

**UNDERSTANDING THE ROLE AND EXPERIENCES OF BIRTH CENTRE AIDES AT
THE OTTAWA BIRTH AND WELLNESS CENTRE: WORK, LEADERSHIP, AND
REPRODUCTIVE JUSTICE**

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Abstract

Free-standing birth centres (FSBCs) were formed in Ontario in 2014 and operate with the support of birth centre aides (BCAs), a novel birth worker role. As a recent introduction to the Ontario maternity care system, there have been no academic inquiries into BCAs and only a handful of investigations on birth centres (Mattison, 2015; Mattison et al., 2020; Murray-Davis et al., 2014; Sprague et al., 2018). From a feminist perspective, an analysis of the BCA role offers a unique opportunity to conduct a feminist analysis of work in healthcare between largely women care providers (i.e., midwives and BCAs), leadership, and reproductive justice activism.

My dissertation consists of three standalone papers based on empirical data gathered through in-depth semi-structured interviews and document analysis at the Ottawa Birth and Wellness Centre (OBWC). For my first paper, “Mapping the Development of Birth Centre Aides at the Ottawa Birth and Wellness Centre”, I applied a feminist sociology of professions framework (Davies, 1996; Witz, 1992) and employed an institutional ethnographic methodology (Smith, 1990) to understand how the BCA role was developed and operationalized in the OBWC. I mapped the development of the BCA role at the OBWC descriptively and visually using the documentary and interview data with key stakeholders from the OBWC (n=16), including BCAs, administrators, and midwives.

In the second paper, “Feminist Leadership in Healthcare: The Case of Birth Centre Aides and the Ottawa Birth and Wellness Centre,” I integrated Tronto’s (1993) ethic of care with Dickson and Tholl’s (2014) LEADS in a Caring Environment leadership framework in an instrumental case study (Stake, 2005) to understand how BCAs lead from their position within the OBWC and how they experience feminist leadership practices in the OBWC. Finally, in my third paper, “Birth Work as Reproductive Activism: The Case of Birth Centre Aides at the

Ottawa Birth and Wellness Centre,” I applied a reproductive justice theoretical framework (Ross, 2017; SisterSong, 2015) through an instrumental case study (Stake, 2005) to understand how BCAs undertake quiet reproductive activism at the OBWC. Taken together, my dissertation offers new knowledge on the role and development of BCAs in the OBWC and contributes to advancing feminist scholarship on healthcare leadership and reproductive justice activism.

Dedication

I write this dedication after more than a year of living amid a global pandemic. In the final month of my thesis preparation, Ontario entered yet another lockdown and ushered in a strict stay-at-home order. For months I have watched friends, family, and colleagues pull away from career advancement opportunities, personal endeavours, and passions to pour themselves into care work. We know that women have taken on the bulk of care during this pandemic. We are the nurses, doctors, childcare workers, teachers, service workers, working from home mothers and stand-in homeschool teachers. We are the midwives and birth centre aides ensuring birthing people still have informed choice, continuity of care and choice of birthplace despite a public health crisis. I dedicate this dissertation to all those who care – in their homes and workplaces, paid and unpaid, visible and invisible. Care work and those who care are the veritable backbone of our world; they deserve so much more than what we currently offer them as a society.

Impetus

I finished my Master's of Arts as a single mother to a child with a disability. My daughter, Ava, was 18 months old and had just recovered from bi-lateral cochlear implant surgery. I was looking at years of therapeutic follow-up and costly device updates. My financial future was uncertain, and I knew the safe choice would be to enter the federal public service and chase job security. At the same time, however, I had always dreamed of pursuing my doctoral degree. I could vividly imagine my future self at the commencement ceremony, walking hand-in-hand with my daughter. It always felt so real but also incredibly out of reach. I completed my application package, but it sat unsubmitted on my desktop. I was contemplating this life decision when my dear friend, colleague, and peer mentor, Karen Lawford, stopped by my campus office after having just successfully defended her doctoral project proposal. I asked her if I should try and pursue my PhD even though I had no idea how Ava and I would survive. Karen answered with a resounding, "fuck, yes." I submitted my application minutes later. I now imagine my future self walking hand-in-hand with all three of my children to accept our shared accomplishment.

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I also want to thank to four-legged members of my family, Charlie and Lola. Charlie was my first dog. We found each other when I was a second-year undergraduate student. He saw me through degrees, moves, babies, and so much more. He was my best friend, my running partner, and later my walking partner. Lola, his vibrant younger sister, got to enjoy five years with him. I am thankful that his last year with us happened to be during a global pandemic because it meant that we were together every single day, walking, exploring, and swimming till the very end. I am indebted to both of them for giving me a reason to look up from my computer from time to time and as a reminder to enjoy the simple things, like an afternoon dip in the river or a spring flowers on a forest walk.

I want to thank my academic mentors and family. I want to thank Dr. Audrey Giles for her dedication to my doctoral journey as both an academic guide, mentor, and resource, as well as an

invaluable support in my personal life. I am so thankful that I took the advice of a dear friend to reach out to Audrey as a co-supervisor. Audrey's twin sister, Dr. Sarah Giles, also deserves recognition for her special contribution to our family; she provided us with our son's name, Kai. Not to be outdone, Audrey very successfully named my second PhD baby and newest addition, Hazel. I want to thank Dr. Ivy Bourgeault. Ivy has been part of my academic journey for over 10 years. She has been steadfast in her support, and I would truly not be writing this dissertation if she had not taken me on as an undergraduate co-op student all those years ago. I am truly indebted to both Ivy and Audrey and I do not take their collective commitment to my journey lightly.

I want to thank the Ottawa Birth and Wellness Centre and, in particular, Elyse Banham and Lesley Hoyles. I want to thank all the wonderful birth centre aides, midwives, and board members who enthusiastically participated in my research – none of this would have been possible without your support.

Finally, I want to thank my husband Rob Hums and children, Ava, Kai, and baby Hazel, who we met just a few short weeks before the defense of this dissertation. Ava, Kai, and Hazel are my greatest achievement to date; they have taught me perseverance and joy. I am privileged to be their mother. Rob, there is no doubt that the past five years have aged us three-fold. In this time, we have seen great joys – our first family home, our first baby, our wedding. We have also seen our fair share of challenges – our first deployment, first posting, followed by our second, third, and fourth home, a pandemic, a pregnancy and illness. This is our accomplishment, and I would not be here without your unconditional love and support.

Scholarships and Awards

I am extremely grateful for every scholarship, award, and assistantship I received during my doctoral studies. I began my doctoral studies as a single mother to a child with a disability which meant that pursuing my doctoral degree was always a question of financial feasibility. Keeping a roof over our heads, attending costly speech and auditory therapy and making sure we had school lunches was a carefully calculated budgeting exercise every month. Without these generous scholarships, awards and assistantships I would not have made it past the first year of my doctoral studies.

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Chapter 1: Introduction

There is a critical lack of information and knowledge regarding birth workers in Canada. The gap is particularly notable for birth centre aides (BCAs) in Ontario's two newly introduced free-standing birth centres (FSBCs), which include the Ottawa Birth and Wellness Centre (OBWC) and the Toronto Birth Centre (TBC). This dissertation takes the format of publishable papers and offers a novel contribution to advancing knowledge on the development of BCAs at the OBWC, feminist practices of leadership in healthcare, and reproductive justice activism. Through the production of three stand-alone but related papers, my dissertation addresses three primary research questions: What are BCAs? How did the BCA role develop and operationalize at the OBWC? How do BCAs experience birth work in the OBWC? In doing so, I map the development and operationalization of the BCA role at the OBWC, I describe the unique and inclusive feminist practices of healthcare leadership, and I described the roles and experiences of BCAs as reproductive justice activists leading system transformation in healthcare. In this chapter, I briefly describe the state of knowledge on BCAs in Ontario, discuss my theoretical approach in each of the papers, describe and reflect on the methodology I employed for the dissertation, and explain the overall structure of the dissertation manuscript format.

Overview of Birth Centre Aides in Ontario

In 2014, a new independent healthcare facility formed in Ontario, FSBCs. These included the OBWC, the site of my dissertation research, and the TBC. Carrying out the day-to-day functions of the FSBCs as a facility (e.g., admitting clients, cleaning, keeping medical supplies in stock, etc.) and supporting the midwives who work therein required the development of a novel birth worker role – BCAs. BCAs provide non-clinical support to midwives in Ontario FSBCs and facilitate the overall functioning of the centres. In the OBWC, at least one BCA staffs the Centre on a 24/7 basis. BCAs are responsible for cleaning and infection control duties (e.g., cleaning birth rooms), stocking medical supplies, coordinating transfers of care during a

birth, registering births, pre-registering Birth Centre clients, conducting Birth Centre tours with prospective clients in their prenatal period, and providing food and drink for clients and their family. BCAs do not act as second attendants, which is a provincially protected clinical role. On rare occasions, BCAs may enter a client's room during a birth to support midwives by taking notes. The presence of BCAs also changes the nature of midwifery work, which has heretofore been poorly understood. While midwifery support roles are common internationally, for instance, there are maternity support workers (MSWs) in the United Kingdom (UK) and maternity care assistants (MCAs) in the Netherlands, the introduction of BCAs in Ontario represents the first instance of a midwifery support role in a Canadian context.

The introduction of FSBCs and BCAs in Ontario represents several important points of departure from existing models of birth centres and midwifery care delivery systems. Though a stand-alone birth centre already existed in Ontario as part of Six Nations Health Services, the two newly funded centres (OBWC and TBC) marked the first instance in which registered Ontario midwives were enabled to provide care outside of the home or hospital (Mattison, 2015). Further, FSBCs are distinct from integrated birth centres (IBCs) in that they are not co-located or governed by hospitals (Gagnon & Vigneault, 2012). This has important implications for the regulatory and governance environment of FSBCs. Unlike hospitals, midwives in FSBCs are not subject to an additional layer of governance by the hospital's medical and professional advisory boards (Gagnon & Vigneault, 2012). Both the OBWC and TBC's operations are overseen by a Board of Directors (OBWC, 2017); notably, midwives, constitute the majority of the directors, while the other members represent the larger community (OBWC, 2017). Having set the operational standards for Ontario FSBCs, the College of Midwives of Ontario (CMO) now regulates not only midwives but also both facilities in accordance with the province's Independent Health Facilities Act 1990 (Ontario). The Ministry of Health and Long-Term are

(MOHLTC) is the government of Ontario ministry responsible for administering the provincial healthcare system, which includes legislation as well as related healthcare services. The OBWC receives provincial funding in the form of a ‘global budget’ from the MOHLTC. The OBWC’s global budget is a lump sum funding that is used to facilitate the Centre (e.g., purchase cleaning supplies, medications, and human resources like BCAs and salaried employees like the Executive Director). It is the responsibility of the Executive Director and Operations Manager to allocate and manage the global budget to meet the Centre’s operational needs.

As a relatively recent introduction in Ontario, FSBCs and BCAs have yet to be examined from an explicitly feminist perspective. This is important, in part, because they constitute a uniquely gendered healthcare environment. From a feminist perspective, FSBCs provide an analytically exceptional opportunity for examination because people who identify as women are the majority of care providers (i.e., midwives), the Centre’s staff (i.e., BCAs) governors (i.e., board of directors and administrative support) and majority of clients (i.e., birthing people) (OBWC, 2017; TBC, 2017). It is critical to conduct ongoing analyses of women’s work in healthcare because of the paradox of their overwhelming presence in this sector (Statistics Canada, 2016) yet their lack of representation in key leadership positions (Bourgeault & Porter, 2019). FSBCs stand as a stark contrast in this regard. Understanding the development of the BCA role in FSBCs is critically important for imagining future iterations of maternity care in Ontario and deepening our understandings of both reproductive justice and feminist healthcare leadership.

At present, there is a critical lack of scholarship on work in birth centres, and in particular the work and experiences of BCAs. This is, in part, due to the fact the birth centres were only introduced in Ontario in 2014. As data become available, there is a growing body of literature on the Ontario birth centre pilot project from an evaluative and midwifery-focussed perspective

(Mattison 2015; Mattison, et al., 2020; Murray-Davis, et al., 2014; Sprague et al., 2018) but researchers have yet to focus the introduction of BCAs from a feminist social science perspective. My dissertation, in the form of three stand-alone papers, addresses this gap in our knowledge by mapping the development of the BCA role in the OBWC, exploring experiences of feminist practices of leadership in the OBWC, and examining BCAs work in the context of reproductive justice.

Theoretical Frameworks

In order to understand the complexities surrounding the development and experiences of BCAs at the OBWC, I employed multiple theoretical frameworks. A feminist sociology of professions framework (Davies, 1996; Witz, 1992) frames my first paper (Chapter 2), an integration of a feminist ethic of care (Tronto, 1993) and LEADS in a Caring Environment frameworks (Dickson & Tholl, 2014) my second paper (Chapter 3), and a reproductive justice framework (Ross, 2017; SisterSong, 2015) my third paper (Chapter 4). In this section, I discuss the unique theoretical approaches in each of the papers.

Paper One: Feminist Sociology of Professions

In the first paper, “Mapping the Development of Birth Centre Aides at the Ottawa Birth and Wellness Centre,” I employed a feminist sociology of professions theoretical framework to understand how the BCA role developed and operationalized in the OBWC. Specifically, I drew upon the foundational work of Witz (1992) and Davies (1996) to help understand how relations of professional power inform the development of midwifery support workers, like BCAs, in the OBWC.

In *Professions and Patriarchy*, Witz’s (1992) drew upon Larson’s (1977, 1979) concept of the professional project, which involves 1) control over a market of expertise, and 2) embarking on a collective process of upward social mobility. She described how these two integrated

processes were different for professional projects led by women. Witz (1992) pioneered a formative theoretical framework to conceptualize women’s professional projects in healthcare, by delineating a gendered occupational closure model that teased out the gendered dimensions of four elements of occupational closure: exclusion, inclusion, demarcation, and dual closure (See Table 1). This gendered occupational closure model was developed originally to locate gender in the historical and contemporary processes of professional projects in the context of emerging medical dominance in the United Kingdom.

Table 1: Key Elements of Occupational Closure (Witz, 1990)

Exclusion	Inclusion	Demarcation	Dual Closure
<ul style="list-style-type: none"> - Practices that separate a professional group from ‘outsiders’ - Excluding people from entering a profession by legislating their exclusion from places that facilitate the required credentials - e.g., historically, women were barred from attending medical schools 	<ul style="list-style-type: none"> - Including women in adjacent roles at the periphery of a profession - Designating certain professions as ‘women’s work’ - e.g., nursing was historically constructed as a role to support physician work with unpaid labour provided by young, unencumbered women 	<ul style="list-style-type: none"> - closing off entry to a profession to all but those who are suitably qualified - Practices like credentialism, licensure, degree programs, etc. - e.g., Medicine required official licensure under various medical acts 	<ul style="list-style-type: none"> - Describes the subordinate group’s response to dominant group’s demarcationary strategies - Combines exclusion and usurpation strategies - Subordinate group does not aim to be included in dominant group - Exercise power by making claim in the division of power - e.g., Ontario midwives did not want to be included among physicians, but rather wanted their own scope of practice and power outside of medicine

Of particular importance in gendered professional projects are the dual closure strategies that describe 1) the usurpational response of subordinate social or occupational groups to demarcationary occupational closure strategies by the dominant social or occupational groups; and 2) the exclusionary response by the professionalizing group vis-à-vis other even more

subordinate groups (Witz, 1990). The subordinate group's strategic aim of using dual closure is not to seek inclusion in the ranks of the occupational group engaged in demarcationary strategies, but rather to exercise power in the form of resistance (i.e., usurpation) while also "consolidating their own position within a division of labour by employing exclusionary strategies" (Witz, 1990, p. 679). For example, as a subordinate occupational group, Ontario midwives engaged in dual closure strategies, resisting the demarcation strategies employed by medicine (e.g., Ontario physicians led a campaign to make it illegal for non-licensed medical practitioners like midwives to attend out-of-hospital births) and enacting exclusionary closure vis-à-vis would-be midwives (e.g., Ontario midwives sought to exclude immigrant and Indigenous midwives' credentials in the professional licensure process) (Bourgeault, 2006; Nestel, 2011).

I used Witz's (1992) gendered occupational closure model to understand how the BCA role developed in relation to the OBWC and the midwives who work therein. Remarkably, this mirrored in part certain elements of Witz's historical analysis of the relationship between medicine and nursing in the context of hospitals. Specifically, I recognized parallels between the historical construction of nursing to support hospital-based physicians and the development of the BCA role of support FSBC-based midwives.

Building upon this Witz-inspired analysis, I drew upon Davies' (1996) integrated profession and institutional analysis to more fully understand the emerging role of BCAs in the institutional context of the OBWC. In *The Sociology of Professions and the Profession of Gender*, Davies (1996) advances Witz's (1990) gendered professional closure model to include an analysis of how structures are also gendered. Similar to Acker's (1988, 1990) exploration of gendering and institutions, Davies' analysis described the gendering of professional organizations and bureaucracy. Institutions, like the healthcare system are gendered in and of

themselves. Gendered professions, like midwifery, and the roles that support them, like BCAs, are working within a much larger gendered system of healthcare. Davies asserted that because gender is most commonly understood as a binary that treats the feminine as inferior to the masculine, the process of gendering will inherently be reproduced in organizations, professions, and work that values a masculine ideal.

In the case of BCAs at the OBWC, I employed Davies'(1996) concept of women's work in healthcare as (typically) being in ill-defined support roles. I used a feminist sociology of professions theoretical framework to facilitate a focus on the institutional components, like the texts of the OBWC (e.g., the proposal for the OBWC and job postings), and the work ascribed to BCAs. A theoretical focus on the gendered processes of professionalization (Witz 1990, 1992) and the gendered structures within professional institutions themselves (Acker, 1988, 1990; Davies, 1996) facilitated my understandings of how BCAs are uniquely gendered in a new healthcare environment like the OBWC.

Paper Two: Feminist Ethic of Care and LEADS in a Caring Environment

In the second paper, "Feminist Healthcare Leadership: The Case Study of Birth Centre Aides and the Ottawa Birth and Wellness Centre," I integrated for the first time two distinct yet complementary theoretical frameworks: feminist ethic of care (Tronto, 1993) and LEADS in a Caring Environment (Dickson & Tholl, 2014). I layered Tronto's ethic of care with Dickson and Tholl's (2014) LEADS in a Caring Environment (LEADS) healthcare leadership capabilities framework to better understand feminist practices of healthcare leadership at the OBWC. Drawing out the data in response to my third research question on BCAs experience of birth work in the OBWC, I focused on BCAs' role as emerging leaders as well as their relationships with the OBWC formal leadership to draw out feminist practices of leadership in the OBWC that inverted the traditional organizational hierarchy.

As an established framework for Canadian healthcare leadership, LEADS (2014) enables researchers to highlight the distinct capabilities of leaders in five domains and contributes to broader attempts to define leadership. In this way, LEADS encourages researchers to ask, “What is leadership?” while a feminist ethic of care frame has researchers asking, “What is this leadership seeking to change?” I applied a feminist ethic of care lens to LEADS as a way to identify opportunities for feminist practices of healthcare leadership that builds upon feminist discussions of leadership as a process geared towards change. Most importantly, I recognized that although Dickson and Tholl (2014) described their framework as LEADS in a Caring Environment, the authors did not conceptualize the care dimensions that are afforded by a discussion of a feminist ethic of care (Tronto, 1993); my integration of these two frameworks was built upon this realization.

Feminist Ethic of Care and Leadership

Women’s work in healthcare has been largely conceived of as care work and, to this end, much of feminist work has focused on categorizing, qualifying, and recognizing care work rather than defining or recognizing care practices in relation to leadership (Adams & Bourgeault, 2003; Riska, 2008). Among the many accounts of women’s care work in both the public and private realm, there is rarely theoretical inquiry into the concept of care itself. Tronto (1993) addressed this theoretical gap in the broader context of political theory in her work, *Moral Boundaries: A Political Argument for an Ethic of Care*. Care, Tronto argued, is not a disposition, nor is it a moral concept, value, set of rules, or principles. Instead, Tronto defined care as a political idea and set of practices that take as their starting point both the essential interdependency of all human beings – or “the fact that not all humans...in the world are equally able, at all times, to take care of themselves” – and the central role of caring in daily human life (p. 162). Care practices, Tronto elaborated, include attentiveness, responsibility, competence, and

responsiveness. Further, care does not only describe the elements entailed in the actual work of care but also the qualities necessary for people to live and work together.

Tronto's (1993) ethic of care is a feminist approach because it recognizes that systems of power (e.g., sexism, racism, colonialism) and privilege (whiteness, wealth, ability, etc.) greatly affect an individual's or community's social location and, in turn, their ability to care (Tronto, et al., 2006). In the context of this research, it is imperative to theorize and recognize care as a set of practices and to consider how these practices have developed in relation to BCAs. In my study, I specifically employed Tronto's (1993) four domains of care—attentiveness, responsibility, competence, and responsiveness—to understand how these practices function in the context of feminist healthcare leadership, as mapped out in the LEADS framework.

LEADS in a Caring Environment

As an established framework for Canadian healthcare leadership, LEADS (2014) enables researchers to highlight the distinct capabilities of leaders in five domains and contributes to broader attempts to define leadership. LEADS is a leadership framework designed to showcase the capabilities required of both formal and informal leaders to meet diverse challenges and bring about cultural shifts in healthcare (Hermosura, 2020). The LEADS acronym represents the five domains of leadership capabilities: Lead self, Engage others, Achieve results, Develop coalitions, and Systems transformation. The LEADS framework is set up in way that intentionally begins with micro-level individual practices (i.e., Lead self) and moves to broader practices and capabilities that have implications for the healthcare system on a macro-level (i.e., Systems transformation). In this way, Dickson and Tholl (2014) intended that the LEADS framework could demonstrate healthcare leaders' distinct capabilities at different levels of interaction and impact (i.e., on the micro, meso, and macro level or on the personal, societal, and system level). Each of the domains comprises four measurable and observable capabilities of

exemplary leadership, which can include important equity, diversity, and inclusion dimensions.

Applied as a theoretical framework, LEADS can help researchers understand the complex processes that characterize leadership in healthcare, but it does not include a feminist analysis of care in healthcare leadership. As such, my integration of Tronto's (1993) feminist ethic of care was a novel contribution to advancing theoretical gaps in healthcare leadership.

Applying a Feminist Ethic of Care Lens to LEADS

I sought to integrate these two seemingly disparate approaches to theoretically frame feminist leadership in the OBWC by weaving Tronto's (1993) ethic of care into a broader understanding and application of Dickson and Tholl's (2014) LEADS in a Caring Environment. Dickson and Tholl (2014) did not explicitly integrate LEADS into a broader equity framework from its inception, though in 2020 the authors agreed to integrate equity, diversity, and inclusion (EDI) focussed text boxes written by the Bourgeault-led Empowering Women Leaders team of which I was a part as a way to update their model (Dickson & Tholl, 2020). If anything, however, the EDI text box approach is a supplementary approach to adequately integrating feminist foundations of leadership into LEADS. The approach I took afforded me the opportunity to conduct a more thorough foundational approach to the integration of a feminist-based leadership practices because women are underrepresented in healthcare leadership literature and in key leadership positions.

In addition to recognizing the equity gaps and cursory focus on care in Dickson and Tholl's (2014) LEADS framework, I also observed parallels between Tronto's (1993) four domains of care as a set of practices and Dickson and Tholl's (2020) LEADS five domains of leadership capabilities. In both cases, Tronto and Dickson and Tholl understand "practices" as imperative to constructing good care and leadership, respectively. In my second paper I recognized how BCAs described practices, like feminist leadership, in the context of macro-level

systemic change (e.g., access to birth place options) which was reminiscent of the fifth domain in LEADS, “Systems Transformations”. In this way, I realized that broader feminist objectives around systemic change could also be mapped onto the healthcare system level changes describes in the LEADS framework (Dickson & Tholl, 2014). More specifically, Tronto (1993) discussed “care” in terms of achieving or pursuing broader social objectives (e.g., providing socially situated and appropriate care where and when needed), which, again, mapped onto the final domain of Dickson and Tholl’s LEADS framework, which is to bring about positive change in Canadian healthcare through systems transformation.

Finally, in both frameworks, there is a focus on advancing social objectives, but Dickson and Tholl’s (2014) LEADS framework lacks an adequate analysis of power in the context of healthcare leadership; for which a feminist ethic of care (Tronto, 1993) enables our understandings of healthcare leadership to include care as a set of practices that is socially situated. It adds a feminist analysis of power and complements the gendered analysis of professional power in the first paper. I drew upon these parallels and opportunities to apply a feminist ethic of care lens to LEADS by applying these principles to BCAs’ relationships with leadership in the OBWC.

Paper Three: Reproductive Justice as a Theoretical Frame

In the third paper, “Birth Work as Reproductive Justice: The Case Study of Birth Centres Aides at the Ottawa Birth and Wellness Centre,” I used a reproductive justice framework. Reproductive justice sits at the intersection of theory and praxis. Ross, a feminist academic and activist, was among the twelve Black women from the Combahee River Collective in the United States who coined the term reproductive justice in 1994. Since then, Ross (2017) has expounded upon the theoretical reach of reproductive justice and made important distinctions between reproductive health, rights, and justice. As she described,

Reproductive justice was never meant to replace the reproductive health (service provision) or reproductive rights (legal advocacy) frameworks. Instead, it was an amplifying organizing concept to shed light on the intersectional forms of oppression that threaten Black women's bodily integrity. It rapidly propelled a growing movement of women of color activists from many social locations to fight for reproductive dignity. (pp. 290-291)

The study of birth work activism requires an interdisciplinary framework to understand where traditional disciplinary boundaries must be challenged. An interdisciplinary and intersectional reproductive justice framework offers a theoretical and practical approach that accounts for the "interlocking matrix of oppression that is frequently parsed into different disciplines such as Native American Studies, Queer Studies, Economics, and African American Studies" (Ross, 2017, p. 291). As an organizing concept, reproductive justice helps to construct an understanding of BCAs as birth workers that is not siloed to one component of reproductive activism. Rather, reproductive justice highlights how BCAs may operate across all three pillars of reproductive activism including, reproductive health, rights, and justice. Moreover, reproductive justice fills a gap left by rights-based frameworks, wherein white feminism left out women not conceptualized as rights holders (e.g., transwomen). Reproductive justice helps to facilitate theoretical connections between activism and community as a "positive approach that links sexuality, health and human rights to social justice moments placing abortion and reproductive health issues in the larger context of wellbeing and health of women, families and communities" (Ross, 2013, p. 11).

In an interesting way, a focus on the quiet reproductive justice activism (i.e., activist practices that are less overt than attending protests or lobbying for legislative change but instead involve organizing and facilitating social change objectives) of BCAs reflects a system transformation element of the LEADS framework from the second paper. The key difference

between BCAs' experiences of "System Transformation" and the one originally proffered by Dickson and Tholl (2014) was that BCAs spoke to a very specific and gendered system of change that focussed on maternity system transformation.

Reflections on the use of Multiple Theoretical Frameworks

In the proposal for this research, I did not anticipate that I would draw upon multiple theoretical lenses across my three papers. I initially proposed a complementary theoretical framework that drew upon feminist sociology of professions (Davies, 1996; Witz, 1990) and ethic of care theory (Tronto, 1993). In the process of data collection and reflexive thematic analysis (Braun & Clarke, 2006; Jenkinson, 2017), however, I realised that my anticipated theoretical framework would not provide a fulsome understanding of the complexity in the themes I was beginning to identify in the data. I thus decided to draw upon different theoretical frameworks in each paper to provide multiple lenses through which to examine BCAs' experiences in the OBWC. In the end, my decision to employ multiple theoretical frames in my dissertation contributed to filling significant gaps in research and knowledge, which would have been made otherwise impossible from a singular theoretical perspective.

Methodology

My overarching methodology begins from a feminist standpoint (Harding, 2004; Hartsock, 2019). As such, it is important to situate myself in the overall research process and design. Following this description, I outline the complementary methodologies adopted across the three papers of this thesis – institutional ethnography (Smith, 1990) and the instrumental case study approach (Stake, 2005).

Situating Myself

I am guided in my approach to my research by feminist reflexivity (Faria & Mollet, 2016; Hemmings, 2012). I am situated by my privileges: I am a white, cis-gendered, highly educated

and middle-class woman. As an undergraduate student I worked as a research assistant in a community health research unit. This work introduced me to concepts of gender, place, and health, which prompted me to take on Women's Studies as a joint major with political science. As I neared the end of my undergraduate degree, I decided I wanted to pursue my interest and focus on birth work as a midwife. I was accepted to attend a provincial midwifery education program, but shortly thereafter learned that I was pregnant. My request to defer my program enrollment by one term to accommodate the birth of my daughter was ironically denied. I applied to the same program the following year and was not accepted. From there, I decided to continue to pursue my journey in academia—baby in tow. As a young graduate student-mother to a child with a disability, I encountered barriers to accessing education that informed my major research paper for my Master's on student mothers.

My research experiences as a doctoral student on projects that proposed evaluative research on birth centres in Ontario, Manitoba, and Quebec, as well as a Status of Women Canada funded project, Empowering Women Leaders in Health, also shaped the focus of my dissertation. I also bring my experiences as a midwifery consumer (in both rural and urban settings) and as a parent to children with identities that are diverse from my own: my daughter lives with a disability and my son is mixed race. My experience as a midwifery consumer emphasized the importance of choice of birthplace in Ontario. I was encouraged by these experiences and connections to pursue my research on Ottawa's newest birth workers—BCAs—and the changing face of maternity care services in the city. It is important to recognize how my experiences as a researcher, midwifery consumer, and parent have shaped the questions I ask, as well as the analysis I bring forward. Finally, making a full range of women's work visible and valued has been a central focus of feminist scholarship (Albelda & Shea, 2010; Benoit & Hallgrimsdottir, 2011; Bourgeault, 2006; England, 2005; Gottfried, 2013) and is the main

motivating factor for this research. I am committed to making the work conducted by birth workers, like BCAs, visible and valued within academic and activist communities and contributing to feminist inquiries of work, activism, and leadership in healthcare.

Institutional Ethnography

In the first paper, “Mapping the Development of Birth Centre Aides at the Ottawa Birth and Wellness Centre,” I explicitly applied an institutional ethnography (IE) approach to develop visual and descriptive maps of the operationalization of BCAs in the OBWC. IE is a social science research methodology developed by Dorothy Smith (1990) as a way to explore, explain, and understand the lived experience of particular actors in a particular setting. As a feminist methodology, it is employed to emphasize how gender is embedded within institutions, policies, processes, and the lived experiences of those who interact with these institutions, policies, and processes (Bisaillon, 2012; Walby, 2013). IE facilitates understandings of the gendered nature of these everyday experiences within the context of institutional logics (Smith, 1990).

I was drawn to use IE because it has been particularly instructive in the study of work processes and how they are coordinated through texts (Grahame, 1998). My research was conceived on the assumption that there was little known about the actual work processes undertaken by BCAs. That made an inquiry into work process texts themselves, like the facility proposal for the OBWC, BCA task diaries, and job postings for the BCA position, critical components of examination. More specifically, I wanted to uncover the work processes involved in the BCAs’ everyday experiences and how this may translate into a fuller understanding of the role – IE as a methodology was applicable for this objective.

In the context of this research, IE provided me with the necessary practical methodological tools to consider how texts (e.g., job postings, policies, task diaries, facility proposals, provincial laws, etc.) influenced the operationalization of BCAs in birth centres. The

use of IE also facilitated increased visibility of previously undocumented work processes among BCAs and, in turn, contributed to a fuller understanding of gendered work in the maternity care system. Describing and mapping the development of BCAs in FSBCs using IE is a unique contribution to making a diverse range of birth work visible in the maternity care system.

I was also inspired by feminist scholars to use IE as a way to study the experiences and processes of a particular policy change (i.e., the Ontario government's introduction of FSBCs and BCAs in the province). For example, Lawford (2017) used IE to study the experiences and processes of Health Canada's evacuation policy for pregnant First Nations women in Manitoba (Lawford, 2017). Lawford's application of IE revealed that First Nations women were largely responsible for ensuring maternity care was provided to themselves and other First Nations women after evacuation due to the lack of coordination among federal, provincial, and municipal services. In my first paper, I used IE to elucidate the ways in which the BCA role developed and operationalized at the OBWC despite a legacy of political push back on similar independent healthcare facilities and related roles.

Challenges to IE. In IE there is no proscribed number of informants (Bisallian & Rankin, 2012). As a novice IE scholar, I was concerned by what I perceived as a low number of interview participants (n=16). When I reflected on my data, which include several textual elements (e.g., the OBWC facility proposal and BCA job postings) as well as interview data, I grew more confident in the IE process and my concerns around the number of interviews eased.

Another objective of IE is to gain an understanding of the activities that people undertake in the day-to-day conduct of their lives (Bisallion & Rankin, 2012), which was a difficult objective in the OBWC because BCAs' availability for interviews was so sporadic. It was not always as easy as simply showing up at the Centre for a scheduled interview, especially if the BCA was dealing with multiple birth room cleans and incoming clients. In an effort to mitigate

this challenge and not impose on the BCAs, I provided all of my participants with my personal cell phone number. When BCAs were available for an interview, they would simple text or call me and I would try to get to the Centre as soon as possible. I navigated both of these challenges (i.e., lack of proscribed interview participants and access to my research site) to produce an IE that is truly reflective of BCAs' experiences in the OBWC.

Decision to exclude observation data. In the proposal for this doctoral research, I included field note templates for observation. I was also granted ethical approval from my University to conduct observation at the OBWC. Indeed, traditionally, ethnographic studies rely heavily on observations as a way to document patterns of social interaction and perspectives of the participants in their local contexts (Smith, 1990). In practice, however, it was very difficult to conduct any kind of observation at the OBWC due to the nature of birth work; midwives were rarely present because they only access the Birth Centre to attend a birth, administrators were present during regular working hours but not always on-site, and BCAs work alone and were not keen to be followed or shadowed by a researcher while they conducted their duties especially when these tasks are highly time sensitive. Most importantly, I was not granted ethics to observe clients during the labour and birth process or enter a birthing room while a client was present. The Centre is not physically large so when a client was present and in labour, it made it almost impossible to conduct observation with BCAs. I quickly realized that observation would not be feasible nor yield the kind of rich ethnographic data anticipated. As a way to buttress the exclusion of observation, I gathered BCA task diaries. BCAs keep detailed task diaries for every shift. The diaries record a full 12-hour shift so that the incoming BCA knows the status of the Centre upon arrival for her shift. I had access to five years of task diaries that I used to develop a table of interactions in Paper One. I also used these diaries to contextualize the work processes BCAs reported during interviews. My decision to exclude observations does not detract from my

IE but is evidence of how IE is a flexible methodology not rigidly maintained by adherence to a pre-determined schema of approaches to data collection. Indeed, in conversation with Smith herself, Diamond (2006) discussed participant observation as a *potential method* among a range of methods available to institutional ethnographers. The BCA diaries as texts for analysis proved to be valuable and unanticipated sources of rich data that supplemented my interviews, enabling a rigorous IE approach.

The IE I conducted contributes new and foundational knowledge on the development of BCAs in the OBWC. In this way, IE was an essential methodological tool needed to analyze and understand the role of a variety of texts in the development of the BCA role and how these texts dictate the development and implementation of the role vis-à-vis midwives in the OBWC. Moving forward, however, I needed to adopt a different methodological approach that would help me focus on BCAs' experiences from their own perspective. An instrumental case study approach (Stake, 2005) complements IE in that it often integrates ethnographic components while also emphasizing flexibility and creativity in the research process. The IE I conducted in my first paper set the scene for a shift to an instrumental case study approach in my second and third papers.

Decision to adopt two methodological approaches. I chose two complementary methodological approaches as a way to utilize the same data set with distinct purposes in mind. It was not always my intention to conduct both an IE and instrumental case study, but I quickly observed that an IE would not provide me with the methodological tools I needed to explore some of the unanticipated themes that emerged around leadership and reproductive justice; adopting two different methodological approaches helped me use the data for different ends. From a practical perspective, the data collection process for both the IE and instrumental case study was the same (described in the Methods section below). The methodological differences

between my IE and instrumental case study were most apparent in the analysis of the data. The IE provided me the proper tools to map the policies and processes involved in the development and operationalization of BCA using a gender lens vis-à-vis midwifery, while the instrumental case study shifted my analytical focus to BCAs' experiences of leadership and reproductive justice as specific entities, both of which could be informed by unique theoretical lenses. Due to the dearth of knowledge on the BCA role in the OBWC, it was essential that I first conducted an IE before I undertook specific theoretically-informed inquiries into BCAs' experiences that emerged from the IE. A methodological shift from an IE to an instrumental case study approach provided me with the methodological tools to conduct theoretically-informed analyses of BCAs' experiences of work, leadership, and reproductive justice at the OBWC.

The Ottawa Birth and Wellness Centre as an Instrumental Case Study

In the second and third papers, "Feminist Leadership in Healthcare: The Case Study of Birth Centre Aides at the Ottawa Birth and Wellness Centre" and "Birth Work as Reproductive Activism: The Case Study of Birth Centre Aides at the Ottawa Birth and Wellness Centre," I used the instrumental case study approach described by Stake (2005). I adopted an instrumental case study approach because it can offer unique insight into the human experience (Stake, 2005). Stake (2005) described case studies as pulling together naturalistic, holistic, ethnographic, phenomenological and biographic research methods. In this way, the case study is often considered to be a palette of diverse methods that can afford the researcher a degree of creative freedom. Stake (1988) wrote that an instrumental case study is a case that is being examined with the objective of providing insight into a particular issue (e.g., healthcare leadership and reproductive justice activism in birth work) or to "redraw a generalization" (p. 137). The case, Stake (1988) explained, is "still looked at in depth, its context scrutinized, its ordinary activities detailed" (p. 138), but all because this helps the researcher understand a broader issue (i.e.,

experiences of birth work, activism, and leadership in healthcare). In this way, Stake (1988, 2005) described the case as playing a supportive role in facilitating our understanding of broader issues, like those that plague women's work in healthcare. Moreover, case studies also allow for a degree of flexibility and do not limit the researcher to excluding findings that are outside the purview of the research questions (Boblin et al., 2013). For example, a case study methodology made it possible for me to identify themes around reproductive activism and feminist healthcare leadership, both of which were not part of my original research questions. The methodological ability to reflect on the experience of BCAs at the OBWC from their perspectives, in their own voices, was paramount throughout my research and also set the groundwork for feminist inquiry.

There exists a long tradition of case study methodology in the field of feminist and gender studies. Researchers have used case studies to look at women's access to maternity services in Canada (Hankivsky & Varcoe, 2007); the role of motherhood in women's health (Varcoe & Doane, 2007); interprofessional conflict among feminized health professions (Adams, 2004); the development and integration of midwifery in Ontario (Bourgeault, 2006); experiences of birthing at home for First Nations women (Kornelsen et al., 2010); and First Nations women's experiences of evacuation for birth (Lawford, 2017). My research on BCAs at the OBWC is at the intersection of the feminist inquiries that have come before and, as such, gave me confidence that a case study would be similarly appropriate for my research.

I chose a feminist approach to a case study to amplify the voices and perspectives of my participants. Wambui (2013) identified the case study as a feminist methodology because it is likely to allow participating women "to construct their own realities and arrive at their own truths" based on their lived experiences (p. 6). As I worked through my semi-structured interviews with BCAs, I soon realised that the "realities" I thought I would uncover did not exist, but rather new and unexpected realities were identified through an iterative analysis of the case

study data. For example, the questions I asked in semi-structured interviews around relationships with midwives and administrators, as well as the qualities of a good BCA, helped me to identify more about the nature of reproductive justice activism and gendered healthcare leadership, than the nature of the interpersonal relationships or BCA skill sets.

Challenges for an instrumental case study methodology. Case studies are often accused of lacking scientific rigour, creating an inability to generalize findings and as being logistically unmanageable (i.e., producing a massive amount of documentation over a long period of time). I agree that case studies, like any research methodology, can become unmanageable in that they can produce a mass amount of data. I do not believe, however, that this is the fault of the methodology but rather due to data management skills or an ill-defined bounded system on behalf of the researcher. An inexperienced researcher may spend longer collecting and sorting through data to make it manageable. Nevertheless, research is an iterative process, and it is this very exercise that can produce the most unexpected findings. Moreover, the accusation that case studies lack scientific rigour has been addressed by both Stake (1995) and Yin (1994), who have produced detailed methodological approaches to conduct case study research that respects both the creativity of the researcher as well as academic rigour more broadly.

The OBWC as a bounded system. A case, explained by Bloor and Wood (2006), is often described as an exploration of a bounded system. A bounded system, such as a community, an institution, an individual or an event represents the object of a case study. In the second and third papers, my case study was bounded by the physical and political boundaries set by the OBWC and the broader Ottawa community. I was bounded by the physical walls of the OBWC but also by those participants who had direct access or experience within the OBWC. For example, Ottawa area midwives do not conduct clinics directly out of the OBWC, but they have privileges to access the Centre with their clients during labour and birth. My bounded system also included

both current and former BCAs, the latter of which no longer work at the OBWC but had experiences and reflections to contribute.

I did not include the TBC as part of my case study because it was made clear early in the research process that the TBC had distinct socio-cultural and political factors that made it unique from the OBWC. Ottawa has a population that hovers around one million, while Toronto is home to almost three million residents and is the most populated city in Canada (Statistics Canada, 2016). Toronto is also far more culturally diverse than Ottawa; in fact, Toronto is often regarded as one of the most multicultural cities in the world with over 51% of the city's residents not born in Canada (City of Toronto, 2021). Conversely, Ottawa is the national capital of Canada and, as such, is home to a large proportion of the country's federal public servants; in March 2020 more than 127,000 (or 42% of all federal public servants) lived in Ottawa, compared to only 41,000 throughout the rest of Ontario and Toronto (Government of Canada, 2021). A large proportion of federal employees means that Ottawa is more affluent than Toronto (e.g., more than one-third of city's residents have an annual household income of more than \$100,000) (Ottawa Insights, 2021). The TBC and OBWC also differ in their annual admission rates. For example, in an evaluation of the Ontario birth centre pilot project in its first year of operation (i.e., 2014) the OBWC and TBC reported 175 and 320 admissions, respectively (Sprague et al., 2018). Important demographic differences, like population size, affluence, and diversity, were key considerations for excluding the TBC from my analysis of BCAs. It was not my intent to conduct a comparative analysis of BCAs and birth centres, which would have been necessary if I conducted a collective case study at both the TBC and OBWC. Instead, I defined the parameters of my case to include the OBWC and the internal relationships, communities and professionals that construct it as a bounded system.

Methods

Prior to submitting my thesis proposal, drafting data collection tools or filing for ethics approval I knew it would be important to cultivate a relationship with the OBWC. The success and viability of my research was entirely dependent upon a healthy relationship with the OBWC that was built on transparency and mutual respect. I made initial informal in-person contact with the OBWC Executive Director at an Ottawa-based event focused on empowering women leaders in healthcare, the project on which I was also involved. At this event, I introduced myself to the Executive Director as a doctoral student and my interest in conducting research with the birth centre. After the event, I was invited to meet in-person with the Executive Director at the OBWC for an informal discussion on my research topic and aspirations. We were able to develop immediate rapport and shared excitement for the proposed project that was just beginning to take form. Soon after, I was invited back to the OBWC to meet in-person with the Executive Director, Operations Manager, and Lead BCA to formally present my thesis proposal. My presentation was again received with excitement and support. We decided the next step would be to co-develop a memorandum of understanding (MOU) that would act as a formal document guiding both parties' research expectations. The MOU outlined my roles and responsibilities as a researcher in relation to the OBWC and was completed in August 2018. Though the request to draft the MOU originated from the Executive Director, it was a suggestion that I supported and embraced in the spirit of cultivating a transparent and feminist-based research process. I drafted an MOU and shared it with the Executive Director, Manager of Operations, and Lead BCA for revisions and feedback. I conducted three rounds of revisions to the MOU based on feedback from OBWC stakeholders before it was finalized. After finalizing the MOU with the OBWC, I submitted my project for research ethics approval, which was granted by the University of Ottawa in January 2019 (File number S-09-18-854).

Participant Recruitment

I was granted ethics approval in January 2019 but, at the request of the Executive Director of the OBWC, I did not begin participant recruitment until March 2019. This was to ensure that I did not interfere with an ongoing series of public consultations at the OBWC. In March 2019, I initiated my participant recruitment by utilizing snowball sampling that started with dissemination of information from the Operations Manager and then eventually relied on word-of-mouth participant recruitment from BCAs themselves. At the outset of participant recruitment I relied heavily on the relationship I built with the OBWC Executive Director and Operations Manager to recruit participants. By way of a referral email from the Executive Director and Operations Manager, I contacted three categories of informants from the OBWC for interviews: past and present BCAs, administrators (e.g., Board of Directors members) and midwives who had attended at least one birth at the OBWC since 2014. The Operations Manager emailed the letter of information and recruitment text to all former and current BCAs (n=33) and Ottawa midwifery groups (n=7) in April 2019.

The Operations Manager sent out the initial letter of information, but I was also able to recruit participants from previous research participants themselves (i.e., snowball sampling). I relied on word-of-mouth exposure for the project from BCAs themselves; after an interview, it was common for the BCA to ask fellow BCAs to participate. It was also common for BCAs to informally discuss their research participation with new BCAs who had not received the initial invitation email because they were onboarded during my data collection period. In this way, my study sample grew like a rolling snowball as former study participants recruited participants among their new colleagues.

To encourage further participation, I offered BCAs a \$20 gift card honorarium for their retailer of choice. I offered this honorarium to participating midwives and administrators as well, but they declined. The Executive Director advertised and communicated the research project at

OBWC team meetings for further exposure. The Operations Manager and Executive Director sent follow up emails to individual BCAs, midwives, and Board of Directors members when the initial response was low. For example, in June 2019, the Executive Director personally contacted individual midwives as well as the entire Board of Directors to solicit participation in the research and the Operations Manager provided the recruitment information to new BCAs. I personally followed up with anyone who emailed me to express interest in the research project (n=18). In my follow up email, I provided the consent form, an overview of the semi-structured interview questions, as well as the option to claim a \$20 honorarium.

Semi-Structured Interviews

Schostak (2006) described the interview in terms of individuals directing their attention towards each other with the purpose of “opening up the possibility of gaining an insight into the experiences, concerns, interests, beliefs, values, knowledge and ways of seeing, thinking and acting of the other” (p. 10). I used an interview guide to add consistency and structure to my interviews but also made sure that conversation was free to develop organically and change between participants (Fylan, 2005). I conducted a total of 16 semi-structured interviews in-person at the OBWC (n=8) and, by participant request, phone interviews (n=8). My participants included BCAs (n=11), midwives (n=2) and administrators (n=3).

I chose to use semi-structured interviews to provide a more appropriate format for discussing sensitive topics than a structured interview. A semi-structured interview provides participants with the opportunity to work through and debrief difficult topics (Fylan, 2005), which is important to my research. This involved the discussion of what may have been traumatic experiences for midwives and BCAs (e.g., emergency transfer of care or a death). For example, in one of my interviews with a BCA the participant recalled a client’s particularly traumatic birth experience that was also this BCA’s first birth experience, she was able to deeply

reflect on how this experience impacted her on a personal level as a pregnant person and mother without unnecessary probing or structured questioning on the topic.

In advance of their scheduled interview, participants submitted their signed letter of consent by email or hard copy. At the time of the interview, I also requested additional verbal consent before I started digitally recording the interview. Due to the small size of the Ottawa birth community (i.e., there were only a total of 33 BCAs, both past and present, when data collection began and only a handful of Board members), I could not guarantee anonymity to participants. This was made explicit in the letter of information and consent as well as verbally reiterated before the interview. This may have affected the decision for some to participate in the study. In an effort to provide a cursory level of anonymity, participants are referred to using pseudonyms and their professional title (e.g., Danielle, BCA).

All of the participants agreed to have their interviews digitally recorded. Each participant was interviewed once. Interviews ranged in length from 20 to 90 minutes. Interviews were transcribed and sent by email to participants for review. Two participants requested revisions to their transcripts: one participant asked for a comment to be removed and one participant clarified the context of a statement. I made the participant-requested revisions in the electronic version of the transcript.

Navigating challenges in my semi-structured interviews. Apart from scheduling interviews with BCAs, which was difficult due to the unpredictability of birth work and my limited flexibility as the caregiver for two young children, I did not encounter significant challenges during the actual interview process. Perhaps one of the more notable challenges was the impact of high turnover among BCAs; many of the BCAs that I interviewed (n=6) were relatively new (e.g., less than six months at the OBWC) to the role and this may have influenced the depth of their reflections and our discussion throughout the interview process. I tried to

compliment the experiences of new BCAs by including interviews with past BCAs, which often yielded deeper and more critical reflections on the BCA role.

Document Collection

I included in my document collection all documents within the public domain that described any aspect of the birth centre pilot project in Ontario and the role of BCAs in the OBWC. For example, I started collecting virtual job postings from the OBWC in 2014, which was a full year before I officially started my PhD program in 2015. The OBWC would frequently post virtual advertisements for BCA positions via their Facebook page, so I was able to easily collect these postings between 2014 and 2020. I was also given access to the OBWC facility proposal, policy forms, BCA learning modules, and BCA task diaries, which are documents that are not within the public domain. The Executive Director and Operations Manager at the OBWC shared digital copies of internal documents with me as part of my document collection process. None of these documents were considered confidential and I was given permission to consult the documents for the purpose of writing my dissertation.

Data Management and Coding

I printed my transcripts for reading and analysis because it was during this time that the COVID-19 pandemic forced school closures. My daughter was now learning from home and needed to use my computer to attend virtual lessons. Eventually, my daughter was supplied with a laptop from the school board to complete her work. After an initial read, I entered all of the interview transcripts into NVivo 11 for further coding and analysis.

Data Mapping

For the first paper, I produced a visual and descriptive map of the development and operationalization of BCAs at the OBWC. I traced the development of BCAs at the OBWC somewhat chronologically, from the first reference to the role as “maternity support workers” in

the OBWC facility proposal to the most recent job postings and BCA departures from the birth centre. I layered my documentary data with semi-structured interviews (n=16) with OBWC stakeholders, including BCAs (n=11), administrators (n=3), and midwives (n=2). The visual map provided an at-a-glance summary of the documents, policies and stakeholders involved in the development of BCAs at the OBWC. I also included two data tables. The first data table tracks changes made to BCA job postings that helped to embellish the descriptive map of the BCA development process and the second table outlines different kinds of interactions involved in the BCA work trajectory (i.e., training, education, etc.,) which reflected data from the BCA task diaries and interviews.

Thematic Analysis

I used reflexive thematic analysis (Braun & Clarke, 2006) grounded in an instrumental case study approach for the second and third papers. I adopted an explicit feminist approach to my thematic analysis (Jenkinson, 2017), which helped to foreground themes related to power in birth work, healthcare leadership, and reproductive activism. A feminist thematic analysis works towards the feminist objective of recovering and valuing women's experiences—this is particularly important within the historically and traditionally feminized area of non-clinical birth work like BCAs. So often these experiences are overshadowed in the literature by the experiences of clinical professionals like physicians and, to a lesser extent, midwives (Carvalho, 2019).

I applied a feminist approach to the thematic analysis method developed by Braun and Clarke (2006). In broad terms, thematic analysis is understood as a method for “analyzing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Braun and Clark (2019) conceptualized themes as stories about particular patterns of shared meaning across the dataset. A theme, Braun and Clarke (2006) argued, captures something important about the data in relation

to the research question and “represents some level of patterned response or meaning within the data set” (p. 82). Braun and Clarke (2006) identified six steps in thematic analysis to help researchers locate thematic analysis in relation to other qualitative analytic methods: familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report.

Braun and Clarke (2019) reflected on the development and application of thematic analysis and clarified that although they describe thematic analysis in terms of steps, this method is not intended to be linear but rather reflexive. I applied Braun and Clarke’s (2006) six steps as a guide to my data analysis but remained attentive to my own reflexivity throughout the process. In practice, being reflexive meant that I conducted several rounds of “analyzing and reporting themes within data” (Braun & Clarke, 2006) that started immediately following an interview. In this way, the coding process was non-linear. For example, after I completed an interview, I wrote down anything that I heard during the interview that was surprising or unanticipated as well as any general reflections; I added preliminary codes to my handwritten notes after an interview. I supplemented my coding process with conversations and input from my supervisors. I conducted weekly calls with my supervisors throughout the data collection process (March 2019 to February 2020) to discuss challenges that I was experiencing in both my academic and personal life as well as themes that I was identifying through my interviews. For example, in phone conversations with one of my co-supervisors, I reflected on how BCAs spoke about the OBWC leadership and their experiences as leaders in the Centre. During our phone conversations my co-supervisor encouraged me to further develop and code around feminist healthcare leadership which eventually led to the development of Paper 2. The phone calls with my supervisors were an instrumental support mechanism for me throughout the research process, and the coding portion in particular, and helped me to remain reflexive in a way that did not

ignore how my personal life (e.g., mental health challenges, children's illness, a pandemic, etc.)

must be accounted for throughout the research process. With respect to reflexive thematic analysis, being mindful of my personal challenges while also having the proper avenue to discuss challenges and opportunities in research helped to inform how, when, and where I identified and explored themes in the data. In this way, thematic analysis lends itself well to a feminist approach due to the shared emphasis on reflexivity that was a central practice throughout my research.

The reflexive nature of thematic analysis also poses significant challenges to the novice researcher. The potential points of discussion are broad, which can make “developing specific guidelines for higher-phase analysis difficult and can be potentially paralyzing for the researcher trying to decide which aspects of their data to focus on” (Braun & Clarke, 2006, p. 97). To some extent, I did experience this challenge in the way that I identified themes in my data throughout my analysis. For example, through thematic analysis I identified unanticipated themes around leadership and reproductive justice, which my supervisors encouraged me to develop more fully into specific chapters. To overcome what Braun and Clarke (2006) refer to as “data paralysis,” I constantly circled back to focus on the overall narratives and themes across interviews, not just within them, which in consultation with my supervisors helped me to decide which themes required deeper analysis or further exploration.

Dissertation Format

My dissertation is prepared in the publishable paper format with three independent but interrelated papers: 1. “Birth Centre Aides at the Ottawa Birth and Wellness Centre”; 2. “Feminist Leadership in Healthcare: The Case Study of Birth Centre Aides at the Ottawa Birth and Wellness Centre”; and 3. “Birth Work as Reproductive Activism: The Case Study of Birth Centre Aides at the Ottawa Birth and Wellness Centre.” The first paper provides a descriptive

and visual map of the development and operationalization of BCAs at the OBWC. Interview data from semi-structured interviews and documents collected from both public and private domains helped to identify opportunities for the development of the BCA role in the OBWC. In the second paper, I describe experiences of feminist leadership practices in healthcare at the OBWC. I conducted a thematic analysis of semi-structured interviews and reviewed peer reviewed literature to identify themes and practices related to feminist leadership at the OBWC. My examination of feminist leadership at the OBWC identified feminist practices of leadership and applied these practices to Dickson and Tholl's (2014) LEADS in a Caring Environment. In the final paper, I explore how/if BCAs experience reproductive justice activism through their work at the OBWC. I conducted a thematic analysis of semi-structured interviews with BCAs (n=11) to identify themes related to reproductive justice. The findings I present in the third paper explore BCAs' experiences of quiet activism in the OBWC and characterized a new reproductive justice frontline in Ottawa, one which is being diligently facilitated by the work of BCAs at the OBWC.

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Chapter 2:

Mapping the Development of Birth Centre Aides at the Ottawa Birth and Wellness Centre

Abstract

Background: The introduction of FSBCs in 2014, which included the Ottawa Birth and Wellness Centre (OBWC) and the Toronto Birth Centre (TBC), also brought about the formation of a new maternity support worker role—birth centre aides (BCAs). I address an important knowledge gap in regards to the BCA role that has developed in this new setting by examining the introduction of BCAs at the OBWC.

Study design and data collection methods: I used institutional ethnography (IE) to map the development and operationalization of BCAs at the OBWC descriptively and visually. My analysis was informed by a feminist sociology of professions theoretical framework to identify and address opportunities and challenges for the BCA role in the OBWC. I collected both documentary data at the OBWC and conducted semi-structured interviews with 16 key stakeholders.

Results: The descriptive and visual map highlights opportunities for the development of the BCA role at the OBWC: building permanency and sustainability into the role by building upon the BCA non-clinical skillset; addressing BCAs' gendered expectations of care by continuing to provide services for BCAs with children; maximizing collaboration between BCAs and midwives to support BCAs future pursuits in midwifery; and bridging the BCA pathway to grow the midwifery workforce.

Conclusions: This paper contributes new and detailed information about the development of BCAs in Ontario by describing the BCA pathway from pre-recruitment through post-employment at the OBWC. It is important to view the BCA role from a gender lens because it can be seen as an ill-defined support role, largely constructed for health professional students and/or young women without caregiving responsibilities, which ultimately dictates how this role

is experienced by BCAs themselves. The high turnover of those in this role seems to be by

design as BCAs move onto other roles in the broader healthcare system or the Centre itself.

The maternity care system that health professionals, pregnant persons, and their families experience today is a reflection of both historical legacies and contemporary gendered dynamics of professional power. Maternity care involves more than the services provided during labour and childbirth; it typically involves care over period of about one year, from preconception to at least six to eight weeks after birth (OMCEP, 2006). In Ontario, Canada, maternity care can involve a range of health personnel, such as fertility experts, psychologists, doulas, midwives, obstetricians, family physicians, nurses, and lactation consultants. The present system is one made up of diverse models of care, regulatory approaches, compensation schemas, scopes of practice, and working environments. The Ontario maternity care system is unique in that it includes three birth place options—home, hospital, or free-standing birth centre (FSBC). The introduction of FSBCs in 2014, which included the Ottawa Birth and Wellness Centre (OBWC) and the Toronto Birth Centre (TBC), also brought about the formation of a new maternity support worker role—birth centre aides (BCAs). In this study, I examine the development of BCAs at the OBWC as an independent organizational case study.

By and large, FSBCs in Ontario are regarded as a resounding success for the provincial maternity care system, and especially within the two communities they serve (Mattison, 2015; Sprague et al., 2018). Both birth centres were created to be another option for midwifery clients, who otherwise had to choose between home and hospital birth; as such, they were created with the midwifery model of care in mind. Briefly, the midwifery model of care in Ontario emphasizes choice of birth place, continuity of care, and informed choice (MacDonald & Bourgeault, 2009). It stipulates that two midwives must be present at every birth: the primary (for the mother) and the secondary (for the baby). Solo practitioners in rural and remote areas of

Ontario practice with a provision that allows for the use of a second birth attendant¹ who is not a registered midwife. BCAs cannot act as second attendants, which is a clinical role in Ontario. BCAs developed as a support role to facilitate midwifery-attended birth in FSBCs, but not with the intention of replacing the second midwife or acting as a second attendant (Gagnon & Vigneault, 2012).

There is little known about the BCA role that has developed in FSBCs, especially in the Canadian context. My focus is not on the efficacy and quality of care delivered by midwives in FSBCs or similar facilities, as this is well-established in the international literature (Hollowell et al., 2011; Olsen & Clausen, 2012; Stapleton et al., 2013) and Canadian scholarship (Mattison, 2018; Gagnon & Darling, 2013). My focus is instead on exploring how the BCA role developed within the unique dynamics of the FSBC and system context of maternity care in Ontario. The dearth of knowledge on the development of maternity support workers like BCAs is an important gap in our knowledge.

To address this gap, I used institutional ethnography (IE) informed by a feminist sociology of professions theoretical framework to analyze how BCA professional boundaries were formed through both policy and experiences. The main objective in conducting an IE is to produce a visual and descriptive map of an otherwise complex policy or social phenomenon. The key questions that guided the development of the descriptive map and visual representations of the operationalization of BCAs in the OBWC included the following: How was the BCA role constructed through texts early in the conception of the OBWC in Ontario? How did the BCA role become operationalized when people began working in these roles? What are the various

¹ A second birth attendant is someone who is authorized by the College of Midwives of Ontario (CMO) to assist a midwifery-attended birth. The second attendant must meet competency requirements set out by the CMO, including the completion of a neonatal resuscitation program which is certified by the Canadian Paediatric Society (CPS). At present, the CPS neonatal resuscitation program will only certify registered health professionals (e.g., nurses and physicians).

roles and responsibilities of a BCA? How does a BCA interact with midwives? Why do BCAs leave this role? Through mapping and describing the development of the BCA role, I identified opportunities for the BCA role in the OBWC and Ontario maternity care.

Gender and Professions in the Ontario Maternity Care System

BCAs have been introduced in a health care division of labour that is predominantly occupied by women. Women account for the vast majority of healthcare workers in Canada (Statistics Canada, 2016). Indeed, womenⁱ comprise 83% of workers in the health care and social assistance sectors, which reflects employment in hospitals, doctors' offices, dental offices, medical laboratories, and nursing and residential care facilities (Statistics Canada, 2016). In maternity care, women make up the majority of the midwifery and obstetrical workforce, nurses, family physicians, doulas, traditional birth attendants, lactation specialists, sleep consultants, and birth centre aides. Despite their prominence, women's work in healthcare has been positioned within what are regarded as the less prestigious "caring" roles in contrast to the more masculine "curing" roles of the dominant profession of medicine (Dodd & Gorham, 1994). As a result, scholarship on women's work in healthcare, and maternity care in particular, falls at the intersection of research in care, professions, and gender.

Professionalization of Midwifery in Ontario

Professionalization, also known as a professional project, refers to a social process wherein an occupational group seeks protected authority over a body of knowledge, skills, and/or expertise and, in doing so, garners professional status and authority (Larson, 1977; 1979, Witz, 1990). The introduction of FSBCs and the emergence of BCAs in Ontario is predicated on the regulation and professionalization of midwifery in Ontario. To advance our understanding of BCAs in Ontario FSBCs, it is first necessary to examine the context within which midwifery, as a professional project, is situated.

Much like the rest of North America, but unlike many British Commonwealth countries, midwifery had been largely eradicated from Canadian women's experiences of pregnancy and childbirth (Bourgeault, 2000). Midwifery entered the Canadian social consciousness with renewed vigour in the 1970s and 1980s in the form of a grassroots social movement offering women-centred, low-tech alternatives to mainstream obstetrical care (Macdonald & Bourgeault, 2009). In the mid-1980s, it was estimated that fifty midwives were providing care to 1,500 birthing women a year in Ontario (Van Wagner, 1988; Tyson, 1991). On December 31st, 1993 the Regulated Health Professions Act (RHPA) and the Midwifery Act were proclaimed. On January 1st, 1994 the College of Midwives of Ontario (CMO) was established to administer the Midwifery Act in accordance with the RHPA (Bourgeault, 2006). In addition to self-regulation legislation and the establishment of a direct-entry education program, midwifery services also became publicly funded. In the post-legislation period, despite having made major gains, the midwives still face a host of internal challenges within the profession, including challenging work-life balance (Bourgeault et al., 2006), mental health challenges (Young et al., 2015), high attrition of students from midwifery training programs (Wilson et al., 2013; Neiterman & Lobb, 2014), and a persistent gender pay gap (Cornish, 2014).

Midwifery was integrated in the Ontario health system initially in home and hospital. Although there were efforts to establish FSBCs in parallel with the newly announced integration of midwifery in Ontario in 1994, it would not be until almost 20 years later that FSBCs would be established in the province. It is at this point that BCAs developed as a new maternity support role to facilitate midwifery-led birth in FSBCs. Previously, a BCA role did not exist in the Ontario context, but with the longer establishment of midwifery in other countries like the Netherlands and the UK, there is a small but instructive literature to provide some additional insights.

Maternity Support Roles in the International Literature

The relatively recent introduction of the BCA role translates into a lack of Canadian research and scholarship. It is instructive, therefore, to consider the international literature on maternity support workers (MSWs) in the United Kingdom (UK) and maternity care assistants (MCAs) in the Netherlands to assist in identifying possible trends in the operationalization of BCAs in Ontario. The UK and the Netherlands have maternity care systems that share some similarities with Ontario. Most notably, the UK and the Netherlands have regulated midwifery, use models similar to FSBCs, and have integrated midwifery support roles.

Maternity Support Workers in the UK

In the UK, maternity support workers (MSWs) play a well-established maternity care role within the National Health Service (NHS). The role of MSWs is to undertake, under the direction and supervision of a registered midwife, tasks and duties for which midwifery training and registration are not required (The Royal College of Midwives, 2016). The Royal College of Midwives (2016) has identified 96 tasks that MSWs can undertake with appropriate training, such as: preparing the clinical area; contributing to midwife-led antenatal and postnatal classes and clinics; and assisting midwives with performing ultrasound scans. Sandall et al. (2007) explained that the diminishing obstetrical workforce and the need to free midwives' time for their extending clinical role has led to greater use of these support workers.

The growth of MSWs in the UK has been welcomed by midwifery managers and supported by social policy surrounding improvements in maternity care, namely, efforts to build capacity within the maternity health workforce (Hussain & Marshall, 2012). Today, the need for MSWs to alleviate pressure on midwives as well as to build capacity within the obstetrical workforce remains critical. The high utilization of MSWs by midwives and the overwhelming

support by the NHS speaks to the opportunity for development of the BCA role in Ontario,

which further necessitate an examination of the BCA role in the Ontario maternity care system.

Maternity Care Assistants in the Netherlands

Similar to the UK, in the Netherlands the maternity care assistant (MCA), or what is known locally as *Kraamzorg*, is an integral role in the Dutch maternity care system (Van Teilingen, 1990). MCAs provide continuity of care for postpartum people and their newborns, which is fundamental to the Dutch midwifery model of care (Royal Association of Dutch Midwives, 2017). MCAs also assist midwives during low-risk at home birth or during outpatient hospital birth (Van Teilingen, 1990). Additionally, MCAs work in the home with women in the post-natal period for a pre-determined number of hours.

Though it seems that midwives in the Netherlands have largely praised and accepted MCAs, scholarship in this area has raised concern regarding the health status of these workers as a workforce. MCAs are responsible for the bulk of care work (i.e., emotional support, household tasks, minor clinical responsibilities), which has had negative implications on the women who work as MCAs (Van Teijlingen, 1990). In Holland, the profession has an extremely high turnover, with stress and burnout constituting the major impetus for MCAs choosing to pursue a different career altogether (Van Teijlingen, 1990).

Overall, the success of MCAs in the Netherlands and MSWs in the UK suggest there is room for similar support roles to develop in the Ontario maternity care system. The application of BCAs in the OBWC is a unique opportunity to examine the emergence of this new maternity support role in the Ontario context.

In sum, not only is there a dearth of literature on maternity support roles like BCAs, much of it is atheoretical. A feminist sociology of professions perspective on this new role breaks new conceptual ground.

Theoretical Framework

A feminist sociology of professions theoretical framework can be used to analyze how the BCA role developed and operationalized in Ontario birth centres. Specifically, I used the work of Witz (1992) and Davies (1996) to help understand how gendered relations of professional power inform the organization of maternity care. A brief analysis of contemporary professional projects is important for situating the integration and development of BCAs in FSBCs.

Gendering Professions and Professional Projects

Larson (1977, 1979) introduced the concept of the professional project as involving 1) control over a market of expertise; and 2) embarking on a collective process of upward social mobility. In the context of healthcare, Coburn and Biggs (1986) and Larkin (1983) noted that medical dominance has meant that developing health occupations usually seek sponsorship from medicine to legitimize their professionalization efforts.

Witz (1992) pioneered a formative theoretical framework from which to conceptualize women's work in healthcare. Building on the scholarship of Parkin (1979) and Larson (1979), Witz (1992) described a gendered occupational closure model, which teased out the gendered dimensions of four elements of occupational closure: exclusion, inclusion, demarcation, and dual closure. Professional demarcation is the process whereby a trade or occupation, like medicine, transforms itself into a true profession by closing off entry to the profession to all but those suitably qualified (Witz, 1992). Professional demarcation is typically achieved by licensure, through barring entry to all except those who have passed certain entrance examinations and grades of training, or by allowing entry only to those who have gained membership of a specific professional body. In the case of medicine, for example, women were historically excluded from institutions in civil society (e.g., medical school) that made it possible to gain licensure and

registration as a medical practitioner (Witz, 1992). The gendered demarcation of medicine also contributed to the construction of nursing as a distinctly gendered support role for physicians; nursing was developed with the needs of physicians in mind by drawing on the largely unpaid labour of young, unencumbered women (Witz, 1992).

Dual closure strategies, on the other hand, describe the response of subordinate social or occupational groups (e.g., midwives or nurses) to occupational closure strategies (e.g., exclusion and demarcation) taken up by the dominant social or occupational groups (Witz, 1990). The subordinate group's strategic aim of using dual closure is not to be included in the ranks of the occupational group engaged in demarcationary strategies, but rather to exercise power in the form of resistance while also "consolidating their own position within a division of labour by employing exclusionary strategies" (Witz, 1990, p. 679). Interestingly, midwives have engaged in dominant occupational closure strategies, like exclusion and demarcation, with respect to doulas. In Ontario birth centres, the operationalization of BCAs in a space professionally dominated by midwives could bring about new experiences of occupational closure in the maternity care system or a new example of pre-existing closure strategies.

Davies's (1996) contribution to theorizing on professional projects, *The Sociology of Professions and the Profession of Gender*, advanced Witz's (1990) gendered professional project model, which focused on gendered processes of professionalization, to include an analysis of how structures are also gendered. Similar to Acker (1988; 1990), which explored gendering and institutions, Davies' analysis brought forward an analysis of the gendering of professional organizations and bureaucracy. Institutions, like the healthcare system, are gendered in and of themselves. Gendered professions are working within a much larger gendered system of healthcare. Davies further asserted that because gender is most commonly understood through forms of binary thought in which the feminine is typically treated as inferior to the masculine,

the process of gendering will necessarily produce organizations, professions, and work that valorize the masculine.

When integrated together, Witz (1992; 1990) and Davies (1996) inform a dynamic theoretical framework from which to analyze professional and para-professional projects in the Ontario maternity care system. More specifically, a feminist sociology of professions theoretical framework facilitates a dual focus on professionalization in the context of gendered institutional systems and professions. A theoretical focus on not only the gendered processes of professionalization (Witz 1990; 1992) but also the gendered structures within professional institutions themselves (Davies, 1996) will facilitate understandings of how the gendered processes involved in the operationalization of BCAs interacts with the structures that are brought about by the professional power embedded within institutions. But it is first instructive to understand the application of a feminist sociology of professions to the profession of midwifery, the profession to which BCAs interact with most directly. Indeed, this analysis will foster an understanding of the dual closure-like relations between midwifery and BCAs.

Methodology

Situating the Researcher

I am guided in my approach to this research by feminist reflexivity (Hemmings, 2012; Faria & Mollet, 2016). I am situated by my privileges: I am a cis-gendered, middle class, white woman. The focus of my study is largely shaped by my research experiences as a doctoral student on projects that proposed evaluative research on birth centres in Ontario, Manitoba, and Quebec. I also bring my experiences as a midwifery consumer (in both rural and urban settings) and as a parent to children with identities that are diverse from my own; my daughter lives with a disability and my son is mixed race. My experience as a midwifery consumer emphasized the importance of choice of birthplace in Ontario. It is important to recognize how my experiences as

a researcher, midwifery consumer, and parent, have shaped the questions I ask as well as the analysis I bring forward.

Institutional Ethnography

I used institutional ethnography (IE) to develop visual (see Figure 1) and descriptive maps of the operationalization of BCAs in the OBWC. IE is a research methodology developed by Dorothy Smith (1990) as a way to explore, explain, and understand the lived experience of particular actors in a particular setting. As a feminist methodology, it is employed to emphasize how gender is embedded within institutions, policies, processes, and the lived experiences of those who interact with these institutions, policies, and processes (Bisaillon, 2012; Walby, 2013). IE facilitates understandings of the gendered nature of these everyday experiences within the context of institutional logics (Smith, 1990). IE complements a feminist sociology of professions theoretical framework because it provides the necessary methodological tools, seeks to uncover how power is embedded with institutional within texts, and it is oftentimes these same texts that organize and distribute gendered professional power in the maternity healthcare system.

As an ethnography, it involves the observation and recording of the life and culture of a particular setting (Grahame, 1998). Therefore, the gaze of IE analyses is on “institutional case management processes and the logic, thinking, and assumptions that support them” (Grahame, 1998, p. 347). Campbell and Gregor (2002) described IE as a methodology that can be used to demystify the seemingly systematic organization of a policy or process that is outside of a person’s knowing. IE has been particularly instructive in the study of work processes and how they are coordinated through texts (Grahame, 1998).

In the context of this research, IE provided me with the necessary practical methodological tools to consider how texts (e.g., semi-structured interviews, job postings, policies, task diaries, facility proposals, provincial laws, etc.) influence the operationalization of BCAs in birth centres.

The use of IE can also facilitate increased visibility of previously undocumented work processes among BCAs and, in turn, contribute to fuller understanding of birth work in the maternity care system.

Methods and Data Sources

I fostered a relationship with the OBWC Executive Director, lead BCA, and Operations Manager over the course of several months. We worked together to co-develop a memorandum of understanding (MOU) for my research. Research ethics approval was granted by my institution, the Research Ethics Board at the University of Ottawa, in January 2019.

Document Collection

I reviewed grey literature, materials from government and non-government organizations, Facebook pages, Twitter, and blogs that described or discussed the OBWC or BCAs to construct the visual representation of the operationalization of BCAs and a descriptive map of this process. Document data collection also included the original facility proposal for the OBWC to the Ministry of Health and Long-Term Care (MOHLTC), hard copies of BCA task diaries, and a series of digital BCA job postings. I excluded material that made sole reference to the Toronto Birth Centre (TBC) because it is unknown if the process, role, and scope of BCAs is the same in this birth centre; the OBWC and the TBC are not administratively joined and do not confer on BCAs.

Semi-Structured Interviews

I utilized snowball sampling to initiate my recruitment. In doing so, I relied heavily on the relationship I built with the OBWC Executive Director and Operations Manager to recruit participants. By way of referral email from the Executive Director and Operations Manager, I contacted three categories of participants from the OBWC for interviews: BCAs (from 2014 to

present), administrators, and midwives who had attended at least one birth at the OBWC since 2014.

After obtaining approval, I conducted a total of 16 semi-structured interviews in-person at the OBWC (n=8) and on the phone (n=8). I conducted interviews with BCAs (n=11), midwives (n=2), and administrators (n=3). I chose to employ semi-structured interviews because I wanted to facilitate the development of organic conversation with my participants (Fylan, 2005). Semi-structured interviews also provide a more appropriate format for discussing difficult topics and give participants the opportunity to work through and debrief issues if necessary. It was important that my participants had the opportunity to debrief because discussions could involve traumatic experiences for midwives and BCAs (e.g., emergency transfer of care or a death) (Fylan, 2005).

Participants provided written and verbal consent prior to the interview. It was impossible to guarantee full anonymity due to small number of past and present BCAs (n=33), and this was acknowledged by my participants. In an effort to provide a cursory level of anonymity, participants are referred to using pseudonyms and their professional title (e.g., Danielle, Birth Centre Aide). All of the participants agreed to have their interviews digitally recorded. Each participant was interviewed once. Interviews ranged in length from 20 to 90 minutes. Interviews were transcribed and sent by email to participants for review. Two participants requested revisions to their transcripts: one participant asked for a comment to be removed, and one participant clarified the context of a statement. I printed hard copies of all transcripts for initial coding and analysis by hand and then uploaded digital copies to NVivo 11 for further coding and analysis.

Results

Mapping the Development of Birth Centre Aides in the Ottawa Birth and Wellness Centre

My research findings are presented in two parts. The first part is a descriptive map, which details the development of BCAs, somewhat chronologically from pre-recruitment to post-employment. The second part is a visual representation of the process, which is found in Figure 1. To structure the results, the descriptive map is presented in five sections: proposal for maternity support workers; advertising the BCA role; aspiring BCAs; midwifery and BCAs; and BCAs as healthcare workers in transition. These sections represent findings from key institutional texts as well as lived experiences of the participants that together make clear the development of BCAs.

Proposal for Maternity Support Workers

There was documented interest in expanding birthplace options in the Ottawa-Carleton region to include birth centres as early as 1987, pre-dating integration of midwifery in the province in 1994 (Chamberlain, et al., 1991; Soderstrom, et al., 1990). Coinciding with the introduction of regulated midwifery in the province in 1994, there was a call for proposals from Ontario MOHLTC for birth centres, with the Toronto Birth Centre winning the bid. A change of government resulted in the cancellation of the program, which effectively shelved dialogue on the issue for another eighteen years (Sutton, 1996).

Conversations were reinitiated only some 20 years later on March 20th, 2012, when the Ontario Premier and the Health Minister announced funding potential for two freestanding, midwife-led birth centres as part of Ontario's Action Plan for Health Care (Sprague, 2016). From March to September 2012, a flurry of activity on behalf of the Ottawa midwifery community and its advocates would culminate in the submission of an application to the MOHLTC for the establishment of a midwife-led birth centre in Ottawa (Gagnon & Vigneault, 2012). The successful proposal detailed a meticulous development and implementation plan for an Ottawa birth centre that would play out over the course of two years. The Ottawa Birth and Wellness Centre (OBWC) opened its doors on February 3rd, 2014.

The application for the establishment of the OBWC to the MOHLTC is where the BCA role was first conceived (Gagnon & Vigneault, 2012). The birth centre proposal, which outlined the organizational structure, placed BCAs reporting directly to the Lead Midwife and the Manager of Operations and Communications (Vigenault & Gagnon, 2012). In the original application, BCAs were referred to as maternity support workers (MSWs). It is unclear from documentation or stakeholder interviews why the role title shifted to the present “Birth Centre Aide,” but this occurred by the time of the first BCA job postings in 2013 (OBWC, Birth Centre Aide Job Posting, 2013). The application for the establishment of the Ottawa birth centre makes reference to MSWs a total of 12 times throughout its 231 pages (Gagnon & Vigneault, 2012). The first mention of MSWs occurs in the form of a proposed organizational structure chart (See Figure 1). The organizational structure of the OBWC places MSWs in line with administrative assistants and the receptionist, all of whom report to the Head Midwife and Manager of Corporate and Community Services, who in turn report to the Director and finally the Board of Directors.

Key functions, processes, and care pathways are described in the “Labour and Birth” section of the OBWC proposal. The first mention of a MSW’s responsibilities and role comes in this section of the proposal, where it is written that “continuous one-on-one support will be provided by midwives and maternity support workers during labour for birthing women” (Gagnon & Vigneault, 2012, p. 57). The labour and birth process is described in a series of seven steps that begin with active labour and admission to the Birth Centre. The second step in the labour and birth process requires the primary midwife to call the second midwife and MSW on call. There are no further references to MSWs in the “Labour and Birth” process.

An additional reference to MSWs is made in relation to supplies and sterilization: “instrument washing and sterilization (similar to that used by the midwifery practices) will be

available in the birth centre to enable midwives or maternity support workers to clean and sterilize instruments” (Gagnon & Vigneault, 2012, p. 58). In the “Operations” section, the proposal outlines the measures that will be taken to ensure that the Birth Centre can facilitate efficient and effective delivery of high-quality healthcare services, such as the “inclusion of maternity support workers to enable the midwives to focus on their clients and clinical tasks” (p. 72).

Finally, in the “Nature of Services Provided” section, we see the most robust description of the MSW role:

Unlike home or hospital birth settings, The Ottawa Birth Centre/Le Centre de naissance d’Ottawa will use maternity support workers. These support workers will be directly employed by the birth centre. The maternity support workers will provide *non-clinical assistance to the midwives* [emphasis added] during labour and birth and will help to maintain a well-functioning facility. Although maternity support workers will be present during labour and delivery, the primary first line of contact for clients will be with the midwives. (Gagnon & Vigneault, 2012, p. 82).

The proposal for the Ottawa Birth Centre set forth a recruitment strategy for administrative assistants, a receptionist, as well as three full-time MSWs (See Figure 3). The recruitment and on-boarding of the inaugural BCAs would occur from 2012 to 2014 in advance of the Centre’s opening in February 2014. The Manager, Corporate and Community Services, was tasked with filling the BCA positions, which occurred through a series of job advertisements (Gagnon & Vigneault, 2012).

Advertising the BCA role. The OBWC job postings are important texts to consider when exploring the development and operationalization of the BCA role because the job postings make the scope of the work known without detail surrounding specific processes or policies. In doing

so, the BCA job postings reveal the core competencies of the BCA role at the OBWC. Further, because the job postings convey basic requirements of the role (e.g., comfortable working alone, access to a vehicle, bilingual, medical background, etc.) to prospective BCAs, they also work to construct perceptions of an ideal candidate. Between 2014 and March 2021, the OBWC employed a total of 33 BCAs on a combination of part-time and full-time basis (Louise, Administrator). The turnover is relatively high for part-time BCAs who are mostly healthcare students moving into their clinical careers, which means advertising and the role and developing a clear job posting has been an ongoing exercise for OBWC administrators (Louise, Administrator). It is important to note, that the turnover for full-time staff was not as high as part-time staff; it was not uncommon for the full-time BCAs that I interviewed to have been working at the Centre for 2-3 years, which represents more than half of the Centre's lifetime.

The first OBWC advertisement for the BCA role was disseminated to employment networks in August 2013 and closed September 2013. The posting was modelled using an advertisement and role description for a birth centre assistant at the Toronto Birth Centre. The one-page advertisement contains a short list of applicant requirements preceded by a brief description of the role, which states:

We are seeking a number of bilingual Birth Centre Aides to be responsible for non-clinical support to midwives and their clients, housekeeping, records management, and administration. This includes preparing and cleaning birthing rooms, clinical and common areas, managing equipment and supplies, receiving clients and their families, and managing client records and bookings. *Birth Centre Aides will report to the Executive Director* [emphasis added]. These positions will involve rotations and an on-call/weekend schedule. (OBWC, Job Posting: Birth Centre Aide, August 2013; emphasis added)

It is not clear from other documents or interviews with stakeholders as to why the reporting structure shifted from the Lead Midwife and Operations Manager to the Executive Director. From 2013 to 2017, no major changes were made to the job posting for BCAs aside from a slight increase to the hourly rate of pay. In 2017 the BCA job posting included minor specificities about the computer literacy requirements and additions to the introductory text:

Birth Centre Aides (BCA) are the face of our organization [emphasis added]: from preparing and cleaning birth rooms, to offering non-clinical support to midwives and clients, to giving tours to potential clients, to managing client records, and much more, *BCAs are the cornerstone of the Ottawa Birth and Wellness Centre* [emphasis added].
(OBWC, Job Posting: Birth Centre Aide, January 2017)

The most recent addition to the BCA job posting came in 2018, when “comfortable working alone” was added as a requirement of the job. The Birth Centre is only funded to staff one BCA per shift, which means that BCAs working night shifts (i.e., 7:00pm to 7:00am) are often working alone if there are no clients. When a BCA is alone, meaning there are no clients in the centre, and all the birth rooms are clean they focus on their “process owner” tasks. Each BCA is a process owner for a particular subset of tasks; for example, there are process owners for medication stocks, client and family meals, and client gift bags (Danielle, BCA).

The pool of potential applicants, the Operations Manager explained, depends on how and where the position is advertised. For example, local university and college nursing programs have constituted a readily available resource for recruiting part-time BCAs. Broader approaches to recruitment, like the use of government job posting services, have hindered the accuracy of how the position is conveyed to applicants:

Sometimes with part-time we’ve sent it out just to the nursing programs, that has turned out to be a really great way for us to hire part-time staff, so in that case it’s a smaller pool.

Other times I've like put it on Indeed or on the government jobs site...the government jobs one is really bad because you have to use their titles...*like birth centre aide does not exist* [emphasis added]. So, I don't know, I use like, medical aide or something, and so you end up getting hundreds of applications from people who are blanket applying. (Louise, Administrator)

The lack of a correct occupational title on government employment platforms has created a barrier to recruiting BCAs. In response, the Birth Centre has opted to advertise through its social media (i.e., Facebook), directly to nursing programs, and with more targeted employment search engines (e.g., Charity Village). Employment search engines like Charity Village are more targeted than Indeed or government employment platforms because they do not require the employer to use a pre-determined job classification system. Louise (Administrator) explained that government platforms required the Centre to classify the BCA job posting as "medical receptionist" or "medical assistant," which is not an accurate description for the work. As a result, the Centre would receive hundreds of applications from people who blanket apply to job classifications (e.g., medical receptionist) rather than a specific posting.

Recruiting BCAs into the role. The OBWC employs a total of 6 BCAs at any given time; 3 BCAs are part-time and 3 BCAs are full-time (Louise, Administrator, OBWC, 2019). The part-time BCA role has relatively high turnover, with an average BCA occupying the role anywhere from 6 months to 2 years (Louise, Administrator). BCAs who are not healthcare worker students tend to stay in the role longer than part-time healthcare worker students. By nature of the work context, which is uniquely situated within the reproductive healthcare sector, the job postings garnered interest from specific communities including non-government organization (NGO) workers, former doulas, nursing students, holistic health practitioners, reproductive health activists, pre-medical school students, and pre-midwifery school students. BCAs that I

interviewed ranged in age 20 to 35 years old and though it is not dictated in policy, all BCAs to date have been women (Louise, Administrator). Candace chose to be a BCA in advance of midwifery school because “the Birth Centre is really the closest you can get to a midwife without being a midwife.” Karen (BCA) is currently a midwifery student and believes that her time as a BCA was critically important to her success as a midwifery student:

I tell anybody anytime, if you want to go into midwifery, something I would suggest is work at a birth centre in all those different capacities, because I have done everything from clean blood off the floor [of birth rooms] to fold pamphlets, to table for the birth centre [at an open house]. (Karen, BCA)

In addition to the NGO sector, doula communities, and midwifery students, many of the current and past BCAs are/were nursing students working in part-time capacities. Cassandra (BCA) recalled seeing the posting for a BCA position on a Facebook page for nursing students at her university:

There was a posting from a girl that works here being like well, we’re looking for new birth centre aides, and I thought that was super cool, just because I’m really interested in the field, in maternity and stuff like that and as a nursing student I probably will end up on a mother-baby unit at the hospital.

BCA Role Definition

The way in which BCAs and midwives interact and interpret policy notes on different BCA processes (e.g., emergency transfer, new client admission, medication inventory, birth room cleaning, etc.) is particularly important because the BCA role was originally conceived as a way to not only facilitate the Centre’s operations, but also to facilitate midwives’ work in this new context. The policy notes are written, updated, and maintained by the Executive Director, Manager of Operations, and Board of Directors (Louise, Operations Manager). When a new

BCA starts at the OBWC, they receive in-house training on the Centre's policies and procedures through a mixture of both independent study and job shadowing (Kayla, BCA). A new BCA will complete learning modules that cover everything from birth room cleaning procedures to the midwifery model of care and policy on emergency transfers. To complete the on-boarding, a BCA will typically attend three partial training shifts and then job shadow another BCA for one 12-hour shift (Kayla, BCA).

Prior to working a solo shift, new BCAs work with the Centre's Lead Midwife to understand important emergency procedures, charting, and transfers. BCAs also said the Lead Midwife often conducts surprise audits as part of ongoing training, which will typically consist of a mock procedure that involves both midwives and BCAs (Danielle, BCA). Outside of training during the on-boarding process, BCAs do not work with fellow BCAs. The OBWC is always staffed by one BCA on 12-hour shifts, while another BCA is on-call. The on-call BCA is only called in when the scheduled BCA requires assistance to complete birth room cleanings for incoming clients (Danielle, BCA).

When a Birth Centre client is in active labour, they call their midwife. The midwife calls the Birth Centre to notify the scheduled BCA that they have a client on route to the Centre. Before the client and midwife arrive, the BCA begins the admission process by pulling up the client's chart; clients pre-register their medical information (provincial health insurance number, midwifery group, etc.) during an OBWC tour that can occur at any time in the client's prenatal period. The midwife usually arrives at the OBWC before their client. The BCA will grant the midwife access to the Centre, which is locked during all hours, and direct her to an examination room (Candance, BCA). When the client arrives, the midwife will conduct an examination to confirm if labour has advanced enough to warrant full admission to the birth centre. Upon admission, the BCA will direct the client and midwife to a clean birth room (Candace, BCA).

From this point, the extent to which BCAs interact with midwives in the Birth Centre depends on the midwife's preference, overall familiarity with the Centre and BCAs, and client needs (Danielle, BCA). Danielle, the most senior BCA at the Centre, explained that the amount of interaction with midwives seems to be largely dependent upon the midwife's preference and working style:

Some midwives talk to us, and we're more involved, I guess, with the births, like getting things or whatever, and some midwives are super self-contained, so they just go in the room and do their thing, and you don't really see them until there's a baby, so it kind of depends... just like how the midwife works. Some of them, they've been doing this forever, and they're not nervous, they're just fine. So, they might not even call you if the baby is coming quickly.

For some BCAs, interacting with a midwife after their client had been admitted to the birth Centre was not necessarily a positive facet of the role. For example, Brenda (BCA) explained that the less a BCA works with a midwife the better because this would typically indicate an uneventful birth. She described her work as a BCA in terms of facilitating the midwife's work:

They call us when they're coming in, and then they come in, and they'll typically say hi, we make sure they have all the paperwork they need, and then *hopefully, usually we don't see them much again until after baby's there, so we just get them set up as best as we can, and then hopefully don't interact with them much again until once the baby is there* [emphasis added]. Otherwise, if they need us, they'll call us ... I've always had really positive interactions with midwives. They're always very happy to have us, from what I've seen, have us as an extra set of hands.

Facilitating midwifery work in the Centre means that BCAs spend a great deal of time cleaning birth rooms and sterilizing equipment. Terminal cleans of birthing rooms are conducted after

every client and take approximately three full hours to complete (Cassandra, BCA). The OBWC BCAs are trained on proper infection control techniques and follow a rigorous protocol to exceed provincial standards (Ellie, Administrator).

On occasion, however, BCAs are called upon to directly support a midwife during a birth. Somewhat rarely, a BCA will be asked to enter the client's room to take notes for a midwife or to help her locate a specific instrument and/or supply. For example, Cara (BCA) said that she was in the client's room for approximately 6 or 7 births in her three years of experience at the Centre. Cara came to the Centre from a doula background and said that being asked by the midwife to enter the client's room during a birth, though rare, were her most positive experiences as a BCA. In reference to her experiences in the client's room Cara said, "the times when I did get to interact with clients or be involved with births were just like amazing, and then I would be like, over the moon for a long time, so that was very rewarding".

As a new role without precedent in the province, the development and definition of the BCA scope of work was not always seamless. Cara (BCA) worked at the Centre as a BCA from 2014 to 2017 during a time when the role was still in its relative infancy. She recalled the frustration she felt trying to navigate this new role:

I think it was kind of like, tricky and at times frustrating because we were...kind of trying to kind of figure out what our role was, you know, like everyone, the admin and the midwives and the birth centre aides, we were all trying to figure out who was going to be in charge of what, and you know how things would happen ...it was at times frustrating and I know this is just the nature of starting, opening a new centre or opening a new business or whatever, um, it was like policies were always changing and procedures were always changing.

When a midwife asks a BCA to enter the birthing room, their role is that of a scribe; they take notes on important milestones that the midwife verbalizes (e.g., vital signs, cervical dilation, etc.). Eleanor (BCA) recalled the few times she had been asked to assist a midwife during a birth:

It's not very often that I assist the midwives. I've maybe gone once or twice into the room because the second wasn't there and I was taking notes, but that's really the extent of the assisting, or go grab the NO2 tank or "I need more green pads" or stuff like that, *but in the room itself, it's really just notetaking* [emphasis added]. (Eleanor, BCA)

For other BCAs, however, the scope of the role was complicated by clinical competencies they were achieving elsewhere, like in nursing or midwifery school. As a clearly outlined non-clinical support role, BCAs cannot and do not assist midwives beyond charting and the facilitation of care. Karen (BCA) recalled feeling pressured to shift between her roles as a BCA and midwifery student:

There were a few instances where the midwives would complain, "I know you know how to do this clinical skill and I need you to do this right now," and I would have to say, "I can't because I'm working as a BCA right now."

BCAs as healthcare workers in transition. For the BCAs interviewed as part of this study, BCA work is largely transitional in nature while they are on their way to other healthcare roles. The majority of BCAs (notably, part-time BCAs) who were interviewed saw their BCA work as a time-limited stepping stone position towards another, more permanent role within the healthcare system. When asked about BCA turnover directly, Danielle (BCA) agreed that BCAs move on when they were no longer learning in the role or it was a planned progression to another healthcare profession, adding that she feels "the skills of BCAs are often underutilized, there's a huge skill set available to midwives with the BCAs that are not being used." Though some BCAs

may have clinical skills they are obtaining elsewhere (e.g., midwifery school), as BCAs their main function is to facilitate midwifery care by maintaining a clean and safe working environment; extending clinical skills to BCAs would have the effect of detracting from BCAs' main role in the Centre as well as a host of liability concerns.

As noted above, the OBWC has employed a total of 33 BCAs on a combination of both a part-time and full-time basis since 2014; the turnover for part-time BCAs is high, but not unexpected (Louise, Administrator). BCAs overwhelmingly described their role as an excellent learning opportunity for those interested in entering nursing, midwifery, and medicine. Eleanor (BCA), a current medical student, explained that when she eventually exhausted unique learning opportunities as a BCA, she moved on to new opportunities:

I kind of felt like I had gotten everything out of the job that I could...Honestly, I was a little bit just kind of tired of the work...It got pretty repetitive and a little bit monotonous, and especially in, I don't know how busy it is now, but you know back in the first few years there weren't a ton of clients coming in...There were a lot of shifts where it would be 12 hours, and I wouldn't speak with a single person, so it was getting pretty boring. I also just, I felt like there wasn't really anywhere to grow, so I had kind of become the most, or one of the most senior BCAs at the time, and I felt like there wasn't anywhere to go up from there...I had learned as much as I could, and I had gotten everything out of the job that I could. (Eleanor, BCA)

Karen (BCA) explained that she decided to leave the Birth Centre when her responsibilities as a midwifery student not only complicated her role as a BCA but also made it difficult to work the required 12-hour shifts. Kayla (BCA) started as a part-time BCA while studying human kinetics, but shortly after entering her role she transitioned to the nursing program. She attributes her program change to her experiences as a BCA and also said, "I don't know that I will be an

RN for the rest of my life, maybe I want to be a nurse practitioner or go to midwifery school later on in life or maybe I want to get to medical school.” Cassandra (BCA) was also a nursing student and said that as a result of her experiences as a BCA, she hoped to work as a labour and delivery nurse.

For others, the demands of BCA work quickly became incompatible with work-life balance after having children. At the time of data collection in 2019², BCAs worked 12 hours shifts, while childcare providers typically operate from 7am to 5pm. This means that BCAs with children rely on informal childcare, which can be unpredictable, or special childcare centres that offer extended hours for healthcare and shift workers. Brenda (BCA) was preparing to go back to work after her maternity leave, she briefly discussed the challenges of childcare and BCA work:

We were lucky when I was working there... my neighbour is a stay-at-home mom, so she was able to take [my son] during the day, and that was very easy because she, her house is literally next to ours, but going back this time with the two kids, I've had them on the list for um, a daycare... [that] caters to shift workers.

Additionally, BCAs often work on-call shifts. When a BCA is on-call, she must be able to reach the birth centre within 45 minutes during her 12-hour on-call shift (Louise, Administrator). It can be difficult to organize last-minute childcare and arrive at work within 45 minutes. It is important to note however, that only two BCAs interviewed had children.

Discussion

Descriptively and visually mapping BCAs' development and roles revealed opportunities and challenges for the occupation in Ontario, including key insights into building upon the BCA skill set to foster permanency within the role and addressing challenges for BCAs who are

² As of 2021, full-time BCAs working Monday to Friday now work 8-hour shifts which is not reflected in this data because it was collected in 2019.

primary caregivers, maximizing collaboration between BCAs and midwives, and bridging the BCA professional pathway with midwifery to grow both workforces. Mapping the development of BCAs in the OBWC provides a simplified picture of the context, policies, and people involved in the development and operationalization of this novel midwifery support role in Ontario. In addition to contributing new scholarship on the work of BCAs, describing the introduction of BCAs at the OBWC makes clear important challenges and opportunities for the role as it continues to change.

Building a BCA Skillset

The BCA skill set was developed both in terms of the needs of the facility (i.e., to clean birth rooms) but also the needs of the professional midwifery staff therein. In this way, the occupational relationship that exists between midwives and BCAs is reminiscent of the relationship that existed between nurses and physicians (Witz, 1990). The BCA role, which has been exclusively filled by women at the OBWC, is gendered because it is yet another example of women's "routine inclusion in ill-defined support roles" (Davies, 1996, p. 661). The position has relatively high turnover among part-time staff because, as noted above, it is viewed by most candidates as a stepping-stone towards a future profession in healthcare. The frequent turnover of part-time, and to a lesser extent, full-time BCAs has the effect of situating the BCA role as job rather than an occupation, the former of which offers little in terms of growth and permanency, BCAs at the OBWC are simply moving on to new opportunities or into different positions within the organization.

Building permanency and sustainability into the role may require the OBWC to reconsider the nature of BCA work itself as well as its recruiting strategies. Many of the BCAs interviewed moved on from the role when they felt they were not learning new skills or professionally growing from their experience. Investing in BCAs will be particularly important in light of an

increasing demand for expertise in infection control and rapidly changing public health standards due to COVID-19; this constitutes an opportunity for a role that is already firmly situated within this skillset.

Maximizing Collaboration Between BCAs and Midwives

As the cornerstone of the Centre, BCAs act as an essential link between the Centre and midwives. BCAs described their relationship with midwives as subtle, but at the same time their work is vital to the success of the centre (Ellie, Administrator). The ways in which BCAs interact and do not interact with midwives illuminate the complexity of the interprofessional relations that have ensued and may also speak to the overall trajectory of a BCA in the broader healthcare system; a trajectory which should be embraced as contributing to a growing midwifery workforce. BCAs work on the periphery of midwifery and, for many of them, their experience as a BCA is a unique learning opportunity on route to another healthcare role. BCAs are keenly aware of the midwifery model of care, as this is a focal point in their on-boarding process, and they are thus ideal candidates to pursue midwifery education and contribute to a growing midwifery workforce; for liability reasons BCAs cannot act as second attendants.

The ill-defined nature of the BCA role is characteristic of gendered support roles in healthcare (Davies, 1996). The ill-defined nature of BCA work is also due to the fact that the role is still relatively new in the maternal healthcare environment. As non-clinical support workers, BCAs are already working to maximize support for midwives in the birth centre environment by facilitating care for clients and, on rare occasions, entering a client's room to take notes for a midwife during a birth. It is clear that BCAs are eager to contribute to the Centre in any way possible. The chronic shortage of midwives in Ontario represents a small opportunity for BCAs to alleviate demands for scarce midwifery resources by furthering their clinical competencies in midwifery school when they leave the Centre. Building a BCA skillset to include clinical

competencies would be extremely complicated in a highly regulated environment like maternity care and for this reason, pursuit of clinical skills would be outside the function and purpose of the role.

Bridging the BCA pathway to grow the midwifery workforce. It is obvious from mapping the development of BCAs that they are already contributing to growing a chronically strained midwifery workforce. In addition to filtering into medicine and nursing, many part-time BCAs enter midwifery training after working as BCAs. For example, two of the BCAs I interviewed were in the application process for midwifery school, while another former BCA was an upper-year midwifery student. There exists opportunity for a more formal transition from BCA to midwifery student that works to both build capacity within the midwifery workforce while also staving turnover among BCAs. At present, women are filtering in and out of the BCA role and facilitating midwifery work through an ill-defined support role; in the absence of adequate funding from the MOHLTC to support a broader BCA role, the current BCA trajectory risks reinforcing negative gendered dynamics of women's work in healthcare (Davies, 1996).

Addressing challenges for BCAs in the context of care. In addition to broadening the BCA scope of non-clinical work to encourage longevity within the role, the OBWC needs to continue to support its BCAs who are parents. The Centre's administrators can continue to offer flexible scheduling for BCAs as well as maternity benefits (i.e., family benefits, 15 week top-up for maternity leave, and paid sick days). Mapping the recruitment process for BCAs at the OBWC provided a composite depiction of the kind of communities that were being sought after for this work. A small a minority of BCAs interviewed (n=2) had dependents, which does not represent all of the BCAs who are parents, while the majority were students (n= 8), and only one BCA was a full-time health professional in the dietetics field outside of the OBWC. This is not to say that the OBWC focusses on recruiting women without children, but rather to emphasize

the challenges that may exist for BCAs who are parents. Brenda (BCA) and Danielle (BCA) discussed difficulty securing childcare for 12-hour shifts and challenges of last minute on-call work. As a result, BCA work may be incompatible with broader care work that takes place in the home that is largely the responsibility of women (Benoit & Hallgrimsdottir, 2011; England, 2005). Balancing care work with BCA work is a challenge to building permanency within the role that could be met by creative solutions from BCAs themselves. For example, Danielle (BCA) suggested setting up a daycare cooperative with other BCAs and employees of the birth centre (like the administrators and receptionists), and Brenda (BCA) discussed the possibility of last minute on-site childcare companies. It is important to note that BCA schedules have changed since data collection took place; as of 2021 full-time BCAs that work from Monday to Friday have an 8 hour shift and part-time BCAs who work on weekends have 12 hour shifts. The move to an 8 hour shift is immensely helpful for securing childcare and is evidence of how the OBWC is working to support its BCAs with caregiving responsibilities.

This study has some limitations that should be considered. Most notably, the BCA sample size (n=11) was small. At the time of data collection there had been a total of 33 BCAs (past and present). The small sample size included a majority of healthcare students (present and aspiring) and only two participants had children; this may not speak to the overall makeup of the BCA workforce. Also, This study focused on the development of BCAs at one birth centre - the OBWC and did not include an analysis of BCAs at the Toronto Birth Centre. It is possible that the development and implementation of the BCA there differed in important ways. The decision to focus on the OBWC was reached rather early in the research process due to the contextual, environmental, and administrative differences that exist between the two birth centres and their home cities. Examining the role of BCAs at the TBC would provide further insight into how the role developed on a provincial rather than municipal level. Future researchers should consider

how broadening the BCA non-clinical skillset by providing new skills and learning opportunities for BCAs may influence how long BCAs stay in the role because they feel more professionally satisfied.

Conclusions

The institutional ethnography presented here is foundational in understanding BCAs as a new cadre of birth workers. The integration of the OBWC into the provincial maternity care system rested heavily on the successful development and operationalization of BCAs, who are the cornerstone of the OBWC. BCAs are not only a small workforce, but they are also a new role in the provincial maternity care system. This study emphasizes how the BCA role was developed through texts (e.g., job postings, OBWC proposal, and policy) and evolved within a setting constrained by professional and organizational policies. There remains a chasm between how this role is experienced by workers and how it can meet the growing needs of the communities it is ultimately meant to serve.

Role Development: Birth Centres Aides at the Ottawa Birth and Wellness Centre

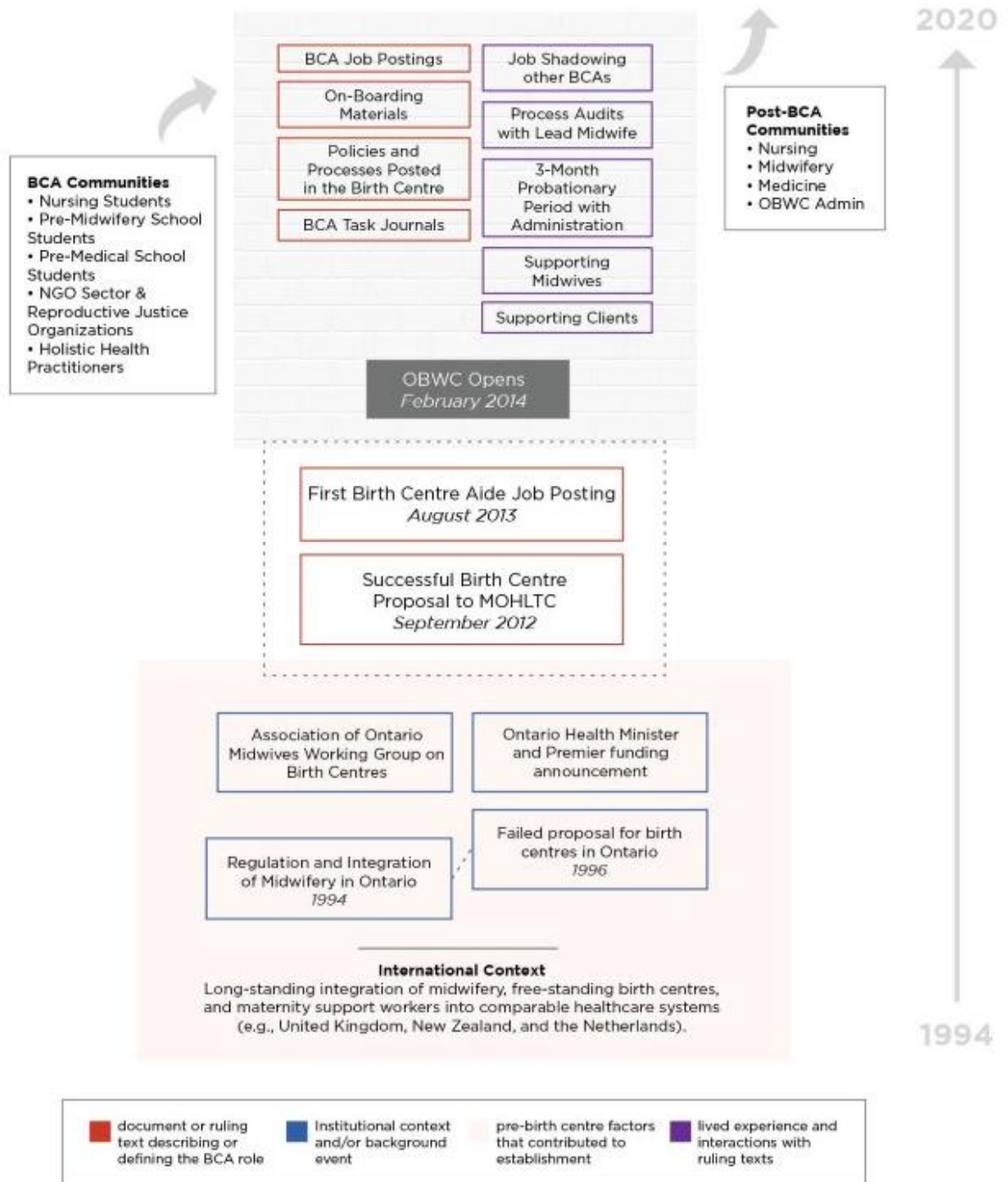


Figure 1: Map of the development and operationalization of BCAs at the OBWC

Birth Centre Aides: Role Development through Experience and Interaction

Role	Type of Interaction	Description of Interaction
OBWC Lead Midwife	Training	<p>Audits: the lead midwife can audit BCAs on certain policies/procedures</p> <p>Training with midwives: the lead midwife provides training for BCAs on policies and procedures related to midwifery scope of practice and care</p>
	Role Definition	<p>Policy change: Lead midwife can recommend policy change around procedures</p>
Midwives	Support	<p>Second Attendant: BCAs may act as a second attendant; this can involve charting, organizing emergency transfer, retrieving instruments</p> <p>Facilitation of Care: BCAs facilitate operations of the midwives' environment; they clean the birthing rooms and equipment, provide assistance and direction to locate instruments and equipment, admit clients, complete live birth registration, and submit charting.</p> <p>Limited interaction</p>
Other BCAs	Training	<p>Training: New BCAs will shadow other BCAs during the training process approximately three times. BCAs will conduct one full shadow shift with the lead BCA before their first solo shift</p>
	Support	<p>On-Call: BCAs work alone; one BCA staffs the birth centre at a time. One BCA is on-call in the event that there is support needed.</p>
	Role Definition	<p>Clarification and Feedback: BCAs provide informal feedback to midwives, the director and manager on certain policies and procedures. Feedback can be taken into account when new policies or role definitions are developed (e.g., request for clarification on cleaning procedures resulted in the expanded definition for this facet of the role)</p>
Administrators (Executive Director & Operations Manager)	Training	<p>On-boarding: the executive director and operations manager facilitate BCA on-boarding</p> <p>Scheduling: The operations manager works with BCAs to schedule shifts around centre's needs</p> <p>Probationary Feedback: The operations manager provides the most direct line of communication to BCAs during the probationary feedback</p>
	Role Definition	<p>Policy change: the Executive director can define and change policies (e.g., tub cleaning procedures)</p> <p>Interaction most intense when BCAs are new</p>
Clients & Family	Support	<p>Birth Centre Tours: BCAs interact with clients during Centre tours</p> <p>Supporting Client Families: BCAs may support client families during labour and birth (e.g., food and drink)</p> <p>Very minimal interaction</p>

Table 1: Role development of BCAs through experience and interactions

Year	Document	Reporting Structure	Remuneration	Qualification Requirements	Role Responsibilities
2012	Birth Centre Proposal	Manager, Operations and Communications	<i>Unknown</i>	<i>Unknown</i>	<ul style="list-style-type: none"> • Non-clinical assistance to midwives • Continuous one-on-one support to clients • Instrument washing and sterilization • Bilingual • Maintain well-functioning facility
2013	Job Posting	Executive Director	\$15/hour	<ul style="list-style-type: none"> • Completion of Highschool • Basic understanding of health care delivery services. • Certification in CPR and first aid. • Computer literacy. • Understanding and commitment to the OBWC'S model of midwifery care. • Must be able to work in, and be sensitive to, a multicultural environment. 	<ul style="list-style-type: none"> • Housekeeping • Health records management and bookings • Administration • Preparing and cleaning birthing rooms, clinical and common areas • Managing equipment and supplies • Receiving clients and their families
2014	Job Posting	Executive Director	\$15/hour \$1.25/hour for on-call		
2016	Job Posting	Executive Director			

				<ul style="list-style-type: none"> • Caring, cheerful and flexible in working styles and client needs. • Reliable, good timekeeper, ability to work under pressure and to use own initiative. • Excellent communication and literacy skills in English and French. • Discretion and sound judgment. • A reliable means of transportation to the Birth Centre within 45 minutes, at all hours. • Good general health. • Current Police Record Check. 	
2017	Job Posting	Executive Director	\$15.50/hour for 3-month probationary period \$16/hour after probation \$1.25/hour for on-call	<ul style="list-style-type: none"> • Comfortable working alone, including overnight. 	<ul style="list-style-type: none"> • BCAs are the face of the OBWC and cornerstone of the organization
2018	Job Posting	Executive Director			

Table 2: Development of the BCA Role at the OBWC through Documents

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Appendix

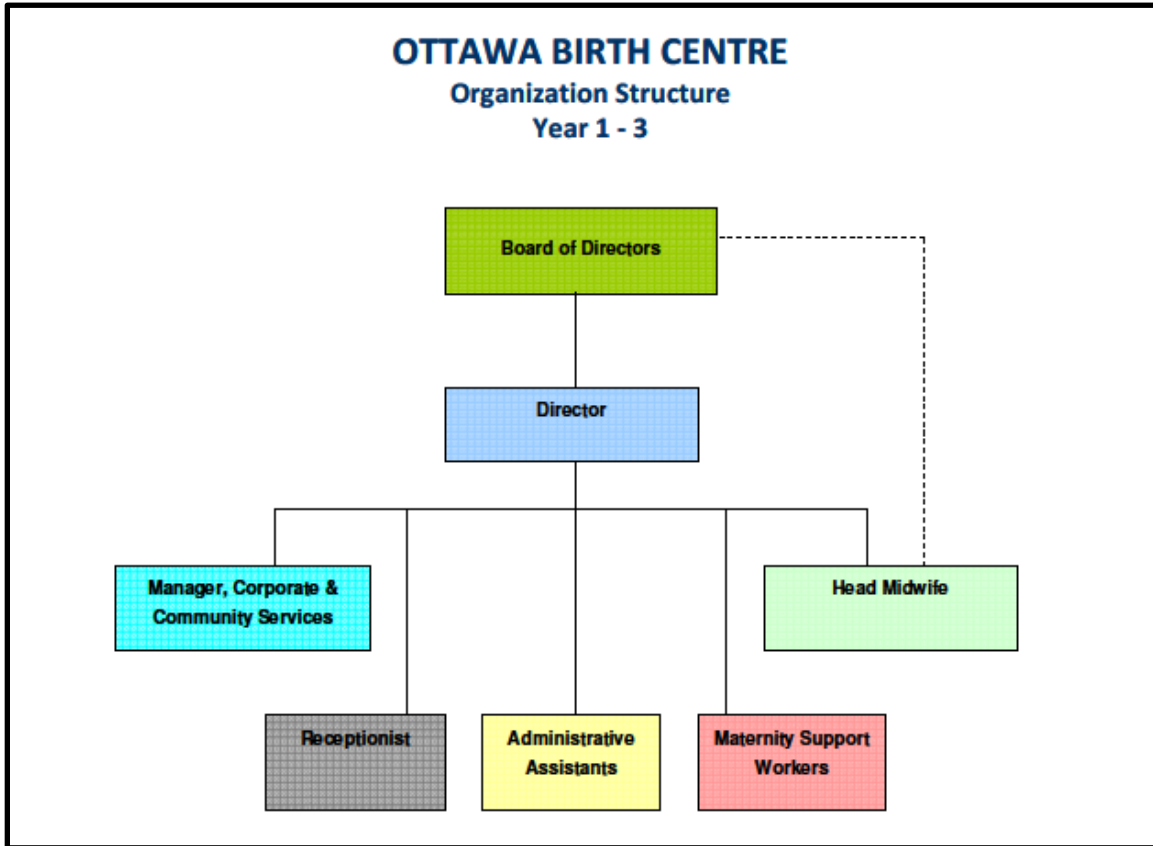


Figure 2: Gagnon, G., & Vigneault, M. (2012). *Proposal: The Ottawa Birth Centre*. Ministry of Health and Long-Term Care.

	Year 1	Year 4 to 6
Birth Centre & Community Space		
Midwives	(45) (a)	(50 to 60) (b)
Maternity support workers	3.0	4.0
Head midwife	0.5	0.5
Director of operations	1.0	1.0
Manager of corporate & community services	1.0	1.0
Administrative assistants	2.0	2.0
Receptionist	1.0	1.0
Students/learners	(2) (d)	(4) (d)
Footnotes		
a licensed with practices partnering in the Birth Centre; number on site will vary		
b estimate based on additional births		
d number expected to be on site, typically		

Figure 3: Gagnon, G., & Vigneault, M. (2012). *Proposal: The Ottawa Birth Centre*. Ministry of Health and Long-Term Care.

Chapter 3:

Feminist Leadership in Healthcare:

The Case of Birth Centre Aides and the Ottawa Birth and Wellness Centre

Abstract

Background: Women make up more than 80% of the healthcare workforce in Canada yet remain vastly underrepresented in key leadership positions. There exists a wealth of scholarship on healthcare leadership, but the literature on feminist healthcare leadership and birth workers is underdeveloped.

Study design and data collection methods: Drawing upon an instrumental case study of Birth Centre Aides (BCAs) at the Ottawa Birth and Wellness Centre (OBWC), three research questions guided this study: What are the key elements of feminist healthcare leadership at the OBWC from the perspective of BCAs? How can we understand BCAs' experiences of leadership within traditional models of healthcare leadership? How do OBWC administrators influence BCAs as feminist healthcare leaders? I applied a feminist ethic of care lens to a prominent healthcare leadership model, LEADS in a Caring Environment, to data collected from a total of 14 interviews with BCAs (n=11) and administrators (n=3).

Results: A thematic analysis of interviews led to the identification of three themes related to leadership from the perspective of BCAs: OBWC administrators lead from care, exemplify collaborative leadership with BCAs, and foster BCAs as emerging leaders. I identified examples of leadership practices as care practices using Tronto's (1993) ethic of care, which is a novel approach to theoretically examining feminist leadership in healthcare.

Conclusions: Integrating care, as a set of practices, into healthcare leadership highlights opportunities for a more fulsome understanding of BCAs' experiences as birth workers and feminist healthcare leadership in the context of the OBWC.

Women make up over 70% of the global healthcare workforce but are notably absent from key decision-making positions (Bonoil et al., 2019; Davies et al., 2019). In Canada, the gender divide in the health sector is even steeper: over 80% of the health sector is comprised of women, and here too they remain vastly underrepresented in healthcare leadership positions (Porter & Bourgeault, 2017; Statistics Canada, 2017). For example, only 8 of the past 152 presidents of the Canadian Medical Association were women and similarly, only 8 women have been Deans of Faculties of Medicine in the history of Canada (Tricco et al., 2021). Working towards transformative change in health systems requires critical reflection on traditional models of healthcare leadership that have produced the current system—one that is clearly segregated by gender.

In Canada's most populated province, Ontario, the introduction of free-standing birth centres (FSBCs) in 2014 represents a unique opportunity to examine feminist iterations of healthcare leadership from the perspective of new birth workers that facilitate, support, and maintain FSBCs—birth centre aides (BCAs). It is important to focus on experiences of leadership from the perspective of BCAs because unlike their clinical counterparts (e.g., midwives, nurses, and physicians), there is little known about how these new birth workers experience, interact, and perceive leadership in healthcare. Indeed, healthcare leadership researchers rarely consider configurations or experiences of leadership among non-clinical healthcare workers, particularly beyond physicians and nurses.

The Ottawa Birth and Wellness Centre (OBWC), which is the focus of this study, is a community-led initiative on behalf of midwives, supporters, and activists. The introduction of the OBWC and the BCAs that staff Centre on a 24-hour basis represents an opportunity for examining feminist healthcare leadership. In a previous paper, I describe how BCAs support

midwifery work in birth centres by providing non-clinical care to pregnant people and their families as well as conduct important administrative duties (see chapter 2). For example, BCAs are responsible for making sure the Centre is accessible to midwives and clients 24/7, new client registration, Birth Centre tours, medical supply inventory, organizing emergency transfers of care, medical charting, birth registrations, infection control (cleaning birthing rooms), laundry (e.g., cleaning bedding for birthing rooms), and food supplies (e.g., ordering and preparing food for clients and their family). Indeed, BCAs play a critical role in supporting the Ontario midwifery model of care, especially choice of birthplace; as essential workers for the birth centres, they are responsible for the day-to-day functions of the Centre (Gagnon & Vigneault, 2012; see chapter two).

The introduction of FSBCs and BCAs represents several important points of departure from existing models of healthcare leadership in Ontario. As an independent healthcare facility, the OBWC is distinct from pre-existing integrated birth centres (IBCs) in that it is not co-located nor governed by a hospital (Gagnon & Vigneault, 2012). This has important implications for the governance and regulatory context of the Centre. Unlike in hospitals, midwives and other personnel in FSBCs, like BCAs, are not subject to an additional layer of governance by the hospital's medical and professional advisory boards (Gagnon & Vigneault, 2012). The OBWC is led by an executive director who reports to and is hired by the Board of Directors. The Clinical Lead Midwife and Operations Manager report directly to the Executive Director while the BCAs and administrative staff report to the Operations Manager. Notably, midwives constitute the majority of the Board of Directors, while the remaining Board seats are held by members of the community, such as representatives from local hospitals and community health organizations.

The College of Midwives of Ontario (CMO) regulates the facility in accordance with the province's Independent Health Facilities Act (1990).

As a relatively recent introduction to the maternity care landscape in Ontario, the OBWC and the role that BCAs play therein represent an interesting case study from a feminist health leadership perspective because it constitutes a uniquely gendered healthcare environment. From a feminist perspective, the OBWC provides an exceptional analytic opportunity to examine feminist leadership because people who identify as women account for the majority, though not all, of the care providers and support workers (i.e., midwives and BCAs), governors (i.e., board of directors and administrative support), and the majority of clients (i.e., birthing people) (OBWC, 2017).

Three research questions guided this study: What are the key elements of feminist healthcare leadership at the OBWC from the perspective of BCAs? How can we understand BCAs' experiences of leadership within traditional models of healthcare leadership? How do OBWC administrators influence BCAs as healthcare leaders? To answer my research questions, I conducted an instrumental case study (Stake, 2005) at the OBWC and applied a feminist thematic analysis (Braun & Clarke, 2006; Jenkinson, 2017) to data collected through semi-structured interviews with BCAs and the OBWC's administrators. To frame this instrumental case study of the OBWC, I drew upon two complementary frameworks. The first is the feminist ethic of care perspective (Tronto, 1993), and the second is the more healthcare focused LEADS in a Caring Environment leadership framework (Dickson & Tholl, 2014). It is critical to conduct ongoing analyses of gendered work and birth work; in particular, women's work in healthcare leadership deserves significant attention because of women's overwhelming presence and

unequal distribution in positions of power in the healthcare sector (Bourgeault et al., 2019) and the current gap in knowledge that exists for BCAs in Ontario FSBCs.

Gender and Healthcare Leadership: A Review

Three key bodies of scholarship on healthcare leadership, gender and healthcare leadership, and feminist healthcare leadership inform this case. There is a diversity of approaches to healthcare leadership in mainstream literature that stands in stark juxtaposition to the lack of scholarship on gender and healthcare leadership and, to an even greater extent, feminist healthcare leadership.

Leadership in the Health Sector

Studies of leadership are vast, and their focus can range from traits and characteristics of leaders to behaviours and processes involved in the construction of leadership models (Chobanuk & James, 2015). In the context of the health sector, leadership is recognized as a key factor in improving healthcare, which has facilitated a scholarly focus on identifying the traits and capabilities of successful leaders (Hermosura, 2020; Marchildon & Fletcher, 2016). A significant number of studies on leadership in health has generated a patchwork of approaches and leadership styles. For example, Turner (2019) identified nine approaches in the healthcare leadership literature, including generalist models (Barr & Dowding, 2008; Dye, 2010; Gopee & Galloway, 2009; Gunderman, 2009), transformational leadership (Choi et al., 2016; Levey et al., 2002; Maccoby et al., 2013), servant leadership (Tropello & Defazio, 2014), ethical leadership (Sahne et al, 2016), complexity leadership (Weberg, 2012), coaching as a leadership style (Hicks, 2014), authentic leadership (Read & Laschinger, 2015), leadership for improvement (DaCosta, 2012), and shared or distributed leadership (Fitzgerald et al., 2013; Rogers, 2014).

In the Canadian context, the capabilities-based framework developed by Dickson and Tholl (2014) emerged as a leading model in Canadian healthcare leadership scholarship because it was developed by drawing upon Canadian-specific data and literature. Dickson and Tholl's (2014) LEADS in a Caring Environment takes a more holistic approach than what Turner (2019) identified in his typology of leadership models by defining twenty leadership capabilities across five distinct domains (See Table 1). Importantly, Dickson and Tholl (2014) advanced conceptions of leading outside of one's official title by "leading from you are" but lacks a fulsome consideration of gender, which brings about opportunities for the integration of feminist perspectives of leadership. I discuss Dickson and Tholl's (2014) LEADS framework in more detail below as part of my integrated theoretical framework, but as a distinctly Canadian contribution to the healthcare leadership scholarship it is important to also acknowledge LEADS (Dickson & Tholl, 2014, 2020) as part of the broader literature in this area.

Over time, different styles and approaches to leadership in the health sector have fallen in and out of favour. Most recently, there has been a shift towards extending the definition of leadership beyond the charismatic role of individuals. Definitions of leadership that rely heavily on an individual's charisma in setting visions to which all organizational actors are supposed to subscribe do not adequately account for the role of power dynamics (Collinson & Tourish, 2015). Despite the robustness of scholarship on healthcare leadership, there remains a critical gap in addressing gender and leadership in the sector, which is surprising given the remarkable gender-based leadership gap.

Gender and Leadership in the Health Sector

The scholarship surrounding healthcare leadership is well-developed (Denis & Van Gestal, 2016; Marchildon & Fletcher, 2016; Turner, 2019), but there is significantly less known

about gender and leadership in the health sector. This gap is even bigger for non-clinical birth workers like BCAs in Ontario FSBCs, because studies to date have largely focussed on midwives' and clients' experiences in these new health facilities (Mattison, 2015; Sprague, 2018). In Canada, women are largely missing from key leadership positions in healthcare (Porter & Bourgeault, 2017). In the most prestigious teaching and research hospitals in Ontario, for example, only five of 23 Chief Executive Officers (CEOs) are women (Bourgeault et al., 2019; Tricco et al., 2021). It is thus of little surprise that the scholarship that is available on gender and healthcare leadership is predominately focussed on women's underrepresentation in key leadership positions (Bourgeault et al., 2019; Carnes et al., 2008; Porter & Bourgeault, 2017), prestigious medical specialties (Harris et al., 2020; Mehta et al., 2017), and to a lesser extent, on gender inequity within the global health workforce (Boniol et al., 2019; Dhatt et al., 2017). At present, gender and healthcare leadership scholars are predominately focussed on *where* women are missing from in formalized leadership positions rather than critically reflecting on leadership itself.

In 2019, Bourgeault et al. (2019) reviewed 111 published articles and 43 grey sources to conduct a gap analysis on the state of knowledge for women's leadership in three key health sectors: healthcare, health sciences, and Indigenous health. They found that across the healthcare literature more is known about the barriers to women's leadership than the facilitators of women's leadership, that interventions are seldom evaluated, that there is a lack of data on allyship in the context of women's leadership in healthcare, and that the literature on women and Two-Spirit leadership in Indigenous health is especially sparse. Moreover, the healthcare leadership literature does not currently include a feminist analysis of leadership, specifically a feminist ethics of care, which has been central component of feminist leadership literature more

broadly (Clover et al., 2018). Indeed, feminist scholars' inquiries of leadership have focused predominately on leadership as a process towards producing change and, in this way, have sought to understand how leadership promotes social change rather than defining leadership as a trait or capability (Batliwala, 2013; Clover et al., 2017).

To address these critical gaps in knowledge, I examined healthcare leadership from the perspective of BCAs and administrators at the OBWC by integrating Tronto's (1993) feminist ethic of care with LEADS in a Caring Environment leadership capabilities framework (Dickson & Tholl, 2014), a prominent leadership model in Canadian healthcare leadership.

Theoretical Framework

I employed a theoretical framework approach that draws from the healthcare leadership model known as LEADS in a Caring Environment (LEADS), which was developed by Dickson and Tholl (2014, 2020), and the feminist ethic of care theory articulated by Tronto (1993). As an established framework for Canadian healthcare leadership, LEADS (2020) enables researchers to highlight the distinct capabilities of leaders in five domains and contributes to broader attempts to define leadership. In this way, LEADS encourages researchers to ask, "what is leadership?" while a feminist ethics of care frame has researchers asking, "what is this leadership seeking to change?" I applied a feminist ethic of care lens to LEADS as a way to identify opportunities for a feminist examination of healthcare leadership that builds upon feminist discussions of leadership as a process geared towards change.

LEADS in a Caring Environment

Dickson and Tholl (2014, 2020) developed LEADS in a Caring Environment (LEADS) capabilities framework as a way to encompass five distinct domains of healthcare leadership in the Canadian context. LEADS is designed to showcase the capabilities required of both formal

and informal leaders to meet diverse challenges and influence positive cultural shifts in healthcare (Dickson & Tholl, 2014, 2020; Hermosura, 2020). Leadership is often assumed to reside in formal leadership or authority roles—that is, it is assumed to be limited to managers and executives. While leadership has strong connections to administration and management, it is also a quality that can be found in anyone who rises to a challenge and uses their skills to engage others in solving the problem (Dickson & Tholl, 2014). The application of LEADS is particularly important in the Canadian context because of its relatively high uptake across the healthcare sector (LEADS Canada, 2021).

The LEADS acronym represents five domains of leadership capabilities: **Lead self**; **Engage others**, **Achieve results**; **Develop coalitions**; and **Systems transformations**. Healthcare leaders must cultivate capabilities across all five domains to effect positive change (Dickson & Tholl, 2014). Dickson and Tholl (2020) used the imagery of DNA to convey how each LEADS domain can be combined or merged in any number of ways to produce effective leaders. Each of these domains comprises four measurable, observable capabilities of exemplary leadership. The capabilities encompassed within each domain (see Table 1) are non-hierarchical but must be equally cultivated to sustain the lifeline of leadership. LEADS can help illustrate how leadership is characterized in mainstream healthcare, but it requires a feminist understanding of care to be integrated with Tronto’s (1993) ethic of care.

Table 1: LEADS in a Caring Environment leadership capabilities framework

Domain	Capabilities
Lead Self	Self-motivated leaders ... <ol style="list-style-type: none"> 1. Are self-aware 2. Manage themselves 3. Develop themselves 4. Demonstrate character

Engage Others	Engaging leaders... <ol style="list-style-type: none"> 1. Foster development of others 2. Contribute to the creation of health organizations 3. Communicate effectively 4. Build teams
Achieve Results	Goal orientated leaders... <ol style="list-style-type: none"> 1. Set direction 2. Strategically align decisions with visions, values, and evidence 3. Take action to implement decisions 4. Assess and evaluate
Develop Coalitions	Collaborative leaders... <ol style="list-style-type: none"> 1. Purposefully build partnerships and networks to achieve results 2. Demonstrate a commitment to customers and service 3. Mobilize knowledge 4. Navigate socio-political environments
Systems Transformation	Successful leaders... <ol style="list-style-type: none"> 1. Demonstrate critical thinking 2. Encourage and support innovation 3. Orient themselves strategically to the future 4. Champion and orchestrate change

Note. Summarized from *Bringing Leadership to Life in Health: LEADS in a Caring Environment*, Dickson and Tholl (Eds.), 2020.

Defining ‘care’ for a feminist healthcare leadership framework. The term “caring” in the LEADS framework title stems from the original analysis of Canadian data on healthcare leadership in 2014, in which the authors found an implicit focus on healthcare leaders’ dedication to the health and well-being of others (i.e., patients and clients) (Dickson & Tholl, 2014). Despite its namesake, it does not capture “care” as a feminist concept but rather as it relates to leaders’ dedication to healthcare. In this way, Dickson and Tholl (2020) understood dedication to the health and well-being of others (i.e., care) as “the common thread that unites people who work in healthcare” (p. 44) rather than as a facet of leadership itself. Conversely, in their ethic of care framework, Tronto (1993) understands care as a set of practices that not only

entails the actual work of caring but also the qualities necessary for people to live and work together. From a theoretical perspective, it is important to distinguish Dickson and Tholl's (2014) use of "caring" from Tronto's (1993) ethic of care because in this study I applied Tronto's understanding of care as a set of practices to the LEADS model, which is a novel approach to examining feminist healthcare leadership.

Feminist Ethic of Care and Leadership

Women's work in healthcare has been largely conceived of as care work and, to this end, much feminist work has focused on categorizing, qualifying, and recognizing care work rather than defining or recognizing care in relation to leadership (Adams & Bourgeault, 2003; Riska, 2008). Among the many accounts of women's care work in both the public and private realm, there is rarely a theoretical inquiry into the concept of care itself. Tronto (1993) addressed this theoretical gap in the broader context of political theory in her work, *Moral Boundaries: A Political Argument for an Ethic of Care*. Care, Tronto argued, is not a disposition, nor is it a moral concept, value, set of rules, or principles. Instead, Tronto defined care as a political idea and set of practices that take as their starting point both the essential interdependency of all human beings—or "the fact that not all humans...in the world are equally able, at all times, to take care of themselves" (p. 162)—and the central role of caring in daily human life.

Commenting on Tronto's (1993) care practices, Barnes (2001) noted that in contrast to dispositions, practices are social phenomena, "owned and controlled by groups that define their correctness and provide ways for members to learn them" (p. 17). In the context of the OBWC, I chose to focus on BCAs' perspectives of administrators' leadership practices because it is BCAs as a group who own and control care as a set of leadership practices in the OBWC. BCAs have the ability to define the correctness of the administrators' leadership practices through their

relationships. For example, when a group owns and control practices, as described by Tronto (1993), they are ultimately in control of what practices are accepted and repeated. In this way, BCAs' experiences (i.e., positive or negative) influence how administrators lead, and which practices are thus reiterated and replicated in the Centre. Finally, it is only when we understand care as a set of practices that we can then begin to identify how this feminist leadership concept can be mapped onto traditional healthcare leadership models, like LEADS.

Tronto's Care Practices Explained. Care practices, Tronto (1993) elaborated, include attentiveness, responsibility, competence, and responsiveness. Tronto's care practices are intended to be sequential; that is, attentiveness is needed before responsibility, competence, and responsiveness. As a care practice, attentiveness refers to "caring about, noticing the need to care in the first place" (p. 125). Next, Tronto defined responsibility as "embedded in a set of implicit cultural practices, rather than in a set of formal rules or series of promises" (pp. 131-132). In this way, responsibility is tied to the feminist objective of advancing social change (e.g., breaking down systemic oppressions like sexism, colonialism, and racism) rather than responsibility as it relates to authoritative or executive power. Responsibility can foster competency, which refers to a leader's ability to give care. Tronto explained that "intending to provide care, even accepting responsibility for it, but then failing to provide good care, means that in the end the need for care is not met" (p. 133). The final care practice described by Tronto refers to the responsiveness of the care-receiver to the care. From a feminist ethics of care perspective, "responsiveness suggests a different way to understand the needs of others rather than to put ourselves into their position, it suggests that we consider the other's position as that other expresses it" (Tronto, 1993, p. 134).

Traditional healthcare leadership models like LEADS do not account for power or privilege in understanding, cultivating, or identifying leaders in healthcare. Tronto's (1993) ethics of care is feminist-based approach because it recognizes that systems of power (e.g., colonialism, racism, sexism, etc.) and privilege (whiteness, wealth, ability, etc.) greatly impact an individual's or community's social location and, in turn, their ability to care (Tronto et al., 2006). In the context of this research, it is imperative to recognize and theorize care as a set of practices and to consider how these practices can be identified in relation to BCAs because they are essential to the OBWC's day-to-day functioning and success, yet they remain absent from the literature on FSBCs or healthcare leadership. I thus employed Tronto's (1993) four domains of care—attentiveness, responsibility, competence, and responsiveness—to understand how these practices can be identified through BCAs' experiences of feminist healthcare leadership at the OBWC.

Applying a Feminist Ethic of Care Lens to LEADS

I developed an integrated approach to theoretically frame BCAs' experiences of feminist leadership in the OBWC by using Tronto's (1993) ethic of care to inform a broader understanding and application of Dickson and Tholl's (2014) LEADS in a Caring Environment. Dickson and Tholl (2014) did not explicitly integrate LEADS into a broader equity framework. I recognized this as an opportunity for the integration of a feminist-based approach because women are underrepresented in healthcare leadership literature and in key leadership positions. Moreover, I recognized parallels between Tronto's (1993) four domains of care as a set of practices and Dickson and Tholl's (2020) LEADS five domains of leadership capabilities. In both cases, Tronto and Dickson and Tholl understood "practices" as imperative to constructing good care and leadership, respectively. I also noted similarities in how Tronto discussed "care"

in terms of achieving or pursuing broader social objectives (e.g., providing socially situated and appropriate care where and when needed) and the broader goal of Dickson and Tholl's LEADS, which is to bring about positive change in Canadian healthcare. Finally, in both frameworks, there is a focus on advancing social objectives, but Dickson and Tholl's LEADS lacked an adequate analysis of power in the context of leadership; a feminist ethic of care broadens our understandings of healthcare leadership to include care as a set of practices. I drew upon these parallels and opportunities to apply a feminist ethic of care lens to LEADS and then mapped this complementary framework onto empirical data collected through semi-structured interviews with BCAs at the OBWC (see Figure 1).

Applying the Complementary Framework to Empirical Data with BCAs. In Figure 1 I present a visual depiction of how I applied my complementary theoretical framework to empirical data collected with BCAs and administrators³ (n=14) at the OBWC. The base of the figure reads "feminist leadership literature" to indicate the foundational nature of this scholarship in understanding Tronto's (1993) ethic of care as feminist leadership practices. Tronto's care practices—attentiveness, responsibility, competence, and responsiveness—are linked to each of the LEADS domains (Dickson & Tholl, 2014), which sit at the top of the figure. The lines from Tronto's care practices to the LEADS domains represent BCAs' experiences of that practice at the OBWC and how it relates to a LEADS domain. In this way, Figure 1 is a depiction of how feminist leadership practices can be complementary and even foundational to healthcare leadership practices, like LEADS, rather than supplementary.

³ I did not include data from semi-structured interviews conducted with midwives (n=2) because unlike BCAs and the Centre's administrators (e.g., Manager of Operations and Executive Director) midwives do not staff the Birth Centre. Midwives are not considered employees of the Centre and, as a result, do not have regular or consistent interactions with the same BCAs. Midwives access the Centre to attend clients during labour and delivery but, with the exception of the Lead Clinical Midwife, do not take part in the day-to-day functioning of the Centre in the same way that the BCAs, Executive Director, and Operations Manager.

Methodology

I employed an instrumental case study methodology, which allowed me to draw upon multiple sources of data to understand a real-life situation (Stake, 2005). An instrumental case study is used to “provide insight into an issue or to redraw a generalization” (Stake, 2005, p. 445). Researchers use instrumental case studies to consider the specifics of a case in detail, but with the ultimate objective of helping them to pursue an external interest outside of the finer details of that case. In the context of this research, an instrumental case study enabled me to offer unique insight into how feminist leadership takes shape in a FSBC.

Creswell (2016) described the qualitative case study approach as an exploration of a “bounded system” that results in a case description comprised of case-based themes. The research conducted for this paper was bounded by the physical and political borders of the OBWC, which includes the clients and midwives who access the centre through six different midwifery groups from within the City of Ottawa. By bounding the case study to the OBWC I was able to reflect on the complexities of healthcare leadership in a community-based maternity care setting through the perspective of BCAs as new birth workers and leaders.

A case study methodology was appropriate for my research because it is a well-established methodology among feminist researchers. There exists a long tradition of case study methodology in the field women’s health, healthcare, and feminist and gender studies. Feminist researchers have used case studies to look at women’s access to maternity services in Canada (Hankivsky & Varcoe, 2007); the role of motherhood in women’s health (Varcoe & Doane, 2007); interprofessional conflict among feminized health professions (Adams, 2004); the development and integration of midwifery in Ontario (Bourgeault, 2006); experiences of birthing at home for First Nations women (Kornelsen et al., 2010); and First Nations women’s

experiences of evacuation for birth (Lawford, 2017). My research on BCAs' experiences of feminist healthcare leadership at the OBWC contributes to a diversity of feminist qualitative case studies in the field.

Garnering Support for Research

I initially made informal contact with the Executive Director of the OBWC at an event hosted by the Empowering Women Leaders in Health project. Shortly after meeting at the leadership event, I met with the Executive Director, Operations Manager, and Lead BCA at the Birth Centre to present my thesis project proposal and to co-develop a memorandum of understanding (MOU) for my research. The MOU outlined my roles and responsibilities as a researcher in relation to the OBWC and was finalized in August 2018. Research ethics approval was granted by my institution in January 2019.

Recruitment

I utilized snowball sampling to initiate my recruitment for semi-structured interviews. A sampling procedure may be defined as snowball sampling when the researcher accesses informants through contact information that is provided by other informants (Noy, 2008). I relied heavily on the relationship I built with the OBWC Executive Director and Operations Manager to recruit participants in a snowball fashion. By way of referral email from the Executive Director and Operations Manager, I contacted two categories of informants from the OBWC for interviews: BCAs (from 2014 to present) and administrators. I included BCAs and administrators in my data collection to facilitate a focus on BCAs' experiences with the Centre's formal leadership in the OBWC. I excluded interviews with midwives from my data analysis because, unlike BCAs and OBWC administrators, midwives do not staff the Centre but rather they have

access privileges. In practice, this means that midwives will only access the Centre to support a client during a birth but are not present in the Centre on a routine basis.

The Operations Manager emailed the letter of information and recruitment text to all former and current BCAs (n=33) in April 2019. The Executive Director advertised and communicated the research project at OBWC team meetings for further exposure. The Operations Manager and Executive Director sent follow up emails to individual BCAs and Board of Directors members when the initial response was low. I personally followed up with anyone who e-mailed me to express interest in the research project (n=18). In my follow up e-mail, I provided the consent form and an overview of the semi-structured interview questions I planned to ask.

Methods

To conduct an instrumental case study, I used multiple methods to collect data. I collected pertinent documents, took notes before and after in-person interviews with BCAs at the OBWC, and conducted semi-structured interviews with BCAs and administrators at the OBWC.

Document Collection

I collected pertinent documents from the OBWC to understand the organizational and policy environment governing the Centre. I was given access to these documents by the Executive Director and Manager of Operations. The Executive Director sent me electronic copies of the facility proposal (Vigenault & Gagnon, 2012), OBWC facility procedures (OBWC, 2016, 2020i), quality assurance procedures (OBWC, 2018a), client information package and Birth Centre tour guide (OBWC, 2018b), governance policies (OBWC, 2019c, 2019d, 2020j), and administrative procedures (OBWC, 2019e). The Manager of Operations shared updated BCA staffing lists (OBWC, 2019g) and schedules (OBWC, 2019f); these documents helped me

understand context around shift work and BCA turnover. The documents I collected from the OBWC, like the facility proposal and policy procedures, helped to me to understand and contextualize the Birth Centre's formal leadership structures.

Semi-Structured Interviews

I started my data collection at the OBWC in April 2019 and completed all in-person data collection activities by February 2020, just a couple of short weeks before the onset of the COVID-19 global pandemic. I conducted a total of 14 semi-structured interviews in person with women at the OBWC (n=8) and on the phone (n=6). I conducted interviews with BCAs (n=11) and administrators (n=3). I chose to employ semi-structured interviews because I wanted to facilitate the development of organic conversation with my participants (Fylan, 2005). Semi-structured interviews also provide an appropriate format for discussing difficult topics and give participants the opportunity to work through and debrief issues if necessary (Fylan, 2005). It was important that my participants had the opportunity to debrief because discussions could involve traumatic experiences for midwives and BCAs (e.g., emergency transfer of care or a death).

Participants gave informed consent. Due to the small size of the Ottawa BCA community (i.e., there were less than 30 BCAs total at the time of data collection), anonymity was not guaranteed to participants; this was made explicit in the information letter and consent form and was reiterated verbally before the interview. In an effort to provide a cursory level of anonymity, participants are referred to using pseudonyms and their professional title (e.g., Danielle, BCA).

All of the participants agreed to have their interviews digitally recorded. Interviews ranged in length from 20 to 90 minutes. Interviews were transcribed and sent by email to participants for review. Two participants requested revisions to their transcripts: one participant asked for a comment to be removed, and one participant clarified the context of a statement. I

made the participant requested revisions in the digital copy of the transcript. I printed hard copies of all transcripts for initial coding and analysis by hand and then uploaded digital copies to Nvivo 12 for further coding and analysis.

Reflexive Thematic Analysis

I followed the reflexive thematic analysis process developed by Braun and Clarke (2006, 2012, 2013, 2019). In broad terms, reflexive thematic analysis is understood as a method for “analyzing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Braun and Clarke (2019) reflected on the development and application of thematic analysis and clarified that although they describe thematic analysis in terms of steps, this method is not intended to be linear but rather reflexive. Braun and Clark (2019) conceptualized themes as stories about particular patterns of shared meaning across the dataset. A theme, Braun and Clarke (2006) argued, captures something important about the data in relation to the research question and “represents some level of patterned response or meaning within the data set” (p. 82). Braun and Clarke (2006) identified six steps in reflexive thematic analysis to help researchers locate thematic analysis in relation to other qualitative analytic methods: familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. I applied the six steps of Braun and Clarke’s (2006) reflexive thematic analysis as a guide to my data analysis.

I specifically adopted a feminist approach to my reflexive thematic analysis, which helped me to foreground themes related to power in BCA birth work, healthcare leadership, and care. Feminist thematic analysis has been used by feminist researchers in maternity care settings before. Jenkinson (2017) conducted a feminist thematic analysis of in-depth semi-structured interviews with women’s, midwives’, and obstetricians’ experiences of refusal of recommended

maternity care. Jenkinson explained that she adopted a feminist thematic analysis to invert the hierarchy traditional in medically dominated maternity settings, “privileging the experiences of women over clinicians, and the experiences of women and midwives, over obstetricians” (p. 2). Similarly, in my research, a feminist iteration of data analysis privileged engagement with BCAs’ perspectives and experiences of leadership over formalized and clinical leadership perspectives (e.g., midwives, administrative leaders, etc.) because the experiences of non-clinical birth workers like BCAs is overshadowed in the existing literature by a focus on midwives and clients in FSBCs (Mattison, 2015; Sprague, 2018). For example, I relied heavily on how BCAs described their interactions, relationships, and experiences with formal OBWC leadership, but in doing so I also recognized how BCAs experienced leadership themselves. Further, a feminist thematic analysis works towards the feminist objective of recovering and valuing women’s experiences—this is particularly important within historically and traditionally feminized area of non-clinical birth work (like BCAs) and maternity care leadership, where these experiences are overshadowed in the literature by the experiences of clinical professionals, like physicians and, to a lesser extent, midwives (Carvalho, 2019).

Situating Myself

Essential to feminist research and knowledge production is the explicit location of the researcher within the work at hand. I am guided in my approach to this research by feminist reflexivity (Faria & Mollet, 2016; Hemmings, 2012;). I am situated by my privileges: I am a cis-gendered, middle-class, white woman. The focus of my study is largely shaped by my research experiences as a doctoral student on research projects that have examined women’s leadership in health care and evaluative research on birth centres in Ontario, Manitoba, and Quebec. I also bring my experiences as a midwifery consumer (in both rural and urban settings) and as a parent

to children with identities that are diverse from my own: my daughter lives with a disability, and my son is mixed race. My experience as a midwifery consumer emphasized to me the importance of healthcare leadership in this sector, while my children influence my own daily reflexive practice as I endeavour to guide them through barriers that I do not experience as a result of my own privilege. As a study in feminist healthcare leadership, it is important to recognize how my experiences as a researcher, midwifery consumer, and parent have shaped the questions I ask as well as the analysis I bring forward.

Results

A feminist thematic analysis of interview data led to the identification of three key themes in regard to BCAs' experiences of feminist healthcare leadership: OBWC administrators lead from care, exemplify collaborative leadership with BCAs, and foster BCAs as emerging leaders. The first theme, leading from care, captures BCAs' experiences with administrators through stories of care. The second theme, collaborative leadership, refers to how BCAs and OBWC administration facilitate healthcare leadership as a collaborative and iterative process. The final theme, emerging leaders, highlights how BCAs experience their role as part of a lifelong leadership trajectory that is firmly grounded in feminist care practices of leadership.

Leading from Care

BCAs spoke about their relationships with management and leadership in terms of care, including how they felt cared for and validated when discussing their challenges. For example, when Cassandra was a new BCA, she was struggling to adapt her sleep schedule to accommodate night shifts (OBWC, 2019f). She reflected on how she felt the Manager of Operations recognized her struggle and took action to care for her in this instance:

Honestly the staff is great [Manager of Operations] is great. She always helps out in any way that she can. She very much cares about all her staff and wants the best for all of us. I did mention to her that I was having trouble, like, adjusting to the night shifts at first, and she was so supportive and just wanted to see if I needed anything. She switched my schedule around so that I could figure out how to recover for my next shift.

Leading from care also refers to the ways in which care as a set of practices is normalized in the OBWC outside of formalized human resource policies (OBWC, 2019c, 2019e, 2020j) and organizational structures (Vigneault & Gagnon, 2012). A simple practice such as how someone in a formalized leadership position signs an email communication can have lasting impact on how leadership is perceived and experienced throughout the organization. Michelle, a BCA, described her experiences with leadership in terms of inclusiveness, kindness, and care: “[The Leadership] is really loving and really inclusive and really kind. So, like one of the bosses signs her emails with ‘love so and so.’ It’s just that kind of workplace, there is so much mutual respect.” Michelle recalled one particularly busy evening at the birth centre that captured how the OBWC leadership demonstrated leading from care. Michelle explained that clients were waiting for clean rooms, and she was working alone; conducting a full clean of a birthing room can take upwards of three hours. The Executive Director did not hesitate to put on scrubs and conduct the clean alongside Michelle. She thought about this interaction and reflected:

We clean up after [births and] it’s amazing, you know, but I just think it’s important that someone like the executive director can come and put on scrubs and help us clean... If something were to happen and a terminal clean were to be done wrong and someone were to contract...something, this place would be shut down. So, to get your people that are on the floor to care about where they work and care about the work they do, you need to have

some sort of mutual respect and kind relationship with your superiors for them...A big part of the [positive] atmosphere that's here has to do with their leadership. It's special. It's exceptional.

Leading from care encompasses experiences of leadership grounded in practices of care. The OBWC practices care as leadership in the way that leaders recognize, validate, and also address the struggles of members, like BCAs, as necessary to the Centre's shared success.

Collaborative Leadership

BCAs' experiences with administrators at the OBWC, though organizationally structured as a hierarchy (Vigenault & Gagnon, 2012), exemplified feminist collaborative leadership. When asked to discuss their relationship with the Birth Centre's management and leadership (i.e., Clinical Lead Midwife, Executive Director, Board of Directors, etc.), BCAs described collaborative relationships founded on mutual respect. For example, Ava (BCA) recalled her relationship with the Lead Clinical Midwife when the OBWC was first opening as a shared learning experience:

[Clinical Lead Midwife] was great. She was really approachable, really open to our suggestions or our concerns or our, you know, complaints or whatever it was. It was cool being there when the Birth Centre opened, because it's a learning experience for everybody you know, so [Clinical Lead Midwife] was always really open to any feedback that we had or um... anything that she could get from us that we could all learn from she was really open to it. She was great. I always felt like I could go to any one of the admin with problems or questions.

Ava described her experience as a BCA in terms of feeling valued by the entire leadership team, which reflects the collaborative nature of leadership in the OBWC (OBWC, 2019c). Ava felt

valued because the feedback she provided the Clinical Lead Midwife was later integrated into a new policy that more clearly outlined a specific infection control procedure which is now included as part of the Centre's BCA training (OBWC, 2019h). There was an understanding that Ava's knowledge and experience as a BCA was vitally important to the success of the Birth Centre. Candace (BCA) echoed Ava's experience when she said that anytime "I'm asked for feedback, I'm asked 'what do you think?', it's not just people talking and telling me what to do." Candace recognized the importance of this small practice as something that validated her experience, knowledge, and contributions to the OBWC as essential to its overall leadership model.

Collaborative leadership is an intentional strategy that OBWC administrators built into a set of practices that BCAs reflect in their shared dedication to the Centre's success. For example, when I asked Kayla (BCA) about her experiences with leadership at the Centre, she recalled how she had been recently asked to come early for a shift and did not hesitate to do so because she felt the success of the Centre was a collaborative effort:

I'm going to make sure that everything's tip top shape for people to come in here. Because I want more people to come in here and to see that this is a good place and to understand this is a safe place. So, I haven't even been working here for that long. But I'm like invested, they called me in early the other day, and I was like, I'm on my way, you know, I'm there, I'm there, I'm coming to help you and most of my co-workers would do the same.

Administrators at the Centre make a conscious effort to build relationships with BCAs because they recognize that positive relationships with BCAs necessitate collaboration with BCAs, who are vital to the success of the Centre. For example, when I asked the Executive Director how often she is able to interact with BCAs, she replied:

Because they work so independently and because they work sometimes night shifts, I try to build relationships with them when I can. So, part of my day might actually be being like “okay, I’m gonna take these thirty minutes to go and have a chat”, um, and you know, it feels informal, it doesn’t feel like work, um but I think a good manager needs to know their staff, so, taking those thirty minutes to get to know your staff is very important to me.

(Executive Director, OBWC)

Emerging Leaders

In the context of this research, BCAs are emerging leaders because of the way they perceive leadership as a means rather than an end. Leadership as a process (i.e., means) as opposed to a title (i.e., end) is encompassed in the theme ‘emerging leaders’ because it captures BCAs’ experience of leadership along a personal trajectory that can go beyond the Birth Centre.

At the time of interview, Karen was a student midwife and former BCA. As an Indigenous person, Karen reflected on her experience as a BCA and, more specifically, how her time as a BCA better equipped her as a midwifery student, not only because she felt confident and comfortable in the Birth Centre environment, but also because it brought her towards her ultimate objective of supporting historically marginalized communities accessing midwifery care:

The reason I do it is because I believe in midwifery and out-of-hospital birth particularly for communities that don’t often get represented in the birth centre that we’re trying to work on but like at my perspective is kind of like a 360 of the different areas of the birth centre, and then definitely as a midwifery student, you know it helped.

Karen is an emerging leader because of the way she draws upon her experiences as a BCA to make change on a specific issue, in this case, to support midwifery-led out-of-hospital birth for underrepresented communities (OBWC, 2016).

Similarly, Cassandra (BCA) was nursing student and reflected on her experiences as a BCA in the context of her future aspirations in healthcare, “I thought [the Birth Centre] was super cool, just cause I’m really interested in the field of maternity and stuff like that and as a nursing student I want to end up on a mother-baby unit at the hospital.” Cassandra felt her experience as a BCA would put her in the best position to lead as a future nurse in maternity care.

In addition to transferring their experiences as BCAs to other parts of the healthcare system, BCAs also spoke about becoming leaders within the Centre itself. Danielle (BCA) was among the first cohort of BCAs hired before the opening of the Centre in 2014. Danielle came to the Birth Centre from a doula and reproductive justice background. She was motivated to work at the Centre because it aligned with her social justice interests and would allow her to continue working in birthing environment, At the time of the interview, Danielle was the Lead BCA, which entails increased responsibilities for training new BCAs (OBWC, 2019e).

Indeed, BCAs are not only leaders when they leave the Centre, but they also take on this role for the community while working at the Centre. BCAs play a key role in communicating the Centre’s services (choice of birth place and midwifery model of care) to the Ottawa community through Birth Centre tours as well as in their personal lives. In this way, BCAs are leading efforts to expand education on birth place options in Ottawa. For example, Kayla (BCA) reflected on how she has taken every opportunity to educate peers, family, and clients about the Birth Centre:

I've noticed that since I have the job here, I'm so proud to tell people that I work here and I'm just like, yeah, I work at a Birth Centre and I'm a birth centre aide and this is what I do and people are asking questions [about the Birth Centre] because a lot of people don't understand that you can have a baby without a doctor, there are no doctors there. You don't learn these things, they aren't part of our educational system. I'm like, of course, you know, when you're accessing the [maternity] care system [in Ottawa], these are actually all your options.

BCAs' emerging leadership in the OBWC reflected a shared commitment to cultivating systemic change—in the Centre itself, in their communities, and for some as clinicians in the healthcare system outside of the OBWC. The motivation to pursue increased responsibility within the Centre (e.g., Danielle, BCA), actively and excitedly communicate maternity care options offered by the OBWC (e.g., Kayla, BCA), or pursue clinical roles as nurses (e.g., Cassandra), midwives (e.g., Karen, BCA), or physicians (e.g., Ava, BCA) spoke to BCAs' experiences as emerging leaders that reflect feminist goals of social change in healthcare environment. In this way, BCAs' emerging leadership echoes a uniquely feminist commitment to healthcare system transformation goals embedded within LEADS (Dickson & Tholl, 2014).

Discussion

Through a feminist thematic analysis (Braun & Clarke, 2006; Jenkinson, 2017) of semi-structured interviews with BCAs (n=11) and administrators (n=3) at the OBWC, I identified three themes in relation to feminist healthcare leadership from the perspectives of BCAs: OBWC administrators lead from care, exemplify collaborative leadership with BCAs, and foster BCAs as emerging leaders. In this discussion, I apply Tronto's (1993) four care practices (i.e., attentiveness, responsibility, competences, and responsiveness) to the three themes that I

identified in the empirical data. I discuss how BCAs' perspectives of administrators' leadership practices as well as their own experiences as emerging leaders can be understood as a set of care practices at the OBWC and how these practices are complementary to Dickson and Tholl's (2014) LEADS in a Caring Environment leadership capabilities framework. Importantly, I did not systematically apply Tronto's set of care practices to all of the LEADS domains (See Table 1). Instead, I focused on drawing out how BCAs and administrators experience care practices as told through the themes I identified by conducting a thematic analysis of the data from my interviews at the OBWC, can be understood in the context of LEADS and Tronto's (1993) feminist ethic of care (See Figure 1).

Feminist Leadership at the OBWC as a Set of Care Practices

Attentive Leaders. Tronto (1993) identified four elements of care as a set of practices that make up a feminist ethic of care: attentiveness, responsibility, competence, and responsiveness. Attentiveness is captured in the first theme that I identified in the data, leading from care, which described experiences of leadership as a recognition of needs, struggle, and validation. The theme "leading from care" captured BCAs' experiences with attentive leaders at the OBWC. For example, when the leadership signed email communications to staff "with love" and the Manager of Operations offered to reorganize a BCA's schedule to help her transition to night shifts, Cassandra (BCA) felt her needs and challenges were being thoughtfully considered and addressed by leadership.

As a care practice, Tronto's (1993) attentiveness was also reflected in the second theme, "administrators exemplify collaborative leadership with BCAs" in the ways in which BCAs and administrators are attentive to the shared objectives of the Centre (i.e., support and facilitate access to out-of-hospital birth for Ottawa communities). Building relationships is central to

collaborative leadership because it cultivates environments centred on shared responsibility (Clover et al., 2017). As a leadership strategy, building collaborative relationships is particularly important due to the sense of precarity surrounding the OBWC; as a pilot project, the OBWC is under constant threat of reduced funding from the province if it does not meet and exceed provincial expectations

In LEADS, attentiveness as a leadership practice can be found at the boundary of the first and second capability domains, “Lead Self” and “Engage Others,” which describes leaders as self-aware, self-motivated, and capable of developing themselves to meet the needs of their team (Dickson & Tholl, 2014). In other words, the LEADS framework defines leadership in terms of an attentiveness to one’s own needs. A feminist ethic of care lens requires LEADS to push beyond attentiveness to the leader’s needs and outwards towards those in need of care in the first place. From a feminist ethic of care perspective, attentive leaders are reflexive leaders. The feminist practice of reflexivity makes clear how power produces knowledge by uncovering the nuanced workings of privilege, positionalities, and systemic oppressions (England, 1994). In this way, a feminist ethic of care broadens our understanding of attentiveness in healthcare leadership to challenge, or at the very least recognize, systemic oppression within healthcare. For example, Karen (BCA) said that she pursued work as a BCA and later a midwife because she recognized that Indigenous communities like her own did not have adequate access to out-of-hospital birthplace options. In this way, Karen recognized the systemic oppression (i.e., colonialism) within the healthcare system and took on work as a BCA and studies as a midwife as ways to be a leader for change in this regard.

Responsible Leaders. The second dimension of care, responsibility, or taking care of, is central to a feminist ethics of care (Tronto, 1993). For example, the third theme, “OBWC

administrators foster BCAs as emerging leaders,” captured BCAs' experiences of responsibility in advancing and supporting the midwifery model of care in the Centre itself, in their communities, and in the broader healthcare system as clinicians when they leave the Centre. Danielle (BCA) was the most senior BCA at the time of our interview and had advanced into a leadership role within the Centre itself as the Lead BCA. Reflecting on her time as a BCA, Kayla discussed how she felt not only responsible but excited to “spread the good news” about maternity care options to her peers and community; Kayla was a second-year nursing student at the time of her interview and commented that even with her educational background, many people did not know that the Birth Centre or midwifery was a maternity care option in Ottawa. Many BCAs, like Karen (BCA) and Cassandra (BCA), for example, left the Centre to enter the healthcare system as clinicians where they could carry forward the feminist leadership practices they experienced therein; Karen was in midwifery school and Cassandra was in nursing school at the time of our interview. Both Karen and Cassandra spoke to their experiences at the OBWC as essential to their clinical pursuits.

Put simply, responsibility is more than what arises out of obligation to a person, role, or task: it is embedded within a set of care practices bounded by distinct socio-historical and political contexts. For example, when Kayla (BCA) recalled being asked to come in early for a shift to help with a birth room clean, she did not hesitate to agree because she felt personally responsible for making sure the OBWC was in “tip top” shape and commented that her colleagues would feel the same. This is an important distinction when we speak about feminist healthcare leadership at the OBWC, because the responsibility to lead is not simply a formal obligation but rather a commitment to advancing broader social justice objectives, like access to the midwifery model of care and out-of-hospital birth.

From a feminist perspective, framing leadership as an action-orientated process is significant because it moves us way from a singular focus on the normative question of *what leadership is* toward a more action-orientated and central question: What “is the nature of change [that] leadership seeks to bring?” (Batliwala, 2013, p. 179). In the context of the OBWC, leadership as a politically oriented action focussed on ensuring reproductive justice, especially access to midwifery-led out of hospital birth for reproductive choice and members of communities who experience marginalization.

In LEADS, the overarching framework does not explicitly address responsibility as a leadership capability, but rather it stresses more generally the importance of leading from where you are, that is, leading outside of a title. From a feminist perspective, Dickson and Tholl’s (2014) concept of leading from where you are would also include an explicit recognition of systemic oppressions (e.g., colonialism, racism, sexism), which is currently lacking in the LEADS framework. Dickson and Tholl (2014) encourage leaders to lead from outside a title, but a feminist ethic of care (Tronto, 1993) helps researchers understand that it is impossible to lead outside of one’s social location (race, gender, ability). Leading outside of a title while also reflecting on her social location (i.e., as an aspiring Indigenous midwife) was certainly true for BCAs like Karen, who moved on from her experience as a BCA into midwifery school. For Karen, she chose to lead from where she was (i.e., a BCA and then a student-midwife) that was explicitly related to her experience of colonialism; her emerging leadership did not exist outside of her identity and experiences as an Indigenous person but it was rather through these experiences that she emerged as a leader.

A feminist examination of healthcare leadership through an ethic of care lens helps researchers understand how leadership can exist outside of formalized roles and must be

contextualized to understand a leader's responsibility to lead. In this way, a feminist ethic of care lens would be used to ask, *why* does Karen feel a responsibility to lead by supporting access to out-of-hospital birth for underrepresented communities? For BCAs like Karen and members of the OBWC leadership, the responsibility to lead comes from a shared commitment to advancing social justice for communities like her own who continue to experience systemic oppression in healthcare (e.g., colonialism, sexism, racism). Leading from her position as a BCA in the OBWC and later as a midwife in her community, Karen is an example of responsible leadership.

Competent Leaders. BCAs' experiences of feminist leadership at the OBWC should not exist at the margins of healthcare leadership, but as new and meaningful contributions to a more nuanced understanding of leadership in the sector. From a healthcare leadership perspective, integrating a feminist ethic of care lens means reconciling the nature of care, which is a "challenge to the notion that individuals are entirely autonomous and self-supporting" (Tronto, 1993, p. 134), with our understanding of leaders as infallible or never in need of care themselves. In simple terms, this means that feminist healthcare leaders recognize that they will not always be solely and wholly competent in every single undertaking. Healthcare leaders can work to develop certain competencies or capabilities, like those described in LEADS, but this has the effect of assuming they will be competent to give care in every situation. As a care practice, Tronto's (1993) competence can be mapped onto the third theme, "administrators exemplify collaborative leadership with BCAs," in the way that BCAs described their collaborative contributions to improving the Centre's policies and procedures.

Collaborative leadership practices, like that kind of leadership experienced by BCAs at the OBWC and captured in the third theme, also exemplify competence in the way they help leaders recognize when someone is in need of a collaborative effort to complete a task. For

example, OBWC administrators demonstrated competence through collaborative leadership practices when they recognize that BCAs may need support or assistance. For example, Michelle (BCA) recalled an instance when the Centre's Executive Director stepped outside of her formal role to help clean birthing rooms on a particularly busy day. Michelle felt that she was competent in completing the cleans but was thankful for the help from the Executive Director to do so in a timely manner.

From a feminist perspective, competency is a collaborative process (Tronto, 1993), which is partly captured by LEADS in the second capabilities domain, "Engage Others." A feminist ethics of care lens on LEADS offers a more holistic approach to competency, as not just professional or leadership competency, but competency to collaborate on shared objectives like providing the best possible experience at the birth centre or develop BCAs as emerging leaders in the Centre, community, and broader healthcare system.

Responsive Leaders. The impetus for much of healthcare leadership literature is improved patient care, improved patient satisfaction, and systems transformation, which has the effect of positioning the patient or client as the vulnerable other. In LEADS, responsiveness may be understood as how the patient (i.e., the vulnerable) receives care from the leader (i.e., the health professional). A feminist examination of healthcare leadership helps researchers understand that vulnerability, which is a prerequisite of care, is also expressed by leaders. It is not enough to simply lead from a position of authority; leadership also means understanding how your care is received. In the context of this study, the person receiving care is not the patient or client but anyone in a leadership relationship (i.e., BCAs are led by care from OBWC administrators through feminist leadership practices).

As a care practice, Tronto's (1993) responsiveness is captured in the first theme, "OBWC administrators lead from care," which describes BCAs experiences of feeling that administrators addressed and validated their struggles. For example, when Cassandra (BCA) was having difficulty adjusting to a night shift schedule (i.e., 12 hour shifts from 7pm to 7am), the Operations Manager was happy to work with her to validate her struggle and address her challenge by amending the schedule in a way that would ease her transition between day shifts and night shifts. It is perhaps not surprising that BCAs at the OBWC described overwhelmingly positive relationships with leadership, which indicates that the leaders were responsive to their needs, concerns, and feedback.

In LEADS, responsiveness is partially captured in the second domain, Engage Others, which focusses on developing and fostering relationships within teams. A feminist iteration of responsiveness in LEADS would require leaders to more fully and continually reflect on the responsiveness of the care receiver (those being led) to the care (leadership) as a central practice of care. In this way, when I mapped responsiveness as a feminist healthcare leadership practice onto LEADS, I recognized that feminist healthcare leadership is an intensely iterative and reflexive process, a practice currently absent from LEADS.

Conclusions

A reflexive feminist thematic analysis (Braun & Clarke, 2006; Jenkinson, 2017) of data collected through an instrumental case study (Stake, 2005) of BCAs' perspectives of administrators' leadership practices at the OBWC led to the identification of three themes in relation to feminist healthcare leadership: OBWC administrators lead from care, OBWC administrators exemplify collaborative leadership, and OBWC administrators foster BCAs as emerging healthcare leaders. The application of two integrative frameworks - Tronto's (1993)

care practices and Dickson and Tholl's (2014) LEADS to the empirical data (i.e., BCAs' and administrators' experiences of leadership practices) - contributed to an imagination of feminist iterations of healthcare leadership practices. I applied Tronto's (1993) care practices to BCAs' experiences of leadership practices in relation to administrators at the OBWC in an effort to make feminist conceptions of leadership foundational to understanding the healthcare leadership models like LEADS. I used LEADS because it was developed in a Canadian context and I recognized parallels between Tronto's care practices and Dickson and Tholl's (2014) capability domains. In doing so, I presented a complementary framework that can help feminist researchers understand how care, as a set of feminist leadership practices, can be integrated into existing models of healthcare leadership. Perhaps most importantly, I applied Tronto's (1993) ethic of care to highlight how BCAs' experiences of feminist leadership at the OBWC do not exist at the margins of healthcare leadership, but rather they exist as opportunities for expanding current conceptions of leadership across our healthcare institutions. This study makes an important contribution to the literature because until now there have been no academic inquiries into BCAs' perspectives on leadership in Ontario FSCBCs or efforts to theoretically integrate feminist leadership practices and a traditional healthcare leadership model.

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Chapter 4:

Birth Work as Reproductive Justice Activism:

A Case Study of Birth Centres Aides at the Ottawa Birth and Wellness Centre

Abstract

Background: In Ontario, Canada, there is a robust history of birth work activism and reproductive justice. In 2014, the introduction of freestanding birth centres (FSBCs) in the province brought about the development of a new birth worker role: Birth centre aides (BCAs). BCAs are essential to the delivery of services at Ontario birth centres. As a relatively new introduction to the Ontario maternity care system, little is known about BCAs as birth workers and their role(s) in reproductive justice in the communities they serve in Ottawa, which is the focus of this study.

Study design and data collection methods: I used a reproductive justice theoretical framework to understand a feminist thematic analysis of eleven semi-structured interviews with BCAs at the OBWC.

Results: I identified two key themes related to reproductive justice: BCAs are non-traditional birth activists, and BCAs are key connectors for reproductive justice to healthcare. The first theme captures BCAs' experiences of "quiet" birth work activism in the OBWC (e.g., facilitating reproductive justice by supporting the midwifery model of care). The second theme describes the transitional nature of BCAs' work and the possible implications this has for reproductive justice when these birth workers move into other areas of the healthcare system (e.g., as doctors, nurses, and midwives).

Conclusions: This paper contributes new and detailed information about BCAs in the context of reproductive justice in Ottawa. My findings make an important contribution to our understanding of how BCAs advance reproductive justice objectives in Ottawa.

In Ontario, Canada, birth workers, activists, and professionals have played instrumental roles in advancing reproductive justice in the province (Bourgeault, 2006; Darling et al., 2013; Nestel, 2011; Van Wagner, 2004). A myriad of interrelated socio-political movements, such as the reproductive rights, justice, women's health, Ontario midwifery, and birth centre movements, have had a transformational impact on the maternity care system. Most recently, in 2014, two birth centres opened in Ontario as part of a Ministry of Health and Long-Term Care (MOHLTC) two-year pilot project: the Ottawa Birth and Wellness Centre (OBWC) and the Toronto Birth Centre (TBC).

Free-standing birth centres (FSBCs) are essential to advancing reproductive justice in Ontario because choice of birthplace (i.e., home, hospital, or birth centre) is a fundamental principle in reproductive justice. These two newly funded centres marked the first instance in which registered Ontario midwives have provided care outside of the home or hospital setting. The fundamental principles of midwifery care in Ontario, informed choice and choice of birthplace, are equally applicable in this new FSBC setting (Association of Ontario Midwives, 2016).

The introduction of FSBCs brought about the development of a novel birth worker role—birth centre aides (BCAs). BCAs facilitate the function of the birth centre, which includes cleaning and infection control duties, medical charting, birth centre tours for clients, staffing the centre on a 24-hour basis, as well as providing non-clinical support for midwives (see chapter 2). Indeed, BCAs are essential to the delivery of services at Ontario birth centres.

In Ontario, access to midwifery services and its model of care constitutes a major facet of the reproductive rights and justice movements in the province. As a relatively new introduction to the Ontario maternity care workforce, there is little known about BCAs as birth

workers and their role in reproductive justice in the communities they serve, and specifically in Ottawa, which is the focus of this study. I did not include the Toronto Birth Centre in the present study because it is not administratively linked to the OBWC and the two cities are unique in both culture, size, and diversity. I previously explored the development and operationalization of the BCA role at the OBWC, which produced a descriptive and visual map of this process (see chapter 2) and feminist practices of leadership in the OBWC, which contributed a new theoretical approach to examine leadership in healthcare (see chapter 3). The analysis in this paper builds upon these foundational pieces by addressing the politics of birth work and how BCAs are working within a reproductive justice framework. My focus in this paper is on exploring BCAs at the OBWC as new birth workers in the context of reproductive justice and the implications this has for broadening our understandings of birth activism.

Two key questions guided my examination of BCAs in the reproductive justice movement in Ontario: How do BCAs identify with the reproductive justice movement? What are BCAs' roles within the reproductive justice movement? I address these questions by using a reproductive justice conceptual framework to inform my thematic analysis of 11 semi-structured interviews conducted with BCAs at the OBWC.

Social Movements, Birth Work, and Activism: A Review

In this section I provide a brief historical review of the reproductive rights; reproductive justice; women's health, home birth, and Ontario midwifery movements; freestanding birth centres; and birth workers (see Table 1). In order to situate the role of BCAs at the OBWC within this historical trajectory, I pay special attention to how objectives and tenets of reproductive justice, like recognizing the role of systemic and interlocking oppression in maternity care and the role of birth worker activists in these movements, have played out in the

Ontario context. Finally, I highlight the historical and contemporary role of birth workers and the introduction of FSBCs in Ontario.

Reproductive Rights, Women's Health and Home Birth Movements

Reproductive rights—the ability to decide whether and when to have children—is a movement in which activists are primarily focussed on advancing reproductive choices (Carathers, 2019; Ross & Solinger, 2017). Reproductive rights have always existed as an idea in the Canadian legal landscape but were most evident as a movement in the 1970s and 1980s. It was during this time that anti-abortion and anti-contraception legislation formed the central issues motivating the movement. Initially, white, middle-class feminists viewed the campaign for legal abortion and contraception as the most important goal in the struggle for women's reproductive autonomy (Nelson, 2003). As the movement gained traction, supporters and activists began to expand on their initial objectives to include issues more broadly related to women's health and birthing. In Canada, selling and advertising birth control was not removed from the Criminal Code until 1969 (Canadian Public Health Agency, 2021). It would be nearly another 20 years for the Supreme Court to strike down the country's anti-abortion law as unconstitutional in *R. v. Morgentaler*, 1988 (National Abortion Federation, 2021). Today, Canada does not have a law regarding abortion; it is treated as any other medical procedure and regulated by provincial and territorial professional bodies.

The reproductive rights movement that emerged in response to state control over women's fertility co-occurred alongside the women's health and home birth movements in the 1970s and 1980s. The women's health movement in Canada focussed on three main issues: the health care delivery system, the development and analysis of social determinants of health, and a commitment to increase the participation of women in all aspects of health care (Boscoe et al.,

2004). At the same time, those in the home birth movement were attending to issues related to the choice of birthplace and choice of provider and, in this sense, it was considered a consumer-led movement (Bourgeault, 2006). In Ontario, all three of these movements—reproductive rights, women’s health, and home birth movements—contributed to the integration and regulation of midwifery in the province.

Birth Activism and the Ontario Midwifery Story

Midwifery entered the Canadian social consciousness with renewed vigour in the 1970s and 1980s in the form of a grassroots social movement offering women-centred, low-technology alternatives to mainstream obstetrical care (Macdonald & Bourgeault, 2009). Most prominently, the midwifery movement was informed by the women’s health and reproductive rights movements and their philosophy of self-knowledge and choice for women in health matters, especially concerning reproduction (Bourgeault, 2006). During this time, midwifery was primarily made up of women who started as doulas and other non-clinical birth attendants and then transitioned to providing clinical care. By the mid-1980s, it was estimated that fifty midwives were providing care to 1,500 birthing women a year in Ontario (Tyson, 1991; Van Wagner, 1988).

By the early 1990s, the Ontario midwifery movement had moved from the relative obscurity that characterised lay midwives in the early 1980s to nearing regulation and integration into the healthcare system. The once small group of women had developed into a community of reproductive rights activists and skillful lobbyists that had set out to reform maternity care in Ontario (Van Wagner, 2004). By 1994, a series of regulations, including the Regulated Health Professions Act and the Midwifery Act, made access to provincially-funded midwifery a reality for people living in Ontario (Bourgeault, 2006). In addition to self-regulation legislation and the

establishment of a direct-entry education program, midwifery was also completely publicly funded; provincial funding played a major role in ensuring access to services that was in line with the movement's reproductive justice objectives. The regulation of midwifery in Ontario also included strategically placed reproductive justice elements within its professional structure, including the establishment of an equity committee that sought to address access issues related to racialization, Indigeneity, and disability (Bourgeault, 2006).

Reproductive Justice Movement

At the same time that activists and birth professionals involved in the Ontario midwifery movement were making major inroads for reproductive rights in the province, there was a growing awareness among its supporters that all of these movements—reproductive rights, women's health, home birth, and Ontario midwifery—did not account for experiences of systemic oppression (e.g., sexism, racism, ableism, colonialism, etc.) (Paterson & Marshall, 2011; Nelson, 2003; Nestel, 2011). The reproductive justice movement emerged largely in response to these gaps in the white, middle-class aspirations of the reproductive rights, women's health, home birth, and Ontario midwifery movements.

The reproductive rights movement focussed on advancing reproductive choices, while reproductive justice is informed by discussions on systemic barriers to access. The Ontario midwifery movement began responding to these discussions (e.g., the Ontario midwifery movement integrated an equity committee within its professional structure) but was heavily criticized for constructing itself as a white woman's movement (Nestel, 2011).

Ross (2017) explained that the term "reproductive justice" was coined in 1994 by a group of twelve American Black women, including herself, in the tradition of the Combahee River Collective, working within and outside the pro-choice movement to "recognize the

commonality of our experiences and, from the sharing and growing consciousness, to a politics that will change our lives and inevitably end our oppression” (p. 286). The reproductive justice movement began with activism from women of colour, and Black women in particular, who examined and spoke about how systems of power work to exclude people from realizing a full range of human rights and freedom, including rights to have or not have children, and the interrelated socioeconomic factors required to access a full range of reproductive possibilities (Ross, 2013; Zucker, 2014). Similarly, Indigenous midwives criticized racist and colonial reproductive legislation that curtailed First Nations’ women access to a full range of reproductive rights (Lawford, 2017; Nestel, 2011). In Canada, the language of “reproductive justice” was traditionally a term used primarily in relation to abortion, but scholarship in this area is also beginning to recognize the affinity between abortion rights and birth activism more broadly (Shaw, 2013).

Ontario midwifery model of care and reproductive justice. Today, access to midwifery services and the midwifery model of care are key components of the reproductive justice movement in Ontario. Major tenets of reproductive justice, including continuity of care, informed choice, and choice of birthplace, make up the three guiding principles of the midwifery model of care. Continuity of care means that the same pair of midwives provide complete care throughout pregnancy, labour, birth, and the first six weeks following birth (Association of Ontario Midwives, 2020). Informed choice entails providing clients with as much information about their care options as possible; midwives support clients to make informed decisions about their care by taking time to discuss and gain a client’s full consent to options like genetic testing and ultrasound. Midwives are the only healthcare professionals who are trained to support out-of-hospital birth and, as such, ensuring that birthing people have choice of birthplace (either

home, hospital, or birth centre) is a pillar of the midwifery model of care (Association of Ontario Midwives, 2020). The integration and regulation of Ontario midwifery in 1994 did not conclude the Ontario midwifery movement, but rather the midwifery movement shifted towards directly supporting the ongoing objectives of reproductive justice movement through professional structures like their model of care and the introduction of FSBCs in Ottawa and Toronto.

Freestanding Birth Centres in Ontario

In 2014, Ontario introduced two FSBCs as part of a two-site pilot project in the province—the OBWC and the Toronto Birth Centre (TBC). The introduction of the OBWC and the TBC was not the first attempt to secure birth centres in the province. Indeed, the Ontario midwifery movement grew in response to the increasing medicalization of childbirth in addition to the burgeoning TBC movement.

The Toronto Birth Centre movement. In 1988, The Independent Health Facilities Act (IHFA) was introduced in Ontario Legislature. The IHFA was primarily envisioned as a way to shift many health services traditionally associated with hospitals to the community (Sutton, 1996). Members of the women's health, reproductive rights, home birth, and Ontario midwifery movements saw this as an opportunity to advance shared goals around choice of birthplace and provider (Sutton, 1996). In 1994, the TBC movement, led by a committee of professionals and supporters, including midwives, doulas, doctors, nurses, and midwifery consumers, submitted an application for the establishment of a FSBC in Toronto. The application was accepted, a site was selected and renovations were nearly complete when it was cancelled in 1996 by the newly elected Progressive Conservative government in the province (Sutton, 1996). It would be more than 18 years until Ontarians would have access to FSBCs in the province.

Ontario Birth Centres become a reality (again). In 2012, the Liberal Ontario provincial government launched the Action Plan for Health Care, which reinvigorated efforts to make FSBCs a reality in the province. At the cornerstone of this initiative was a drive towards the deinstitutionalization of care, captured in the slogan, “Right Care at the Right Time in the Right Place” (Hoskins, 2014). More recent healthcare reforms in Ontario have committed to improving the health system by providing faster access to interprofessional care within community-based settings, which marks a departure from traditional hospital-based care (Mattison et al., 2020; MOHLTC, 2018). These broader health reforms have included midwives as primary care providers and birth centres as non-hospital settings led by midwives. In 2014, the introduction of two midwifery-led birth centre pilot sites in Ottawa and Toronto was considered a substantial collective win for the reproductive rights, reproductive justice, and women’s health movements.

The introduction of FSBCs in 2014 ushered in a new era for Ontario registered midwives, wherein “choice of birthplace” encompassed not only home or hospital but also birth centre. The OBWC, which is the focus of this study, is an important site of change for reproductive justice in Ottawa. The success and viability of Ontario FSBCs is predicated upon midwives who access these centres as well as the BCAs who uphold the midwifery model of care and ensure the day-to-day facilitation of the centres (see chapter 2). There is little known about BCAs as birth workers and their role(s) in broader reproductive justice movement. The literature on Ontario midwives and the historical role that these birth professionals have played in the reproductive rights and justice movements emphasizes our gap in knowledge as it relates to BCAs.

Table 1: Peak Periods of Activity for Key Social Movements

1970s	1980s	1990s	2000s	2010s	2020s
Reproductive Rights Movement					
Women’s Health Movement					
Home Birth Movement					
Ontario Midwifery Movement					
			Reproductive Justice Movement		
		Toronto Birth Centre Movement			
				Ontario Freestanding Birth Centres	

Birth Centre Aides, Birth Work, and Quiet Activism

A “birth worker” is a “caregiver and advocate that supports birth givers to navigate the struggles and triumphs of reproductive experiences” (Apfel et al., 2016, p. 103). In the literature, there is often a distinction made between non-clinical birth workers, such as doulas and BCAs, and medically trained and regulated maternity care professionals, such as midwives. Birth workers play an instrumental role in providing non-clinical support to birthing people at different points in the reproductive process (Rigg et al., 2017). For example, contemporary birth workers include labour doulas, abortion doulas, lactation consultants, lay midwives, birthing assistants, and most recently, in the Ontario context, BCAs. Unlike doulas, who on focus on providing non-clinical support to a specific client (Carvalho et al., 2017), BCAs provide non-clinical support to midwives in the OBWC and facilitate the Centre’s functioning on a day-to-day basis (see chapter 2).

BCAs are new birth workers in Ontario. Birth workers, like pre-legislation lay midwives in Ontario, played a critical role in advancing reproductive justice objectives in the province (Bourgeault, 2006). Social movements, like the reproductive rights, reproductive justice,

women's health, home birth, and Ontario midwifery movements, relied on the visible organizing and communication efforts of activists on the frontline of protests and mass movements to gain traction for their cause and create change. More recently, however, the literature has differentiated between the visible work of activists (e.g., directly organizing social protests) and the work of 'quiet' pragmatic activists because their less visible work facilitates the objectives of a movement on the periphery (Pagano, 2014). A typology of activists is not present in the academic literature, but the grey literature speaks to this phenomenon as part of a larger "diversity of tactics" or as "introvert activism" (Brown, 2021; Lin, 2014; Pagano, 2014). Quiet activists are often under the radar, yet they are vital to the life of a social movement. The historical and contemporary roles of midwives advancing reproductive justice is well defined (Bourgeault, 2006) but lacks a contemporary analysis of BCAs.

Gaps in Knowledge

Birth workers are in a unique position as insiders to the maternity care system to facilitate and act as reproductive activists because they operate at the boundary between the medical system and community. In the case of BCAs, their role on the frontline of the OBWC uniquely positions these workers to advance and support reproductive justice in the communities they serve. As a new cadre of birth workers, at least in the Canadian context, there is little known about where and how BCAs fit into the broader reproductive justice movement, and how/if BCAs may identify their work with reproductive justice. This is an important gap in our knowledge because BCAs are critical part of a larger transformation in Ontario maternity care, wherein care is increasingly shifting to community settings, like birth centres that rely on non-clinical support workers to deliver services (Mattison, 2020). The deinstitutionalization of

healthcare in Ontario, and maternity care in particular, creates new opportunities for activists like BCAs in the reproductive justice movement.

Theorizing Birth Work from a Reproductive Justice Framework

Reproductive justice sits at the intersection of theory and praxis. Reproductive justice is both a movement, as discussed above, as well as a conceptual frame that can be used to understand how systems of oppression and privilege shape people's reproductive experiences. Ross (2017) has expounded upon the theoretical reach of reproductive justice, and she has made important distinctions between reproductive health, rights, and justice:

Reproductive justice was never meant to replace the reproductive health (service provision) or reproductive rights (legal advocacy) frameworks. Instead, it was an amplifying organizing concept to shed light on the intersectional forms of oppression that threaten Black women's bodily integrity. It rapidly propelled a growing movement of women of color activists from many social locations to fight for reproductive dignity. (pp. 290-91)

Reproductive justice is orientated by the concept of intersectionality. First articulated by Crenshaw (1989), intersectionality is both a theoretical tool and a framework for action initially used to explicitly examine the ways in which race, class, sexuality, and gender oppression simultaneously marginalize Black women and women of colour. In the context of reproductive justice, intersectional organizing and scholarship recognizes that intersecting identities, such as race, class, gender, sexual orientation, ability, language, age, religion, and national origin operate to influence a person's access to a full range of reproductive rights (Ross, 2006; Silliman et al., 2004).

Reproductive justice is thus both interdisciplinary *and intersectional*; it offers a theoretical and practical approach that accounts for the "interlocking matrix of oppression that is

frequently parsed into different disciplines such as Native American Studies, Queer Studies, Economics, and African American Studies” (Ross, 2017, p. 291). In terms of its practical approach, reproductive justice directly implicates activism by addressing intersecting oppressions, analyzing power systems, and centering the most marginalized (SisterSong, 2015). Birth work is political and therefore implies the pursuit of justice through activism; reproductive justice offers the appropriate theoretical tools to examine such activism (Carathers, 2019).

As an organizing concept, reproductive justice helps to construct an understanding of BCAs as birth workers that is not siloed to one component of the reproductive justice movement. Rather, reproductive justice highlights how BCAs may operate across all three pillars of reproductive activism, including reproductive health, rights, and justice. In the context of the OBWC, reproductive justice can highlight how the shared objectives of reproductive justice focused socio-political movements are experienced by birth workers on the new and somewhat ambiguous frontlines of an everchanging movement. Reproductive justice is well suited to inform my research that examines BCAs’ role(s) within the Ottawa reproductive justice movement because it centres activists’ experiences of social change within the healthcare system that is itself reproducing systemic oppressions (e.g., racism, colonialism, etc.)

Methodology

I employed an instrumental case study methodology (Stake, 2005), through which I drew upon many multiple sources of data to understand a real-life situation: The role of BCAs at the OBWC in the reproductive justice movement. An instrumental case study is used to “provide insight into an issue or to redraw a generalization” (p. 445). I used instrumental case study as a methodology to consider the specifics of the OBWC case in detail.

All case studies are bounded (Creswell, 2016). The research conducted for this case study was bounded by the physical and political borders of the OBWC, which includes the City of Ottawa and the surrounding geographical communities it serves as well as the midwives who access the Centre. By bounding the case study to the OBWC, I was able to reflect on the experiences of BCAs and reproductive justice within a specific socio-political and institutional context.

A case study methodology was appropriate for my research because it is a well-established methodology among feminist researchers. There exists a long tradition of case study methodology in the field women's health, healthcare, and feminist and gender studies. Feminist researchers have used case studies to look at First Nations women's experiences of evacuation for birth (Lawford, 2017), the feminization of medicine and other healthcare professions (Adams, 2004; Lindsay, 2005; Riska, 2010), women's access to maternity services in Canada (Hankivsky & Varcoe, 2007); the role of motherhood in women's health (Varcoe & Doane, 2007); the development and integration of midwifery in Ontario (Bourgeault, 2006); and experiences of birthing at home for First Nations women (Kornelsen et al., 2010). My research on BCAs' experiences of reproductive justice at the OBWC contributes to a diversity of feminist qualitative case studies in the field. The success and viability of my case study at the OBWC was heavily dependent upon my relationship with staff and leaders of the Centre itself; fostering a positive relationship and garnering support for my research was a logical next step in building the case study.

Garnering Support for Research

I initially made informal contact with the executive director of the OBWC at an EDI-focused event for a project entitled, Empowering Women Leaders in Healthcare, Health

Sciences, and Indigenous Health. Shortly thereafter, I met in person with the executive director, operations manager, and lead BCA at the Centre to present my thesis project proposal and to co-develop a memorandum of understanding (MOU) for my research. The OBWC provided me with a letter of support to conduct my research; I included the letter of support as part of my ethics application to my institution. The MOU outlined my roles and responsibilities as a researcher in relation to the OBWC and was finalized in August 2018. Research ethics approval was granted by my institution in January 2019.

Recruitment

I used snowball sampling to initiate my recruitment. Snowball sampling means that I relied on the positive working relationship I built with the OBWC Executive Director and Operations Manager to recruit participants through the OBWC internal staff mailing system and by word of mouth. By way of a referral email from the Executive Director and Operations Manager, I contacted three categories of informants from the OBWC for interviews: BCAs (who worked at the OBWC from 2014 to present), administrators, and midwives who had attended at least one birth at the OBWC since 2014. The Operations Manager emailed the letter of information and recruitment text to all former and current BCAs (n=33) and Ottawa midwifery groups (n=7) in April 2019. The Executive Director advertised and communicated the research project at OBWC team meetings for further exposure. The Operations Manager and Executive Director sent follow-up emails to individual BCAs, midwives, and Board of Directors members when the initial response was low. I personally followed up with anyone who e-mailed me to express interest in the research project (n=18). In my follow up e-mail, I provided the consent form and an overview of the semi-structured interview questions.

Situating Myself

I am guided in my approach to this research by feminist reflexivity (Faria & Mollet, 2016; Hemmings, 2012). My feminist reflexive practice is cultivated by my personal experiences and commitment to reproductive justice. As a third-year undergraduate student I was inspired to apply to midwifery school as a way to continue my birth work activism outside of academia. Shortly after receiving my letter of acceptance to an Ontario-based midwifery program I learned I was pregnant. My request to defer my enrollment until after the birth of my daughter, a one term delay, was denied. When I realized it was no longer possible for me to be a birth worker or birth professional as I had originally envisioned, I chose to continue contributing to the reproductive rights and justice movements through my academic work. Making a full range of women's work visible and valued has been a central focus of feminist scholarship (Albelda & Shea, 2010; Benoit & Hallgrimsdottir, 2011; Bourgeault, 2006; England, 2005; Gottfried, 2013) and is an important motivating factor for my research. I am committed to making the work conducted by birth workers, like BCAs, visible and valued within academic and activist communities and contributing to feminist inquiries of reproductive justice.

Methods and Data Sources

Document Collection

I collected pertinent documents from the OBWC to understand the organizational and policy environment governing the Centre. I was given access to these documents by the Executive Director and Manager of Operations. The Executive Director sent me electronic copies of the facility proposal (Vigenault & Gagnon, 2012), OBWC facility procedures (OBWC, 2016, 2020i), quality assurance procedures (OBWC, 2018a), client information package and Birth Centre tour guide (OBWC, 2018b), governance policies (OBWC, 2019c, 2019d, 2020j), and administrative procedures (OBWC, 2019e). The Manager of Operations shared updated

BCA staffing lists (OBWC, 2019g) and schedules (OBWC, 2019f); these documents helped me understand important context around BCAs' day-to-day experiences at the Centre. I excluded material that made sole reference to the Toronto Birth Centre (TBC) because it was not the focus of this inquiry.

Semi-Structured Interviews

I conducted a total of 11 semi-structured interviews. My in-person data collection began in April 2019 and concluded by February 2020, just two weeks before the onset of the global pandemic. Most were in-person at the OBWC (n=8), while several were conducted over the phone (n=3). The interviews I conducted in-person at the OBWC were with current BCAs while the interviews conducted over the phone were with past BCAs. I chose to employ semi-structured interviews because I wanted to facilitate the development of organic conversation with my participants (Fylan, 2005). Semi-structured interviews also provide a more appropriate format for discussing difficult topics and give participants the opportunity to work through and debrief issues if necessary. It was important that participants had the opportunity to debrief because discussions could involve re-visiting traumatic experiences for BCAs (e.g., emergency transfer of care) (Fylan, 2005).

Participants gave verbal and written consent to participate. Due to the small size of the Ottawa BCA community (i.e., there were only 33 BCAs total at the time of data collection), anonymity was not guaranteed to participants; I made this explicit in the letter of information and consent form and verbally reiterated before the interview. In an effort to provide a cursory level of anonymity, participants are referred to using pseudonyms and their professional title (e.g., Danielle, BCA).

All of the participants agreed to have their interviews digitally recorded. Each participant was interviewed once, and interviews ranged in length from 20 to 90 minutes. Interviews were transcribed and sent by email to participants for review. One participant requested revisions to her transcript: she clarified the context of a statement. I made the participant requested revision directly in the digital copy of the transcript. I printed hard copies of all transcripts for initial coding and analysis by hand and then uploaded digital copies to NVivo 11 for further coding and analysis.

All of the semi-structured interview participants identified as women. The self-described racial and ethnic identities of the BCAs interviewed represented a diversity of identities: Black, Indigenous, North African, and white. The BCAs ranged from 20 to 35 years of age. Of the BCAs interviewed, one current BCA had dependents and one BCA was on maternity leave and planned to return to her position. None of the rest reported having dependents. As per job requirements, all of the BCAs interviewed were bilingual (English/French).

Thematic Analysis

For the thematic analysis, I followed the method developed by Braun and Clarke (2006; 2013, 2019). Thematic analysis is understood as a method for “analyzing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). Braun and Clark (2019) conceptualized themes as stories about particular patterns of shared meaning across the dataset. A theme, Braun and Clarke (2006) argued, captures something important about the data in relation to the research question and “represents some level of patterned response or meaning within the data set” (p. 82). Braun and Clarke (2006) identified six steps in thematic analysis to help researchers locate thematic analysis in relation to other qualitative analytic methods: familiarizing yourself with

your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

Braun and Clarke (2019) reflected on the development and application of thematic analysis and clarified that although they describe thematic analysis in terms of steps, this method is not intended to be linear but rather reflexive. I applied the six steps of Braun and Clarke's thematic analysis as a guide to my data analysis, which contributed to the development of an iterative coding practice. My interview guide did not include direct questions related to reproductive justice or activism, but as I coded the data, I identified distinct themes around these topics. Most often, when I asked motivations for pursuing birth work in the OBWC or reflections on "what makes a good BCA," participants shared information that centred on reproductive choice, rights, and activism.

I specifically adopted a feminist approach to my thematic analysis, which helped me to foreground themes related to power in birth work, care work, and reproductive activism. Further, a feminist thematic analysis can be used to work towards the feminist objective of recovering and valuing women's experiences (Spencer et al., 2017)—this is particularly important within the historically feminized area of non-clinical birth work, where these experiences are overshadowed in the literature by the experiences of clinical professionals, like physicians and, to a lesser extent, midwives (Carvalho, 2019). Other scholars have employed this approach. For example, Jenkinson (2017) conducted a feminist thematic analysis of in-depth semi-structured interviews with women's, midwives', and obstetricians' experiences of refusal of recommended maternity care. Jenkinson explained that she adopted a feminist thematic analysis to invert the hierarchy traditional in medically dominated maternity settings, "privileging the experiences of women over clinicians, and the experiences of women and midwives, over obstetricians" (p. 2).

Results

A feminist thematic analysis of 11 semi-structured interviews with BCAs at the OBWC led to my identification of two key themes: 1) BCAs are non-traditional activists within the OBWC and reproductive justice movement, and 2) BCAs are key connectors for reproductive justice to healthcare.

BCAs are Quiet Activists

Rather than speaking directly to activism and reproductive justice, which were not explicitly included as part of the semi-structured interview guide, BCAs often discussed these topics indirectly through conversations on their motivations to work at the OBWC. None of the BCAs I interviewed said that BCA work was just a job; in every instance BCAs' motivations to pursue the work at the Centre was linked to broader social justice objectives, many of which are directly aligned with reproductive justice. For example, when asked why she wanted to be a BCA, Candace replied:

I think everyone is here because they want to be... Uh again, there is...other jobs you can be paid a lot more doing less... and maybe because there is also, you're a tiny part of a big mission that is a meaningful mission. Yes, you're not a midwife, but you're part of something important.

Kayla noted that she was drawn to her work as a BCA after her exposure to the midwifery model of practice through an educational placement with midwives in her community. She reflected on her experience in the birth centre and said, "I just really liked the values and the way it worked."

Some BCAs were more direct in discussing their desire to be involved in the Ottawa birth and midwifery community. For example, Eleanor was interested in working more closely with the Ottawa birth community and supporting access to the services offered at the Centre (OBWC,

2018b). She was already a trained healthcare provider in dietetics but felt that working as a BCA would be more intrinsically fulfilling. When asked why she was interested in working with the birth centre, despite having a full-time dietetics practice, she said:

I figured, well, this would be a good way to get within that kind of world, and even though it wouldn't be a clinical role, it'd be more of a supporting role and administrative role. At least I'd be able to kind of see what's going on there and get to know the midwives and things like that... it was an opportunity to help, and I figured, well, I had some extra time in my schedule.

Many BCAs came to the OBWC from activist community backgrounds or as other kinds of birth workers, like doulas. For example, Danielle (BCA) was working towards being a doula and as part of a local reproductive justice community organization before the applying to work at the Centre in 2014. She spoke about being drawn position because she wanted to believe in the work she was doing: "I wanted to be like interested in what I was doing, and I wanted it to be in this kind of field." Similarly, Ava (BCA) was among the first cohort of BCAs to join the OBWC in 2014 (OBWC, 2019g). Ava also came from a doula background and discussed her motivations to pursue BCA work as a way to further advance her work with the Ottawa sexual and reproductive health community:

I've always been really interested in women's health and like sexual reproductive health, so it kind of seemed perfect. I was really excited. I also started volunteering with Mothercraft Ottawa, so providing volunteer doula support, so I was kind of getting into the groove of sort of maternal and sexual reproductive health.

For many BCAs, working at the OBWC came as part of a broader commitment or interest in social justice and reproductive rights, rather than a pay cheque. BCAs described their

motivations to work in the Centre not only as an opportunity to advance social justice objectives but as a way to gain a unique perspective on reproductive healthcare options. In this way, BCAs reflected on their time at the Centre as a critical learning experience.

BCAs as Key Connectors for Reproductive Justice to Healthcare

Past and present BCAs often reflected on how their experiences at the birth centre had influenced their future pathways into healthcare work. Ava was a BCA for three years before she started a master's program to study sexual and reproductive health and later as a medical student. At the time of this interview, Ava was a second-year medical student. When asked why she decided to leave the birth centre, she reflected:

I had kind of become the most, or one of the most, senior birth centre aides at the time and I felt like there wasn't anywhere to go up from there. Yeah, it just kind of felt like I had learned as much as I could, and I had gotten everything out of the job that I could. From there I was also working kind of casually at the hospital...and then I went abroad, and I did research in abortion access in Thailand with [name of academic supervisor] and then after that I started medical school.

Ava discussed her time as a BCA as an educational opportunity that she could call upon as a physician (OBWC, 2019h). In concrete terms this meant that Ava was drawing upon her learning experiences as a BCA, experiences which were seeped in tenets of reproductive justice, to inform her work as a physician.

Other BCAs came to the birth centre as healthcare students and saw BCA work as a way to complement future aspirations (OBWC, 2019g). For example, Karen was a midwifery student when she joined the birth centre. For Karen, her work as a BCA was part of learning and appreciating every aspect of the midwifery model of care, in particular, choice of birthplace for

members of communities that experience marginalization. She felt that her time as a BCA gave her unique insight into the birth centre and its services, which would improve her future work as a midwife. Karen spoke to her experience at the birth centre:

The reason I did it [became a BCA] is because I believe in midwifery and out-of-hospital birth, particularly for communities that don't often get represented in the birth centre that we're trying to work on but like at my perspective is kind of like a 360 [degrees] of the different areas of the birth centre, and then definitely as a midwifery student.

Candace (BCA) applied to work at the Centre as a way to experience, support, and learn from the midwives she would encounter on the job as an aspiring midwife. She reflected on her desire to be a midwife and continue apply her experiences as a BCA in her future roles:

I want to be a midwife. I applied to be a midwife. I'm still waiting for the answer, but...my main reason is I want to get as close as possible to the lives, professional lives of a midwife and see how it is and, and everything really around birth and working around that. I want to explore that, and...the midwife world seems to be very closed in the way that unless you're a midwife, or maybe a doctor, healthcare professional, it's all very mysterious.

Candace grew up in a family of health professionals, including a physician father, which influenced her to pursue midwifery rather than medicine because, as she reflected, "we can do a lot better." In her eyes, the BCAs and midwives were part of the "doing better."

Kayla (BCA) was originally a student in human kinetics when she joined the Centre as BCA in 2019. She attributes her time with the Centre as influencing her program change to nursing. She discussed how she considers her time as a BCA to be part of a learning experience that she will eventually translate or connect to a clinical setting outside of the Centre:

I really appreciate the experience and the relationships that I make here. I get to learn such a wide variety of things, from like infection control to like cleaning rooms, to like learning about medical charting, and just the different people you meet. So, all of the religions and ethnicities and gender and just everyone that you get to meet here, I just think that this is such a unique place to experience all of these things that you wouldn't be able to experience without like job experience, because I don't have a degree yet. I'm just a student. So, this is such an interesting introduction for me to be able to have access to all of this before I get a clinical role in the future, you know.

BCAs, both past and present, reflected on their work at the Centre in terms of gaining invaluable experience that impacted their future aspirations in healthcare.

Discussion

Through my feminist thematic analysis of 11 semi-structured interviews with BCAs I identified two key themes: BCAs are non-traditional activists; and are key connectors for reproductive justice to healthcare. The first theme, "BCAs are quiet activists," captures BCAs experiences of their role in the OBWC as more than just a job and describes BCAs as facilitators of reproductive justice in the Centre. The second theme, "BCAs are connectors for reproductive justice to healthcare," looks at BCAs experiences of their role as a learning opportunity steeped in reproductive justice that ultimately influence their future pursuits in healthcare work outside of the Centre. Taken together, the themes I identified reflect a new kind of reproductive justice frontline in Ottawa, one which is being diligently and quietly facilitated by birth workers like BCAs in the OBWC. BCAs are among a new typology of reproductive justice activists that finds themselves working within the same systems (i.e., the healthcare system) that they seek to change; recognizing and valuing this new quiet activism and BCAs' corresponding potential for

systemic change is an important step towards understanding the changing nature of the reproductive justice movement in Ottawa and the role of BCAs therein.

Recognizing and Valuing Quiet Activism in Reproductive Justice

Reproductive justice sits at the intersection of theory and praxis and directly implicates activism by addressing intersecting oppressions, challenging power systems, and centring the most marginalized (Ross, 2017; SisterSong, 2015). BCAs' experiences of quiet activism in the OBWC are characterized by key acts of facilitation, such as by facilitating the midwifery model of care and access to the Centre for members of communities that have been marginalized.

BCAs' identity as quiet activists is not a label that they explicitly adorned. Indeed, none of the BCAs that I interviewed referred to themselves as activists or made direct reference to the reproductive justice movement. Nevertheless, the quiet activism of their everyday work is exemplified by their motivations to pursue BCA work because it is aligned with their social justice ideals. These subtle acts, like working as a part-time BCA despite having a full practice in dietetics (Eleanor, BCA) or taking on BCA work as a midwifery student to help support access to the centre for members of the community who experience marginalization (Karen, BCA), are distinct from the more overt acts of political organizing we saw among birth work activists in earlier social movements.

Unlike their counterparts in the Ontario midwifery community, where there is a history of overt political organizing and activism (Bourgeault, 2006; Carathers, 2019), BCAs support and advance reproductive justice in a far less visible manner. BCAs are equipped with policy instruments (e.g., policies that ensure gender inclusive language and safe smudging practice for clients) that allow them to facilitate an environment that is conducive to reproductive justice, but the participants in this study did not directly acknowledge this role as quiet activists. Indeed, the

terms “activist” or “reproductive justice” were not mentioned by BCAs during interviews. Although they may not have used the talk, they did walk the walk.

As quiet activists, BCAs may not be the figurative face of the reproductive justice movement in Ottawa, but their key acts of facilitation in the OBWC contribute to maintaining the successes secured by previous activists in the reproductive justice movement. For example, BCAs are critical to facilitating access to a safe and inclusive birth centre for the community’s most marginalized members (SisterSong, 2015; see chapter two). For example, Ava (BCA) pursued work as a BCA because she recognized that the OBWC was ensuring safe and inclusive access to out-of-hospital birth (i.e., choice of birthplace) for Indigenous members of her community. In doing so, BCAs perform a role that is vital to the maintenance of the midwifery model of care (i.e., choice of birthplace) within an institutional context (i.e., midwifery and birth centres) that is actively working to breakdown systemic barriers to accessing reproductive choice. As birth workers, BCAs are made even more unique by their position within the Ontario maternity care system; many BCAs experience their work as a transitional, that is, they leave the Centre to pursue healthcare work as midwives, doctors, or nurses. In the context of reproductive justice, this means that BCAs can act as key connections between reproductive justice community and the wider healthcare system.

BCAs Connect Reproductive Justice to Healthcare

Birth workers like BCAs are unique because they largely experience their work as transitional; many of the BCAs in this study are/were students and do not/did not stay at the Centre for extended periods of time. The time-limited nature of BCA work has important implications for broadening our understandings of how the reproductive justice movement is gaining traction outside of communities like the OBWC. BCAs are moving into other positions

within healthcare and carrying forward experiences of birth work that are fundamentally rooted in reproductive justice. For example, Kayla (BCA) is a nursing student, Karen (BCA) is a midwifery student, and Ava (BCA) is a medical student. Kayla, Karen, and Ava all discussed their work at the Centre is akin to an educational placement and often spoke about how they used or were influenced by their experiences to pursue other clinical healthcare work. BCAs are thus actively connecting their reproductive justice learning experiences from the Centre to other areas of the healthcare system.

BCAs reflect on their experiences at the OBWC as learning experiences that demonstrate the values and beliefs of the Ontario midwifery model of care and reproductive justice, more broadly. Previously, reproductive justice activists existed at the periphery of the traditional medical system rather than within it as clinicians. This is true even for midwives who, despite regulation and integration into the provincial healthcare system since 1994, still experience the healthcare system as outsiders (Bourgeault, 2006; Bourgeault et al., 2012; Sharpe, 2001). BCAs at the OBWC are moving into areas of the healthcare system in which concepts of reproductive justice may be outside of the traditional model of care (e.g., medicine and nursing) and thus offer new and unique pathways for advancing reproductive justice in these institutional contexts. When BCAs transition from birth work to other areas of the healthcare system, either as birth professionals or otherwise, they carry forward these learning experiences as key connectors for reproductive justice, which may act as foundations of practice and create opportunities to further advance reproductive justice goals outside of birth centres.

Conclusions

Taken together, the two themes I identified in my interviews with 11 BCAs at the OBWC illustrate how quiet activists play key roles in facilitating and advancing reproductive justice in

Ottawa. BCAs are playing a crucial role in advancing reproductive justice objectives as quiet activists in Ottawa and as novel connections for reproductive justice to healthcare. In addition to contributing to new scholarship on BCAs as birth workers in the context of activism, this study makes clear the unique role of these workers as they forge new pathways for reproductive justice in healthcare broadly. BCAs' motivations to pursue work in the Centre was always more than just a job, but rather an opportunity to uphold their social justice ideals while also working towards clinical roles outside the Centre.

As a qualitative case study, the results are limited to the OBWC and may not necessarily reflect experiences of BCAs at the TBC. BCAs' experience in Toronto may reflect the unique demographic and cultural makeup of the communities the TBC serves. The BCAs in this study discussed serving members of communities that experience marginalization and appreciating the diversity of the Centre as a workplace, but they did not unpack these experiences in a way that could speak to the role of intersecting systems of oppression in their work. In the future researchers should explicitly explore how BCAs experience and address intersecting oppressions in birth centres as a way to advance discussions on reproductive justice in these new birth spaces. Finally, the data collection for this study concluded prior to the onset of the COVID-19 global pandemic. We know that that ongoing negative impact of the pandemic on women (Qian & Fuller, 2020; Sevilla & Smith, 2020; Shafer et al., 2020) and healthcare workers (Brophy et al., 2021; Ehrlich et al., 2020; Regenold & Vindrola-Padros, 2021), both of which describe the BCAs in this study, has been dramatic. In the coming years, it will be critical to examine how the pandemic has influenced reproductive justice in the context of birth work.

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Chapter 5:
Conclusions

Three key questions guided my doctoral research: What are Birth Centre Aides (BCAs)? How did the BCA role develop in the Ottawa Birth and Wellness Centre (OBWC)? What are BCAs' experiences of their role in the OBWC? I addressed these questions, and several sub-questions, in three standalone papers. Together, these papers represent important contributions to understanding BCAs' roles in the OBWC, feminist leadership in birth centres as new healthcare settings, and BCAs' experiences of reproductive justice activism.

In this conclusion, I draw out the key contributions made across each of my three papers, how together they address key gaps in knowledge, and the implications my findings have for advancing theory, policy and practice. I discuss the limitations of my research and make recommendations for future researchers to build upon the foundational work I have offered here. Finally, I present concluding thoughts on my doctoral work as a whole and provide insight for moving forward.

Overview of the Dissertation Manuscripts

My research makes important contributions to understanding the development of BCAs as new birth workers in the context of Ontario's freestanding birth centres (FSBCs), feminist healthcare leadership theory, and reproductive justice activism literature. As a relatively recent introduction in Ontario, there is little known about FSBCs in the province and the BCAs who maintain the centres' day-to-day functioning. At present, there is no literature on BCAs but there does exist international scholarship on similar midwifery and maternity support roles (Griffin et al., 2012; Hussain & Marshall, 2011; Sandall et al., 2007). In Ontario, the sparse FSBC literature that is available focusses on midwives' or clients' experiences in birth centres (Gagnon & Darling, 2013; Murray-Davis et al., 2014) or on clinical outcomes in these new facilities (Sprague et al., 2018). The experiences and contributions of BCAs in Ontario FSBCs is a major

gap in the existing scholarship that I have endeavoured to address through my dissertation research.

Paper One: Mapping the Development of BCAs at the OBWC

In my first paper, “Birth Centre Aides at the Ottawa Birth and Wellness Centre,” I used feminist sociology of professions as the theoretical framework and institutional ethnography as the methodology to understand how the BCA role has been developed and operationalized in the OBWC. I mapped the development of the BCA role at the OBWC descriptively and visually using data from semi-structured interviews with key stakeholders from the OBWC (n=16), including BCAs (n=11), administrators (n=3), and midwives (n=2). I also used grey literature and documents from the OBWC (e.g., the original OBWC facility proposal) to further inform the development of the descriptive and visual maps.

Through the mapping process, I identified several opportunities for the development of the BCA role at the OBWC: building permanency and sustainability into the role by building upon the BCA non-clinical skillset; maximizing collaboration between BCAs and midwives to encourage the pursuit of midwifery education; and bridging the BCA pathway to grow the midwifery workforce. I contributed new and detailed information about the development of BCAs in Ontario by describing the BCA pathway from pre-recruitment through post-employment at the OBWC. I made clear the important challenges and opportunities for BCAs as the role continues to develop. The visual and descriptive map that I produced is a novel contribution to Ontario FSBC literature because it is the only study on the BCA role in the Canadian literature. Until now, knowledge and resources about the BCA role could only be found through intermittent job postings on the Centre’s website

Paper Two: Feminist Leadership in Healthcare

The foundational work I conducted in my first paper laid the groundwork for an exploration of themes related to feminist healthcare leadership in my second paper, “Feminist Leadership in Healthcare: The Case of Birth Centre Aides and the Ottawa Birth and Wellness Centre.” In my first paper, the viability of the opportunities that I identified for the BCA role in the OBWC implied the continued success of the Centre. The BCA role can only exist and continue to develop if the Centre itself remains operational. From what I observed in the mapping process, the success of the OBWC to date relied not only on continued government funding but also on a strong leadership. When I asked BCAs about their relationships and experiences with the Centre’s leadership, they were keen to attribute and highlight the exceptionally positive working environment in the Centre to its leaders.

Additionally, I was drawn to explore BCAs’ relationships and experiences with leadership as a result of my work on a parallel project that had the objective of empowering women leaders in healthcare, health sciences, and Indigenous health. As a research assistant on the aforementioned project, I contributed to a gap analysis of women’s leadership in healthcare which exposed a significant gap in feminist healthcare leadership (Bourgeault et al., 2019). This literature resonated with what I was finding in my thesis data. When I conducted an additional review of the existing scholarship on healthcare leadership and feminist leadership for my dissertation, I identified the extent of the gap between these two fields of study. The existing body of healthcare leadership literature, though robust, did not intentionally or explicitly integrate feminist leadership models and vice versa.

In my second paper thus, I addressed the gap in feminist healthcare literature by conducting an instrumental case study (Stake, 2005) to understand experiences of feminist leadership among BCAs and the Centre’s administrators (e.g., Executive Director and Manager

of Operations). For my theoretical framework, I integrated Tronto's (1993) ethic of care with Dickson and Tholl's (2014) LEADS in Caring Environment leadership capabilities model to understand and identify feminist leadership practices in the OBWC. I purposefully privileged Tronto's ethic of care over LEADS to take feminist understandings of care as starting point for approaching healthcare leadership—an approach that did not previously exist in the literature. I developed a visual to further illustrate how Tronto's care practices (i.e., attentiveness, responsibility, competence, and responsiveness) can form a foundation from which to theorize feminist healthcare leadership using traditional models like LEADS.

I then used a feminist thematic analysis (Braun & Clarke, 2006; Jenkinson et al., 2017) of interviews with OBWC stakeholders, including BCAs and administrators, to identify three themes related to feminist leadership in the OBWC: OBWC leadership lead from care, are collaborative leaders, and foster BCAs as feminist healthcare leaders. The themes I identified related to experiences of feminist leadership at the OBWC and the corresponding complementary theoretical framework I used to understand these themes is a novel contribution to bridging feminist and healthcare leadership literatures. By integrating Tronto's (1993) conception of care as a set of practices into the LEADS healthcare leadership model (Dickson & Tholl, 2014), I identified feminist healthcare leadership practices in the OBWC.

As an underdeveloped area of study, it is important to offer theoretical contributions as well as practical opportunities (i.e., care practices) for the integration of a feminist healthcare leadership model in real life situations. Beyond the theoretical contributions, there are also practical implications for the findings I discussed in the second paper. I presented concrete examples of feminist care practices in healthcare as leadership by using BCAs and administrators' experiences in the OBWC. Care practices, like signing email communications to

a team with “love” or offering assistance to a BCA who needs help completing a birth room clean despite one’s job title, are examples of feminist leadership in practice. BCAs also implemented feminist leadership practices as emerging leaders. For example, many of the BCAs I interviewed were either in the process of transitioning to clinical work (e.g., as nurses, physicians, or midwives) or had already done so; the transition to clinical roles was influenced by experiences that reflect feminist leadership practices in the OBWC. My research on leadership in the OBWC offers practical examples of feminist healthcare leadership and can be used to further develop best practices in the area.

Paper Three: BCAs as Reproductive Justice Activists

My findings presented in the first two papers contributed to addressing gaps in our knowledge around the BCA role in Ontario FSBCs and bridging feminist and healthcare leadership literatures. In the third paper, I turned my focus back to BCAs’ experiences of birth work to explore themes around reproductive justice and activism. In the first paper, I mapped BCAs’ experiences of their role but did not engage with more nuanced themes around motivation to pursue birth work as a BCA. I attended to this gap in the third paper, “Birth Work as Reproductive Justice Activism: The Case Study of Birth Centre Aides at the Ottawa Birth and Wellness Centre.”

In the third paper, I conducted an instrumental case study (Stake, 2005) at the OBWC and applied a reproductive justice theoretical framework (Ross, 2017; SisterSong, 2015) to a feminist thematic analysis (Braun & Clarke, 2006; Jenkinson, 2017) of semi-structured interviews with BCAs to understand how/if BCAs related to reproductive justice and activism. I also reviewed literature on birth workers and reproductive justice activism in Ontario grey literature to understand the socio-political context surrounding birth work in the OBWC and Ontario. I used

reproductive justice as a theoretical frame to help me identify two themes related to BCAs and reproductive justice activism at the OBWC: BCAs are quiet reproductive justice activists and BCAs are key connectors for reproductive justice in healthcare.

The first theme, “BCAs are quiet activists,” captured BCAs experiences of their role in the OBWC as more than just a job and constructed BCAs as facilitators of reproductive justice in the Centre. In the second theme, “BCAs are key connectors for reproductive justice in healthcare,” I looked at BCAs experiences of their role as a learning opportunity steeped in reproductive justice that ultimately influenced their future pursuits in healthcare work outside of the Centre. In their role as connectors for reproductive justice, BCAs are acting as healthcare system insiders from a knowledge base that is informed by reproductive justice as a result of their experiences in the Centre. Taken together, the themes I identified in the third paper constructed a new kind of reproductive justice frontline in Ottawa, one that is being diligently and quietly facilitated by birth workers like BCAs in the OBWC and advanced by BCAs on a maternity system level by the Centre’s alumni as they move into new healthcare roles.

The literature surrounding birth work and activism is ripe with accounts of reproductive justice activists organizing via socio-political movements (Nelson, 2003; Ross, 2017), publicly advocating for reproductive justice (Carathers, 2019; Nestel, 2011; SisterSong, 2015), and advancing reproductive rights in the Ontario (Bourgeault, 2006; Shaw, 2013; Sutton, 1996). The grey literature provides an introduction to the concept of “quiet activism,” but similar discussions do not exist in the academic literature (Brown, 2021). There are no accounts of the less visible, quiet activism of birth workers who uphold and facilitate key structures of reproductive justice in the province, like BCAs in the OBWC. My findings in the third paper contribute new and

valuable accounts of quiet birth work activism to scholarship on reproductive justice and birth work.

In addition to contributing to new scholarship on BCA birth work as quiet activism, my findings in the third paper have important implications for understanding how BCAs' experiences of reproductive justice may have a system-level ripple effect. BCAs discussed their birth work at the OBWC as a learning experience they called upon to inform future aspirations in healthcare. BCAs often left the Centre to pursue roles in other areas of the healthcare system as midwives, nurses, and doctors. By understanding their BCA role as a learning experience, former BCAs can offer our healthcare system access to reproductive justice-informed care providers. In this way, it can be seen as an example of the "S" or system transformation part of the LEADS framework, employed in the second paper. The system transformation in this case would be maternity system transformation.

Implications of the Dissertation for Theory, Policy and Practice

Taken together, the three papers in this dissertation contribute new and detailed knowledge to our understanding of BCAs in the OBWC, bridging feminist and healthcare leadership literature and diversifying accounts of reproductive justice activism in birth work. My research has important implications for theory and policy in feminist and gender studies and Ontario maternity care. In this section, I identify implications of my research for theory, practice, and policy.

Making BCAs Visible in Feminist Accounts of Work

The scholarship on FSBCs to date tends to focus on midwives' and clients' experiences in FSBCs (Mattison, 2015; Sprague, 2018) despite the essential role that BCAs play in the day-to-day facilitation and function of these centres. This mirrors the historical invisibility of nursing

work, as a backdrop to the more prominent medical work and relations with patients (Witz, 1992). My dissertation contributes important knowledge to the development of new accounts of BCA birth work that were previously absent from the literature. It is particularly important that feminist analyses of work continue to build a complete account of work in healthcare because more than 80% of people who work in this sector are women (Statistics Canada, 2016). By not only visually and descriptively mapping the development of BCAs at the OBWC, but also engaging with feminist scholarship and literature around healthcare leadership and reproductive justice, I have provided a fulsome and unique academic account of BCAs' experiences of work in the OBWC from their perspectives, which is important because academic inquiries to date have focussed on midwives' and clients' experiences. Indeed, BCAs' voices have been overshadowed by clinical and service level approaches despite the essential roles they take on in FSBC.

Moreover, through mapping the development of the BCA role at the OBWC I identified important theoretical linkages between feminist sociology of professions and the gendered construction of BCA work vis-à-vis midwives. The development of the BCA role is reminiscent of how nursing was constructed in relation to medicine's professional project; nursing was developed to facilitate the work of physicians in hospitals (Witz, 1992) much in the same way the BCA role was developed to facilitate the OBWC and the midwives who work therein. In this same vein, I identified the development of the BCA role as another example of gendered work; the BCA role is an ill-defined healthcare support role (Davies, 1996) that is predominately filled by young, unencumbered (i.e., child free) women. My dissertation extended traditional feminist sociology of professions by teasing out the gendered demarcationary strategies at play outside of

the traditional medical model (in the OBWC) and within feminized healthcare roles (e.g., midwifery).

Theoretical Foundations for Feminist Leadership in Healthcare

Traditional healthcare leadership models like LEADS in a Caring Environment (Dickson & Tholl, 2014) do not address the systemic inequities and systems of oppression that contribute to experiences of leadership in healthcare. At the same time, while feminist leadership literature is socially located and accounts for the role of power and privilege in leadership, feminist scholars in this area do not engage with leadership in healthcare, despite the ongoing underrepresentation of women in key leadership positions in this sector (Bourgeault & Porter, 2019). Experiences of leadership at the OBWC provide a novel account of feminist leadership practices in healthcare. In the second paper, I identified examples of leadership practices as care practices using Tronto's (1993) ethic of care, which is a novel approach to theoretically integrating feminist leadership in healthcare. This is the first mapping of these two frameworks, which makes a unique contribution to this literature. I privileged Tronto's ethic of care over LEADS to foreground the role of systemic inequities (e.g., racism, colonialism, etc.) within traditional healthcare leadership. As the academic community's collective awareness around issues related to equity, diversity, and inclusion in healthcare leadership continues to grow, I believe it is imperative that scholars outside of feminist and gender studies contribute theoretically just models for understanding leadership. The integrated theoretical framework and examples of care practices as leadership practices that I presented in my third paper can inform emerging discussions on equity in healthcare leadership.

In my third paper, I described how BCAs are contributing to a healthcare system transformation when they transition from the Centre into clinical roles as connectors for

reproductive justice (e.g., as nurses, midwives, and physicians). In this way, BCAs practice feminist healthcare leadership because they are working to transform how gender functions within the healthcare system to curtail reproductive justice (e.g., access to birth place). This ties into fifth domain in the LEADS framework (Dickson & Tholl, 2014), which is *Systems Transformation*; it speaks explicitly to a leader's ability to contribute to health system transformation. The dual focus on a "systems transformation" from a gender system and health care system with a specific focus on maternity care is another novel theoretical contribution.

Practical Implications: Bridging Program for BCAs to Clinical Healthcare Roles

The findings I presented throughout this dissertation describe the BCA role as transitional in nature. In some senses, this mirrors the transitional nature of activist work – in this case quiet birth activism to advance reproductive justice. The transitional nature of BCA work means that for many BCAs, their work is experienced as an educational opportunity. Many BCAs, though not all, either join the Centre as healthcare worker students (e.g., nursing, midwifery, and medicine) or enter these training programs after they leave the Centre. I recommend that the OBWC work with local healthcare training programs to develop a formal bridging program for BCAs to other clinical healthcare roles. A similar program exists in the United Kingdom for Maternity Support Workers (MSWs) who wish to transition into midwifery (Hutchinson, 2014). In fact, in the British context the MSW bridging program has played a key role in the country's effort towards building capacity within the aging midwifery workforce (National Health Service, 2017).

A bridging program in Ontario would not only provide educational credits and development for BCAs on the technical and administrative skills required to facilitate a birth centre, but it may also act as a way to embed core tenets in reproductive justice, like choice of

birth place and informed choice, in nascent practitioners in midwifery, nursing, medicine and other health and caring professions. Additionally, a bridging program could contribute more specifically to building capacity within the midwifery workforce; this is especially pertinent when midwifery groups cannot meet the demand for their services in the province and turn away 4 out of 10 clients seeking care (Senger, 2020). The OBWC could leverage its existing relationships with Ottawa area midwifery groups to promote a BCA to midwifery bridging option, which could contribute to addressing the provincial shortage of midwives.

Policy Implications: Continued and Secure Funding for Ontario FSBCs

The findings in this dissertation reassert the importance of providing access to birth place options for people in Ontario as a critical component of an ongoing discussions around reproductive justice. In their role as quiet activists, BCAs are taking on the work of facilitating and upholding this key tenet of reproductive justice, which could be easily undermined by a new government mandate that does not include continued or adequate funding for Ontario FSBCs (e.g., the cancellation of the Toronto Birth Centre in 1996). Evaluative research has demonstrated that these centres provide a safe birthplace option, in addition to home or hospital, for midwifery-led birth for low-risk pregnant people and are in high demand within their communities (Mattison, 2015; Sprague, 2018). Thus, it is essential for the MOHLTC to provide secure and ongoing funding for the existing FSBCs in Ontario, while also considering expanding birth centres as a birthplace option across province.

Methodological Limitations and Challenges

As with all research, there were important methodological challenges and limitations experienced. In this section I discuss methodological challenges I encountered concerning ethics

approval, participant recruitment and scheduling of interviews, the interruption experienced by global pandemic.

Ethics Approval Process and Confidentiality

The ethics approval process is understandably rigorous when proposing research in maternity care environments, like the OBWC, where you are likely to interact with birthing people. Receiving ethical clearance from my institution to conduct my data collection was perhaps one of the most time-consuming components of my research. I submitted my application for ethics in September 2018 and did not receive my Certificate of Ethics Approval until January 2019. The lengthy, but necessary, ethics approval process caused me to lose the momentum and rapport I had built with the OBWC in anticipation of starting my research. By the time I received my ethics in January 2019, the OBWC asked me to delay data collection until March 2019 in order to accommodate their ongoing public consultation for which they had hired private consultants to conduct on the Centre's behalf. I began data collection promptly in March 2019 and concluded in February 2020.

From an ethical perspective, it was very difficult to conduct in-person research at the birth centre during births. I did not seek ethics to observe clients and working midwives in the birth rooms or during labour. As a result, it was difficult to observe BCAs while also maintaining client confidentiality and giving the appropriate space to labouring clients and their attending midwives. Clients are often walking around the Centre during their labour, which meant I often had to quickly leave certain areas while I was observing BCAs. The ethical challenges I experienced while conducting in-person research with BCAs at the Centre made it easier to conduct interviews on the telephone (n=8) rather than on site (n=8).

Participant Recruitment and of Scheduling Interviews

I knew at the outset of my research that the participant pool would be small. When I started data collection in March 2019, there were a total of 33 BCAs (both former and present), many of whom were no longer in touch with the OBWC or had even moved out of province. In the end, I garnered participation from 11 BCAs. In addition to securing participation from BCAs, I encountered challenges to scheduling interviews due to the unpredictability of BCA work. The OBWC staffs one BCA at a time on rotating 12-hour shifts (see chapter two). I scheduled interviews with BCAs who would need to cancel several times to accommodate a new client admission or an urgent birthing room clean. As a result, it often took me weeks to find an appropriate opportunity to complete an interview with a BCA. To mitigate this challenge, I met BCAs at the Centre in an on-call fashion; if they experienced a lull in their shift, they would simply text me to drop by the Centre. Of course, I was also restricted in my flexibility as the parent to two young children.

The COVID-19 Pandemic

On March 11th, 2020, the World Health Organization declared COVID-19 a pandemic. In Canada, the Government responded by taking drastic measures to limit the spread of the novel coronavirus by closing non-essential services (e.g., retail and leisure), schools, and moving workplaces online wherever possible. The ongoing impact of the pandemic on women as primary care providers in the home (Oleschuk, 2020; Qian & Fuller, 2020; Sevilla & Smith, 2020; Shafer et al., 2020) and as healthcare workers has been particularly dire (Brophy et al., 2021; Ehrlich et al., 2020; Regenold & Vindrola-Padros, 2021). Fortunately, I had completed my data collection at the OBWC just weeks before the onset of the pandemic in Ottawa, but this did not completely shield my research from the effects of a global pandemic. I struggled to navigate the research process (e.g., data analysis and writing) from home with my two children and partner without the

support of schools and childcare. I also knew that the OBWC was struggling to adapt its services for the community in a pandemic and, with this in mind, I felt it was inappropriate to request further research support from an already strained workforce. As a result, I did not conduct follow-up interviews with any of my participants, which may have offered further insight into key themes I explored in the dissertation.

Limitations Inherent to a Single Organizational Case Study

The OBWC and TBC are not administratively linked. The FSBCs function completely independent of each other and both submitted independent facility proposals to the Ministry of Health and Long-Term Care (MOHLTC) in 2012. I also knew from my role in 2014 as a research assistant on a project that proposed comparative research on BCAs and midwives in the OBWC and TBC that the TBC's leadership did not want to participate in non-mandated academic research. The TBC and OBWC already participate in ongoing monitoring and evaluation research as requirements of the MOHLTC pilot project program (see Sprague et al., 2018). Logistically, I also knew that it would be difficult for me to manage data collection in two Centres that were more than 500km apart. At the time of my data collection, it was typical and expected that I would undertake on-site, in-person research. For these reasons, I chose to not include the TBC in my research. The exclusion of the TBC from my research is a methodological limitation because my results may not be applicable to the TBC and future birth centres in Ontario.

In Canada, healthcare is provincially regulated. There is substantial variability in terms of access to services, regulated healthcare professionals (i.e., midwifery), and facilities across the country. For example, birth centres have been functioning in Quebec since 1994 (Blais et al., 2000) but did not open in Ontario until 2014. The diversity of healthcare service models, models

of care, and funding models seen across the country means that the experience of BCAs and the OBWC may be unique to not just Ontario, but perhaps Ottawa. At the same time, however, there is an opportunity for the results from my research at the OBWC to be applied on a case-by-case basis while taking into consideration the differences that exist in any given municipal, provincial, or territorial context.

A comparative case study, such as the one that I assisted in developing a proposal for in 2015 as part of an inter-provincial research team, would have yielded valuable data for extending an analysis of BCAs and birth centres beyond Ottawa and Ontario. But, unfortunately, this did not garner the funding that would have been necessarily for me to have extended beyond the OBWC. A comparative case study of BCAs at the OBWC and the TBC may have generated important learning opportunities for the two centres and may have improved and aligned the BCA role across Ontario rather than in just Ottawa, which would have addressed a different, albeit valuable research question. It will be interesting to continue to document how the BCA role develops in Ottawa and Toronto and perhaps highlight opportunities for comparative research and collaboration in the future.

Future Research

My research journey has taken me down many unexpected paths and lines of inquiry. I initially hoped that my findings would at the very least contribute to understanding the development and operationalization of BCAs at the OBWC (see chapter two). I truly did not anticipate that I would contribute to building scholarship on feminist healthcare leadership (see chapter three) or reproductive justice activism (see chapter four). As new birth workers in a relatively new healthcare facility, there is still much to be known about BCAs and Ontario FSBCs. Future research should continue to focus on BCAs' experiences and work in FSBCs

because this is an area of inquiry that has received little attention. In particular, I think researchers should continue to map BCA work and after these birth workers leave the centres to understand the impact past BCAs may have on the broader healthcare system as quiet activists.

In the field of feminist and gender studies, there is ample opportunity for future researchers to build upon the foundational work I have presented here—both theoretically and practically in the context of the COVID-19 pandemic. From a theoretical perspective, future researchers should endeavour to extend a feminist sociology of professions lens to the development of birth work support roles (e.g., BCAs) that exist at the periphery of the mainstream maternity care system. Within the sociology of professions literature, it would be important to consider how/if changes to the BCA role will influence the way in which the role is perceived (e.g., job, occupation, or profession) and the implications this perception can have on the future development of the role (and how it is used for career development of BCAs individually). Future feminist sociology of professions researchers could examine the role of privilege in birth work, particularly for the BCA role. In my research, I did not meaningfully engage with an analysis of BCA privilege because I was primarily focused on how gender-based systems of oppression influenced the development of the BCA role. As a result, I did not shed adequate light on the various privileges experienced by BCAs. For example, the vast majority of BCAs had access to a vehicle, were able bodied, and had or were attending a secondary educational institution. In the future researchers could focus on how privilege is also part of the development of birth worker roles like BCAs. It is particularly important to conduct an ongoing analysis of gendered professional projects in the context of changing and emerging professions, like midwifery and BCAs.

Moreover, future researchers should make a concerted effort to bridge the feminist leadership and healthcare leadership theoretical divide. In my second paper, I provided the theoretical underpinning for a feminist healthcare leadership model, while in my third paper I highlighted the role of BCAs as leaders themselves in reproductive justice activism and system transformation. Future researchers should build upon the foundational approach I have provided here by continuing to examine and identify feminist practices in healthcare leadership.

In the context of the COVID-19, we know from emerging scholarship that the pandemic is exacerbating systemic inequalities and inequities (e.g., racism, sexism, ableism, etc.). The extent to which the pandemic has/will influence experiences of birth work, gender, and healthcare remains to be seen. My data collection concluded before the onset of the pandemic, which provides an ample “before” from which we can begin to understand an “after.” Unfortunately, when the after will actually begin seems fleeting; at the time of writing (i.e., April 2021), Ontario had just declared a third wave of the COVID-19 pandemic and ushered in yet another stay-at-home and lockdown order.

Final Thoughts

I consider myself among an extremely fortunate generation when it comes to Ontario maternity care. It is only by pure chance and privilege that I have lived the majority of my adult life in Ottawa and the surrounding areas. I have never known unregulated or unfunded midwifery because it was integrated into provincial healthcare system in 1994, which was more than 17 years before I would seek out midwifery care for myself. I have never experienced barriers to accessing a broad range of reproductive choices, including abortion services, in my city. I have witnessed the successful introduction of a birth centre and now have the OBWC as an additional birthplace option that I could have personally accessed for the birth of my daughter, Hazel, just

weeks before the defense of this thesis. It would appear that, if anything, I have impeccable timing when it comes to having a full range of maternity care options available and accessible.

These monumental successes in maternity care and reproductive justice that have come as a result countless peoples' tireless effort, of which I have benefited. Activists and the academic community must never fall into a state of complacency when it comes to past successes. For example, in the final month of my thesis preparations, the midwifery education program (MEP) at Laurentian University, which is one of three in the province and the only program to offer a French stream, was abolished by the University's administration. The loss of the Laurentian University MEP came as a complete surprise to the community. Indeed, these swift administrative changes remind us that our non-mainstream maternity care system, which underpins women's right to choose, is under constant threat in Ontario. As discussions continue to unfold in the coming months and years, it will be interesting to see if the Laurentian MEP will transfer to the University of Ottawa and consider what this may mean for the OBWC. Currently, the University of Ottawa does not host a MEP but as an officially bilingual university located in a city that is home to several midwifery groups, an established nursing program, and a birth centre, it would certainly offer a robust backdrop from which to re-invigorate and possibly grow the midwifery program. With this in mind, I want to contribute to our continued and collective push forward towards realizing a truly feminist maternity care system. I believe that BCAs' roles and experiences of birth work, feminist healthcare leadership, and reproductive justice activism in the OBWC is part of a new and exciting frontier in maternity care, one which is not immune to a host of challenges and, as such, deserves the ongoing support of future feminist inquiries.

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Appendices

- A. University of Ottawa Ethics Certificate
- B. Participant Recruitment E-Mail Text
- C. Letter of Information and Consent for Birth Centre Aide Interviews
- D. Letter of Information and Consent for Administrator Interviews
- E. Letter of Information and Consent for Midwife interviews
- F. Interview Guide for Birth Centre Aide Interviews
- G. Interview Guide for Administrator Interviews
- H. Interview Guide for Midwife Interviews
- I. Memorandum of Understanding between Yvonne James and the Ottawa Birth and
Wellness Centre
- J. Statement of Contributions

Appendix A: University of Ottawa Ethics Certificate

09/01/2019

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-09-18-854
Titre du projet / Project Title	The Emergence of Birth Centre Aides as a Novel Maternity Support Role in Freestanding Birth Centres: An Institutional Ethnography of Gendered Professions
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	09/01/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	08/01/2020

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Yvonne JAMES	Institut d'études des femmes / Institute of Women's Studies	Chercheur Principal / Principal Investigator
Audrey GILES	École des sciences de l'activité physique / School of Human Kinetics	Superviseur / Supervisor
Ivy BOURGÉAULT	École de gestion Telfer / Telfer School of Management	Co-superviseur / Co-supervisor

Conditions spéciales ou commentaires / Special conditions or comments

Appendix B: Participant Recruitment Email Text**The Emergence of Birth Centre Aides as a Novel Maternity Support Role in Ontario Freestanding Birth Centres: A Feminist Intersectional Analysis of Gendered Professions**

Dear _____,

We are contacting you to invite you to participate in an important doctoral project research study conducted by Yvonne James and her supervisors at University of Ottawa on the development and operationalization of the birth centre aide role (BCA) in Ontario freestanding birth centres (FSBCs).

We are specifically examining the role of social categories like gender, race, and class on experiences and perceptions of BCA work in the Ottawa Birth and Wellness Centre (OBWC). We are interested in what the development of the BCA role in Ontario can teach us about maternity support workers in the province. We would like to interview people who know about BCAs , including OBWC clients, administrators, midwives, and BCAs themselves (both past and present). If you are interested in getting more information about taking part in this study, please read the letter of information attached below or contact the lead investigator YVONNE JAMES directly by using her email.

Please note that you are not required to participate in this study. The research team member who contacts you will not inform anyone at Ottawa Birth and Wellness Centre who participated or did not. If you are currently employed at the OBWC, taking part or not taking part in this study will not affect your status at the OBWC. If you start participating in the study, you can withdraw at any time without consequence.

This study has received approval by the University of Ottawa Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-5387

Email: ethics@uottawa.ca

Sincerely,

[NAME] [TITLE]

Appendix C: Letter of Information and Consent for Birth Centre Aide Interviews



uOttawa

Faculté des sciences sociales
Faculty of Social Sciences

Institut d'études féministes
et de genre / Institute of
Feminist and Gender Studies

Yvonne James
University of Ottawa
Institute of Feminist and Gender Studies
Faculty of Social Sciences
120 University, Social Sciences Building
Room 11002 Ottawa, Ontario, Canada K1N 6N5

Letter of Information and Consent form for Birth Centre Aide Interviews

- Title of Study:** **The Emergence of Birth Centre Aides as a Novel Maternity Support Role in Ontario Freestanding Birth Centres: A Feminist Intersectional Analysis of Gendered Professions**
- Investigator and Supervisors:** Yvonne James, Ph.D (c)
Institute of Feminist and Gender Studies
University of Ottawa
Lead Investigator
- Dr. Ivy Bourgeault
Telfer School of Management
University of Ottawa
Co-Supervisor
- Dr. Audrey Giles
School of Human Kinetics
University of Ottawa
Co-Supervisor
- Invitation to Participate:** You are invited to participate in the above mentioned doctoral project research study conducted by Yvonne James and her co-supervisors.
- Purpose of Study:** From this research we will learn more about the development and operationalization of the birth centre aide (BCA) role in Ontario freestanding birth centres (FSBC). This research will explore the BCA role from four perspectives: BCAs themselves, midwives, FSBC clients, and FSBC administrators. The purpose of this study is to inform future policy on birth centre support roles, midwifery support roles, and FSBCs more broadly.
- Participation:** As a participant in this study, you have been asked to participate in an interview. The interview explores your experiences as a BCA in the Ottawa Birth and Wellness Centre (OBWC). The interview is anticipated to take 45-60 minutes and will be conducted at time and location convenient to you. If you wish to participate in this interview, please contact Yvonne James, the doctoral candidate lead investigator.

- Benefits:** Taking part in this study will not benefit you directly. However, this research may bring some indirect benefits to you. In particular, in doing this research, we hope to learn more about the development of and operationalization of the BCA role to better inform future iterations of the role as well as policy on birth centre support roles. In particular, this research is interested in how social categories like race, gender, and class may impact BCA work experiences. We hope that what is revealed through this study will help us further develop the BCA role to best meet the needs of the workers, the birth centre, and the healthcare system more broadly.
- Confidentiality:** The interviews will be audio-recorded. The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Yvonne James and her co-supervisors. Your answers to open-ended questions may be used verbatim in presentations and publications but you will not be identified. You will have the opportunity to review your transcripts; the researcher will provide you with two weeks to confirm and/or make revisions to your interview transcripts.
- Anonymity:** Anonymity is not guaranteed. There is no identifying information that will link you to your particular data set and you will in no way be identified in any written publication resulting from the study. However, participant's identities are sometimes revealed by the stories they tell. In an effort to maintain confidentiality, participants will be identified using pseudonyms that will be randomly assigned. If you agree to allow the interview to be audio-recorded, your pseudonym will be used if your data is used in future publications.
- Data Storage:** Physical records will be kept in the locked office of the lead investigator, Yvonne James, and electronic documents and audio recordings will be stored in a password-protected, encrypted folder on the personal computer of the lead investigator and her supervisors.
- Voluntary Participation:** You are under no obligation to participate. If you choose to participate, you may refuse to answer any questions. You indicate your consent to participate in the study by signing and returning this consent form. If you change your mind about participating, you may simply inform one of the investigators of your desire to withdraw. If you withdraw from the study, you will also have the opportunity to withdraw your interview data.
- Information about Results:** The research findings will be made available to participants and other interested parties upon completion of the study via e-mail.

If you have any questions or require more information about the study itself, you may contact the lead researcher, Yvonne James, at the above mentioned e-mail address or phone number.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa ON K1N 6N5, tel.: 613-562-5387 or ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

- 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
- 3. I agree to take part in the above study.
- 4. I agree to the use of anonymised quotes in publications
- 5. I would like to receive a summary of the study's results. Please send them to this email address:

Name of Participant

Signature

Date

Name of Researcher

Signature

Date

Appendix D: Letter of Information and Consent for Administrator Interviews

uOttawa

Faculté des sciences sociales
Faculty of Social Sciences

Institut d'études féministes
et de genre / Institute of
Feminist and Gender Studies

Yvonne James
University of Ottawa
Institute of Feminist and Gender Studies
Faculty of Social Sciences
120 University, Social Sciences Building
Room 11002 Ottawa, Ontario, Canada K1N 6N5

Letter of Information and Consent form for Administrator Interviews

Title of Study: **The Emergence of Birth Centre Aides as a Novel Maternity Support Role in Ontario Freestanding Birth Centres: A Community Based Institutional Ethnography of Gendered Healthcare Work**

Investigator and Supervisors: Yvonne James, Ph.D (c)
Institute of Feminist and Gender Studies
University of Ottawa
Lead Investigator

Dr. Ivy Bourgeault
Telfer School of Management
University of Ottawa
Co-Supervisor

Dr. Audrey Giles
School of Human Kinetics
University of Ottawa
Co-Supervisor

Invitation to Participate: You are invited to participate in the above mentioned doctoral project research study conducted by Yvonne James and her co-supervisors.

Purpose of Study: From this research we will learn more about the development and operationalization of the birth centre aide (BCA) role in Ontario freestanding birth centres (FSBC). This research will explore the BCA role from four perspectives: BCAs themselves, midwives, FSBC clients, and FSBC administrators. The purpose of this study is to inform future policy on birth centre support roles, midwifery support roles, and FSBCs more broadly.

Participation: As a participant in this study, you have been asked to participate in an interview. The interview explores your experiences as an administrator at the Ottawa Birth and Wellness Centre (OBWC) in relation to the work performed by BCAs. The interview is anticipated to take 45-60 minutes and will be conducted at time and location convenient to you. If you wish

to participate in this interview, please contact Yvonne James, the doctoral candidate lead investigator.

- Benefits:** Taking part in this study will not benefit you directly. However, this research may bring some indirect benefits to you. In particular, in doing this research, we hope to learn more about the development of and operationalization of the BCA role to better inform future iterations of the role as well as policy on birth centre support roles. In particular, this research is interested in how social categories like race, gender, and class may impact BCA work experiences.
- Confidentiality:** The interviews will be audio-recorded. The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Yvonne James and her co-supervisors. Your answers to open-ended questions may be used verbatim in presentations and publications but you will not be identified. You will have the opportunity to review your transcripts; the researcher will provide you with two weeks to confirm and/or make revisions to your interview transcripts.
- Anonymity:** Anonymity is not guaranteed. There is no identifying information that will link you to your particular data set and you will in no way be identified in any written publication resulting from the study. However, participant's identities are sometimes revealed by the stories they tell. In an effort to maintain confidentiality, participants will be identified using pseudonyms that will be randomly assigned. If you agree to allow the interview to be audio-recorded, your pseudonym will be used if your data is used in future publications.
- Data Storage:** Physical records will be kept in the locked office of the lead investigator, Yvonne James, and electronic documents and audio recordings will be stored in a password-protected, encrypted folder on the personal computer of the lead investigator and supervisors.
- Voluntary Participation:** You are under no obligation to participate. If you choose to participate, you may refuse to answer any questions. You indicate your consent to participate in the study by signing and returning this consent form. If you change your mind about participating, you may simply inform the investigator of your desire to withdraw. Upon withdrawal from the study, you will also have the option to withdraw your interview data.
- Information about Results:** The research findings will be made available to participants and other interested parties upon completion of the study via e-mail.

If you have any questions or require more information about the study itself, you may contact the lead researcher, Yvonne James, at the above-mentioned e-mail address or phone number.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa ON K1N 6N5, tel.: 613-562-5387 or ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

- 2. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- 3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
- 3. I agree to take part in the above study.
- 6. I agree to the use of anonymised quotes in publications
- 7. I would like to receive a summary of the study's results. Please send them to this email address:

Appendix E: Letter of Information and Consent for Midwife Interviews

uOttawa

Faculté des sciences sociales
Faculty of Social SciencesInstitut d'études féministes
et de genre / Institute of
Feminist and Gender Studies

Yvonne James
University of Ottawa
Institute of Feminist and Gender Studies
Faculty of Social Sciences
120 University, Social Sciences Building
Room 11002 Ottawa, Ontario, Canada K1N 6N5

Letter of Information and Consent form for Midwife Interviews

Title of Study: **The Emergence of Birth Centre Aides as a Novel Maternity Support Role in Ontario Freestanding Birth Centres: A Community-Based Institutional Ethnography of Gendered Healthcare Work**

Investigator and Supervisors: Yvonne James, Ph.D (c)
Institute of Feminist and Gender Studies
University of Ottawa
Lead Investigator

Dr. Ivy Bourgeault
Telfer School of Management
University of Ottawa
Co-Supervisor

Dr. Audrey Giles
School of Human Kinetics
University of Ottawa
Co-Supervisor

Invitation to Participate: You are invited to participate in the above mentioned doctoral project research study conducted by Yvonne James and her co-supervisors.

Purpose of Study: From this research we will learn more about the development and operationalization of the birth centre aide (BCA) role in Ontario freestanding birth centres (FSBC). This research will explore the BCA role from four perspectives: BCAs themselves, midwives, FSBC clients, and FSBC administrators. The purpose of this study is to inform future policy on birth centre support roles, midwifery support roles, and FSBCs more broadly.

Participation: As a midwife, you have been asked to participate in an interview. The interview explores your experiences as a midwife in relation to BCAs at the Ottawa Birth and Wellness Centre (OBWC). The interview is anticipated to take 30-40 minutes and will be conducted at time and location convenient to you. If you wish to participate in this interview, please contact Yvonne James, the doctoral candidate lead investigator.

- Benefits:** Taking part in this study will not benefit you directly. However, this research may bring some indirect benefits to you. In particular, in doing this research, we hope to learn more about the development of and operationalization of the BCA role to better inform future iterations of the role as well as policy on birth centre support roles. In particular, this research is interested in how social categories such as race, gender, and class may impact BCA work experiences.
- Confidentiality:** The interviews will be audio-recorded. The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Yvonne James and her co-supervisors. Your answers to open-ended questions may be used verbatim in presentations and publications but you will not be identified. You will have the opportunity to review your transcripts; the researcher will provide you with two weeks to confirm and/or make revisions to your interview transcripts.
- Anonymity:** Anonymity is not guaranteed. There is no identifying information that will link you to your particular data set and you will in no way be identified in any written publication resulting from the study. However, participant's identities are sometimes revealed by the stories they tell. In an effort to maintain confidentiality, participants will be identified using pseudonyms that will be randomly assigned. If you agree to allow the interview to be audio-recorded, your pseudonym will be used if your data is used in future publications.
- Data Storage:** Physical records will be kept in the locked office of the lead investigator, Yvonne James, and electronic documents and audio recordings will be stored in a password-protected, encrypted folder on the personal computer of the lead investigator and her supervisors.
- Voluntary Participation:** You are under no obligation to participate. If you choose to participate, you may refuse to answer any questions. You indicate your consent to participate in the study by signing and returning this consent form. If you change your mind about participating, you may simply inform one of the investigators of your desire to withdraw. Upon withdrawal from the study you will also have the option to withdraw your interview data.
- Information about Results:** The research findings will be made available to participants and other interested parties upon completion of the study via e-mail.

If you have any questions or require more information about the study itself, you may contact the lead researcher, Yvonne James, at the above-mentioned e-mail address or phone number.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa ON K1N 6N5, tel.: 613-562-5387 or ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

3. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

- 4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
- 3. I agree to take part in the above study.
- 8. I agree to the use of anonymised quotes in publications
- 9. I would like to receive a summary of the study's results. Please send them to this email address:

Name of Participant

Signature

Date

Name of Researcher

Signature

Date

Appendix F: Interview Guide for Birth Centre Aide Interviews

Introduction

The purpose of this study is to examine the emergence of the birth centre aide role in freestanding birth centres in Ontario. The primary objective of this research is to gain a full understanding of how the BCA role has developed and operationalized in relation to midwives and, as well, in relation to clients. The results from the study will be used as part of my doctoral research project at the Institute of Feminist and Gender Studies at the University of Ottawa.

Demographics

Name	
Age	
Gender	
Location of work	
Marital status	
Number of dependents	
Ethnicity/race/background	
Languages spoken	
Net household income	

Work History

1. How long have you worked at the birth centre?
2. What was your motivation for pursuing the BCA position?
 - a. Financial, political, social motivations?
3. What are your professional aspirations in this position?
 - a. How long do you plan on working as a BCA?
 - b. Is this a short-term or long-term position?
 - c. Is your role as a BCA a stepping stone towards a different role in the field?
4. What kind of training or education did you complete prior to working at the birth centre?
 - a. Do you feel you were well prepared for your duties as a BCA?
5. Has the birth centre provided you with additional education or training?
 - a. If yes, did you find this training useful and relevant?

Nature of Work

6. How would you describe the nature of your work (full-time, part-time, contract)?
7. How many hours per week do you typically work?
8. Do you work shift work (12 hours) or overnight?
 - a. What are the shift rotations?
 - b. What are the benefits/disadvantages of the BCA work schedule?
 - c. How does the on-call schedule work?
9. Is the birth centre permanently staffed by a BCA even if there is not an active birth?
10. How/who makes the monthly work schedule?
 - d. Is this an iterative process?
 - e. Can you amend the schedule relatively easily?
11. Do you have any paid vacation or sick days?
12. Do you have any form of job security in this position?
13. Have you witnessed any kind of significant BCA turnover?
 - f. If yes, why do you think BCAs leave the position?
14. How are you remunerated (hourly rate or salaried)?
 - g. What is the hourly rate/average salary?
 - h. Do you think the BCA compensation is fair?
15. Do you have any kind of health benefits in this role?
 - i. Do you have access to maternity leave?

Work Context: A Day in the Life

16. What does your typical day look like as a BCA?
17. How much time during a typical shift do you spend on administrative tasks?
 - a. What activities do these include?
18. How much time during a typical shift do you spend on educational tasks?
 - b. What activities do these include?
19. How much time during a typical shift do you spend working with midwives?
 - c. In what capacity are you assisting midwives?
 - d. Are the midwives aware of your role's parameters?
 - e. Do the midwives utilize your role equally?
 - f. How would you describe your relationship with the birth centre midwives?
 - g. Have you ever felt that your race/ethnic background has been a factor in your interactions with midwives; *this does not necessarily mean negatively, for example, you may have rapport with a midwife from a similar ethnic background.*
20. How much time during a typical shift do you spend with clients?
 - h. In what capacity are you working with clients?
 - i. How do you introduce yourself/role to clients?
 - j. How would you describe your relationship with clients?
 - k. Have you ever felt that your race/ethnic background has influenced your interactions with clients? *For example, shared language or religious custom, or negatively in relation to racism (implicit/explicit)*
21. How often or in what capacity do you interact with birth centre administrators?
 - l. Are you involved in any governance activities?

22. Do you feel you are a valued and respected member of the birth centre?
23. To what degree are you included/consulted in birth centre activities?
24. Do you find your work challenging?
25. Do you find your work stressful?
26. Do you find your work rewarding (other than financially)?
 - m. In what way do you feel 'rewarded'?
27. In what ways do you think that socioeconomic status or access to resources shapes or influences your work as a BCA?
 - n. Access to a vehicle? Access to childcare? Access to personally financed continuing education?
28. What do you think makes a 'good' BCA?
 - o. Of all your duties and tasks, what do you feel are the most important to your role?
29. Do you think BCA work is conducive to a healthy work-life balance?
 - p. If yes, why?
 - q. If no, why and how could it be improved?

Conclusions

1. Is there anything else that I should know or that you would like to add to our conversation about BCAs?

Appendix G: Interview Guide for Administrator Interviews

Introduction

The purpose of this study is to examine the emergence of the birth centre aide role in freestanding birth centres in Ontario. The primary objective of this research is to gain a full understanding of how the BCA role has developed and operationalized in relation to midwives and, as well, in relation to clients. The results from the study will be used as part of my doctoral research project at the Institute of Feminist and Gender Studies at the University of Ottawa.

Demographics

Name	
Age	
Gender	
Location of work	
Marital status	
Number of dependents	
Ethnicity/race/background	
Languages spoken	
Net household income	

Work History

1. What is your position title(s) within the birth centre?
2. Do you hold concurrent or multiple positions? *For example, as a midwife and Board member*
3. How would you describe the nature of your work (related to administration)?
 - Full time/part time or contract?
4. How long have you worked with the birth centre in this role?
5. What kind of training, qualifications, or education did you undertake in order to be suitable for this position?
6. Did the birth centre offer you any additional training or education for your position?

Working with BCAs

1. How many hours per week do you typically spend in the birth centre?
2. Do you interact on a daily or weekly basis with midwives?
3. Do you interact on a daily or weekly basis with BCAs?

4. How does your position/responsibility affect the BCAs?
 - a. Scheduling? Remuneration? Vacation? Job posting? Recruitment?
5. How are the BCA wages funded? From the MOHLTC?
 - a. Is funding received for the BCA specifically, or is there general funding which must be shared between 'other' staff?
6. How do you decide the valuation of this role? Is there a standard between the two birth centres?
7. Who drafted the BCA duties and responsibilities?
 - a. Were several groups involved in determining the extent of this role?
8. Since you hired the first BCA, have the roles and responsibilities associated with this role changed at all?
9. Is there any formal training around the introduction of BCAs with midwives or clients?

Conclusions

10. How do BCAs contribute to the birth centre? Why do you think this role was introduced?
11. Are there challenges associated with employing BCAs?
12. Do you think the BCA role has opportunity to offer more to the birth centre if their qualifications expanded? *For example, if they were able to perform standard medical checks for midwives.*
13. How do you think birth centre can maximize or improve the BCA role?
14. Is there anything else that I should know or that you would like to add to our conversation about BCAs?

Appendix H: Interview Guide for Midwife Interviews

Introduction

The purpose of this study is to examine the emergence of the birth centre aide role in freestanding birth centres in Ontario. The primary objective of this research is to gain a full understanding of how the BCA role has developed and operationalized in relation to midwives and, as well, in relation to clients. The results from the study will be used as part of my doctoral research project at the Institute of Feminist and Gender Studies at the University of Ottawa.

Demographics

Name	
Age	
Gender	
Location of work	
Marital status	
Number of dependents	
Ethnicity/race/background	
Languages spoken	
Net household income	

Work History

1. How long have you work as a midwife?
2. Which midwifery group/collective do you work with?
 - a. How large is your group?
3. How would you describe the nature of your work? (full-time/part-time)
4. How long have you attended to clients at the birth centre?
5. How often do you attend a client's birth at the birth centre?
 - a. How many clients per month or week?
6. Is this your first time attending clients in a birth centre? (*If from different jurisdiction she may have previously worked in a FSBC*)
7. Did you receive any additional training or education to work at the birth centre?

Work Context

8. How does working in a birth centre differ from a hospital or home?
9. Birth centres are uniquely gendered, when compared to hospital birth in particular; in what ways do you think gender influences your work in the birth centre?
 - a. How do you experience gender in the birth centre?
10. Which environment—home, hospital, or birth centre—do you think is most conducive to midwifery work? Why?
11. Are you involved in any of the governance or planning activities for the birth centre?
 - a. If yes, in what capacity?
12. Are you aware of the additional services offered by the birth centre?
 - a. To what extent do you communicate the availability of services to your clients?
13. Are you familiar with all of the birth centre employees (i.e., BCAs)?
 - a. Have you been formally introduced to the BCAs and any other administrative staff?
14. Did you receive any training or education on how to work with a BCA?
 - a. Are you aware of the BCA's role, responsibilities, and duties?
15. During a typical birth how much time do you spend interacting with the BCA?
16. In what ways does a BCA support the midwife?
17. How would you describe the nature of your relationship with the BCA during a birth?
18. Have you ever felt that your race/ethnicity/background has influenced your interactions with a BCA?
19. What level of interaction does a BCA have with your client?
 - a. Does the level of interaction depend on the midwife or BCA?
 - b. Does the level of interaction depend on the client?
20. How do your interactions with the BCA affect/impact your time with the client?
21. In what ways do you think a BCA can facilitate your work?
 - a. What opportunities, if any, do you see for BCAs in midwifery?
 - b. What challenges, if any, do BCAs pose to midwifery?
22. How do you think BCAs differ from doulas?
23. In what ways do you think socioeconomic status or access to resources shapes or influences BCA work?
 - a. Do you think BCAs share a similar socioeconomic status?
24. Do you think there is opportunity for an expanded BCA role?
25. What do you think makes a 'good' BCA?
26. Do you think this is a valuable role within the birth centre?
27. Do you think there is anything that is important for this research that has yet to be explored in this interview?

Conclusions

2. Is there anything else that I should know or that you would like to add to our conversation about BCAs?

**Appendix I: Memorandum of Understanding between Yvonne James and the
Ottawa Birth and Wellness Centre**

MEMORANDUM OF UNDERSTANDING ON

Doctoral Research Activities Related to Examination of Birth Centre Aides in Freestanding Birth
Centres in Ontario

BETWEEN THE

OTTAWA BIRTH AND WELLNESS CENTRE
2260 Walkley Road
Ottawa, Ontario
K1G 6A8

AND

YVONNE JAMES
Lead Investigator, Doctoral Candidate
University of Ottawa
Institute of Feminist and Gender Studies
Ottawa, Ontario

1. PURPOSE/OBJECTIVE/GOALS

The purpose of this MOU is to establish a framework for collaboration between the Ottawa Birth and Wellness Centre (OBWC) and Yvonne James (the researcher) in pursuing research activities related to the completion of her doctoral project at the University of Ottawa in the Institute of Feminist and Gender Studies. In general, the researcher intends to focus on the emergence of birth centre aides (BCAs) in the context of Ontario freestanding birth centres (FSBCs).

2. BACKGROUND

In 2014, a new type of regulated independent healthcare facility formed in Ontario, free-standing birth centres (FSBCs). The centres were opened as publically funded pilot projects and included the Ottawa Birth and Wellness Centre (OBWC) and the Toronto Birth Centre (TBC). FSBCs include a novel health worker support role—birth centre aides (BCAs). BCAs work alongside midwives in providing non-clinical care to birthing people and their families in the birth centres. While midwifery support roles are common internationally, for instance, there are maternity support workers (MSWs) in the United Kingdom (UK) and maternity care assistants (MCAs) in the Netherlands, the groundbreaking introduction of BCAs in Ontario represents the first instance of an institutionalized midwifery support role in a Canadian provincial context.

As a relatively recent introduction to the maternity care landscape in Ontario, FSBCs and BCAs have yet to be examined from a feminist perspective, which is important, in part, because

they constitute uniquely gendered professional environments. From a feminist perspective, FSBCs provide an analytically exceptional opportunity for examination because people identifying as women constitute the majority of professionals and paraprofessionals (i.e., midwives and BCAs), governors (i.e., board of directors and administrative support), and clients (i.e., birthing and laboring people) (Ottawa Birth and Wellness Centre, 2017; The Toronto Birth Centre, 2017). It is critical to conduct ongoing analyses of what has been sociologically gendered as women's work; in particular, people identifying as women in the healthcare workforce deserve significant attention because of their overwhelming presence and unequal distribution in positions of power in this sector. Finally, understanding the emergence of the BCA role in FSBCs is critically important for future iterations of maternity care, and the maternity care workforce in Ontario.

I have identified four research questions that centre on the above-mentioned transformations in Ontario maternity care. My primary research question guides three sub-questions: (1) how did the BCA role emerge, develop, and operationalize in the context of FSBCs?; (2) how do BCAs interact with professional workers (i.e., midwives)?; (3) how do BCAs interact with clients?; and (4) what are the implications of the BCA role on midwifery work and the maternity care workforce, more broadly? My research has the overarching objective of making visible the sociological processes (i.e., gender and race) involved in the recent inclusion and development of BCAs in the Ontario healthcare system. More specifically, the objectives of my proposed research are four-fold: (1) to study how the introduction of FSBCs and the inclusion of BCAs in Ontario can illuminate individuals' experiences of the sociological processes that construct professional and paraprofessional work; (ii) to explore the gender and race dynamics, professional trajectory, and history of BCAs in Ontario; (iii) to examine the relationship between BCAs and midwives; (iv) and to investigate how BCAs impact client experiences of midwifery care and birth in FSBCs.

3. ROLES AND RESPONSIBILITIES

Each party intends to implement the following provisions of this MOU, under the responsibility of the Executive Director, the Ottawa Birth and Wellness Centre and the researcher, the University of Ottawa.

Yvonne James, the researcher, and the OBWC agree to confer and consult prior to any release or publication of data generated through jointly conducted research. The researcher and the OBWC agree to strive toward co-authorship for publications with the exemption of the doctoral thesis component result from this research. Prior to submitting any manuscript or document co-authored by the OBWC and the researcher for outside review or journal submission, each party shall be offered 30 days to review such proposed publication.

The researcher intends, according to the knowledge translation and mobilization objectives of this research, to:

- Allow the OBWC access to certain non-confidential data generated by the researcher;
- Provide the OBWC with analyses of the data in plain language;
- Provide access to all data and models resulting from the research efforts under this MOU;
- Make data and publications available for use at public OBWC events, sessions, or professional activities

The OBWC intends to:

- Allow access to institutional data, namely, historical data resulting from the proposal process, human resources data, job postings, task grids for BCAs;
- Provide access to the OBWC for research activities pertaining to the project, in particular, to interact with BCAs during working hours, subject to workload constraints and availability.

4. GENERAL TERMS AND CONDITIONS

The Researcher shall:

- Ensure that the Research Project shall not in any way infringe on the provision of OBWC services to clients.
- Conduct the Research Project in such a way that does not impact or interfere with the OBWC's compliance with the College of Midwives of Ontario Clinical Practice Parameters and Facility Standards.
- Ensure the Research Project aligns with the OBWC's values and is compliant with OBWC's Policies and Operating Procedures.
- Use the appropriate safeguards to prevent the inappropriate use or disclosure of Personal Health Information (PHI), other than as specifically provided by this MOU.
- Protect any Confidential Information obtained during the course of this Research Project.

5. INDEMNIFICATION AND INSURANCE

The Researcher agrees to indemnify and save the OBWC harmless from all loss, liability, judgments, claims, costs, demands, damages or expenses, in any way caused by the Researcher, its partners, agents, employees and/or clients related to or arising out of this Research Project or other matters to which this MOU pertains, including all legal expenses and costs incurred by the OBWC in defending any legal action pertaining to the above.

Each party shall, at its own expense maintain sufficient liability and policies of insurance in all respects.

6. INTELLECTUAL PROPERTY

The parties agree that any copyrightable subject matter, including but not limited to training, or educational and informational material, or journal articles, except for the thesis component of this research, will be placed in the public domain.

The parties agree that for the purposes of academic merit, the researcher may be placed as the first author on academic journal submissions.

The parties agree that any intellectual analyses resulting from the research activities may be claimed as the intellectual property of the researcher for the purposes of her doctoral dissertation.

7. POINTS OF CONTACT

The following individuals are designated points of contact for the MOU:

The Ottawa Birth and Wellness Centre:
Executive Director

The Researcher:
Yvonne James, Lead Investigator

8. MODIFICATION/DURATION/TERMINATION

This MOU will be effective when signed by all parties. This MOU may be amended at any time by the mutual written consent of the parties. The parties will review this MOU every 12 months to determine whether it should be revised, renewed, or cancelled. This MOU may be terminated by either party at any time by one party notifying the other party in writing 90 days in advance of the termination date.

9. JURISDICTION

Any disputes arising out of this agreement will be governed by Ontario law.

Appendix J: Statement of Contributions

Chapters 2,3, and 4 were written as stand-alone publishable papers. Each paper is multi-authored with Yvonne James as the primary author for all papers and Dr. Audrey Giles and Dr. Ivy Bourgeault as co-authors upon submission to a peer-reviewed journal. Yvonne James developed the original topic for the doctoral dissertation, completed the ethics preparations, developed and conducted the semi-structured interviews, and wrote each of the publishable papers. Dr. Giles and Dr. Bourgeault aided in the conceptualization and writing of the papers. Co-authorship recognizes their contributions.

ⁱ I use the term “women” in this paper not as a binary but in reference to those people who identify as women.