer and Trans Midwives.

The support to midwives' associations rendered by CAM is in part informed by a research collaboration beginning in 2020 between CAM and the McMaster Midwifery Research Centre. The results of this seminal research highlighted that to strengthen midwifery (education, regulation, services, and pay equity), we must lead with organizational capacity-building for midwives' associations.[14,17] Results provided a road map of the main elements required to build and sustain midwives' associations. This framework can be found in a previous publication as well.[14] From this work, CAM also recognized that there was a significant gap in their knowledge in terms of the capacity-building needs of their Canadian member associations. Furthermore, leadership from all Canadian member associations agreed that it might be beneficial to gain some understanding of their strengths and gaps in capacity. Therefore, in 2021, a second phase of this research collaboration was undertaken specifically to understand and assess the capacity of midwives' associations in Canada. The purpose of our study was to use an intersectional feminist approach to understand the capacity of the Alberta Association of Midwives (AAM), particularly as it pertained to its role in the sustainability of the midwifery profession in Alberta.

METHODS

Study design

We used Yin's single case study design to understand the role and capacity of AAM as it pertained to the sustainability of the profession.[18] The single-case study approach can be used when there is a need to obtain an in-depth appreciation of an issue, event, or phenomenon of interest in its natural real-life context.[18] It is particularly useful when the research aims to uncover a relationship between a phenomenon and the context in which it is occurring. In our study, the phenomenon of interest was the AAM and its relationship to the midwifery context in Alberta at the time of the study. We applied the reporting guidelines for organizational case studies.[19] The study was approved by McMaster University's Hamilton Integrated Research Ethics Board (HiREB Project #: 7489) and Mount Royal University's Health Research Ethics Board (HREB Project #102590).

Feminist intersectionality and transformative theories

Transformative and feminist intersectional theories underpinned the research process to understand how gender, race, and other intersections (rural, remote, language, colonialism, xenophobia, etc) factor into the AAM's role and capacity to support the profession.[20,21] This theoretical approach supported a research design that incorporated considerations of racism, anti-colonialism, and any other form of oppression. Specifically, theories shaped the research design, sub-questions, data collection, and analysis to integrate and highlight how gender, race, indigeneity and power relations, and the negotiation of power intersected and impacted the midwives' association and midwives. Transformative theory was woven into the research process to foster equitable, collaborative relationships, research validity, and local ownership of research. For example, the AAM was involved in the study's conception, design, recruitment, and knowledge translation.

Researcher characteristics and reflexivity

The research team comprised insiders (midwives and midwifery students) of the midwifery profession. The AAM recommended to hire the midwifery education program and midwifery student researchers as part of the research team to support research capacity-building for midwifery in the province. The majority of the team originally comprised midwifery students from the Bachelor of Midwifery Program, School of Nursing and Midwifery at Mount Royal University, Calgary, and later, as their careers progressed, from University of British Columbia (UBC) Midwifery program and as practicing midwives in Alberta. The advantage of insider positioning is that researchers have lived in the context of midwifery in Alberta. Insider positioning was supported by transformative theory, as it promoted trustworthiness and collaboration between researchers and participants.[21]

Case selection and context

The selection of AAM as a case study was informed by engagement and consultation with the CAM Board of Directors. AAM was one of three Canadian jurisdictions selected, alongside the Association of

Midwives of Newfoundland and Labrador (AMNL) and the Association of Nova Scotia Midwives. Each midwives' association was examined as a separate case study to explore the specific role of the association within its respective midwifery context. Findings from all three case studies were shared internally with CAM and the participating member associations.

Founded in 1986, the AAM has navigated substantial changes in the midwifery care landscape over the past 37 years. The AAM was established through the merger of the Alberta Council and Register of Domiciliary Midwives (ACRDMA) and the Western Nurse Midwives Association (WNMA).[7] Midwifery gained legal recognition in Alberta in 1992, followed 6 years later by the establishment of a regulatory framework that enabled midwives to register. Unlike many other jurisdictions, regulation did not coincide with public funding. The introduction of public funding in 2009 marked a turning point and was followed by significant growth in the profession. Since then, the number of registered midwives has increased fourfold to approximately 150. Annual birth attendance rose from 975 in 2009 to 5323 in 2021. Since its inception in 2011, Mount Royal University's Bachelor of Midwifery program has graduated 100 midwives. Historically, the AAM was operated by an executive board supported by volunteers; however, over the past decade, the organization has worked to build a structured staff team to support the board and advance AAM's mandate.[8]

Sources of evidence, sampling recruitment

As with the case study design, multiple perspectives can be sought regarding the phenomenon of interest. The two sources of evidence in this case study were key informant interviews with midwife collaborators in Alberta and documents and podcasts. Collaborator was any individual, group, or organization that had an interest or was affected by AAM. This could include clients, healthcare providers, policymakers, midwives, Indigenous midwives, and student midwives/Indigenous midwives. Documents and podcasts were used as additional sources of evidence to provide contextual and historical insight into the case. Sources included policies, reports, archival records, and publicly available podcasts.

Recruitment for key informant interviews used a multi-stage purposive sampling approach. Where possible, the research team sought to include Indigenous and racialized midwives, as well as participants working in both rural and urban settings and across diverse practice models. Individuals were invited to participate via email or in person. Interviews were conducted face-to-face, by telephone, or virtually. Indigenous and racialized participants were offered the option of being interviewed by a Métis or racialized researcher. Semi-structured interview guides were designed to elicit midwife collaborators' perspectives on AAM as well as their views on the impacts of gender, race, and other intersecting factors on midwifery practice and leadership in Alberta.[14]

In total, nine documents, eight publicly released AAM podcasts, and 17 key informant interviews comprised the sources of evidence for this study. Key informant interviews were conducted between November and December 2021 and were audio-recorded with participant consent. Midwifery students were involved in participant recruitment and were trained in qualitative interviewing by shadowing senior researchers prior to conducting most interviews. Written informed consent was obtained from all participants before each interview.

Analysis

Data analysis used a combined deductive and inductive approach. An initial coding structure was developed deductively using the "Framework for Strengthening Midwives' Associations,"[14] while inductive analysis allowed for the identification of themes emerging from the data. Interviews were transcribed using the AI notetaker Otter.ai, and interviews, documents, and podcasts were organized and coded concurrently using the research tool ATLAS.ti (web version).

Coding was undertaken by a subset of research team (Kirsty Bourret, Ashlyn Wiens, Alyssa Wiens, and Luca Surkan). To support inter-coder consistency and shared interpretation of the framework, the team initially coded one transcript collaboratively and refined the coding structure. Three team members (Ashlyn Wiens, Alyssa Wiens, and Luca Surkan) conducted the remaining coding across all data sources. The principal investigator

(Kirsty Bourret) then generated preliminary themes by identifying patterned meanings across codes, iteratively reviewing themes in relation to the coded data and original sources, and defining and labelling each theme. Co-authors reviewed the themes and associated codes, and refinements were made through team discussion until consensus was reached (Kirsty Bourret, Deepali Upadhyaya, Ashlyn Wiens, Alyssa Wiens, and Luca Surkan).

RESULTS

The results were organized into two themes: (1) the AAM's evolving capacity in governance structures, leadership development, and trust-building with its membership; and (2) the role of AAM in supporting midwifery health systems in Alberta, namely anti-racism, Indigenous midwives and truth and reconciliation and rurality (Table 1).

Alberta Association of Midwives' capacity and role in Alberta

Enhancing the capacity of AAM with a two-branched governance structure

Participants acknowledged how the AAM has grown tremendously over the past 5 or so years. During the early years, the association was small and executed voluntarily by practicing midwives. After regulation and government funding of midwifery, the number of midwife members grew in the province:

> We were still running on volunteerism, running things out of people's homes, getting hospitals to give us a meeting room every now and again. (...) It took quite a while for the association to strengthen once they started to get more midwives." (Interview #13)

With increased funding from the membership, the organization could eventually change to a two-branched organization with an executive midwife board and operational employees. With the addition of staff and some subsidies for the executive board, midwives could focus on the needs of their members, which included increasing the visibility of midwives through strategic advocacy. Strategic advocacy was identified as a key competency of midwifery leadership in the association:

> I see the value in having strong leadership who has the time and space to work to build the organization and make it something that will represent our interests and just be that person at the table that people respect. When we're talking to the government, we're talking

Table 1. Themes and sub-themes.

Themes	Sub-themes	
Midwives' association capacity	Governance	Two-branched structure with an executive midwife board and operational staff enhances midwife visibility, integration, and strategic advocacy.
	Leadership	Integrating midwives into leadership with equitable pathways and support for racialized, Indigenous, and rural midwives.
	Membership	Maintaining open communication to ensure strategic advocacy reflects the needs and values of all members.
Role of midwives' association	Rural midwifery	Developing targeted support and leadership pathways to strengthen midwives practicing in rural and innovative care settings.
	Anti-racism	Implementing anti-racism initiatives within the association, holding members accountable, and providing mentorship for racialized midwives in leadership.
	Indigenous midwifery	Midwives' association leverages its position to support Indigenous midwives to reclaim birth practices, and drive policy and programming change.

> to those who wield so much power over us. (Interview #4)

Equitable pathways to leadership in midwifery

Leadership expertise within the association was seen as very important for the growth and sustainability of midwifery, yet for participants, access to leadership positions needed to be perceived as equitable. For example, access to time and remuneration to reduce their workload while holding leadership positions with AAM was perceived as a barrier. In other words, they could not afford to be leaders:

> There are so few of us. To be honest, I would love to have leadership roles. But I can't, there's no way because I won't survive (...) It's just we need more of us. (Interview #6)

For some participants, the association's role was to support and grow aspiring leaders throughout the province. Many rural midwives acted as leaders in their community, but because of time constraints and their busy rural practice, they were unable to hold formal leadership positions (e.g., within the association):

> Not all leaders are in positions of formal authority, and not all people in positions of formal authority are leaders. To me, leadership is number one. (Interview #3)

Maintaining transparency as an element of trust with membership

Another common point of discussion for participants was the relationship between the association and its members. For them, the AAM represented the voices and needs of its members. As their operational budget was funded predominantly by membership fees, the AAM was perceived as working for the membership. Their primary role for members was collective bargaining with the government, namely negotiating for increase in salaries. Participants were cognisant of how the AAM was working in a context that did not value or understand the role of the midwifery profession within the health system. Negotiations were perceived as challenging, and participants felt the weight of this responsibility and the importance AAM with funders such as Alberta Health Services and the government:

> But I think the relationship that we have with our only funders, which are our midwives and our members, and our responsibility, as the collective bargaining agent on their behalf to negotiate their funding, is going to require careful attention over the next couple of years. I think if not handled with that level of attention, it will be problematic. (Interview #9)

Overall, participants did not feel that the AAM was able to succeed in pay equity. Furthermore, they felt resentful of their higher membership fees with little perceived benefits to them in practice. A lack of visible progress and impact led them to feel undervalued by their association and were further demotivated, given their experiences of marginalization as a profession and an increasing economical strain:

> We last had a compensation increase in 10 years ago. You need to fund these people because this is a service we see value in (...) to have them see the value in giving us equitable increases for cost of living or, you know, funding our overhead in a way that's appropriate or you know. (Interview #4)

Participants expressed that they wanted the AAM to be able to advocate for increased salaries and better working conditions; however, they also disclosed hesitation about paying their membership fees when concrete advocacy efforts weren't perceived or seen:

> And we're still paying. What is it that we're seeing? And for them, concretely, they think about their fair compensation, which allows us to all exist in this world. (Interview #10)

Lack of success with negotiations was compounded by a perceived lack of transparency and communication between the AAM and membership. Participants noted that, as the membership grew, communication sometimes became unidirectional, with information flowing from the association

to members, rather than fostering a two-way conversation. These conditions led to an erosion of trust and membership engagement:

> I think between members, you know, understanding and feeling like they're being heard and being able to take that and be efficient with people's voices and putting plans and action into place. But I do think it can be pushed aside in the name of being more efficient. I think that that still needs to be key because if not you lose the trust of your membership. (Interview #11)

Role of the midwives' association in midwifery health systems

Considerations for the context of rural midwifery

According to participants, access to birth services in rural Alberta had been decreasing over the years. Historically, the majority of midwives practiced in the two major urban centers of the province, Edmonton, and Calgary. Recently, the province had created policies to increase the number of rural midwifery practices, but participants still described barriers for midwives working in rural areas:

> But if they're supported, they will be there long-term; I can get burnt out easily. I think I've come across a lot of problems just with COVID. For example, I can think of one practice in the South where only one midwife was there for some time. I mean, that's not overly sustainable when you're working in a rural practice. (Interview #16)

Compared to their urban colleagues, rural midwives often worked in alternative models of care based on the needs of their communities. Yet often they were not being remunerated. For them, these differences required the AAM to be cognizant of their professional and financial needs will differ:

> We don't do the traditional midwifery role; we also do a doctor role within our rural hospital. We're on call for the docs. We're also providing education to the community. We're helping with prenatal education pieces. We're doing school education pieces. We're doing well-women's support. Because people will call for any women's health issues, and it goes beyond my scope, but at the same time, when you're in a small community, sometimes that's just what happens. (Interview #6)

Participants working in rural practices also highlighted the importance of having midwifery students who originated from rural communities and completed rural placements to foster a love for, and to grow the future of, rural midwifery in Alberta. Finally, while many rural parts of the province were populated by Indigenous communities, participants emphasized that Indigenous midwives, birth workers, or healers were not recognized officially and therefore were not able to provide services. Participants who were non-Indigenous recognized the tension they experience when providing services to these communities as outsiders:

> Because I know, as a white woman, that I do not fully comprehend the vast cultural differences that people have. (...). (Interview #2)

Overall, rural midwives in Alberta faced unique professional, financial, and cultural challenges, including limited support, alternative care roles, and unrecognized Indigenous birth workers. For participants, the AAM needed to ensure they considered the unique context of rural midwives, support rural training pathways, and work for the recognition of Indigenous midwives.

Racism in the profession and the AAM

Participants perceived the midwifery profession as failing to provide a safe environment for racialized people, either within education programs or in practice. They emphasized the importance of midwives in Alberta first reflecting on their own inherent biases:

> I find that there is a lot of racism within the midwifery profession itself, and there are a lot of white saviours and within the midwifery profession itself, so I think before we look outward to solving some of the issues on the

> outside involving anti-racism care, we must look inward first. (Interview #6)

Participants described a legacy of eroded trust between racialized midwives and the AAM, with ongoing experiences of exclusion and systemic oppression. Transparently acknowledging these harms was seen as essential to repairing trust:

> Our leadership must acknowledge that we've been propagators of racism. And like we just went through a process where we did a reconciliation. We didn't acknowledge an apology or commitment, and we've, excuse me, "messed up" part of it. (Interview #9)

Participants noted that the AAM had recognized its role in perpetuating the *status quo* and had undertaken internal anti-racism work while actively working to hold its membership accountable to similar standards. Despite these efforts, progress was slow, and the initiatives did not always have a positive impact on the midwifery community. Nevertheless, there was broad recognition that the AAM was making some efforts to evolve and confront its role in sustaining white supremacist systems:

> We're trying hard, but I don't think we're getting it right.... some folks feel that trust has been lost, and those midwives feel like they haven't been represented or supported, haven't been protected from discrimination or not having equal access to opportunities, and have not had equal representation in our association. (Interview #4)

Building trust with racialized midwives required addressing both underrepresentation in leadership and the broader organizational barriers that had contributed to past harm. Participants perceived the AAM as underrepresenting racialized midwives in leadership and was not a safe space for racialized leaders. They emphasized that increasing representation required organizational reflection and additional support for racialized midwives, including mentorship opportunities to learn about leadership and the AAM. Participants also suggested that the association advocate for reducing barriers for internationally educated midwives.

The impact of colonialism and Indigenous midwifery and the role of AAM

Participants identified a need to acknowledge and actively support Indigenous midwifery in Alberta. They discussed how the Federal health system forcibly removed birth from Indigenous communities and, as a result, led to bilateral systems that delegitimized Indigenous knowledge and cultures of birth and birthing workers. For participants, bringing birth back to communities through Indigenous midwifery would be a critical act of reconciliation:

> In many places, we don't have many Indigenous midwives because of the barriers to getting into that. Because of education systems and all those things. And so, I think it's something we must work towards is (sic) to strive in our education systems to reduce the barriers so more Indigenous people can become trained and serve their communities because that is the source of healing. (Interview #12)

Participants emphasized that Indigenous ways of knowing related to birth and reproductive health were not adequately reflected or supported within current western systems, including midwifery. In Alberta, many Indigenous midwives remained unrecognized, limiting their ability to practice in culturally grounded ways. Participants stressed the importance of seeking out and centring these voices to understand how the AAM could better support Indigenous midwifery and help Indigenous communities reclaim their birthing practices:

> The Indigenous midwifery leaders aren't registered midwives. They are the aunties. They are the elders. They are the birth workers who have been doing this work for time immemorial and are not recognized at that regulation or policy level. (Interview #7)

Participants emphasized the importance that AAM advocated for the acknowledgment of Indigenous midwifery formally. Participants viewed

AAM's role as a leader in recognizing Indigenous midwives at regulation levels and in other policies, such as Indigenous midwifery education pathways:

> I think that if the association and the college were to have these conversations about recognizing Indigenous midwives (…) If we were to gain that recognition, that would go a long way to challenge those power structures that are kind of holding Indigenous midwives down. (Interview #7)

DISCUSSION

Our study provides a substantial scholarly contribution concerning the role of midwives' associations and the evolution of midwifery in Alberta and Canada. The profession in Alberta continues to face barriers to integration, including a lack of professional recognition, a limited scope of practice, delayed funding mechanisms, and non-pay equity.[9] Midwifery in Canada faces well-documented systemic barriers, many of which stem from societal constructs of gender, the profession's association with the female gender, and the resulting devaluation of the profession.[9,22] A recent example reflecting this reality was when midwives in the province of Ontario, led by the Association of Ontario Midwives, lodged a landmark human rights tribunal case alleging that midwives were underpaid based on gender. The Ontario government was ordered by the Human Rights Tribunal of Ontario to remedy the gender pay gap, including a 20% compensation adjustment retroactive to 2011, and compensation for "injury to dignity."[23,24] This landmark decision set a precedent for other gender-segregated professions globally.

Our results further exemplify and describe how systemic discrimination impacts midwives differently in Canada, particularly based on race and indigeneity. For example, our findings emphasize how the AAM's capacity, structures, and processes contribute to the historical exclusion and disenfranchisement of racialized and Indigenous midwives within the leadership of the organization and the profession. Newly emerging from this work is how the interconnectedness of rurality and remoteness combines with other identities to form unique disadvantages and exclusion for midwives. Rural and remote midwives face unique challenges when providing quality healthcare in these regions, compared to their urban counterparts, and the AAM must ensure that the needs and solutions for these midwives are listened to.[24] Finally, Indigenous midwifery remains on the periphery in Alberta, and Indigenous midwives can greatly benefit from the AAM's support to advocate for systemic change in response to truth and reconciliation.

Pertaining to the organizational capacity of AAM, it is known that midwifery in Canada was a "grassroots movement, born out of social activism and the struggle for [cisgender female rights]."[25] The eventuality of the regulated midwifery profession in Alberta, similar to other areas in Canada, resulted from a small number of people, homogenous in values and demographics. Typical of most midwives' associations, the founding midwives of the AAM volunteered alongside one another to lobby for regulation and pay equity while practicing midwifery.[14] This style of growth has challenges and opportunities. On the one hand, fewer people who complete the share of the work can benefit from rapid decision-making. However, smaller organizations with limited funding revenue rely heavily on midwives who might not have leadership skills or competency in organizational functions. Associations such as the AAM then rely on *ad hoc* development of competencies, such as financial management or funding acquisition, and lack proper expertise, leading to tensions and mistrust among members. For example, members spoke of a lack of transparency with their membership fees and perceived a lack of direct benefits of AAM, particularly in their perceived lack of success with pay negotiations. Lack of equal pay and high membership fees are compounded by the undervaluation of midwives, burnout, and exhaustion, which were exacerbated by the challenges brought about by the COVID-19 pandemic.[2]

On the positive side, the organizational transformation and growth from a volunteer-run board to a structured entity were crucial for responsiveness to members, strategic planning, and advocacy.[14] When associations can grow their organizational capacity, their technical capacity improves to support their leaders. Subsequently, impact of the organization also improves.[14] Yet, in

the study, there were concerns about the midwives association's capacity to grow leaders and the lack of equitable access to leadership roles within the profession. A scoping review of midwifery leadership in Canada found that midwives have little access to information and training within midwifery to support their ability to lead an organization within the health system.[26] Yet, specific barriers in leadership pathways for racialized and Indigenous midwives in Canada are only beginning to be highlighted. Investments in leadership training and equitable access to training that includes anti-racism system's thinking, innovation, vision, organizational awareness, and governance are therefore crucial for capacity-building of the organization and diverse midwifery leaders.[26]

Our study illuminates the ongoing issues of racism within the midwifery profession in Alberta. Similar to the findings from the United States and central Canada, our study participants shared that interpersonal and structural racism is a common experience within the profession, including barriers for racialized midwives to enter and maintain positions of midwifery leadership in the AAM.[4,27] Initiatives that are designed to support and create pathways for Indigenous and racialized midwives must provide an enabling environment, so that all midwife leaders can sustain their work. There was also an emphasis on the need for the AAM to take concrete actions that dismantle racism in the profession and work toward true inclusion, such as reducing barriers for internationally educated midwives, who are often newcomers and racialized.[27]

Finally, our results reveal the critical need to acknowledge and actively support Indigenous midwifery in Alberta. Similar to the "Indigenous Midwife" legal exemption in Ontario, participants called for AAM to advocate for legislative reform to ensure official recognition of Indigenous midwives and the return of birth to Indigenous communities. According to NCIM, the exemption clause in the Ontario Act allows for Indigenous communities to formally recognize their knowledge keepers to legally provide care as midwives.[28] This Ontario legislation served as a lever for the Association of Ontario Midwives to secure government funding for the Aboriginal Midwifery Program, starting in 2016, which is a formal pathway to practice, with the financing and implementation of community-led Indigenous midwifery. While there are still barriers for Indigenous midwives in Ontario, the association is purposefully growing its advocacy efforts with governments, the public, and Indigenous communities. Other Canadian jurisdictions, such as Alberta, are not able to make the same headway within similar political, educational, funding, and healthcare mechanisms.

Implications and Recommendations

Results from this study were initially shared with the AAM along with some early recommendations to consider in terms of dismantling systemic racism and inequity and creating decolonized, anti-racist, and anti-oppressive processes within the midwifery health system. Recommendations highlighted the AAM's role in Indigenous midwifery in the province. These recommendations, as stated below, informed strategic discussions for the AAM when initially shared in 2023.

1. Increase representation at leadership levels in AAM and explore with membership how to promote safe and inclusive space and leadership mentorship for racialized and Indigenous midwives.
2. Advocate for anti-racist and anti-oppressive pathways to midwifery practice for internationally trained midwives.
3. Engage with Indigenous midwives, elders, and Nations to explore the elimination of barriers for Indigenous midwives to practice, such as regulation levels/exemption clauses, education pathways, partnering with communities to return birth to Indigenous communities, and increasing awareness of Indigenous midwifery at the membership and public levels.
4. Continue ongoing anti-racism training with their membership and incorporate other relevant continuing education modules, such as Indigenous midwifery and truth and reconciliation, trauma- and violence-informed care, inclusive language in practice, and unconscious bias.
5. Advocate and support midwives working within alternative models of practice, particularly rural and remote midwives.

Strengths and Limitations

Our article offers important insights into the evolution of AAM and highlights how professional associations can influence advocacy, governance, and equity within the profession. The article's strengths dwell in its clear use of feminist intersectional and transformative frameworks, its engagement with diverse voices, and its grounding in both documentary evidence and key informant interviews, which provide rich context. However, its reliance on a single case study design limits broader generalizability, and some findings, particularly around systemic racism and Indigenous midwifery, point to the areas that are more suggestive, rather than being fully developed. The study is strongest in revealing lived experiences and organizational dynamics, but further comparative research would strengthen its policy impacts.

CONCLUSION

Our findings carry significant implications for the midwifery profession and healthcare in Canada. We contribute to the evidence that midwives' associations can support the sustainability and impact of midwifery and are well positioned to influence policy and governments' investments in the profession. Being of "high capacity" means implementing internal anti-oppression approaches to organizational operations and activities. Our results highlight that in Alberta, a paradigm shift within the AAM, with a commitment to anti-racist practices, is critical to create a safe environment for all midwives and birthing individuals. Furthermore, midwives' associations have a role in truth and reconciliation by taking concrete action to support Indigenous midwifery, acknowledging historical injustices, and actively working toward a more equitable and inclusive future.

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AUTHOR CONTRIBUTIONS

Kirsty Bourret: conceptualization, methodology, formal analysis, investigation, data curation, writing: initial draft, writing: review and editing, supervision, project administration, and acquisition of funding. Deepali Upadhyaya: methodology, formal analysis, investigation, writing: initial draft, writing: review and editing, supervision, project administration, and acquisition of funding. Alyssa Wiens: methodology, formal analysis, investigation, writing: initial draft, and writing: review and editing. Luca Surkan: methodology, formal analysis, investigation, writing: initial draft, and writing: review and editing. Ashlyn Wiens: methodology, formal analysis, investigation, writing: initial draft, and writing: review and editing.

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