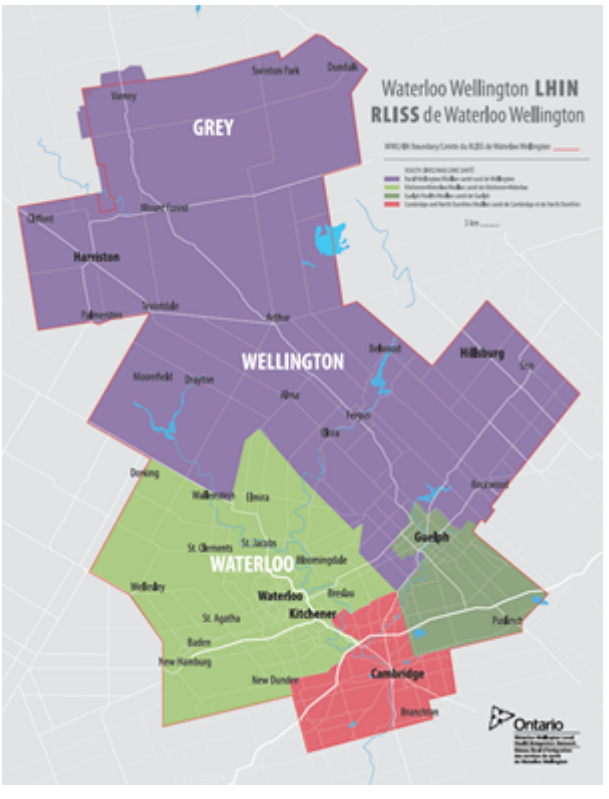
# VACCINATING PREGNANT WOMEN: EXPLORING MIDWIVE'S PERSPECTIVES REGARDNG VACCINATION IN PREGNANCY IN THE WATERLOO-WELLINGTON REGION

APPENDIX

by

Michelle Simeoni

## APPENDIX A: Waterloo-Wellington LHIN




As of Q3 2013, the WWLHIN's 775,000 residents included the following population demographics:

- 9,000 residents who self-identify as Aboriginal
- 15,500 residents who are Francophone
- 93,000 residents who are visible minorities
- 103,000 residents who are over the age of 65

The WWLHIN includes all of the following communities:

- Aberfoyle
- Alma
- Ariss
- Arkell
- Arthur
- Ayr
- Baden
- Ballinafad
- Bamberg
- Belwood
- Blair
- Bloomingdale
- Branchton
- Heidelberg
- Hespeler
- Hillsburgh
- Holstein
- Keldon
- Kenilworth
- Kitchener
- Linwood
- Little Lake
- Macton
- Mannheim
- Marden
- Maryhill

- Breslau
- Brisbane
- Brucedale
- Cambridge
- Clifford
- Clyde
- Conestoga
- Conn
- Crieff
- Crosshill
- Damascus
- Dorking
- Drayton
- Dundalk
- Eden Mills
- Elmira
- Elora
- Eramosa
- Erin
- Fergus
- Floradale
- Galt
- Glen Allan
- Guelph
- Harriston
- Hawkesville
- Haysville
- Moorefield
- Morriston
- Mount Forest
- New Dundee
- New Hamburg
- Ospringe
- Palmerston
- Petersburg
- Phillipsburg
- Preston
- Puslinch
- Rockwood
- Roseville
- Rothsay
- Salem
- St. Agatha
- St. Clements
- St. Jacobs
- Swinton Park
- Teviotdate
- Varney
- Wallenstein
- Waterloo
- Wellesley
- West Montrose
- Winterbourne

**(20)**

## Appendix B

| | |
|---|---|
| Standard: | The Ontario Midwifery Model of Care |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

# THE ONTARIO MIDWIFERY MODEL OF CARE

## Purpose

The key purpose of this document is to define the Ontario midwifery model of care.

## Definition

The College of Midwives of Ontario cites with agreement the International Confederation of Midwives' definition of a midwife, in keeping with Canadian Association of Midwives and Canadian Midwifery Regulators' Consortium, as follows:

"A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units."[1]

[1] Revised and adopted by ICM Council June 15, 2011

| | |
|---|---|
| Standard: | The Ontario Midwifery Model of Care |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

## Midwifery Scope of Practice

Notwithstanding the above ICM definition, the midwifery scope of practice in Ontario is defined as the:

> "assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries."[2]

## Ontario Midwifery Model of Care

Midwifery care is offered in community settings where midwives act on their own authority to deliver primary care. Midwives provide prenatal care in the community, attend births in the setting chosen by the woman, and provide early postpartum care in the woman's home.

Midwives working together in practices maintain a philosophy of care that is consistent with CMO standards and ensure a coordinated approach to clinical practice, facilitated by regular meetings, regular peer reviews and practice protocols required by the CMO.

## Philosophy of Midwifery Care

Midwives in Ontario promote normal birth and provide client-focused care. The following statements provide a framework to the philosophy of midwifery care practiced in Ontario:

- Midwives view pregnancy and childbirth as a healthy and normal physiologic process and a profound event in a woman's life.
- Midwives respect and support their clients so that they may give birth safely, with power and dignity.
- Midwives respect the diversity of women's needs and the variety of personal and cultural meanings that individuals, families and communities bring to the pregnancy, birth, and early parenting experience.
- Midwives promote optimal health throughout the childbearing cycle and maintain a focus on preventive care.
- Midwives encourage women to actively participate in their care throughout pregnancy, birth and postpartum period and make choices about the manner in which their care is provided.

[2] Midwifery Act 1991, c. 31, s. 3.

| | |
|---|---|
| Standard: | The Ontario Midwifery Model of Care |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

- Midwives provide education and counselling to support women making informed choices.
- Midwives promote decision-making as a shared responsibility, between the client, her family (as defined by the woman) and her caregivers. The client is recognized as the primary decision maker.
- Midwives provide care that is continuous, personalized and non-authoritarian.
- Midwives provide care that is responsive to women's social, emotional, cultural and physical needs.
- Midwives respect women's right to choice of caregiver and place of birth and attend births in a variety of settings, including home, hospital and birth centre.
- Midwives support the appropriate use of technology as required in the provision of midwifery care.
- Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcomes for the woman and her newborn.

## Continuity of Care

Midwives make the time commitment necessary to develop a relationship of trust with the woman during pregnancy to be able to provide safe and individualized care, to fully support the woman during labour and birth, and to provide comprehensive care to mother and newborn throughout the postpartum period.

Continuity of care is achieved when a relationship develops over time between a woman and a small group of no more than four midwives.[3] Midwifery care is provided by the same small group of midwives from the onset of care (ideally, at the onset of pregnancy), during all trimesters, and throughout labour, birth and the first six weeks postpartum. The midwifery practice ensures there is 24-hour on call availability by one of the group of midwives known to the woman.[4] One midwife is identified as the Coordinating Midwife responsible for coordinating care and for identifying who is responsible if she is not available. The midwifery practice must arrange for opportunities for the client to meet her assigned midwives to support the provision of care by known midwives.

3 The standard for continuity of care does not restrict the number of midwives who may work together in a practice.

4 Midwives from different practices may occasionally share the care of a client (to help cover holidays, for example).

| | |
|---|---|
| Standard: | The Ontario Midwifery Model of Care |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

## Two Midwives at a Birth

Two midwives attend each birth regardless of setting except in circumstances permitted by the College of Midwives under approved Alternate Practice Arrangements.

## Choice of Birthplace

As custodians of normal birth, midwives offer out-of-hospital birth, where supported by midwifery standards. It is in the best interests of the public that midwives attend births in both hospital and out-of-hospital settings (which currently includes home, birth centre and clinic). Midwives support the woman's right to choose where she gives birth.

## Informed Choice

Informed choice is a collaborative information exchange between a midwife and her client that supports client decision-making. Informed choice is a fundamental principle of midwifery care in Ontario.

Midwives recognize the client as the primary decision-maker and facilitate the collaborative process of informed decision-making by:

- Fostering a relationship of trust and respect between midwife and client.
- Providing relevant information in a collaborative and non-authoritarian manner.
- Considering the experience, feelings, beliefs, values and preferences of the woman.
- Making a best effort to ensure the client fully understands all relevant information prior to making a decision.
- Allowing adequate time for decision-making by the client.
- Supporting the client's decision.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO

ORDRE DES SAGES-FEMMES DE L'ONTARIO

# PRESCRIBING AND ADMINISTERING DRUGS

## Purpose

The purpose of this standard is to describe CMO expectations regarding the prescribing and administering of drugs.

Midwifery standards of practice refer to the minimum standard of professional behaviour and clinical practice expected of midwives in Ontario.

## Definition

Midwives have the requisite knowledge, skills, and judgment to prescribe drugs from the list of Designated Drugs. Any drug that can be administered by a midwife according to the Ontario Regulation 884/93 Designated Drugs can be prescribed by the midwife.

## Standard

The authority of midwives, according to the Ontario Regulation 884/93 Designated Drugs, to initiate a prescription for a drug, is limited to treating conditions that they can diagnose and for which they can provide the necessary counseling, informed choice decision making and ongoing management of care.

In the course of engaging in the practice of midwifery, midwives may use any drug and may administer any substance by injection or inhalation on the order of a member of the College of Physicians and Surgeons of Ontario. Midwives may also administer, prescribe or order any drug or substance that may lawfully be purchased or acquired without a prescription.

**TO ENSURE SAFETY**

**Midwives must:**

- Assess the client, conducting laboratory and diagnostic investigations as appropriate
- Comply with relevant federal and provincial legislation

- Adhere to all relevant standards, guidelines or policies established by agencies or organizations (e.g., public health unit or blood banks) involved in the provision or control of any of the authorized drugs or substances
- Provide either a written, or when necessary, a telephone prescription or verbal order
- Consider whether the drug is a safe and effective treatment for the specific client circumstances
- Provide the client and/or client representative with the necessary information about the drug prescribed including expected therapeutic effect, potential side effects, contraindications and precautions
- Consider drug resistance, medication errors, infection control and safety, when they prescribe and/or administer any substance from the regulation
- Ensure there are adequate systems in place to prevent prescription fraud
- Ensure proper reporting of drug reactions and medication errors (*Appendix 2, Reporting Adverse Drug Reactions and Medication Errors*)
- Monitor the client's response to the drug therapy after prescribing, and continue, adjust dosage or discontinue the drug therapy as appropriate.

**RECORD KEEPING**

**Midwives must:**

- Conduct a medical history and document the symptoms and/or conditions being treated
- Obtain a full understanding of the drugs the client is taking using the "Best Possible Medication History" (see *Appendix 3* for an example of what can be included)
- Document in the client's record, in a timely manner, all telephone prescriptions or verbal orders
- Provide a follow-up care plan as appropriate and document in the client's record
- Document the client's response to the drug therapy
- Ensure proper recognition and management of medication errors including documentation and reporting as outlined by Association of Ontario Midwives (*Appendix 2*, *Reporting Adverse Drug Reactions and Medication Errors*)
- Ensure proper risk management reporting when drug reactions or medication errors occur in a hospital (*Appendix 2*)

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

**LEGAL PRESCRIPTION:**

- Midwives may only prescribe drugs for the intended purpose as described in the *Guideline to Prescribing and Administering Designated Drugs* (below) and the amended Ontario Regulation 884/93 Designated Drugs.
- Midwives may not self-prescribe a drug, or prescribe a drug for a family member outside the provision of midwifery care, or when there is a conflict of interest. [1]
- Midwives will document the drug prescribed and the prescription number in the client's record.

**A legal prescription prepared by a midwife must include:**

- A prescription number
- Full date (day, month and year)
- Client's name
- Client's address (if available)
- Name of drug, drug strength (where applicable), dose and the quantity of the prescribed drug
- Full instructions/directions for use of the prescribed drug
- Refill instructions, if any
- Printed name of the midwife prescriber with telephone number and address
- College registration number and the professional designation
- Midwife's signature

**MIDWIVES OBTAINING CONSULTS AND PROVIDING INTER-PROFESSIONAL CARE, RELATING TO PRESCRIPTIONS:**

- May not delegate the act of prescribing a drug
- Notify any relevant health care provider involved in the client's care when clinically appropriate and document that this notification has been given
- Consult with appropriate health care professional if the client's response to the drug therapy is other than anticipated

[1] CMO Standard *Caring for Related Persons*

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |


When midwives continue drug therapy initiated by another health care professional they must:

- Provide and document ongoing assessments
- Monitor and document the client's response to the drug therapy
- Communicate the client's response and change to or discontinuation of drug therapy to the initiating health care provider as appropriate
- Consult with appropriate health care professional at any point in the continuing drug therapy as appropriate

**ENSURING APPROPRIATE STORAGE**

**Midwives must:**

- Ensure recommendations for storage and handling issued by the medication/ vaccine's manufacturer are followed
- Dispose unused and expired medications/vaccines/blood products in accordance to the guidelines set forth by public health and blood bank

## Guideline to Prescribing and Administering amended Ontario Regulation 884/93 Designated Drugs

The following guideline applies to the substances that have been added to the Ontario Regulation 884/93 Designated Drugs (as of February 2010), which midwives are able to independently prescribe and administer for their clients in the community, hospital or other sites of midwifery practice.

## ANTIBIOTICS

When prescribing and administering antibiotics midwives are expected to adhere to recommendations to minimize the risk of developing antibiotic resistance. The safest effective available agent should be prescribed or administered.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

**Antibiotics, intravenous**:

**1. Group B Streptococcus**

**Ampicillin, Cefazolin, Clindamycin, Erythromycin, Penicillin G**
Intravenous (IV) antibiotics may only be prescribed and administered on the member's own responsibility to the expectant mother for the prophylaxis of neonatal Group B streptococcus during the intrapartum period.

When a pregnant woman requires treatment for or prophylaxis for Group B streptococcus and she is allergic to penicillin G, laboratory confirmation of drug sensitivities to the culture should be obtained to ensure that the most appropriate antibiotic is selected. Ampicillin is an alternative choice to penicillin, and cefazolin is recommended in penicillin allergic patients. In patients at high risk for anaphylaxis to penicillin, intravenous clindamycin or erythromycin is recommended.[2]

**Intravenous antibiotics cannot be prescribed on the member's own responsibility in any other situation.**

**Antibiotics, oral:**

Oral antibiotics may only be prescribed by the member in the course of routine provision of midwifery care.

This includes treatment for:

**1. Urinary tract infections (UTI)** [3]

**Ciprofloxacin, Sulfamethoxazole-trimethoprim, Nitrofurantoin, Trimethoprim**

---

[2] Centre for Infectious Disease Preventions and Control, Canadian Task Force on Preventive Health Care's *Prevention of Early-onset Group B Streptococcal Infection in the Newborn*) (updated 2002). Available online at http://www.ctfphc.org/
SOGC clinical practice guidelines no. 149, September 2004. "The prevention of early-onset neonatal group B streptococcal disease." JOGC, Sept 2004: 826-32
[3] Urinary tract infections in pregnancy, M Lee RPh, P Bozzo, A Einarson RN, G Koren MD

Oral (PO) antibiotics should be prescribed after culture and sensitivities have been identified. Sulfamethoxazole-trimethoprim and trimethoprim should be avoided in first trimester of pregnancy due to increased risk of neural tube defects (NTDs). If clinically required during first month of pregnancy, a high dose of folic acid (4mg/day) should be given to prevent NTDs. [4]

Sulfamethoxazole-trimethoprim should be avoided in the last 2 to 6 weeks of pregnancy since sulfonamides may displace bilirubin from albumin binding sites and cause kernicterus in infants, especially at preterm.

Fluoroquinolones (e.g., ciprofloxacin) should not be prescribed during pregnancy unless the benefit outweighs the risk and all other antibiotic options have been eliminated.

**If symptoms persist after the prescribed course of treatment, a consultation with a physician is required**

**2. Mastitis**

**Amoxicillin-clavulanic acid, Cephalexin, Ciprofloxacin, Clindamycin, Cloxacillin**

Antibiotics are prescribed only for fever and signs and symptoms of blocked duct that do not resolve within 24 hours or are worsening quickly after non-pharmacological treatment.

**If symptoms persist after the prescribed course of treatment, a consultation with a physician is required.**

**3. Bacterial Vaginosis**

**Clindamycin, Metronidazole**

Women with a past history of premature labour and who have Bacterial Vaginosis (BV), whether or not it is symptomatic, may benefit from treatment with antibiotics. Bacterial vaginosis during pregnancy is associated with premature rupture of the

[4] Medication Safety in Pregnancy and Breastfeeding, by Gideon Koren MD, Motherisk

membranes, chorioamnionitis, preterm labour, preterm birth and post-cesarean delivery endometritis. During pregnancy, treatment is recommended for symptomatic patients and asymptomatic women with BV who have had a previous preterm birth. The goal is to reduce the risk of preterm prelabour rupture of the membranes and low birth weight.

**If symptoms persist after the prescribed course of treatment, a consultation with a physician is required.**

**Antibiotics, topical:**

**1. Breast and Nipple Pain**

**Mupirocin-betamethasone valerate-miconazole (All Purpose Nipple Ointment)**

Topical antibiotics may be used as part of a therapeutic regime for breast and nipple pain. All Purpose Nipple Ointment is a combination antibiotic, antifungal and low dose steroid cream that may be used to treat persistent nipple pain. It is used as a topical treatment for candidiasis of the nipple in the breastfeeding woman, with or without secondary bacterial infection. The cream should be applied sparingly to the nipples after each feeding and not washed or wiped off, even prior to the next feed. All Purpose Nipple Ointment is not recommended for use in pregnancy. While generally well tolerated, All Purpose Nipple Ointment should not be used over large areas of the skin, and is not intended for prolonged use. **If the condition has not improved within a week, a consultation with a physician is required.**

## NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (ORAL)

**1. Postpartum Pain**

**Diclofenac, Naproxen**

Oral non-steroidal anti-inflammatory drugs (NSAIDS) may be used to treat postpartum pain. The general approach to the use of NSAIDs in any population is to use the lowest dose for the shortest period of time to reduce the risk of any adverse events including GI bleeding. NSAIDs should not be given to clients who are asthmatic or allergic to ASA. Ibuprofen is the least potent of the NSAID group and at formulations up to 400

mg is available as an OTC. Naproxen and acetaminophen have been proven to have the same effect on postpartum pain. [5]

## ANTI-HEMORRHAGICS AND OXYTOCICS

### 1. Management of postpartum bleeding

**Carbetocin, Misoprostol**

Oxytocics and anti-hemorrhagics are to be administered for the management of postpartum bleeding on the member's own responsibility. The choice of agent and method of administration will be dependant upon the clinical scenario and availability of these medications.

**Carbetocin - off label**

Carbetocin (e.g., Duratocin®) is approved for use in Canada for the prevention of uterine atony and postpartum hemorrhage following elective cesarean section under epidural or spinal anesthesia. It was shown to be effective for the off-label treatment of postpartum hemorrhage following vaginal birth, and is used as a second-or-third line agent in Ontario hospitals, used only after oxytocin and ergonovine maleate, where available, have been attempted.

**Midwives are not authorized to use Carbetocin to treat anything other than postpartum hemorrhage.**

**Misoprostol – off label**

Misoprostol is a synthetic prostaglandin Eanalog that is approved for use as an antisecretory agent with protective effects on the GI mucosa. It was shown to be effective for the off-label treatment of postpartum uterine atony or postpartum hemorrhage uncontrolled by the use of oxytocin. Misoprostol is a second-or-third line agent, used only after oxytocin and ergonovine maleate, where available, have been attempted. Misoprostol should not be taken by anyone with a history of allergy to

[5] Skovlund et al, European Journal of Clinical Pharmacology, 1991, Volume 40, Number 6, pg. 539-542.

prostaglandins. If misoprostol is administered as a third line agent in response to a postpartum hemorrhage occurring out-of-hospital, transport to hospital and consultation with a physician is indicated. The use of misoprostol for prevention of PPH or for the induction of labour is currently under evaluation. Its use for induction of labour in the presence of a living fetus is restricted to clinical trials. Midwives CANNOT prescribe or order misoprostol for this application. However, where a physician has ordered misoprostol for induction of labour in a non-viable pregnancy, the midwife may continue to be involved in the woman's care.

**Midwives are not authorized to use Misoprostol to treat anything other than postpartum hemorrhage.**

## LOCAL ANESTHETICS

1. **Perineal Repairs in Immediate Postpartum**

**Bupivacaine, Chloroprocaine**

Local anesthetics are to be administered on the member's own responsibility for the management of pain during the repair of the perineum in the immediate postpartum period. The choice of agent and method of administration will be dependent upon the clinical scenario, the local community standard and availability of these medications.

**Bupivacaine (MARCAINE)**

Amide local anesthetic for infiltration block anesthesia for use during perineal repair that is slightly slower acting (5-10 minutes) but has a longer duration of effect (2-4 hours). Lidocaine (Xylocaine) is an amide local anesthetic and remains available to midwives.

**Chloroprocaine (NESACAINE)**

Ester local anesthetic for infiltration block anesthesia for use during perineal repair, that is rapid acting and has a shorter duration of effect (less than 30 minutes). This local anesthetic is more likely to cause hypersensitivity.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

**All local anesthetics are approved for use by midwives only on perineal repairs in the immediate postpartum.**

## OTHER DRUGS

### 1. Domperidone – off label

Domperidone is an antidopaminergic drug approved for the treatment of nausea and vomiting. It has been used off-label to enhance breastmilk production in women where non-pharmacologic methods have proven ineffective and/or in women with a previous history of inadequate milk supply. Domperidone must not be given intravenously. Caution should be used in patients with hepatic disease and with those taking anticholinergics, since they may antagonize the effect of the domperidone in the GI tract. It should not be co-administered with ketoconazole due to the increased risk of QTc prolongation and associated heart arrhythmias.

**Midwives are not approved to use Domperidone to treat anything other than inadequate milk supply.**

### 2. Measles / Mumps / Rubella (MMR) Vaccine

(E.g., M-M-R® II, Priorix®) Women found to be rubella-susceptible during the antenatal period should be offered MMR vaccine in the immediate postpartum period. Women without detectable antibodies or no prior vaccination for rubella should be immunized only if they are not pregnant at vaccination time and if pregnancy is avoided for 1 month following vaccination. MMR vaccine should not be administered to individuals who are pregnant (the possible effect on the fetus is not known), have acute febrile respiratory or other infections, or any acute illness, have a history of sensitivity to neomycin or gelatin; have blood dyscrasias, lymphomas or other generalized malignancies; have untreated active tuberculosis; or are undergoing treatment with immunosuppressive agents of any kind. Breastfeeding is not a contraindication to receiving this vaccination. Whenever vaccines are administered the midwife must send a record of immunization to the physician to whom care is transferred at 6 weeks postpartum. A record of immunization should also be sent to the local public health unit in communities where this is required.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

**3. Varicella Zoster immune globulin**

(E.g., VariZIG™) Varicella zoster immune globulin is recommended for susceptible people, including pregnant women, provided that significant exposure has occurred. Administration of varicella zoster immune globulin is recommended for prevention or reduction of severity of maternal infections within 4 days of exposure to the varicella zoster virus. Greatest effectiveness of treatment is expected when it is begun within 4 days of exposure; treatment after 4 days is of uncertain value. Pregnant women may be at a higher risk of complications from chickenpox than healthy adults. The decision to administer varicella zoster immune globulin to a pregnant woman should be evaluated on an individual basis. The clinician should consider the patient's health status, type of exposure, and likelihood of previous unrecognized varicella infections before deciding whether to administer varicella zoster immune globulin. If after careful evaluation of all available information, which may include the use of reliable and sensitivity tests for varicella antibody, a normal pregnant woman with significant exposure to varicella is believed susceptible, varicella zoster immune globulin may be administered. It is not known whether it is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when varicella zoster immune globulin is administered to a nursing mother.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

## APPENDIX 1

**Alphabetic List of Drugs in Midwives' Authority**

Any drugs that can be administered by a midwife according to the Ontario Regulation 884/93 Designated Drugs can be prescribed by the midwife

*The following drugs are designated in regulation as substances or drugs that midwives may **administer by injection** on their own responsibility:*

Ampicillin — for the purpose of preventing neonatal group B streptococcal disease
Bupivacaine — for the purpose of local anaesthesia for episiotomy or the repair of tears
Carbetocin
Carboprost tromethamine
Cefazolin — for the purpose of preventing neonatal group B streptococcal disease
Chloroprocaine — for the purpose of local anaesthesia for episiotomy or the repair of tears
Clindamycin — for the purpose of preventing neonatal group B streptococcal disease
Dimenhydrinate
Diphenhydramine hydrochloride
Epinephrine hydrochloride
Ergonovine maleate
Erythromycin — for the purpose of preventing neonatal group B streptococcal disease
Hepatitis B immune globulin
Hepatitis B vaccine
Intravenous fluids
Lidocaine hydrochloride with or without epinephrine —for the purpose of local anaesthesia for episiotomy or the repair of tears
Measles-mumps-rubella virus vaccine
Oxytocin - for the purpose of treating postpartum hemorrhage
Penicillin G — for the purpose of preventing neonatal group B streptococcal disease
Phytonadione
RhD immune globulin
Varicella Zoster immune globulin

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

*The following drugs are designated as drugs that midwives may **administer by inhalation** on their own responsibility:*

Nitrous oxide Therapeutic oxygen

*The following drugs are designated as drugs that midwives may **prescribe** on their own responsibility:*

Amoxicillin-clavulanic acid —for the purpose of treating mastitis Cephalexin — for the purpose of treating mastitis
Ciprofloxacin (oral)
Clotrimazole
Clindamycin (oral)
Cloxacillin (oral)
Diclofenac (oral)
Domperidone — for the purpose of promoting lactation
Doxylamine succinate-pyridoxine hydrochloride
Ergonovine maleate (oral)
Erythromycin ophthalmic ointment
Folic acid (oral; greater than 1mg/dose)
Hepatitis B immune globulin
Hepatitis B vaccine
Hydrocortisone anorectal therapy compound
Metronidazole (oral)
Miconazole
Misoprostol — for the purpose of preventing postpartum hemorrhage
Mupirocin-betamethasone valerate-miconazole (topical)
Naproxen (oral)
Nitrofurantoin — for the purpose of treating urinary tract infections
Nystatin
Phytonadione
RhD immune globulin
Sulfamethoxazole-trimethoprim (oral)
Trimethoprim — for the purpose of treating urinary tract infections

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

## APPENDIX 2

**Reporting Adverse Drug Reactions and Medication Errors**

Reporting Adverse Drug Reactions

You can report any suspected adverse drug reactions to drugs and other health products to the Canada Vigilance Program by visiting the Reporting Adverse Reactions to Drugs and Other Health Products page at: http://hc-sc.gc.ca/dhp-mps/medeff/report-declaration/reporting-declaration-eng.php

The site offers the Canada Vigilance Reporting Form for use in the reporting by health care professionals and clients via fax, mail, online or phone.

Canada Vigilance Regional Office phone 1 866- 234-2345 and fax 1 866-234-678-6789

Reporting Medication Errors

Consider reporting any medication errors confidentially to The Institute for Safe Medication Practices Canada, an independent national non-profit agency. Contributing to this database provides information for the purpose of developing policies to prevent future adverse events. For information about this non-profit organization, go to their home page at http://www.ismp-canada.org, or their page with information about reporting medication incidents at Canadian Medication Incident Reporting and Prevention System (CMIRPS) http://www.ismp-canada.org/cmirps.htm.
For further information about incident reporting, refer to the AOM (www.aom.on.ca) and HIROC (www.hiroc.com) websites.

| | |
|---|---|
| Standard: | Prescribing and Administering Drugs |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | September 25, 2013 |
| Date to be Reviewed: | April 2016 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

COLLEGE OF MIDWIVES OF ONTARIO
ORDRE DES SAGES-FEMMES DE L'ONTARIO

## APPENDIX 3

**Best Possible Medication History (BPMH)**

**Best Possible Medication History (BPMH)** is a medication history obtained by a healthcare provider which includes a thorough history of all regular medication use (prescribed and non-prescribed), using a number of different sources of information. The BPMH is different and more comprehensive than a routine primary medication history (which is often a quick patient medication history).

The BPMH involves a:

1. Patient medication interview where possible.
2. Verification of medication information with more than one source as appropriate including:
   - o family or caregiver
   - o community pharmacists and physicians
   - o inspection of medication vials
   - o patient medication lists
   - o medication profile from other facilities
   - o prescription drug claim histories of Ontario Drug Benefit (ODB) recipients (Drug Profile Viewer)
   - o previous patient health records

The BPMH includes drug name, dose, frequency and route of medications a patient is **currently taking,** even though it may be different from what was actually prescribed. Using tools such as a guide to gather the BPMH may be helpful for accuracy and efficiency. (A BPMH Interview Guide is available here).

If a patient is unable to participate in a medication interview, other sources may be utilized to obtain medication histories or clarify conflicting information. Other sources should never be a substitute for a thorough patient and/or family medication interview. For patients who present prescription bottles and/or a medication list, each individual medication and corresponding dosing instruction should be verified, if possible. Frequently, patients take medications differently than what is reflected on the

prescription label. Also, patients may not have updated their personal list with newly prescribed medications. [6]

Midwives should ensure that client's reporting drug allergies are asked the extent and type of allergy, sensitivity or reaction they have had and this should be documented in the client's record.



[6] Queen's University, Office of Interprofessional Education and Practice. *Medication Reconciliation: A Learning Guide*. Web page retrieved August 19, 2010 on the World Wide Web at: http://meds.queensu.ca/courses/assets/modules/mr/4.html

| | |
|---|---|
| Standard: | Routine Childhood Vaccinations |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | November 25, 2013 |
| Date to be Reviewed: | April 2015 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

# ROUTINE CHILDHOOD VACCINATIONS

## Purpose

This standard sets out the expectations for midwives who discuss routine childhood vaccinations with their clients.

Midwifery standards of practice refer to the minimum standard of professional behaviour and clinical practice expected of midwives in Ontario.

## Definition

Routine childhood vaccinations refer to all vaccines that are routinely administered to Ontario children commencing in early infancy, not including the Hepatitis B vaccine.

## Background

The administration of routine childhood vaccinations on a midwife's own responsibility is not within the scope of midwifery in Ontario. Midwives are authorized to administer routine childhood vaccinations on the order of a physician. Vaccinations normally commence at two-months of age, after clients and their newborns are typically discharged from midwifery care. However, midwifery clients may have questions regarding routine vaccinations prior to receiving well-baby care from their family physician, pediatrician or nurse practitioner.

## Standard

If clients wish to engage in a discussion with their midwife regarding routine vaccination, the midwife shall:

- Clearly inform the client that the administration of routine childhood vaccinations is outside the scope of midwifery.
- Inform the client of community standards and the Ontario vaccination schedule.
- Inform the client of the benefits and risks of vaccination supported by peer reviewed research evidence.
- Encourage clients to seek information from trusted sources, including other regulated health care providers in their circle of care, the Ontario Ministry of Health and Long-Term Care, Health Canada and the World Health Organization.

| | |
|---|---|
| Standard: | Routine Childhood Vaccinations |
| Reference #: | STCMO_C09252013 |
| Approved by: | Council |
| Date Approved: | November 25, 2013 |
| Date to be Reviewed: | April 2015 |
| Revision date(s): | -- |
| Effective date: | January 1, 2014 |
| Attachments: | none |

College of Midwives of Ontario
Ordre des Sages-femmes de l'Ontario

- Inform the client of the midwife's bias, if any.
- Document the discussion on vaccine in the client's record.

Midwives should develop a practice protocol on the topic of routine childhood vaccinations to support them in providing consistent and accurate information to clients.

## Appendix C

Region of Waterloo Public Health: Epidemiology and health analytics team- Data Request Results (p. 27-35)

April 6, 2017

## Data Citation:

A. Statistics Canada, 2013. National Household Survey Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-010-X2011032. Released June 26, 2013.

B. Statistics Canada, 2002. Census Profile. 2001 Census. Statistics Canada Catalogue no. 92-378-2011.

## Data Use Restrictions:

Must reference data sources (see above data citation)

## Results:

### Table 1: Number of Mennonite persons, by age, sex and immigration status, Kitchener-Cambridge-Waterloo and Guelph Census Metropolitan Areas (CMAs), 2011 (A)

| | Measure | Kitchener, Cambridge and Waterloo CMA | Guelph CMA |
|---|---|---|---|
| **Sex** | Male | 4625 | 115 |
| | Female | 5115 | 145 |
| **Age Group** | Less than 15 years | 1970 | 30 |
| | 15 to 24 years | 1490 | 25 |
| | 25 to 34 years | 1070 | 65 |
| | 35 to 44 years | 1125 | 15 |
| | 45 to 54 years | 1445 | 70 |
| | 55 to 64 years | 1180 | 45 |
| | 65 years and older | 1465 | 10 |
| **Immigration Status** | Immigrant | 775 | 15 |
| | Canadian-born | 8920 | 245 |

Table 1 shows the total number of individuals in both the Kitchener-Cambridge-Waterloo and Guelph CMA who reported their religion as Mennonite on the 2011 National Household Survey. (Definition for CMA is in the Important Definitions and Cautions section).

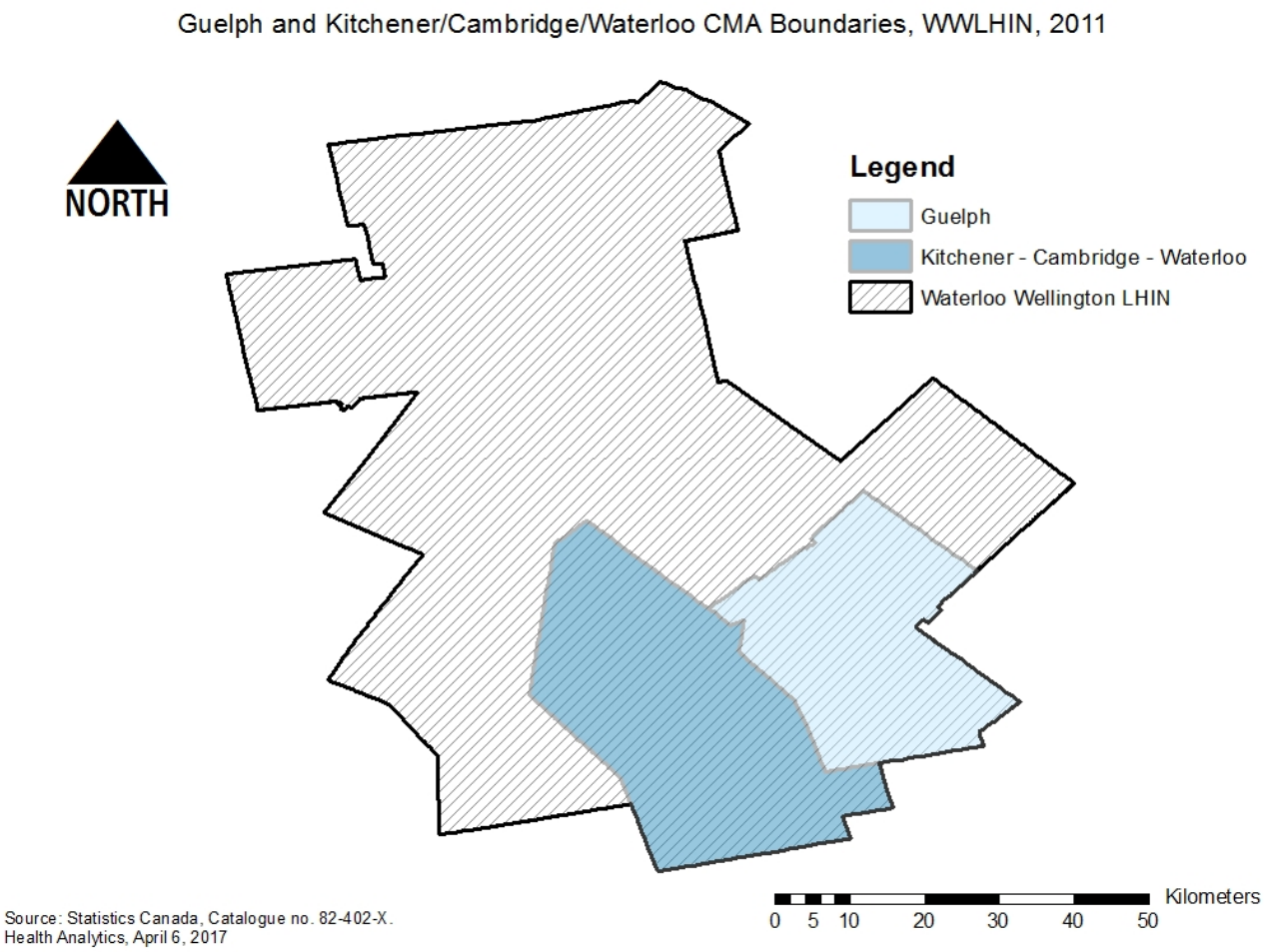
**Table 2: Number of Mennonite persons, Waterloo Public Health Unit and Wellington Dufferin Guelph Public Health Unit, 2001 (B)**

| | | |
|---|---|---|
| **Waterloo Public Health Unit** | Mennonite Population | 16,660 |
| | Total Population | 433,870 |
| **Wellington Dufferin Guelph Public Health Unit** | Mennonite Population | 4,615 |
| | Total Population | 235,210 |

Data was pulled from Statistics Canada 2001 Census religion table. The total number of individuals who reported Mennonite for religion in Waterloo Region Health Unit, which includes Waterloo, Kitchener, Cambridge, Wellesley, Woolwich, North Dumfries and Wilmot was 16, 660. The entire population reported in the 2001 Census for Waterloo Region was 433, 870.

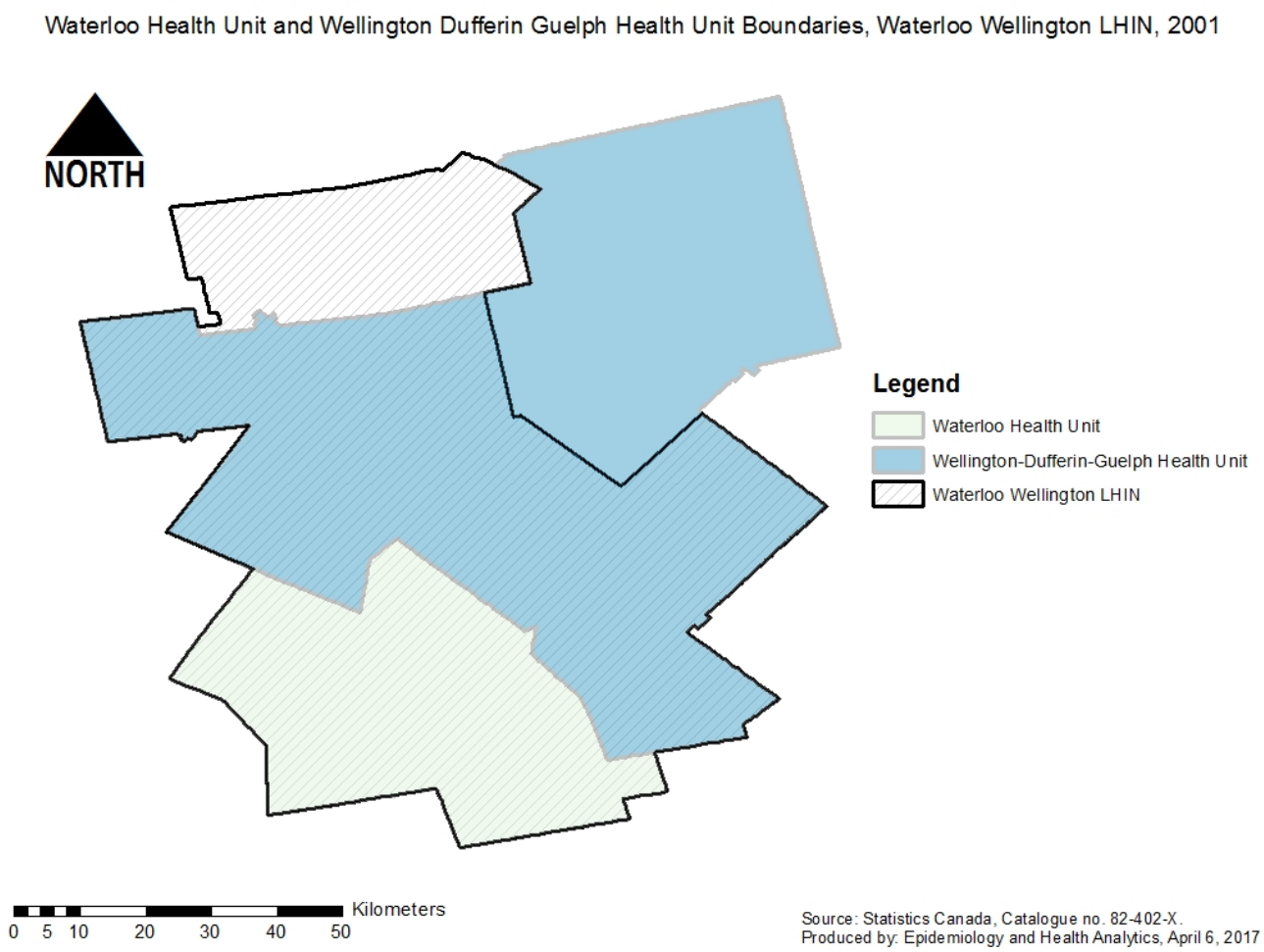
The total number of individuals who reported Mennonite for religion in Wellington Dufferin Guelph Region, which includes Minto, Wellington North, Mapleton, Centre Wellington, Guelph/Eramosa, Erin, Guelph, Puslinch, East Luther Grand Valley, East Garafraxa, Amaranth, Mono, Mulmur, Shelburne, Orangeville and Melancthon was 4, 615. The entire population reported in the 2001 Census for Wellington Dufferin Guelph Health Unit was 235, 210.

**Figure 1: Guelph and Kitchener/Cambridge/Waterloo CMA boundaries overlapping Waterloo Wellington LHIN**




It is important to note that the data obtained from the 2011 National Household Survey is only representative of only the metropolitan areas of the entire Waterloo Wellington LHIN region.

**Figure 2: Wellington Dufferin Guelph Public Health Unit and Waterloo Region Public Health Unit boundaries overlapping Waterloo Wellington LHIN**




The data from the 2001 Census was obtained for both the Waterloo Region Public Health Unit and the Wellington – Dufferin – Guelph Public Health Unit. It is important to note that these areas differ from the boundaries of the Waterloo Wellington LHIN.

## Important Definitions and Cautions:

A census metropolitan area (CMA) is formed by one or more adjacent municipalities centred on a population centre (known as the core). A CMA must have a total population of at least 100,000 of which 50,000 or more must live in the core. To be included in the CMA, other adjacent municipalities must have a high degree of integration with the core, as measured by commuting flows derived from previous census place of work data.

Statistics Canada employs rounding of numbers to the nearest multiple of five to ensure confidentiality. Because of the imprecision introduced by this rounding methodology, summing individual cell values should be avoided if possible. Caution must be taken when interpreting the data, especially in situations where data counts are low.

Due to the voluntary nature of the 2011 NHS, caution must be used when interpreting the data. Further, due to changes in the survey methodology from 2006 and previous census years, direct comparisons, including the calculation of growth rates, percentage and absolute changes should not be made. Interpretations based on the NHS survey data are presented as estimates.

For 2011 National Household Survey (NHS) estimates, the global non-response rate (GNR) is used as an indicator of data quality. This indicator combines complete non-response (household) and partial non-response (question) into a single rate. The value of the GNR is presented to users. A smaller GNR indicates a lower risk of non-response bias and as a result, lower risk of inaccuracy. The data from the 2011 NHS for Guelph CMA had a GNR of 25.4% and 23.4% for Kitchener, Cambridge and Waterloo. Values around above 25% are generally recognized as being poorer quality, with higher risks of inaccuracy.

Permanent resident refers to a person who has acquired permanent resident status and has not subsequently lost that status. They are entitled to live and work in Canada indefinitely. Includes immigrants who landed in Canada prior to May 10, 2011.

EPIDEMIOLOGY AND HEALTH ANALYTICS TEAM

# DATA Request Results

Region of Waterloo PUBLIC HEALTH


**Contact Information**:

**Region of Waterloo Public Health**
Epidemiology and Health Analytics Team
99 Regina Street South, Third Floor
Waterloo, Ontario N2J 4V3
Canada

Phone: 519-575-4400
Fax: 519-883-2241
TTY: 519-575-4608
Website: http://chd.region.waterloo.on.ca/
Email: eha@regionofwaterloo.ca


Accessible formats of this document are available upon request. Please call the Coordinator, Health Communications at 519-575-4400 ext. 2244, (TTY 519-575-4608) to request an accessible format.

Internal access to document: DOCS #2390688

## Appendix E: Framework

| Domain (definition) | Construct |
|---|---|
| 1. Knowledge<br><br>(An awareness of the existence of something) | Knowledge (including knowledge of condition /scientific rationale) Procedural knowledge Knowledge of task environment |
| 2. Skills<br><br>(An ability or proficiency acquired through practice) | Skills<br><br>Skills development Competence Ability Interpersonal skills Practice<br><br>Skill assessment |
| 3. Social/Professional Role and Identity<br><br>(A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting) | Professional identity Professional role Social identity Identity<br><br>Professional boundaries Professional confidence Group identity<br>Leadership<br>Organisational commitment |
| 4. Beliefs about Capabilities<br><br>(Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use) | Self-confidence<br><br>Perceived competence Self-efficacy Perceived behavioural control Beliefs<br><br>Self-esteem Empowerment Professional confidence |
| 5. Optimism<br><br>(The confidence that things will happen for the best or that desired goals will be attained) | Optimism<br><br>Pessimism<br>Unrealistic optimism<br>Identity |
| 6. Beliefs about Consequences<br><br>(Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation) | Beliefs<br>Outcome expectancies<br>Characteristics of outcome expectancies<br>Anticipated regret<br>Consequents |
| 7. Reinforcement<br><br>(Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus) | Rewards (proximal / distal, valued / not valued, probable / improbable) Incentives<br>Punishment<br>Consequents<br>Reinforcement<br>Contingencies<br>Sanctions |
| 8. Intentions<br><br>(A conscious decision to perform a behaviour or a resolve to act in a certain way) | Stability of intentions<br>Stages of change model<br>Transtheoretical model and stages of change |
| 9. Goals | Goals (distal / proximal)<br>Goal priority |

| | |
|---|---|
| (Mental representations of outcomes or end states that an individual wants to achieve) | Goal / target setting<br>Goals (autonomous / controlled)<br>Action planning<br>Implementation intention |
| 10. Memory, Attention and Decision Processes<br><br>(The ability to retain information, focus selectively on aspects<br>of the environment and choose between two or more alternatives) | Memory<br>Attention<br>Attention control<br>Decision making<br>Cognitive overload / tiredness |
| 11. Environmental Context and Resources<br><br>(Any circumstance of a person's situation or environment that discourages or encourages the development of skills and<br>abilities, independence, social competence, and adaptive behaviour) | Environmental stressors<br>Resources / material resources Organisational culture /climate<br>Salient events / critical incidents<br>Person x environment interaction<br>Barriers and facilitators |
| 12. Social influences<br><br>(Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours) | Social pressure<br>Social norms<br>Group conformity<br>Social comparisons<br>Group norms<br>Social support<br>Power<br>Intergroup conflict<br>Alienation<br>Group identity<br>Modelling |
| 13. Emotion<br><br>(A complex reaction pattern, involving experiential, behavioural,<br>and physiological elements, by which the individual attempts to deal with a personally significant matter or event) | |
| 14. Behavioural Regulation<br><br>(Anything aimed at managing or changing objectively observed or measured actions) | Self-monitoring<br>Breaking habit<br>Action planning |

All definitions are based on definitions from the APA dictionary of psychology

## Appendix F: Interview Guide

| | |
|---|---|
| 1 | What does your role as a midwife entail? |
| 2 | How does your role differ from other maternity care providers? |
| 3 | What is a typical day for you? |
| 4 | How many patients do you provide services for at one time? Per year? |
| 5 | Do you feel your case-load is restricted by provincial regulation? |
| 6 | Where do you most often provide services for your patients?<br>-home hospital clinic? |
| 7 | What do you think is the role of midwives in the maternity care field regarding vaccination?<br>a. What do you think is your role as a midwife and maternity care provider regarding vaccination for your pregnant patients?<br>b. Do you ever discuss recommend vaccinations for infants as well [that is post partum vaccinations] |
| 8 | What information are you provided about provincial recommendations for vaccination during pregnancy? (if any?)<br>a. Are you provided with information about childhood and infancy vaccine recommendations to prepare patients for when they are no longer under your care? |
| 9 | Do you feel comfortable recommending vaccines during pregnancy?<br>a. [If comfortable] why? [if not] what would you need/might help you to become comfortable recommending vaccination during pregnancy?<br>b. Do your perceptions of vaccines change depending on the patient/person being vaccinated (example for people who are not pregnant) |
| 10 | Do you ever provide recommendations or have discussions with your patients regarding vaccines, specifically influenza?<br>a. Would you consider it part of your routine practices<br>b. If it is considered part of your routine practice when do you normally address it?<br>c. How do you address it?<br>d. Can you walk me through a typical interaction or conversation regarding vaccine recommendation. |

| | |
|---|---|
| 11 | Does your support or hesitancy of vaccines change based on the specific vaccine? (i.e: MMR versus, polio versus TDAP versus influenza]<br>a. Do your recommendation practices change based on specific vaccines? [example are you comfortable to recommend some but not others] |
| 12 | Is vaccination something you discuss in your training and/or in the workplace?<br>a. Do your colleagues share your perceptions of vaccination? |
| 13 | How do you approach discussion of vaccination with your patients?<br>a. If the patient has never raised the discussion how do you address this [either for or against] |
| 14 | At <u>what stage of the pregnancy</u> are you comfortable discussing or recommending vaccines?<br>a. What vaccines are you comfortable discussing/recommending? |
| 15 | Do the patients you encounter share your perceptions of vaccines?<br>a. How do you respond? |
| 16 | What are some challenges you face in the discussion or recommendation of vaccines with your pregnant patients? |
| 17 | What do majority of your patients think about vaccination during pregnancy?<br>a. Are they supportive? Or are they against being vaccinated or discussing the potential for vaccination?<br>b. Do they support vaccination outside of pregnancy?<br>c. Do they support vaccination of infants?<br>d. Why? |
| 18 | Have you had any clients that have changed their vaccine practices between first and subsequent pregnancies?<br>a. If yes, Did they move from vaccinate → not vaccinate OR not vaccinate→ vaccinate<br>b. Did they provide reason for this? If so what was the reason? |
| 19 | Have you experienced a change in your personal behavior/recommendation practices since you began practicing midwifery? |
| 20 | What do you perceive as the benefits of vaccination during pregnancy? [This can pertain to all vaccines in general or specific vaccines.] |

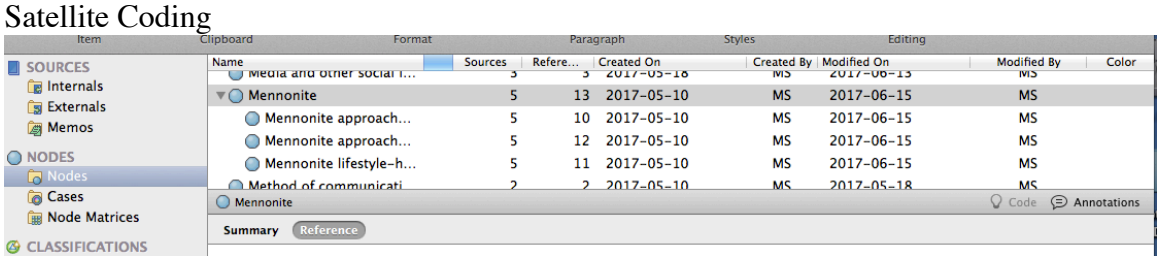
| | |
|---|---|
| 21 | What do you perceive as the risks of vaccination during pregnancy?<br>a. This can pertain to all vaccines in general or specific vaccines.<br>b. |
| 22 | What are some benefits and concerns your patients have expressed? |
| 23 | In your experience, do pregnant women normally receive vaccination for influenza? |
| 24 | Do you think discussion or recommendation between yourself and your patients increases the chances of uptake? |
| 25 | Have you ever found your recommendation or discussion to be an influencing factor on your patient's uptake? |
| 26 | Does your action as a provider change based on patient opinion/ perspective? |
| 27 | How do you approach or address a pregnant women that is **unsure** or against vaccination? |
| 28 | What is the main barrier in your ability to recommend and discuss vaccines?<br>a. What are some systemic barriers you face [part of your training, did you learn about it in school, does your place of employment support vaccination, do you feel it is something you are suppose to be talking about?<br>b. Who else is involved in this?<br>c. What are some personal? |
| 29 | How do you work with other maternity care providers (family doctors, OB, physicians in hospital)?<br>a. How is this communication maintained<br>b. Do you find there is sufficient continuity of care within the maternity field? |
| 30 | What is your main source of information regarding vaccination and current vaccine recommendations? |
| 31 | Do you trust the information you receive?<br>a. Do your colleagues? |
| 32 | How can information translation on vaccines be improved upon? |
| 33 | What would be an efficient/more efficient way for you to receive information from health authorities? |
| 34 | What do you think is one way vaccine uptake can be facilitated more effectively in Ontario? |

## 4

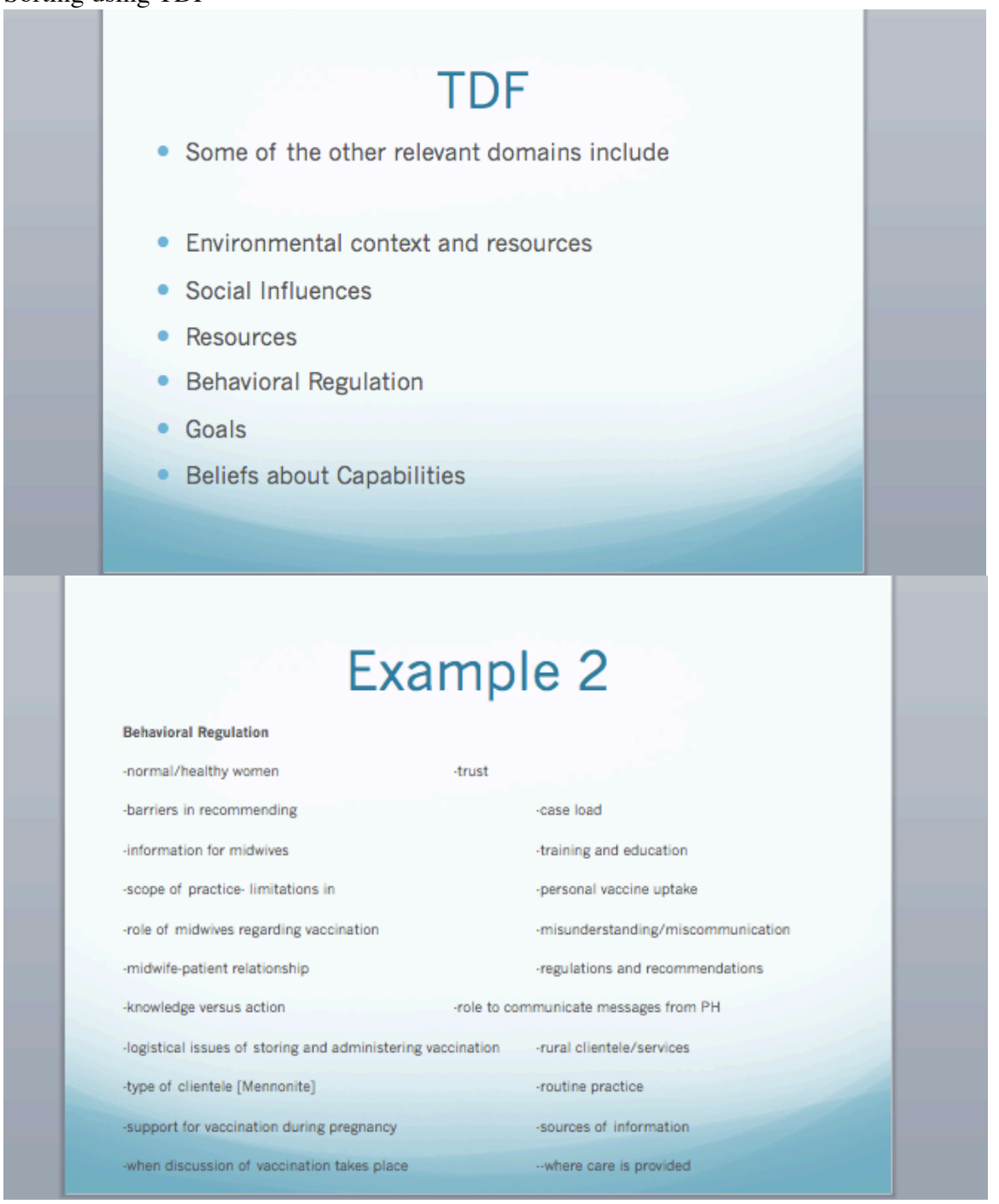
| | |
|---|---|
| 35 | Would you be comfortable administering vaccines if scope of practice allowed? |
| 36 | In your opinion should scope of practice [both in general and regarding vaccines] be expanded for midwives? |
| 37 | Is there anything you would like to add before we conclude?<br><br>Thank you for taking the time to review this questionnaire and I look forward to interviewing you. |

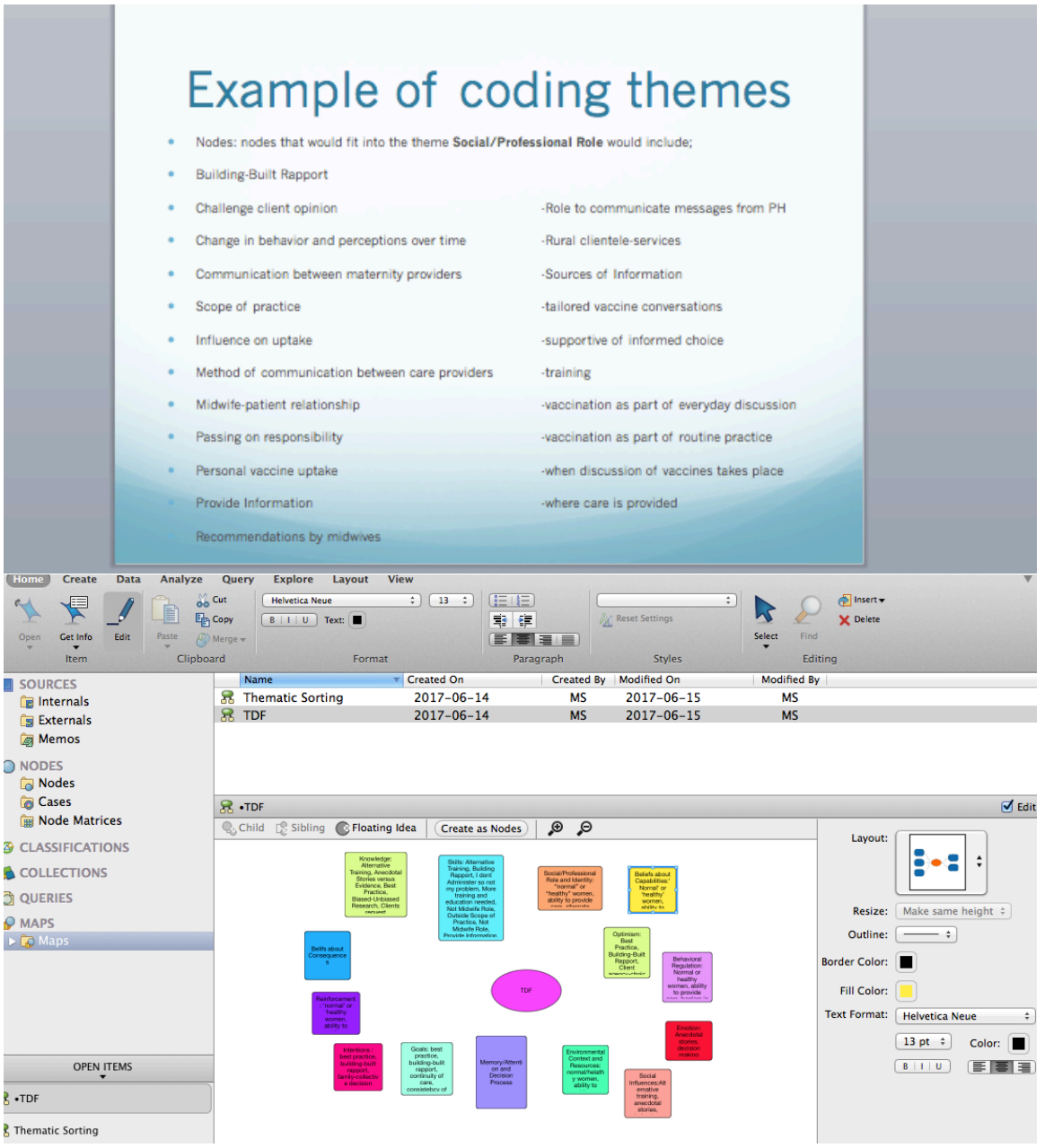
## Appendix G

Satellite Coding




Sorting using TDF




Example of coding themes
Nodes: nodes that would fit into the theme Social/Professional Role would include;
Building-Built Rapport
Challenge client opinion
Change in behavior and perceptions over time
Communication between maternity providers
Scope of practice
Influence on uptake
Method of communication between care providers
Midwife-patient relationship
Passing on responsibility
Personal vaccine uptake
Provide Information
Recommendations by midwives
-Role to communicate messages from PH
-Rural clientele-services
-Sources of Information
-tailored vaccine conversations
-supportive of informed choice
-training
-vaccination as part of everyday discussion
-vaccination as part of routine practice
-when discussion of vaccines takes place
-where care is provided
Home
Create
Data
Analyze
Query
Explore
Layout
View
Open
Get Info
Edit
Paste
Cut
Copy
Merge
Item
Clipboard
Helvetica Neue
13
Text:
Format
Paragraph
Reset Settings
Styles
Select
Find
Insert
Delete
Editing
SOURCES
Internals
Externals
Memos
NODES
Nodes
Cases
Node Matrices
CLASSIFICATIONS
COLLECTIONS
QUERIES
MAPS
Maps
OPEN ITEMS
•TDF
Thematic Sorting
Name
Created On
Created By
Modified On
Modified By
Thematic Sorting
2017-06-14
MS
2017-06-15
MS
TDF
2017-06-14
MS
2017-06-15
MS
•TDF
Edit
Child
Sibling
Floating Idea
Create as Nodes
Knowledge: Alternative Training, Anecdotal Stories versus Evidence, Best Practice, Biased-Unbiased Research, Clients
Skills: Alternative Training, Building Rapport, I dont Administer so not my problem, More training and education needed, Not Midwife Role, Outside Scope of Practice, Not Midwife Role, Provide Information
Social/Professional Role and Identity: "normal" or "healthy" women, ability to provide
Beliefs about Capabilities: Normal' or 'healthy' women, ability to
Beliefs about Consequence s
Optimism: Best Practice, Building-Built Rapport, Client
Behavioral Regulation: Normal or healthy women, ability to provide
TDF
Reinforcement "normal' or 'healthy women, ability to
Emotion: Anecdotal stories, decision makins
Intentions : best practice, building-built rapport, family-collectio n decision
Goals: best practice, building-built rapport, continuity of care, consistencv of
Memory/Attenti on and Decision Process
Environmental Context and Resources: normal/health y women, ability to
Social Influences:Alt ernative training, anecdotal stories,
Layout:
Resize:
Make same height
Outline:
Border Color:
Fill Color:
Text Format:
Helvetica Neue
13 pt
Color:

Further Sorting/Memoing

**Codes Sorting**

| Known | New Findings |
|---|---|
| -'Normal' and 'healthy' women<br>-ability to provide care is limited by scope of practice<br>-alternative training options<br>-anecdotal stories v. evidence<br>-autism<br>-barriers in recommending exist<br>-behaviors and practices can be shaped by clinic<br>-best practice is standard of care<br>-biased and unbiased research is present<br>-building/built rapport | -challenge clients opinion [some midwives don't feel it is their role to challenge client choice however some feel it is their role as a provider to do so which is where we see conflict in role as well as inconsistency]<br>-change in behavior [ some midwives find a change in their behaviors and practices since training or since beginning career; reasons for these changes vary]<br>-there is confusion within midwifery due to: lack of guidelines, standards and |

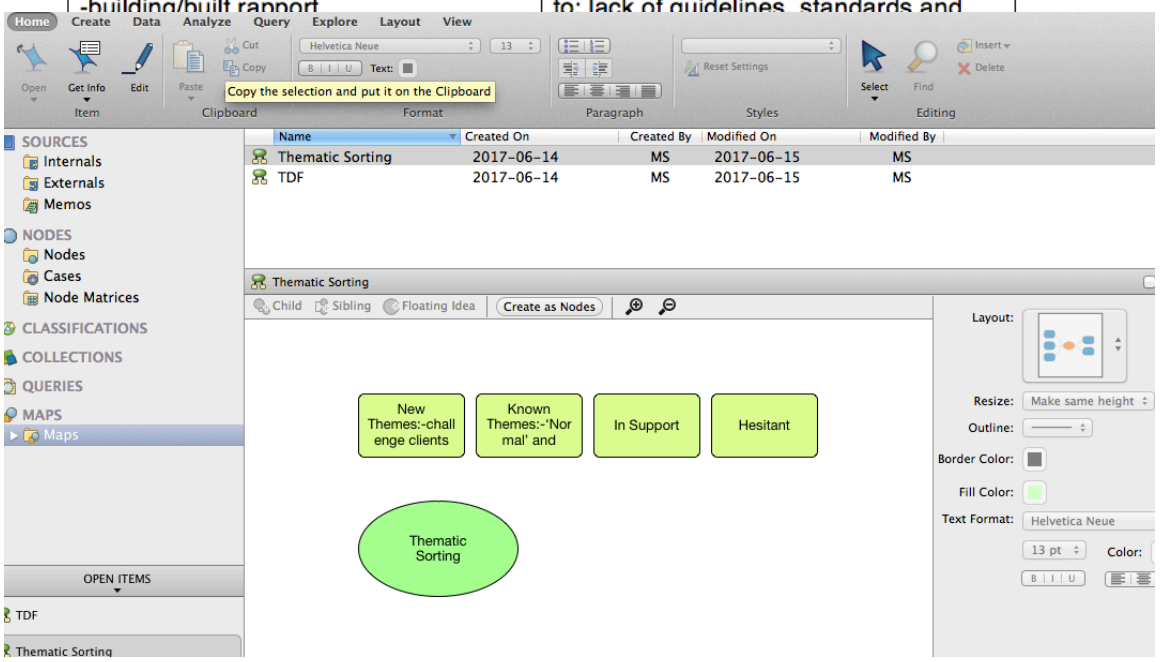


Table 4: TDF Domains and Corresponding Sorted Codes

| Domains | Codes | Number of Codes |
|---|---|---|
| Knowledge: an awareness of the existence of something | Anecdotal Stories versus Evidence, Best Practice, Biased-Unbiased Research, Clients request information, Communication between providers, confusion within midwifery, consistency of information, continuity of care, contradiction in midwifery, dialogue with provider, expanding scope of practice, health during pregnancy, historical influence, hesitancy, "i don't administer so not my problem", importance of vaccines, immunity, improving care-information, incorrect approach to vaccine discussion, influence on uptake, influence on vaccine uptake influenza vaccine important, information translation, informed choice discussion, just following recommendation, knowledge v.s action, lack of knowledge, lack of standards and guidelines, less medicalized approach, limitations and barriers, Mennonite, Mennonite approach ect., messaging by health authorities, method of communication, midwife-patient relationship, midwife approach to care, midwives not supportive, midwives should be offering choices only, misunderstanding-miscommunication, more training and education needed, not midwife role, not standard prenatal care, only supportive outside pregnancy, outside scope of practice, personal v. professional role, personal vaccine uptake, possibly risk of vaccination, pregnancy is time of compromised immunity, promotion, provide information, quality of vaccine research, question flu vaccine effectiveness, range of support, recommendations by midwives, risks of not being vaccinated, role of midwife regarding vaccination, role to communicate messages from PH, rubella vaccine, rural clientele, scope of practice, selective recommendation, sources of information, support influenza vaccine, supportive of informed choice, tailored vaccine conversation, training, travel vaccines, vaccination as part of routine, vaccine as part of everyday, vaccine specific, vaccines are necessary, when discussions of vaccines happen | 73 |
| Skills: An ability or proficiency acquired through practice | Alternative Training, Building Rapport, I don't Administer so not my problem', More training and education needed, Not Midwife Role, Outside Scope of Practice, Not Midwife Role, Provide Information, Recommendations by Midwives, Role to Communicate Messages from PH, Scope of Practice, Tailored Vaccine Conversations, Training, Vaccination as part of routine practice, When discussion of vaccination takes place | 15 |
| Social/Professional Role and Identity: a coherent set of behaviors and displayed personal qualities of an individual in a social or work setting | "normal" or "healthy" women, ability to provide care, alternate training, barriers in recommending, best practice, building rapport, challenges of existing standards, change in behavior among midwives, childhood and post partum, client choice-agency, communication between providers, confusion within midwifery, continuity of care, contradiction in midwifery, dialogue with provider, decision making during pregnancy, doesn't come up at work, | 94 |

| | | |
|---|---|---|
| | expanding scope, collective decision making, follow through, hepatitis, hesitancy, historical influence, " I don't administer so not my problem, importance of vaccine, improving care-information, individual empowerment, influence on uptake, influences on vaccine uptake among patients, influenza is recommended, Information Translation, informed choice discussion, just follow recommendations, knowledge versus action, lack of knowledge, lack of standards and guidelines, less medicalzed approach, limitations and barriers, logistical issues of vaccination, mandatory vaccination, media and other social influences, Mennonite etc, messaging by health authorities, method of communication, midwife-patient relationship, midwife approach to care, midwives not supportive of vaccination, midwives should be offering choices, more training and education needed, not midwife role, not standard prenatal care, only if brought up, only supported outside pregnancy, outside scope, passing on responsibility, personal v. professional, personal vaccine uptake, pertussis, promotion, provide information, public health, public interest, question flu vaccine, range of support among providers, recommendations by midwives, region specific, responsibility, role of midwife regarding vaccination, role to communicate messages from PH, rubella, scope of practice, rural clientele-service, selective recommendation, setting standards, societal v. individual responsibility, sources of information, standards outlined by health authorities, support influenza vaccine, supportive of informed choice, tailored vaccine conversation, training, travel vaccines, type of clients, vaccination as part of routine practice, vaccines part of everyday discussion, vaccine specific, vaccines are necessary, when discussions of vaccines take place, where care is provided, who has control | |
| Beliefs and Capabilities: acceptance of the truth, reality or validity about an ability, talent or facility that a person can put into constructive use | 'Normal' or 'healthy' women, ability to provide care limited by scope, barriers in recommending, best practice, building rapport, case load, challenge clients opinions, challenges of existing midwifery scope, childhood and post partum, communication between providers, continuity of care, dialogue with providers, "I don't administer so not my problem", improving care-information translation, individual empowerment, influence on uptake, information translation, just follow recommendations, knowledge v. action, lack of knowledge, lack of standards and guidelines, less medicalized approach, limitations and barriers, logistical issues of vaccination, mandatory vaccination, midwife-patient relationship, midwives not supportive, midwives should be offering choices only, more training and education, not midwife role, not standard prenatal care, only if brought up, only supported outside pregnancy, outside scope of practice, passing on responsibility, personal v professional role, personal vaccine uptake, pertussis, rubella, promotion, provide information, recommendations by midwives, range of support my midwives, responsibility, role of midwives regarding vaccination, role to communicate messages from PH, | 61 |

| | | |
|---|---|---|
| | scope of practice, selective recommendation, setting standards, sources of information, standards outlined by PH, support influenza vaccine, supportive of informed choice, tailored vaccine conversation, training, travel vaccines, trust, type of clients, vaccine specific, who has control | |
| Optimism: the confidence that things will happen for the best or that desired goals will be attained | Best Practice, Building-Built Rapport, Client agency-choice, Influence on Uptake, Informed Choice Discussion, Midwife-Patient Relationship, Midwife Recommendations, Promotion, Public Interest, Provide Information | 10 |
| Beliefs about Consequences: acceptance of the truth, reality or validity about outcomes of a behavior in a given situation | Autism, labelled an anti-vaxer, exposure to toxins and preservatives, possible risk of vaccine v. actual risk of disease, risk of not being vaccinated, risks of being vaccinated | 6 |
| Reinforcement: increasing the probability of a response by arrange a dependent relationship or contingency, between the response and a given stimulus | 'normal' or 'healthy women, ability to provide care limited by scope, autism, barriers in recommending, challenge client perspectives, cost, change in behavior over time, challenges of existing scope of practice, exposure to toxins, health during pregnancy, hepatitis, herd immunity, hepatitis, immunity, improving care, individual empowerment, influence on uptake, information translation, informed choice discussion, lack of knowledge, lack of standards and guidelines, limitations and barriers, logistical issues, mandatory vaccination, media and other social influences, Mennonite approach to pregnancy/health, messaging by health authorities, method of communication by health authorities, midwife-patient relationship, midwife approach to care, midwives not supportive of vaccines, midwives should be offering choices only, misunderstanding-miscommunication, more training and education needed, newer vaccines, not midwife role, not standard prenatal care, only of brought up, outbreak/exception, outside scope, pass on responsibility, pertussis, possible risk v. actual risk, pregnancy time of compromised immunity, promotion, protection of baby is priority, provide information, quality of vaccine research, public interest, public health , question flu vaccine, recommendations by midwives, region specific, risks of not being vaccinated, risks of being vaccinated during pregnancy, role of midwives regarding vaccines, rubella, rural clientele-services, scope of practice, selective recommendation, social v. individual responsibility, standards and guidelines outlined by college and HA, support for influenza vaccine during pregnancy, supportive of informed choice, training, transparency, traumatic memory or experience, trust, clientele, vaccination as part of routine practices, vaccine as part of everyday discussions with colleagues, vaccine specific, when discussion of vaccination takes place, who has control | 82 |
| Intentions: A conscious decision to perform a behavior or a resolve to act in a certain way | Best practice, building-built rapport, family-collective decision making influence on uptake, promotion, provide information | 5 |
| Goal: mental representation of outcomes or end states that an individual wants to achieve | Best practice, building-built rapport, continuity of care, consistency of information, convenience-accessibility, dialogue with provider, expanding scope of practice, family-collective decision making, | 24 |

| | | |
|---|---|---|
| | follow through, improving care-information for midwives, individual empowerment, influence on uptake, information translation, informed choice discussion, more training and education needed, promotion, provide information, unbiased research, communicate messages from PH, set standards regarding vaccination, support informed choice, transparency, trust, vaccination as part of routine practice | |
| Memory, attention, and decision process: the ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives | Alternative training, behaviors and practices shaped by clinic, best practice, challenging client opinions, biased-unbiased research, clarity of information, change in behavior among provider, communication between maternity care provider and patient, consistency of information, decision making during pregnancy, dialogue with provider, doesn't come up in workplace, family-collective decision making, follow through, fragility of pregnancy, influence on uptake, hesitancy, incorrect approach to discussion, influences on uptake among patients, influenza is recommended by PH, important for baby, important for mother, information translation, informed choice discussion, knowledge v. action, less medicalized approach to birthing, confusion within midwifery, contradiction in midwifery, lack of knowledge, misunderstanding-miscommunication, more training and education needed, media and other social influences, newer vaccines, only supported outside pregnancy, passing on responsibility, possible actual risk of disease, protection of baby is priority, question flu vaccine effectiveness and evidence, conflicting research, quality of vaccine research, recommendations by midwives, risks of not being vaccinated, risks of vaccination during pregnancy, selective recommendations, support influenza vaccine during pregnancy, supportive of informed choice, tailored vaccine conversation, training, transparency, traumatic memory or experience, trust, vaccination as routine, vaccination as part of everyday discussions with colleagues, when discussion of vaccination takes place | 53 |
| Environmental Context and Resources: Any circumstance of a persons situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behavior | Normal/healthy women, ability to provide care, alternative training, anecdotal stories v evidence, barriers in recommending, biased/unbiased research, case load, challenges of existing scope, change in behavior among midwives, childhood and post partum, clarity of information, client-agency, client perceptions, client request for information, communication between providers, conflicting research, confusion within midwifery, consistency of information, continuity of care, contradiction in midwifery, convenience-accessibility, cost of vaccine, decision making during pregnancy, dialogue with provider, doesn't come up in workplace, expanding scope of practice, flu season, fragility of pregnancy, health during pregnancy, hesitancy, historical influence, don't administer, influenza is recommended, influenza vaccine important for mother and baby, information translation, informed choice discussion, knowledge v action, label of anti-vaxxer, lack of knowledge, lack of standards and guidelines, less medicalised approach, limitations | 96 |

| | | |
|---|---|---|
| | and barriers, logistical issues of vaccination, mandatory vaccination, media and other social influences, Mennonite approach etc, messaging by health authorities, methods of communication between providers, midwife-patient relationship, midwife approach to care, midwives not supportive, misunderstanding /miscommunication, more training and education needed, not midwife role, not standard prenatal care, only if brought up, outbreak-exception, outside scope of practice, personal v professional role, personal vaccine acceptance, possible risk of vaccine v actual disease, pregnancy is time of compromised immunity, promotion, protection of baby, protection of mother, protection of baby is priority, provide information, public health, quality of vaccine research, question flu vaccine research, recommendation by midwife, region specific, responsibility, risks of not being vaccinated, role of midwife regarding vaccines, role to communicate info form PH, rural clientele-services, scope of practice, selective recommendation, setting standards, societal v individual responsibility, sources of information, standards outlined by PH, support influenza vaccine, supportive of informed choice, tailored vaccine conversation, training, traumatic memory or experience, type of clients, vaccination as part of routine practice, vaccine as part of everyday discussion, vaccine specific, when discussion of vaccines takes place, where care is provided, who has control | |
| Social Influences: those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviors | Alternative training, anecdotal stories, behaviors and practices shaped by clinic, biased-unbiased research, change in behavior, client perceptions, conflicting research, confusion within midwifery, contradiction in midwifery, convenience-accessibility, cost, decision making during pregnancy, doesn't come up at work, flu season, fragility of pregnancy, historical influence, don't administer, label of anti-vaxxer, lack of standards and guidelines, less medicalised approach, limitations and barriers, media and other social influences, Mennonite population etc, messaging by health authorities and PH, midwife-patient relationship, midwife approach to care, not midwife role, only if brought up, outbreak-exception, scope of practice/outside scope of practice, personal v. professional role, possible risks, public health, public interest, quality of vaccine research, region specific, responsibility, role of midwives regarding vaccination, rural clientele-services, setting standards, societal v. individual, sources of information, traumatic memory/experience, trust, type of clients, vaccine as routine discussion, vaccine as everyday discussion, when discussion of vaccines take place, who has control | 59 |
| Emotion: a complex reaction pattern, involving experiential, behavioral, and physiological elements, by which the individual attempts to deal with a personally significant matter or event | Anecdotal stories, decision making during pregnancy, family-collective decision making, fragility of pregnancy, hesitancy, midwife-patient relationship, trust, traumatic experience, risk | 9 |
| Behavioral Regulation: anything aimed at managing or changing | Normal or healthy women, ability to provide care, barriers in recommending, best practice, building | 65 |

| | | |
|---|---|---|
| objectively observed or measured actions | rapport, challenge clients opinion, challenges of existing scope, change in behavior, client perceptions, client choice-agency, confusion within midwifery, dialogue with provider, doesn't come up in workplace, expanding scope of practice, improving care-information, incorrect approach to vaccine discussion, individual empowerment, influence on uptake, influenza is recommended by PH, influenza vaccine important informed choice discussion, just follow recommendation, knowledge v. action, lack of knowledge, label of anti-vax, lack of standards and guidelines, less medicalized approach, limitations and barriers, mandatory vaccination, media and other social influence, Mennonite approach etc, more training and education needed, not midwife role, not standard prenatal care, only if brought up, outbreak, outside scope of practice, pass on responsibility, personal v. professional role, personal vaccine uptake, risk of being vaccinated, risk of not being vaccinated, promotion, pregnancy is time of compromised health, provide information, public interest, region specific, responsibility, role of midwife regarding vaccination, role to communicate messages form PH, scope of practice, rural clientele-services, societal v individual responsibility, support influenza vaccine, support informed choice, tailored vaccine conversation, training, trust, vaccination as part of routine, vaccine part of everyday, vaccine specific, when discussion takes place, who has control | |

All definitions are based on definitions from the APA dictionary of psychology.

**Interview 3: [redacted]: ID#003**
[redacted]
May 2, 2017
11:00AM
26 Minutes
(519)-[redacted]

*start recorder
Michelle: So umm first did you have a chance to look through the attachments I had sent to you?

[redacted]: Yes, so I looked at both but didn't have a working printer so I can print it and scan it today if you want.

Michelle: oh well, we can do verbal consent or if you want you can send it back its really up to you.

[redacted]: yeah if you wanna do verbal that's fine. Can I just say that I read over it and I consent or do you have to read it to me?

Michelle: Nope you can just say that you can confirm that you have read it and you consent to all the points

[redacted]: I do and I consent to all the points.

Michelle: Excellent thank you so much!

[redacted]: [haha] no problem.

Michelle: And now the demographic questionnaire. So I am going to ask you a few questions. Umm…I know that these are identifiable questions, they are not actually put in the final paper they are just used more for trends and things like that.

[redacted]: yeah you had said in your email, no that's totally fine, I get how that can be helpful.

Michelle: so first your age?

[redacted]: is [redacted]

Michelle: and your place of employment?

[redacted]: Uhh [redacted].

Michelle: and number of years experience?

[redacted]: This is [redacted] as a practicing midwife.

Michelle: Ohh exciting!

[redacted]: yeah! Its considered [redacted], I don't know if you want to differentiate between those.

Michelle: sorry could you repeat that?

[redacted]: so [redacted]

Michelle: yes okay. And your training and education?

[redacted]: McMaster

Michelle: and so your work experience is one year at countryside midwives correct?

[redacted]: yeah that's correct.

Michelle: [haha] okay so not too lengthy.

[redacted]: no [haha]

Michelle: Alright. Umm so now ill move onto the interview guide.

[redacted]: Sure

Michelle: So some of these are just more for background and to hear about what your perspective is so some of them are really general and basic and some of them are to hear more about your personal experiences and your opinions.

[redacted]: yeah

Michelle: So what does your role as a midwife entail?

[redacted]: umm I provide primary care to pregnant women throughout their pregnancy, labor birth and then the post partum as well as their newborns for six weeks during the post partum.

Eric 2017-6-14 9:41 PM
**Comment [1]:** Professional role, professional boundaries

Michelle: Excellent. And how do you find your role differs from other maternity care providers?

[redacted]: umm in some ways it's more comprehensive and in some ways it's less. So we provide complete care to pregnant women and their new borns, which is different then

obstetricians who just look after the women and the fetus. But more similar to the family doctors who would look after the whole unit although the continuity of care is different. And then in ways it is less comprehensive are that it's short term. Like it's just until 6 weeks post partum where as the family doctor would look after you for your whole life. I think umm... is that sort of what you are looking for?

Eric 2017-6-14 9:43 PM
**Comment [2]:** Professional role, professional boundaries

Michelle: yeah no that's exactly what I am looking for thank you. And could you maybe, I know this is a difficult question because every appointment would be different but maybe walk me through a typical appointment for you.

[redacted]: yeah sure. So a typical appointment is somewhere between half an hour and an hour and it usually includes talking about any tests or screening that would be offered to the women or her newborn and providing her with information. The risks the benefits the alternatives. And answering any questions she might already have about that test or screen or topic. And then if there are any things that we had talked about from the week before that are to be done that particular week then we would do those tests and screens in the office or in her home if that's where we are.

Eric 2017-6-14 9:44 PM
**Comment [3]:** Professional role, professional boundaries

Michelle: okay, and how many patients do you provide services for at one time possibly? Or per year?

[redacted]: umm about, I would say about 40 and 4 newborns at one time on any given day. Um like that are in my care, not that I see every day but that I am primary care provider for and then there would be other women who I look after on the weekends.

Michelle: okay. And do you feel that your case-load is restricted by the provincial regulations for midwives?

[redacted]: It is, there is a maximum that you are allowed to provide care to. I believe that is 49 women in a year.

Michelle: yeah that's right I believe that is the correct number, around 49.

[redacted]: okay good, have other women said that okay good [haha] its good to have similar answers.

Michelle: [haha] where do you most often provide services for your patients?

[redacted]: ohhh ummm….ohhhh

Michelle: I know it varies…

[redacted]: yeah it depends on the client. So I would say about 50% of my clients most of the services I offer to them are in their home because we have a lot of clients where we provide all of their prenatal care at home. And then the other 50% I would say most of it

is actually divided between the clinic and the hospital if you are looking at actual numbers of hours that I spend with a women. Is that what you are thinking?

Michelle: yeah no that's perfect thank you

[redacted]: Okay. Yeah just because if the labor is long we may spend more time in the hospital but if the labor is a couple of hours then actually more of our time will be spent in the clinic.

Michelle: Alright. Good. And what do you think your role of a midwife is regarding vaccination.

[redacted]: ohhhhhhh. So when people talk about vaccination usually the first thing I think about is routine childhood vaccinations and so I always say oh we don't have to talk about vaccinations at all because they are out of our care at six weeks so we just say follow up with your family doctor at 8 weeks for your routine childhood vaccinations. And most of the time people don't talk with me about vaccinations, their routine childhood vaccinations anyways. Occasionally someone will ask me about them but I think there are questions later on that talk about how I feel about that so maybe ill just leave it at that…

Michelle: okay we will save those [haha]

[redacted]: and in terms of other vaccinations, the other one, like if I think more about it, the other vaccinations that I do talk about are Rubella because at the very first visit when I offer prenatal blood work I talk about the rubella immunity public health blood work that we offer to everyone and so I explain what rubella is and why most people have immunity and what happens if you don't have immunity then we would offer you a booster in the post partum and why we care about rubella. And the other one that I don't routinely talk about is the influenza vaccination.

Michelle: okay.

[redacted]: mmhmm.

Michelle: so you don't tend to bring up vaccinations for post partum you just say talk to your doctor at 8 weeks and you don't tend to have those discussions?

[redacted]: yeah so we say it is important to book an appointment for your newborn at 8 weeks with your family physician and the reason that we say the 8 week mark is important is because that is the first time that they will be umm eligible for the first set of vaccinations.

Michelle: okay. And are you as a midwife provided provincial recommendations about vaccinations and things during pregnancy and for childhood?

Eric 2017-6-14 9:45 PM
**Comment [4]:** Professional boundaries, environmental context—does the place in which care is delivered influence information flow?

Eric 2017-6-14 9:51 PM
**Comment [5]:** Professional boundaries—it's not my job

Eric 2017-6-14 9:51 PM
**Comment [6]:** Intentions, social influences—not feeling inclined to talk about it unless patients bring it up

Eric 2017-6-14 9:53 PM
**Comment [7]:** Professional boundaries—vaccines are more relevant to the current point of discussion/intervention

Eric 2017-6-14 9:53 PM
**Comment [8]:** Less relevant to current work

[redacted]: Ummm are we provided? Um I am sure that things have come through our box to say like there are the new updated childhood vaccinations… but I don't… its not like we go to a workshop on it every year or anything.

Michelle: okay. And do you feel comfortable recommending vaccines during pregnancy. So for example the influenza vaccine?

[redacted]: I do [said with hesitation]. In that if a client said that 'is it safe for me to take this?' I know the answer is yes. Like I don't have to go and look that up. And I know that the answer is more then yes. I know that the answer is actually that it is recommended that you have this vaccination during pregnancy.

Michelle: okay…so you don't tend to bring up the discussion of vaccination you wait for your client to bring it up.

[redacted]: nooooo no no I don't. And this certainly is…. The study that you are doing is certainly making me reflect on that…but there is no good reason that I don't…

Michelle: Right… it's just whatever your routine practice is ….you just haven't made it part of or gotten into it…

[redacted]: right exactly, its just not part of it. Its not that it couldn't be or shouldn't be its just that its not.

Michelle: okay. And is there anything that you think might help you or improve you to incorporate that into your practices?

[redacted]: mhmm I think that it would actually be a very simple thing to include and all it would be ummm …probably when that vaccination is recommended for us to get a little notice in out mailbox that says now is the time for you to recommend this vaccination and maybe a little…and that reminds me at every appointment to talk about the influenza vaccination. Like I don't think it would be hard at all to implement.

Michelle: and do you feel strongly against any vaccines? Either against during pregnancy or childhood?

[redacted]: uhh no I don't think so

Michelle: and do you find it is something that comes up as general discussion in your workplace or did it come up a lot in your training?

[redacted]: It did not come up a lot in our training…and I would say it doesn't. No. I guess the one we would talk about would maybe be the hepatitis vaccine for newborns who would be at risk. Hepatitis B sorry.

Eric 2017-6-14 9:56 PM
**Comment [9]:** Reinforcement—little incentive or push to promote uptake. Bleeds into professional role, I think.

Eric 2017-6-14 9:57 PM
**Comment [10]:** Knowledge—awareness that vaccines are safe leads to comfort

Eric 2017-6-14 9:58 PM
**Comment [11]:** Incentive/social influences--not feeling inclined to talk about it unless patients bring it up

Eric 2017-6-14 10:04 PM
**Comment [12]:** Behavioural regulation—self-monitoring

Eric 2017-6-14 10:02 PM
**Comment [13]:** Perceived competence/self-efficacy—they do not doubt their ability to implement this change

Eric 2017-6-14 10:03 PM
**Comment [14]:** Self-efficacy

Eric 2017-6-14 10:04 PM
**Comment [15]:** Professional boundaries, incentives

Michelle: and how do you… well first at what stage of pregnancy…lets go there first…at what stage of pregnancy are you most comfortable discussing and recommending patients get vaccines?

[redacted]: it is not part of my practice do I don't have any.

Eric 2017-6-14 10:05 PM
**Comment [16]:** Professional boundaries

Michelle: so you have no preference?

[redacted]: no.

Michelle: so if your patient is an outright refuser of vaccines and you are aware of this, you would not try and encourage them to uptake vaccines?

[redacted]: ummm I …so if I client has made it clear to me that they have no interest in vaccines and they don't wish to discuss them then I certainly would not push that further. Ummm if a client says something that's a little more ambiguous like I am a little unsure about vaccines or I don't usually get them or I don't really know what that one is then absolutely I would talk about it. But I am not going to try and change someone's mind I suppose. I whole-heartedly believe that if you know the risks and benefits and you have chosen to decline something that is recommended then that is okay with me…I am okay with that.

Eric 2017-6-14 10:05 PM
**Comment [17]:** Social influences—interaction

Eric 2017-6-14 10:06 PM
**Comment [18]:**

Eric 2017-6-14 10:07 PM
**Comment [19]:** Intentions—not to change someone's decision?

Michelle: and do you find a lot of your patients do support or get or ask about vaccines? Or do you find that it's 50/50? Or do you find that more are not really supportive of vaccines.

[redacted]: so I think that is two separate questions. So do clients talk to me about vaccination…maybe like one in ten would bring up something about some kind of vaccination…

Eric 2017-6-14 10:07 PM
**Comment [20]:** Social influences—how often do patients probe or initiate discussion about vaccines

Michelle: oh really…

[redacted]: yeah… but do clients support vaccinations whole-heartedly I would say I happen to work in a community that there is a large group of our clients. Like maybe 30 or 40% that don't routinely vaccinate their children and don't participate in any routine vaccination practices.

Michelle: and do you think that's because you are a more rural location? Maybe because you serve a rural population? You have a lot of Mennonites…things like that?

[redacted]: yeah so it's, I think it is more to do with the cultural group that I serve and they happen to live rurally.

Eric 2017-6-14 10:08 PM
**Comment [21]:** Social inlfuences—social norms, group norms; Environmental context and resources—rurality, organizational culture/climate

Michelle: okay

[redacted]: so I don't think it is inherit to where we are because there are lots of English clients who want all the vaccinations and all the tests and everything.

Michelle: Right. And are there any other challenges that you find that you face in your recommendations and discussions of vaccines with your patients? So maybe these could be systemic or these could be in your workplace?

[redacted]: yeah so I would say there is a few. So for my old order folks who experience a lot of barriers regarding transportation and even my old colony Mennonite community who maybe done drive or they only have one vehicle and they are definitely experiencing poverty…that's not like… going into town to go to the pharmacy and get a vaccination or make an appointment with the family doctor to get rubella vaccination like boosters and those kinds of things…. that's not a priority for them. Ummm other things I can think of could include…I think midwives use to do the MMR boosters in the post partum…like I think we use to keep them in the clinic and be able to give them and now we don't…well this practice group at least and the one that I was at before but I don't know about all over Ontario. But because it was to fussy…like in terms of monitoring the fridge temperature and keeping check of everything and making sure that… you know it was just too much.

Eric 2017-6-14 10:12 PM
**Comment [22]:** Environmental context and resources—transportation as a barrier/resource

Eric 2017-6-14 10:13 PM
**Comment [23]:** Professional boundaries

Eric 2017-6-14 10:13 PM
**Comment [24]:** Beliefs about capabilities—task was perceived as too difficult/tedious

Michelle: right right…there is a lot of logistics that goes into storing and giving vaccines.

[redacted]: yes. It's not a simple process and I think they just said 'were not doing it anymore'. And I do think that changes the uptake because for example if I had an old order lady in my office and she was in determinant or not immune to rubella in the pregnancy and we talked about the booster and she accepted it…I think if I could say 'I can give it to you right today before you leave' she would say yes. But if I tell her she has to go to her family doctor to get it when she books her appointment for her newborn she might just not ever book that appointment or just forget to get it.

Eric 2017-6-14 10:14 PM
**Comment [25]:** Outcome expectancies

Eric 2017-6-14 10:15 PM
**Comment [26]:** Beliefs about capabilities—task perceived as too difficult/tedious

Michelle: Right. So it's a convenience thing.

[redacted]: yeah I think that matters a lot. And same with the influenza… like people aren't going to make extra trips into the community…

Michelle: Right…which is part of the challenges of the more rural lifestyle…its more about the convenience and being accessible.

[redacted]: Accessibility, right. Yeah.

Michelle: and have you had any patients who have told you any personal stories about vaccination…so either maybe they went from being a non-vaxxer to a vaxxer or the other way around or they have shared a negative story of vaccines that made them change their perceptions of vaccines? Or even your perceptions of vaccines?

[redacted]: No. No nothing like that. But I'm just brand new so I am sure you get some better answers from the other midwives.

Michelle: [haha] yeah no that's okay! And have you experienced a change in your personal behaviors, perceptions or recommendation practices since you began practicing or even since you began studying?

[redacted]: yeah I think I use to feel a little ambivalent towards the influenza vaccine specifically and we had a case review of a women who had a cough and over night developed fever, walked into the ER and ummm basically coded in the emergency waiting room and then was intubated at a care center and had an emergency delivery…like it was…it shocked me. I was shocked.

Eric 2017-6-14 10:16 PM
**Comment [27]:** Outcome expectancies? What construct is closest to "provider's own attitudes towards vaccines"?

Eric 2017-6-14 10:18 PM
**Comment [28]:** Emotion

Michelle: Yes of course that's terrible.

[redacted]: like just hearing that one story. Just one story that we talked about made me look up more information about influenza vaccination and why it is important for women to have during pregnancy and why even though in that moment I thought 'I am going to recommend this to everyone for sure'…it didn't actually happen.

Eric 2017-6-14 10:23 PM
**Comment [29]:** Knowledge of the importance of vaccines

Michelle: Okay. So what do you perceive as the benefits of the influenza vaccine during pregnancy.

[redacted]: I think of it as protecting the mother. Umm I think for someone like myself or for healthy non-pregnant people to be getting the influenza vaccination I think of that as protecting the community and protecting other people where as I think of the women having the influenza vaccine as protecting herself because he is a vulnerable population.

Michelle: Ahh okay interesting. And what are some benefits and concerns your patients have expressed maybe in your experience.

[redacted]: We don't talk about it enough…I'm sorry…

Michelle: Ohh no that's okay…that's totally okay! And in your experience do the women…and I know in my interviews so far I haven't…this answer has been tricky to get because I know the midwives have ben saying that they don't know what their clients end up doing in the end or once they leave the office. So what I'm starting to learn about midwives is that they don't often end up following through with what their clients end up doing once they leave their office? So a lot so far have been saying they don't have an answer for this one but do you know if any or a lot of the women that you do discuss vaccination with do go through and increase their uptake of vaccines or the influenza vaccination?

[redacted]: Mmhmm that's true. We don't know what they end up doing once they are out of our care. But yeah I think I am far too new to notice any kind of a pattern…I mean that would definitely be…it would just be anecdotal do I don't know how valuable that would be anyway umm yeah I'm not sure. But I do know we don't end up knowing what they end up doing…its not like the family doctor sends us a note to say that 'yes so and so

came to see me and they did get their vaccination'. I mean that would be nice, I would love it but we don't.

Michelle: and that's actually my next question…do you find there is good communication and continuity of care between yourself and the family doctors and OB's and things like that?

[redacted]: There is during the pregnancy but once that 6 week post partum mark hits, they are discharged from our care and in terms of privacy we are no longer allowed to be receiving information about them. So that would, that's why that doesn't happen. Sometimes, like a more experienced midwife might have a better answer for this because they would have more continuity because they have repeats, so they are coming back for their next pregnancy and then she could ask them about it like 'did you get your first baby vaccinated?' or when she is going to discharge that second or third or fourth pregnancy she can say like 'do you remember getting childhood vaccinations with your last baby?' but I don't have that experience.

Michelle: right right. That's perfectly fine. I was actually hoping to get some newer midwives into my study so I am quite happy.

[redacted]: oh good good.

Michelle: umm what is your main source of information for either just new recommendations in general practices or new vaccine recommendations um that you use in your care?

[redacted]: umm new recommendations? Umm the guidelines I follow most closely are the Society of Obstetricians and Gynecologists and the Canadian Pediatric Society...that's who I pay the most attention to…I would say that public…[haha] I have kind of a fussy relationship with public health and the public health inspector. We feel very differently about some of the things they do and don't do. So I value all of their information about vaccination but I would say it doesn't come readily to our office the way others do. Umm would I read them if they came through absolutely. It's certainly harder to get things into practice then it is to just distribute information.

Michelle: Right…are there ways you feel that… for example public health could improve this information translation for you.

[redacted]: umm I feel…I like when…and this is me personally. I like when members from the community, like different specialties come to our office and give a presentation about new things that are happening in the community or guidelines that have changed or recommendations that have changed. I find that in person communication sessions very helpful. And I like when there are concrete guidelines and algorithm's…like we recommend this at this time.

Eric 2017-6-14 10:28 PM
**Comment [30]:** Outcome expectancies—knowing that promoting vaccines is actually working would help

Eric 2017-6-15 3:19 PM
**Comment [31]:** Professional boundaries, outcome expectancies—it would be useful to know what happens after

Eric 2017-6-15 3:22 PM
**Comment [32]:** Knowledge, professional boundaries

Eric 2017-6-15 3:22 PM
**Comment [33]:** Perceived competence, outcome expectancies

Eric 2017-6-15 3:23 PM
**Comment [34]:** Knowledge—procedural knowledge

Eric 2017-6-15 3:24 PM
**Comment [35]:** Skills development, professional boundaries, helps improve self-confidence or perceived competence.

Michelle: Okay. And is there any way getting information could be more efficient for you? Um so I know you just said the presentations and things like that, but is there anything that would be more efficient for you on a day-to-day basis?

[redacted]: umm I think this exists somewhere because I am sure that I have seen it before but I don't know if its easy enough for me to just Google and pull up but it would be nice to have a chart that lists…I'm sure it exists. But I feel like maybe it would be useful to have that. It's honestly so rare that I am talking about it that it is not on my radar.

Eric 2017-6-15 3:25 PM
**Comment [36]:** Self-efficacy

Michelle: No that's okay. Umm would you be comfortable administering vaccines if scope of practice allowed? Because obviously midwives um don't administer the vaccines but if they were to change…

[redacted]: Ohh yeah like influenza? Yeah I wouldn't mind that…except for the fussiness of storing it but the actual act of administering it is okay with me because we administer other tings that can have I guess reactions so I don't, I would be okay with that. And I certainly thing it would change the uptake.

Eric 2017-6-15 3:26 PM
**Comment [37]:** Professional boundaries

Eric 2017-6-15 3:27 PM
**Comment [38]:** Reinforcememt, perceived competence—how easy or feasible would this implementation be? Would it be tedious?

Michelle: mmhmm and are there other areas of midwifery that you feel could be expanded?

[redacted]: in terms of vaccinations?

Michelle: No just in general.

[redacted]: ohhh yeah so many ! so many areas.

Michelle: Okay now I would like to just circle back to the Mennonites for a second because I know you brought them up at the beginning but I just wanted to ask you a little bit about how you have noticed umm if there practices and trends in their care and things like that…some of the main differences you have noticed between your Mennonite clientele and your other clientele.

[redacted]: ummm

Michelle: if any.

[redacted]: umm in terms of vaccination?

Michelle: it can be any type of care, it can be in terms of vaccinations um…there approach to care in general. Do you find they have a lot of vaccine uptake, or curiosity about vaccines?

[redacted]: umm I would say umm as a whole they use less vaccination then my English clients. But its not to say, I would never say as a group they don't vaccinate at all because that is certainly not the case. They are getting their children…they are sorry. Some old

order Mennonites are getting their children vaccinated, some are not. And I could never look at one or talk with a family and tell you whether or not they are vaccinating their children…it really does seem to be a personal choice in those communities. Umm what else ….I don't think the influenza vaccine is something that they are doing. Like I would say I would say childhood vaccinations they are okay with most often. Lots of women, most women I would say are Rubella immune so most women it would seem are getting vaccinated ummm these is not Hepatitis B there and I don't think they are getting vaccinations for Hep B. They are also not a part of the public school system to vaccinations that we do in school they maybe are not getting... but I honestly don't know a whole lot about all those vaccinations and when they happen for children.

Eric 2017-6-15 3:43 PM
**Comment [39]:** Any patterns are not consistent enough to draw any conclusions or assumptions re: cultural/social norms?

Eric 2017-6-15 3:38 PM
**Comment [40]:** Environmental context and resources—organizational culture—those not in the public school system less likely to get vaccinated?

Michelle: Right... no that's okay. And what proportion of your clientele would you say are Mennonite? Versus the English.

[redacted]: uhmm 50%

Michelle: good okay.

[redacted]: and that includes so old order Mennonites groups, I would also put older Amish groups in there, old colony Mennonites. Like a whole different spectrum of Mennonite groups and they are have different beliefs.

Michelle: Right. Very cool, very interesting.

[redacted]: yeah

Michelle: well that's all of my main questions, now I leave the floor open to you. If anything comes to mind or if there is anything you would like to say regarding this topic then the floor is open to you.

[redacted]: okay um I don't think here is anything else I have to add.

Michelle: no? okay then I thank you very much for your time. I really really appreciate it.

[redacted]: oh no problem at all.

Michelle: I really hope you enjoy your day and you week and thank you so much for taking the time to talk to me

[redacted]: thank you! Thank you so much! No problem. And do you send out like I know it'll be a while before this is all finished but do you send a copy of the study?

Michelle: I certainly can. I will mark it down that you would like one. And I am aiming to finish around August. So you can expect it around then [haha].

[redacted]: yeah that would be lovely! That's fast wow. Okay.

Michelle: Amazing thank you so much!

[redacted]: Thank you take care.

Michelle: You too, bye [redacted].

* beep [phone hang up]

recording end.

## Appendix H

| | |
|---|---|
| Blue Heron Midwives | Phone: (519) 954-0300 \| Fax: (519) 954-8861<br>Address: 30 Dupont St E #105<br>Waterloo, ON N2J 2G9<br>**info@blueheronmidwives.com** |
| St Jacobs Midwives | Phone: (519) 664-2542<br>Address: 9 Parkside Drive, Unit 2<br>St. Jacobs, Ontario, N0B 2N0 |
| Midwives of Headwater Hills | Phone: (519) 941-2676 \| Fax: (519) 941-2696<br>Address: 205467 County Rd. 109<br>Amaranth, ON L9W0V1<br>**Info@midwivesofheadwaterhills.ca** |
| Kitchener Waterloo Midwifery Associates | (519) 569-8679<br>Address: 900 King St W. Unit 8<br>Email: info@kwmidwifery.ca |
| Born Midwives | Phone: (519) 267 7266<br>Address: 766 Hespeler Road #205<br>Cambridge On |
| Cambridge Midwives | Phone: 519 624-9708 \| Fax: 519 624-1493<br>Address: 22 George Street N.<br>Cambridge ON<br>Email: cmidwives@bellnet.ca |
| Country Side Midwifery Services | Phone: Milverton 519-595-4815 ; Palmerston 519-343-5559 \| Fax: Milverton 519-595-8176 ; Palmerston 519-343-4365<br>Address: 336 Main St. W, Palmerston<br>c/o Tracy Zemmelink PO Box 760, Palmerston, ON |
| Genesis Midwives | Phone: 519 568-8282 \| Fax: 519 568-8277<br>Address: 751 Victoria St. S, Unit 204 Kitchener ON<br>Email: info@genesismidwives.ca |
| Guelph Midwives | Phone: 519 823-9785 \| Fax 519 823-9251<br>Address: 176 Wyndham St N, 2nd Floor, Guelph ON<br>Email: info@guelphmidwives.com |
| Midwives Grey Bruce<br>[Out of district but services WW area] | Phone: 519-371-2886 \| Fax: 519 371-3326<br>Address: 265 8th St E, Owen Sound ON |
| The Centre for Family Medicine | Phone: (519) 904-0656<br>250 Laurelwood Drive |
| Andrew Street Family Health Centre | Phone:(519) 804-9234<br>Address: 16 Andrew St. |
| Centre for Family Medicine | Phone: (519) 783-0020<br>Address: 10 Victoria Street S. |

| | |
|---|---|
| Center for Family Medicine | Phone: 519-783-0020 \| Fax: 519-783-0034<br>Address: 10B Victoria St S<br>Kitchener, ON |
| eHealth Centre for Excellence | Phone: 226 336-9885 \| Fax: 519 783 0034<br>Address: Williamsburg Town Centre<br>1187 Fischer Hallman Road, Kitchener ON |
| Centre for Family Medicine: Joseph Street Site | Phone: 519 578-2100 \| Fax: 519 578-2109<br>Address: 25 Joseph St. Kitchener, ON |
| Centre for Family Medicine: Wellesely Site | Phone: 519 656-2220 \| Fax: 519 656 3173<br>Address: 3742 Nafziger Rd. Wellesely ON |
| East Wellington Family Health Team | Erin Clinic 519-833-9396<br>Rockwood Clinic 519-856-4611<br>Administration: 519-833-0343<br>Address: 6 Thompson Cres, Unit 1<br>Erin ON.<br>Email:info@ewfht.ca |
| Grandview Medical Centre Family Health Team | Phone: 519 623 4200 \| Fax 519 623 2564<br>Address: 167 Hespler Rd, Cambridge ON |
| Guelph Family Health Team | Phone: 519 837 4444 \|Fax: 519 837 2202<br>Address: Old Quebec Street Mall<br>55 Whyndham St N, Ste 212<br>Guelph ON |
| Mango Tree Family Health Team [Guelph Location] | Phone: 519-224-0540 \| Fax: 519-224-0550<br>Address: 28 Brock Road N. Guelph ON |
| Mango Tree Family Health Team [Kitchener Location] | Phone: 519-224-0541 \| Fax: 519-224-0546<br>Address: 550 King St E, 2nd Fl. Kitchener ON |
| Minto-Mapleton Family Health Team | Phone: Drayton and Palmerston Office: 519-638-2110<br>Fax: Drayton: 519-638-5096<br>Clifford: 519-327-4767<br>Address: Mapleton Health Centre<br>11 Andrews Dr W<br>Drayton, ON |
| Mount Forest Family Health Team | Phone: 519 323 0255 \| Fax: 519 232 2113<br>Address: 525 Dublin St<br>Mount Forest, ON |
| New Vision Family Health Team [Belmont Clinic] | Phone: 519 576-4070 \| Fax: 519 567 4109<br>Address: Belgage Medical Building<br>525 Belmont Ave W, Unit 206<br>Kitchener, ON |
| New Vision Family Health Team [Greenbrook Clinic] | Phone: 519 578 3510 \| Fax 519 579 6040<br>Address: 421 Greenbrook Dr, Unit 23B |

| | |
|---|---|
| | Kitchener, ON |
| Two Rivers Family Health Team | Phone: 519 740 5010<br>Address: 350 Conestoga Blvd, Unit B12<br>Cambridge, ON<br>Email: admin@tworiversfht.ca |
| Two Rivers Family Health Team [Hespler Medical clinic] | Phone: 519 629 4615<br>Address: 350 Conestoga Blvd, Unit B12<br>Cambridge, ON<br>Email: admin@tworiversfht.ca |
| Upper Grand Family Health Team | Phone: 519 843 3947 \| Fax: 519 843 3786<br>Address: Highlands Plaza, 753 Tower St. S<br>Fergus ON<br>Email: info@uppergrandfht.org |

*Additional Clinics Added in second round of recruitment on following ethics approval on July 7, 2017.*

| | |
|---|---|
| Family Midwifery Care of Guelph | Phone: 519 763 8568 \| Fax: 519 7630671<br>Address: 672 Woolwich St , Unit 1<br>Guelph ON |
| Stratford Midwives | Phone: 519 271 3490 \| Fax: 519 271 6264<br>Address: 386 Cambria St, Suite 101<br>Stratford ON<br>Email: stratfordmidwives@gmail.com |
| Grand Valley Midwives | Phone: 519 928 2323 \| Fax: 519 928 2343<br>Address:<br>Fergus ON<br>Email: info@grandvalleymidwives.ca |
| Talbot Creek Midwives | Phone: 519 637 2224\|<br>Address: St. Thomas ON & Komoka ON<br>Contacted Via Online Request |
| Women Care Midwives | Phone: 519 645 0316\| Fax: 519 645 8802<br>Address: 101-345 Westminster Ave<br>London ON<br>Email: admin@midwives.on.ca |
| Thames Valley Midwives | Phone: 519 433 5855\| Fax: 519 433 8306<br>Address: 343 Maitland Street Suite 1<br>London ON<br>Email: info@tvn.ca |
| Midwives of Windsor | Phone: 519-252 4784<br>Address: 3357 Walker Rd. Unit #3<br>Windsor, ON<br>Email: midwivesofwindsor@outlook.com |
| | |

| | |
|---|---|
| Midwives Collective of Essex County | Phone: 519 252 4700<br>Address: 1455 Pelissier St.<br>Windsor, ON<br>Email: mcec@mac.ca |
| Niagara Midwifery Practice | Phone: 905-684 6377<br>Address: 13 Lyman St.<br>St Catherine, ON<br>Email: admin@niagaramidwives.com |
| Sages-Femmes Renaissance Midwifery | Phone: 905-714 7258<br>Address: 196 East Main St.<br>Welland, ON<br>info@renaissancemidwifery.ca |
| Lincoln Community Midwives | Phone: 289 566 9350<br>Address: 5000 King St.<br>Beamsville, ON<br>No email provided. |
| Midwives of East Erie-Simcoe | Phone: 905-701-7428 OR 519-410 6525<br>Address: Victoria St E. Dunnville, ON<br>Email: midwiveseasterie@rogers.com |

*Toronto Clinics Contacted Following Discussion with Samantha Meyer July 20, 2017*

| | |
|---|---|
| Women's Care Clinic Toronto | Phone: 416-256-4139<br>Address: Toronto ON<br>Email: info@womenscareclinic.ca |
| The Midwives Clinic of East York- Don Mills | Phone: 416-424-1976<br>Address: 1 Leaside Park Drive, Unit 3.<br>Toronto ON<br>Email: themidwivesclinic@bellnet.ca |
| Kensington Midwives | Phone: 416-928-9777<br>Address: 340 College St. Suite 450<br>Toronto, ON<br>Email: kmw@kensingtonmidwives.ca |
| Riverdale Community Midwives | Phone: 416 922 4004<br>Address: 43 River Street, Toronto ON<br>Email: info@riverdalemidwives.com |
| Seventh Generation Midwives Toronto | Phone: 416-530-7468<br>Address: 525 Dundas St E<br>Toronto ON<br>No email provided |
| Midwives Collective Toronto | Phone: 416 963 4398<br>Address: 1203 Bloor St W<br>Email: midwivescollective@gmail.com |
| Community Midwives of Toronto | Phone: 416 944 9366<br>Address: 344 Bloor St W, Toronto ON<br>No Email Provided |
| Midwifery Care- North Don River Valley | Phone: 416 222 0093 |

| | |
|---|---|
| | Address: 200 Finch Avenue West, Unit 109<br>Toronto, ON<br>Email: admin.mcndrv@bellnet.ca |
| Midwife Alliance | Phone: 416 534 9161<br>Address: 166 The Queensway.<br>Toronto, ON<br>Email: Not Provided |
| Diversity Midwives | Phone: 416 609 8187<br>Address: 10 Bimbrok Road<br>Scarborough<br>Email: info@diversitymidwives.com |
| West End Midwives | Phone: 416 792 5665<br>Address: 102-1017 Wilson Ave<br>North York, ON<br>Email: info@westendmidwives.ca |
| Family Care Midwives | Phone: 416 477 2633 OR 905 553 5899<br>Address: 9983 Keele St, Unit 102 Vaughan<br>Email: Not Provided |
| East Mississauga Midwives | Phone: 905 232-5455<br>Address: 2555 Dixie Rd<br>Mississauga ON<br>Email: info@themidwifeclinic.ca |
| Sages-Femmes Rouge | Phone: 416 286 2228 O 905 409 6447<br>Address: 91 Rylander Blvd, Unit 1020<br>Scarborough, ON<br>Email: rougevalleymins@gmail.com |

Outside of Toronto Area

| | |
|---|---|
| Midwives of Lindsay and The Lakes | Phone: 705-324-4664<br>Address: 41 Russell St. West<br>Lindsay ON<br>Email: midwivesoflindsay@gmail.com |
| Kawartha Community Midwives | Phone: 705-745-7640<br>Address: 295 Stewart Street<br>Peterborough, Ontario K9J 3N2<br>Email: kawartha_midwives@bellnet.ca |
| Grand Valley Midwives | Phone: 519 928 2323<br>Address: 2 Main St S, Grand Valley ON<br>Email: info@grandvalleymidwives.ca |
| Midwifery Care of Peel and Halton Hills | Phone: 905-569-9995<br>Address: 101 – 2227 South Millway<br>Mississauga, ON L5L 3R6<br>Email: midwiferycare@mcphh.ca |
| Midwives of Chatham Kent | Phone: 519 358 1888 |

| | |
|---|---|
| | Address: 100 King St. West<br>Chatham ON<br>Email: midwivesofchathamkent@bellnet.ca |
| Midwifery Services of Lambton Kent | Phone: 519 337 2229<br>Address: 1315 Michigan Ave<br>Sarnia ON<br>Email: info@sarniamidwives.com |
| The Hamilton Midwives | Phone 905 527 8919<br>Address: 186 Hughson Street South<br>Hamilton ON<br>Email: info@hamiltonmidwives.ca |
| Community Midwives of Brantford | Phone: 519 751 6444<br>Address: 217 Terrace Hill Suite 100<br>Brantford, ON<br>Email: cmob@on.aibn.com |
| Burlington Area Midwives | Phone: 905 592 2905<br>Address: 159 Plains Road West<br>Email: info@burlingtonmidwives.com |
| | |
| | |

*** Locations were gathered from a Google search as well as from the websites listed below for a total of 29 possible recruitment locations (10 midwifery clinics and 19 family health clinics).**

http://www.wwhealthline.ca/listServices.aspx?id=10065
http://www.wwhealthline.ca/listServices.aspx?id=10655
http://www.aom.on.ca/practice_map.aspx

Insert Clinic Name,

My name is Michelle Simeoni and I am a graduate student form the University of Waterloo in the School of Public Health and Health Systems working under the supervision of Samantha Mayer. I am conducting my thesis work on midwives in the Waterloo-Wellington region and their knowledge, attitudes, beliefs and behaviors regarding recommendation and discussion of flu vaccine with their pregnant clients. I am currently seeking midwives who would be interested in participating in telephone or face-to-face interviews.

Participation would require scheduling a face-to-face or telephone interview for approximately one hour of semi structured interviewing to discuss topics related to vaccination during pregnancy, vaccine hesitancy and vaccine uptake in maternal care. I would like to assure you that the study has been reviewed and received ethical clearance through a University of Waterloo Research Ethics Committee.

If you have interest in participating in this study I ask that you please see the attached flyer and contact me for more detailed information. I also ask that you please forward this email to your staff and display this flyer within your clinic to aid in recruitment it would be greatly appreciated.

Sincerely

Michelle Simeoni

**Recruitment Document: Phone Script**

Hello,

My name is Michelle Simeoni and I am a graduate student form the University of Waterloo in the School of Public Health and Health Systems working under the supervision of Samantha Mayer. May I have a moment of your time to discuss my research with you. I am conducting my thesis work on midwives in the Waterloo-Wellington region and their knowledge, attitudes, beliefs and behaviors regarding recommendation and discussion of the influenza vaccine with their pregnant clients. I am currently seeking midwives who would be interested in participating in telephone or face-to-face interviews.

Participation would require scheduling a face-to-face or telephone interview for approximately one hour of semi structured interviewing to discuss topics related to vaccination during pregnancy, vaccine hesitancy and vaccine uptake in maternal care. This study has been reviewed and received ethical clearance through a University of Waterloo Research Ethics Committee.

May I forward you an informational letter and flyer to be displayed in your clinic to aid in recruitment? I ask that you please spread the word and pass on my contact information to midwives who may be interested in participating in my study.

Thank you for taking the time to speak with me today.

UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES

# STUDY ON VACCINE RECOMMENDATION PRACTICES AMONG MIDWIVES

## PARTICIPANTS NEEDED

We are conducting a study through the University of Waterloo School of Public Health and Health Systems exploring midwives knowledge, attitudes, behaviours and beliefs in discussing and recommending the seasonal flu vaccine to their pregnant clients in the Waterloo-Wellington Region. We are looking for volunteer research participants.

You are invited to participate in a study that includes a one time telephone or face-to-face interview about vaccine discussion or recommendation practices and experiences as a maternity care provider. The time commitment for the short demographic questionnaire and interview will be approximately half an hour and will take place in an agreed-upon location.

There is no remuneration for participation in this study.

This study has been reviewed by, and received ethics clearance through a University of Waterloo Office of Research Ethics.

**Please contact Michelle Simeoni at msimeoni@uwaterloo.ca if you would like more information about this study.**

| |
|---|
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| msimeoni@uwaterloo.ca<br>647-528-4471 |
| [msimeoni@uwaterloo.ca<br>647-528-4471 |

UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES

# STUDY ON VACCINE RECOMMENDATIONS AMONG MIDWIVES

## PARTICIPANTS NEEDED

We are conducting a study exploring midwives knowledge, attitudes, behaviours and beliefs in discussing and recommending the flu vaccine to their pregnant clients in the Waterloo-Wellington Region. The results from this study will be used build knowledge around vaccine hesitancy and improve knowledge and recommendation practices among providers. Participants will be recruited from various maternity care and family health clinics in the Waterloo-Wellington Region.

You are invited to participate in a one time telephone or face-to-face interview about vaccine discussion or recommendation practices and experiences as a maternity care provider. The time commitment for the short demographic questionnaire and interview will be approximately half an hour and will take place in an agreed-upon location. If you are interested in finding out more, ***please email msimeoni@uwaterloo.ca:***

If you have any additional questions, please do not hesitate to contact me using the email address above. You are also welcome to contact Dr. Samantha Meyer for further information. This study has been reviewed by, and received ethics clearance through a University of Waterloo Office of Research Ethics.

I appreciate your time,

**Michelle Simeoni**
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : msimeoni@uwaterloo.ca

Dr. Samantha Meyer
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : samantha.meyer@uwaterloo.ca

UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES

**Detailed Letter of Information**

**Vaccinating Pregnant Women: Exploring midwives' perspectives regarding vaccination in pregnancy in the Waterloo-Wellington Region**

Dear Potential Participant,

My name is Michelle Simeoni and I am a Master's student in the School of Public Health and Health Systems at the University of Waterloo. I am conducting a research study as a part of my degree. The topic is vaccine hesitancy among midwives within the Waterloo Wellington Region. This letter will give you more information so that you can make an informed decision about your participation.

Participants for this study will be recruited from the various Midwifery, Maternity care and family health clinics in the Waterloo Wellington Region.

**What will I have to do?**

You are invited to participate in a one-time, telephone or face-to-face interview. The interview will take place in agreed upon location. You will be emailed a letter of information, a short questionnaire and the interview questions ahead of time to allow for some preparation for the interview. The questions on the short questionnaire will ask you some personal questions, such as your experience levels, personal experience with clients and perceptions of vaccines. The questions I will ask during this interview will focus on your experiences with vaccines within your time as a maternal care provider. You can skip any questions you do not wish to answer during the interview. The time commitment for the interview is approximately half-hour.

Your participation in this study is voluntary and you can withdraw your participation at any time without any consequences. If you choose to participate, your identity will remain confidential. With your permission, the interview will be audio recorded using a handheld device and transcribed. All audio recordings will be stored in an encrypted folder on the researchers computer and only accessible by the researcher to provide increased confidentiality for the participant. Your name will not be disclosed in any report or thesis. However, with your permission, I may use your exact quotations. Any electronic recordings will be stored on a password-protected laptop and will be erased after seven years. The paper-based short demographic questionnaire and any notes I take will be stored in a locked cabinet in my supervisor's office for seven years.

After the interview, I may ask for your permission to re-contact you at some point over the next several months, to verify some of my initial findings.

**Are there any risks or benefits to my participation?**

It is anticipated that this study poses a minimal risk to you. You will be asked for some personal information and stories during the survey and interview, which may cause some emotional discomfort. There is also the potential for participants to experience tension based on their opposing views with the researcher regarding vaccination during pregnancy however the interviews will be conducted in an unbiased manor and the content of the interviews will be kept confidential and

unidentifiable.  As a researcher I am interested in hearing all viewpoints and pass no judgement on personal opinions and choices expressed during interviews. Participants are free to skip questions that they are uncomfortable answering or end then interview at any point.

By participating in this study you receive no direct benefit, however, you have the opportunity to provide potential scientific and societal benefits. Your responses and insights will help provide a deeper understanding of vaccine hesitancy among health providers, more specifically the underrepresented midwives, across Canada. The results may be used to develop policy papers and initiatives to improve vaccine recommendation and uptake across Canadian

**What will we do with your results?**

This study is being conducted in partnership with **Canadian Immunization Research Network** (**CIRN)**, a network of vaccine researchers that works closely with Public Health Agency of Canada (PHAC) to develop and test methodologies related to the evaluation of vaccines as they pertain to safety, effectiveness, program implementation and evaluation. CIRN has contributed to immense amounts of valuable vaccine research through studies, publications and knowledge translation.

The results from this study will be published in a thesis, which I am happy to provide for you. Some of your responses to the questions in the interview may be included as direct quotes but you will be referred to by a pseudonym (i.e., not your real name). The conversations we have during the interview will be recorded with an electronic recording device. These recordings will be stored on a password-protected computer that only I will have access to. These recordings will be kept until December 2023 and then destroyed.

I would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 22112). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.If you have any additional questions, please do not hesitate to contact me using the email address listed below.

Thank you for your consideration of contributing to this study!

**Michelle Simeoni**
Student Investigator
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : msimeoni@uwaterloo.ca

**Project Supervisor**
Dr. Samantha Meyer
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : samanthe.meyer@uwaterloo.ca

UNIVERSITY OF WATERLOO

**FACULTY OF APPLIED HEALTH SCIENCES**
519-888-4567, ext. 31346 | fax 519-746-6776
ahsrecep@uwaterloo.ca | uwaterloo.ca/applied-health-sciences

## ***Consent of Participant***

By providing consent, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted by Michelle Simeoni of the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, received satisfactory answers to my questions, and have been given any additional details I requested. I am aware that the study is voluntary and I may withdraw from participating without penalty at any time by advising the student investigator of this decision. I understand that my participation in this study a one-time, face-to-face or telephone interview, approximately one hour in duration, which will take place in private meeting space. I understand that I can refrain from answering any of the questions on the survey or during the interview. I am aware that only the student investigator and the members of the research team will have access to the information that I provide in the interview, although my identity will remain confidential. I understand that the records of the interview will be destroyed after seven years. I understand that there are minimal risks anticipated to me as a participant in this study.

This study has been reviewed by, and received ethics clearance through a University of Waterloo Research Ethics Committee

---

Please check the boxes

- ☐ I agree to let my answers to open-ended questions be included as anonymous quotes in the final report.
- ☐ I consent to the audio recording of my responses during the interview.
- ☐ I consent for the transcripts and other non-identifiable data to be included in other related research projects to be completed by either the researcher or other research's/research groups
- ☐ With full knowledge of all foregoing, I agree, of my own free will, to participate in this study

Participant Name:_____ Date:_____

Participant Signature:_____

Witness Signature:_____

**Michelle Simeoni**
Student Investigator
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : msimeoni@uwaterloo.ca

**Project Supervisor**
Dr.Samantha Meyer
School of Public Health and Health Systems
Faculty of Applied Health Sciences
University of Waterloo
E-mail : samantha.meyer@uwaterloo.ca

Permission to Re-Contact

To ensure that the findings of this study accurately represent your experiences, I will be contacting participants during the analysis process to engage in quote checking. With your permission, I would like to contact you sometime over the next six months to have a conversation with you regarding my final results. This conversation be over email or telephone and will refer only to the study you have consented to participate in, titled "Vaccinating Pregnant Women: Examining the Nature of Hesitancy Among Midwives in the Waterloo-Wellington Region". If you agree to be contacted, you are not obligated to take part in a telephone or email conversation with me. Your name and contact information will only be available to my research committee members and myself.

I agree to be contacted for a follow-up telephone/email conversation by the student investigator, Michelle Simeoni, regarding the results of the study "Vaccinating Pregnant Women: Examining the Nature of Hesitancy Among Midwives in the Waterloo-Wellington Region". I understand that this agreement does not obligate me to take part in a telephone/email conversation and that I can ask for my contact information to be deleted at any time.

Name:_____

Telephone #:_____

E-mail Address:_____

Best Time to be Contacted:_____

## Appendix L

Demographic Questionnaire

I would like to learn a little bit about you!

1. Age _____

2. Place of Employment _____

3. Number of Years Experience_____

4. Training and Education (years and location)

_____

_____

5. Work Experience

_____

_____

_____

| Participant ID | Age | Education | Place of Employment | Years of Experience |
|---|---|---|---|---|
| ID_001 | Refused | McMaster 1998 | St. Jacobs Midwives | 18 |
| ID_002 | 37 | McMaster Bachelor of Hea | St. Jacobs Midwives | 9 |
| ID_003 | 26 | McMaster | Countryside Midwives | 1 |
| ID_004 | 38 | McMaster Midwifery Educ | Cambridge Midwives | 12 |
| ID_005 | 37 | Schooling in Texas then wi | St Jacobs Midwives | 10 or 11 |
| ID_006 | N/A | McMaster Midwifery Educ | College of Midwives | Not Practicing |
| ID_007 | 47 | McMaster University (4 ye | Genesis Midwives | 14 |

Ontario Medical Association

*In conjunction with the*

Ontario Ministry of Health and Long-Term Care

# Antenatal Record 1

| Patient's Last Name | Patient's First Name | | | | |
|---|---|---|---|---|---|
| Address – number, street name | | Apt/Suite/Unit | | | |
| City/Town | Province | Postal Code | Partner's Last Name | Partner's First Name | |
| Telephone - home | Telephone - Work | Language | Age | Occupation | Educational Level |
| Date of birth YYYYMMDD | Age | Occupation | Educational Level | Ethnic or Racial Backgrounds: Mother / Father | |
| OHIP No. | Patient File No. | Marital status | Birth attendant | Newborn care | Family Physician |

Allergies or Sensitivities (describe reaction details)

Medications/Herbals

## Pregnancy Summary

LMP YYYYMMDD — Certain Yes ☐ No ☐

Cycle q _____ — Regular Yes ☐ No ☐

Contraceptive type — Last Used YYYYMMDD

EDB (by dates)

**Final EDB**

Dating Method
- ☐ Dates
- ☐ $T_1$ US
- ☐ $T_2$ US
- ☐ ART (e.g. IVF)

| Gravida | Term | Premature | Abortuses | Living |
|---|---|---|---|---|
| | | | | |

## Obstetrical History

| No. | Year | Sex M/F | Gest. age weeks | Birth weight | Length of labour | Place of birth | Type of delivery | Comments regarding pregnancy and birth |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

## Medical History and Physical Exam (provide details in comments)

**Current Pregnancy**

| | |
|---|---|
| 1. Bleeding | Y / N |
| 2. Nausea/vomiting | Y / N |
| 3. Smoking ___cig/day | Y / N |
| 4. Alcohol, street drugs | Y / N |
| 5. Occup./environ. risks | Y / N |
| 6. Dietary restrictions | Y / N |
| 7. Calcium adequate | Y / N |
| 8. Preconceptual folate | Y / N |

**Medical History**

| | |
|---|---|
| 9. Hypertension | Y / N |
| 10. Endocrine | Y / N |
| 11. Urinary tract | Y / N |
| 12. Cardiac/pulmonary | Y / N |
| 13. Liver, hepatitis, GI | Y / N |
| 14. Gynaecology, breast | Y / N |
| 15. Hem./immunology | Y / N |
| 16. Surgery | Y / N |
| 17. Blood transfusion | Y / N |
| 18. Anaesthetic compl. | Y / N |
| 19. Psychiatric | Y / N |
| 20. Epilepsy, Neurological | Y / N |
| 21. Other | Y / N |

**Genetic History**

| | |
|---|---|
| 22. At risk population (e.g.: Ashkenazi, consanguinity , CF, sickle cell, Tay Sachs, thalassemia) | Y / N |

Family history of:

| | |
|---|---|
| 23. Developmental delay | Y / N |
| 24. Congenital anomalies | Y / N |
| 25. Chromosomal disorders | Y / N |
| 26. Genetic disorders | Y / N |

**Infectious Disease**

| | |
|---|---|
| 27. Varicella susceptible | Y / N |
| 28. STDs / HSV / BV | Y / N |
| 29. Tuberculosis risk | Y / N |
| 30. Other | Y / N |

**Psychosocial**

| | |
|---|---|
| 31. Poor social support | Y / N |
| 32. Relationship problems | Y / N |
| 33. Emotional/Depression | Y / N |
| 34. Substance abuse | Y / N |
| 35. Family violence | Y / N |
| 36. Parenting concerns | Y / N |
| 37. Relig. / cultural issues | Y / N |

**Family History**

| | |
|---|---|
| 38. At risk population (e.g.: DM, DVT/PE, PIH/HT, postpartum depression, thyroid) | Y / N |

**Physical Examination**

Ht._____ Wt._____

BMI_____ BP _____

| | |
|---|---|
| 39. Thyroid | N / Abn |
| 40. Chest | N / Abn |
| 41. Breasts | N / Abn |
| 42. Cardiovascular | N / Abn |
| 43. Abdomen | N / Abn |
| 44. Varicosities / extrm. | N / Abn |
| 45. External genitalia | N / Abn |
| 46. Cervix, vagina | N / Abn |
| 47. Uterus | N / Abn |
| 48. Size: _____ weeks | |
| 49. Adnexae | N / Abn |
| 50. Other | N / Abn |

## Initial Laboratory Investigations

| Test | Result | Test | Result |
|---|---|---|---|
| Hb | | HIV | |
| MCV | | ☐ Counseled and test declined | |
| ABO | | Last Pap | |
| Rh | | YYYYMMDD | |
| Antibody Screen | | GC/Chlamydia | |
| Rubella immune | | Urine C&S | |
| HBsAg | | | |
| VDRL | | | |
| Sickle Cell | | | |

| Prenatal Genetic Screening | | Result |
|---|---|---|
| a) All ages-MSS, IPS, FTS | ☐ | |
| b) Age ≥ 35 at EDB-CVS/amnio | ☐ | |
| c) If a or b declined, then MSAFP | ☐ | |
| d) Counseled and test declined | ☐ | |

## Comments

Ontario Medical Association

*In conjunction with the*

Ontario Ministry of Health and Long-Term Care

# Antenatal Record 2

| Patient's Last Name | Patient's First Name |
|---|---|
| Birth attendant | Newborn care |
| Family Physician | **Final EDB** |

| G | T | P | A | L |
|---|---|---|---|---|
| | | | | |

| **Allergies or Sensitivities** | **Medications / Herbals** |
|---|---|
| | |

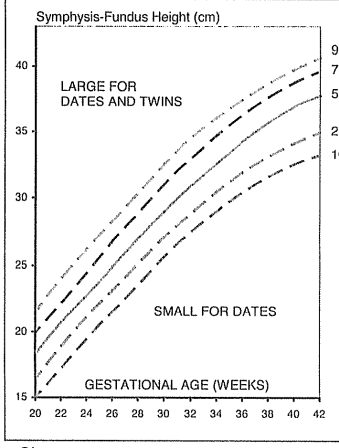
| **Identified Risk Factors** | **Plan of Management** |
|---|---|
| | |

**Recommended Immunoprophylaxis**

**Rh neg.** ☐ **Rh IG Given:** YYYY/MM/DD | **Rubella booster postpartum** ☐ | **Newborn needs: Hep B IG** ☐ **Hep B vaccine** ☐

**Subsequent Visits**

| Date | GA (weeks) | Weight. | B.P. | Urine Prot. | SFH | Pres. Posn. | FHR/ FM | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | IPS, FTS, NT best done between 11w0d and 13w6d |
| | | | | | | | | MSS best done between 15w0d and 17w6d |
| | | | | | | | | Ultrasound for fetal anatomy best done between 18 and 20 weeks |
| | | | | | | | | |
| | | | | | | | | Antenatal 1 to L&D when final EDB known and Initial Laboratory Investigations complete |
| | | | | | | | | |
| | | | | | | | | Arrange for Prenatal Education Classes |
| | | | | | | | | 24-28 week blood work with 1 hr. GCT |
| | | | | | | | | Rh Immunoprophylaxis at 28 weeks |
| | | | | | | | | |
| | | | | | | | | Group B Strep. screening best done between 35 and 37 weeks |
| | | | | | | | | Antenatal 2 to be sent to Labour and Delivery |
| | | | | | | | | |
| | | | | | | | | Review Labour and Delivery plans: |
| | | | | | | | | -pain management in labour |
| | | | | | | | | -admission and discharge timing |
| | | | | | | | | -postpartum contraception |
| | | | | | | | | |




**Ultrasound**

| Date | GA | Result |
|---|---|---|
| | | Dating scan (if done) |
| | | 18-20 weeks for morphology |
| | | |
| | | |

**Additional Lab Investigations**

| Test | Result |
|---|---|
| Hb | |
| ABO/Rh | |
| Repeat ABS | |
| 1 hr. GCT | |
| 2 hr. GTT | |
| GBS | |
| | |
| | |
| | |
| | |

**Discussion Topics**

| | | |
|---|---|---|
| ☐ Exercise | ☐ Preterm labour | ☐ Breastfeeding |
| ☐ Work plan | ☐ PROM | ☐ Circumcision |
| ☐ Intercourse | ☐ APH | ☐ Discharge planning |
| ☐ Travel | ☐ Fetal movement | ☐ Car seat safety |
| ☐ Prenatal classes | ☐ Admission timing | ☐ Depression |
| ☐ Birth plans | ☐ Pain management | ☐ Contraception |
| ☐ On call providers | ☐ Labour support | ☐ Postpartum care |

## Appendix

# Ethics Review Feedback (L1b) (ORE # 22112)

ORE Ethics Application System <OHRAC@uwaterloo.ca>

Thu 3/23/2017 10:54 AM

To: Samantha Meyer <samantha.meyer@uwaterloo.ca>; Elena Neiterman <elena.neiterman@uwaterloo.ca>; Heather MacDougall <hmacdougall@uwaterloo.ca>; Samantha Meyer <samantha.meyer@uwaterloo.ca>;

Cc: Michelle Simeoni <msimeoni@uwaterloo.ca>;

Dear Researcher:

This note is to advise you that the ethics review of your ORE application:

Title: VACCINATING PREGNANT WOMEN: EXAMINING THE NATURE OF VACCINE HESITANCY AMONG MIDWIVES IN WATERLOO-WELLINGTON REGION.
ORE #: 22112
Principal/Co-Investigator: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Collaborator: Elena Neiterman (elena.neiterman@uwaterloo.ca)
Collaborator: Heather MacDougall (hmacdougall@uwaterloo.ca)
Faculty Supervisor: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Student Investigator: Michelle Simeoni (msimeoni@uwaterloo.ca)

has been completed. Acceptance of the application on ethical grounds is conditional on revisions and/or additional information. Below is a summary of recommendations for revisions as well as any related comments or questions.

---
Recommended Revisions and/or Comments::

A. Comments on the Form 101 and Procedures:

1. Form 101, Sec. C.3.b: Please clarify the recruitment of contacts provided by Drs. Meyer, Neiterman and Deacon. Will they send recruitment emails on behalf of M. Simeoni, or provide M. Simeoni with the contact information of potential participants? The distinction may affect the wording of the recruitment email. The online Form 101 has been set to editable.

2. Survey: The Form 101 does not make any mention of a survey/questionnaire, only the interview and that the interview questions will be sent in advance. However, some of the supporting documents talk about both an interview and a survey. In the information letter the survey is describes as primarily a demographic survey - but the interview guide also contains demographic questions at the start. Perhaps there was originally a plan to include a survey, but this was changed to ask all the questions in the interview. If there is a survey as part of the procedure please revise the Form 101, Sec. C.1.b to include the survey and provide a copy of the survey to the ORE. If there is not a survey, then this should be removed from the supporting documents (comments below assume this).

3. Form 101, Sec. G.1: The plan is to de-identify the transcripts to protect participant confidentiality - especially given the social risks identified in Sec. E.1. However, it seems the audio recordings are remaining as identifiable data. We recommend three options to further protect participant confidentiality with respect to the recordings; 1 ) store the audio files in an encrypted folder,

2) delete the audio recordings after the transcripts have been prepared , 3) work with the audio files to edit out identifiable details. Please revise Sec. G.1 with one of these options, or another method, to provide increased confidentiality for participants with respect to the audio files.

4. Form 101, Sec. F.2: This states written consent will be obtained from all participants. Does this mean that for phone interview participants they will sign, scan, and email a copy of the consent form to the researcher? In other words, there are no plans to use verbal consent?

5. While going through the supporting documents, several minor typos and errors were noticed. Researchers may want to do a final careful read and edit of the documents before they are used with participants.

B. Comments on the Recruitment Email to Clinics:

1. Please revise the brief ethics statement to the correct version: "This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee." Note: it has to be "a" instead of "the" because there are two research ethics committees at UW.

C. Comments on the Recruitment Poster (Document with the contact info tabs):

1. 1st para.: Please add information on affiliation with UW and SPHHS.

2. 2nd para.: Please revise first sentence to, "You are invited to participate in this study that includes a one time ...".

3. 2nd para.: Following comment A.2, above, please remove the reference to a survey if appropriate.

4. 2nd para.: Should read "agreed-upon location."

5. 3rd para.: Please revise "compensation" to "remuneration" (compensation is used when there is payment due to potential injury from participation - primarily in clinical trials).

6. 4th para.: Please revise as per comment B.1, above. Additionally, the second instance of the ethics statement (after the contact information) can be removed.

D. Comments on the Recruitment Email (the other recruitment document without contact info tabs):

1. It is assumed this document is the email that will be sent to individual potential participants (e.g. contacts of Dr. Deacon), and not a second poster. If this is incorrect, please clarify, and provide a copy of the email recruitment to individuals.

2. 2nd para.: Please revise to, "You are invited to participate in a one time ...".

3. 2nd para.: Following comment A.2, above, please remove the reference to a survey if appropriate.

4. 3rd para.: Please revise the ethics statement as per comment B.1, above.

E. Comments on the Information and Consent Letter:

1. Please confirm if the information letter is sent to participants ahead of the interview (when the interview questions/guide is sent).

2. Salutation: Please revise to "Dear Potential Participant".

3. What will I have to do section: Please revise to, "You are invited to participate in a one-time .".

4. What will I have to do section: The first two paragraphs contain references to the survey. Following comment A.2, above, please remove the reference to a survey if appropriate.

5. What will I have to do section, 2nd para.: Revise the confidentiality procedures for the audio recordings, as per comment A.3, above.

6. What will I have to do section, 2nd para.: Please remove the no anticipated risk statement as risks are covered in the section below.

7. Risks section: Following comment A.2, above, please remove the reference to a survey if appropriate.

8. Risks section: For clarity, please break this paragraph into two paragraphs. One discussing risks and the other discussing benefits. Additionally, the risks paragraph should disclose specific risks discussed in the Form 101, Sec. E.1 - participants concerned about others knowing what they say in the interview, tension between participants who oppose vaccination of pregnant women and the researcher. The section should also state how risks are being mitigated - e.g., participants can skip questions, the participant's participation and identity will be kept confidential and identifiable data stored securely, the researcher is interested in hearing all viewpoints on vaccination.

9. Risks section: For the paragraph on benefits, please state that there is no direct benefit for participants (as per the 101. Sec. D.1). Additionally, the potential scientific and societal benefits from Sec. D.2 of the Form 101 would be better here than the current stated benefits. First, the opportunity to contribute one's data is generally not considered a personal benefit. Second, participants who oppose vaccination would likely not consider improving vaccination uptake a benefit. Additionally, the use of the results in the work of CIRN is already covered in the next section, and participants can themselves decide whether they consider that a benefit or not.

10. What will we do with your results section: In the 2nd paragraph, the last three sentences can be deleted as that information is covered earlier in the letter.

11. Please revise the ethics statement to the new version: "This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# 22112). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca."

12. Consent Form: Please revise the liability statement to, "By providing your consent, you are not waiving .".

13. Consent Form, 2nd para.: Following comment A.2, above, please remove the reference to a survey if appropriate.

14. Consent Form: The "Please check the boxes" statement should be above the first checkbox, not within the first checkbox statement.

15. Consent Form, 1st checkbox: The first part of the statement seems to be asking if the interview data can be used in the study, which is not necessary as that is part of agreeing to be in the study in general. That can be removed and the second part should be changed to "I agree to let my answers .".

16. Consent Form, 2nd checkbox: This should say phone interview as well, or just interview (remove "face-to-face").

17. Consent Form: Section D.2 of the Form 101, states participants will give written consent for their data to be included in other related research projects. If this is still the plan then this can be added as a checkbox statement. It should be clear if by data you

mean the raw, identifiable data (recordings) or the de-identified transcripts. It should also be clear if these are other research projects done by the current researchers or other researchers/research groups (if the latter, it should not be identifiable data, as already stated in D.2).

F. Comments on the Feedback Letter:

1. 4th para, 1st and 2nd sentence: Please revise to the following, or similar, "Your participation and any identifying information you share in the interview is confidential. This means that any parts of the interview that could identify you will be removed or kept private."

2. 4th para, 3rd sentence: Recommend revising to, "Only members of the researcher team will have access" or "Only the student researcher and her supervisor will have access to identifying information from the interview." If the full recordings are being kept (see comment A.3), and turned over to Dr. Meyer, then she will also have access to identifiable data.

3. Please revise the ethics statement as per comment E.11, above.

Researcher(s), this summarizes the feedback from the ethics review of your application. Revised materials should be provided to the Office of Research Ethics in hard copy or by email to ohrac@uwaterloo.ca

Please indicate the ORE number to which the changes refer when submitting revisions and highlight or use track changes in the revised section(s) to expedite the ethics review of these documents.

Please feel free to contact me at the extension given below about any of the above comments.

Best wishes,

---

Nick Caric
Research Ethics Advisor
Office of Research Ethics
East Campus 5 (EC5), 3rd Floor
519.888.4567 ext. 30321
ncaric@uwaterloo.ca

Sign up for our listserv at http://uwaterloo.us10.list-manage.com/subscribe?u=734de426ca7ee1226a168b091&id=46fdcbfea2

# Ethics Clearance of Modifications, no comments (ORE # 22112)

ORE Ethics Application System <OHRAC@uwaterloo.ca>

Tue 5/23/2017 10:24 AM

To: Samantha Meyer <samantha.meyer@uwaterloo.ca>; Elena Neiterman <elena.neiterman@uwaterloo.ca>; Heather MacDougall <hmacdougall@uwaterloo.ca>; Samantha Meyer <samantha.meyer@uwaterloo.ca>;

Cc: Michelle Simeoni <msimeoni@uwaterloo.ca>;

Dear Researcher:

A Request for ethics review of a modification or amendment (ORE 104) to your ORE application:

Title: Vaccinating Pregnant Women: Exploring Midwives' Perspectives Regarding Vaccination in Pregnancy in the Waterloo-Wellington Region
ORE #: 22112
Principal/Co-Investigator: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Collaborator: Elena Neiterman (elena.neiterman@uwaterloo.ca)
Collaborator: Heather MacDougall (hmacdougall@uwaterloo.ca)
Faculty Supervisor: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Student Investigator: Michelle Simeoni (msimeoni@uwaterloo.ca)

---

together with a copy of relevant materials, was received in the Office of Research Ethics on:

May 12, 2017 - 1) Minor change to project title on all documents that mention the thesis title (ie., information letter.) New title 'Vaccine Hesitancy Among Midwives in Waterloo-Wellington Region (old title was Vaccinating Pregnant Women: Examining the Nature of Vaccine Hesitancy Among Midwives in Waterloo-Wellington Region.)

The proposed modification request has been reviewed and has received full ethics clearance.

**********

Note 1: This project must be conducted in accordance with the description in the application and modification for which ethics clearance has been granted. All subsequent modifications to the protocol must receive prior ethics clearance through the Office of Research Ethics.

Note 2: Researchers must submit a Progress Report on Continuing Human Research Projects (ORE Form 105) annually for all ongoing research projects. In addition, researchers must submit a Form 105 at the conclusion of the project if it continues for less than a year.

Note 3: Any events related to the procedures used that adversely affect participants must be reported immediately to the ORE using ORE Form 106.

---

Nick Caric
Manager
Office of Research Ethics
East Campus 5 (EC5), 3rd Floor
519.888.4567 ext. 30321
ncaric@uwaterloo.ca

Sign up for our listserv at http://uwaterloo.us10.list-manage.com/subscribe?u=734de426ca7ee1226a168b091&id=46fdcbfea2

# Ethics Clearance of Modifications, no comments (ORE # 22112)

ORE Ethics Application System <OHRAC@uwaterloo.ca>

Fri 7/7/2017 4:14 PM

To: Samantha Meyer <samantha.meyer@uwaterloo.ca>; Elena Neiterman <elena.neiterman@uwaterloo.ca>; Heather MacDougall <hmacdougall@uwaterloo.ca>; Samantha Meyer <samantha.meyer@uwaterloo.ca>;

Cc: Michelle Simeoni <msimeoni@uwaterloo.ca>;

Dear Researcher:

A Request for ethics review of a modification or amendment (ORE 104) to your ORE application:

Title: Vaccinating Pregnant Women: Exploring Midwives' Perspectives Regarding Vaccination in Pregnancy in the Waterloo-Wellington Region
ORE #: 22112
Principal/Co-Investigator: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Collaborator: Elena Neiterman (elena.neiterman@uwaterloo.ca)
Collaborator: Heather MacDougall (hmacdougall@uwaterloo.ca)
Faculty Supervisor: Samantha Meyer (samantha.meyer@uwaterloo.ca)
Student Investigator: Michelle Simeoni (msimeoni@uwaterloo.ca)

---

together with a copy of relevant materials, was received in the Office of Research Ethics on:

July 6, 2017 - 1) Recruitment - Expand study sample to all of Ontario to recruit more participants (i.e., 3 - 5.) 2) Update information letters, recruitment flyer and email to note change in recruitment area to now include all of Ontario. 3) Recruitment methods will remain the same as outlined in the original protocol.

The proposed modification request has been reviewed and has received full ethics clearance.

**********

Note 1: This project must be conducted in accordance with the description in the application and modification for which ethics clearance has been granted. All subsequent modifications to the protocol must receive prior ethics clearance through the Office of Research Ethics.

Note 2: Researchers must submit a Progress Report on Continuing Human Research Projects (ORE Form 105) annually for all ongoing research projects. In addition, researchers must submit a Form 105 at the conclusion of the project if it continues for less than a year.

Note 3: Any events related to the procedures used that adversely affect participants must be reported immediately to the ORE using ORE Form 106.

---

Nick Caric
Manager
Office of Research Ethics
East Campus 5 (EC5), 3rd Floor
519.888.4567 ext. 30321
ncaric@uwaterloo.ca

Sign up for our listserv at http://uwaterloo.us10.list-manage.com/subscribe?u=734de426ca7ee1226a168b091&id=46fdcbfea2

## Appendix N: Requirements for Initial Registration as a Midwife

Requirements for Initial Registration as a Midwife in a Canadian Jurisdiction (pg. 135)

## REQUIREMENTS FOR INITIAL REGISTRATION AS A MIDWIFE IN A CANADIAN JURISDICTION* – Updated to August 9, 2011

| JURISDICTION | British Columbia | Alberta | Saskatchewan | Manitoba | Ontario | Quebec | Northwest Territories | Nova Scotia | New Brunswick | Nunavut |
|---|---|---|---|---|---|---|---|---|---|---|
| NAME OF REGULATOR | College of Midwives of British Columbia<br><br>www.cmbc.bc.ca | Alberta Health Disciplines Committee<br><br>Email: heather.cameron@gov.ab.ca | Saskatchewan College of Midwives<br><br>www.saskmidwives.ca | College of Midwives of Manitoba<br><br>www.midwives.mb.ca | College of Midwives of Ontario<br><br>www.cmo.on.ca | L'Ordre des Sage-femmes du Québec<br><br>www.osfq.org | Northwest Territories Health Professions Licensing<br><br>www.hlthss.gov.nt.ca | The Midwifery Regulatory Council of Nova Scotia<br><br>www.mrcns.ca | Midwifery Council of New Brunswick<br><br>E-mail: beth.mcginnis@gnb.ca | Government of Nunavut Professional Practice – Health & Social Services<br>E-mail: hssregistrar@gov.nu.ca |
| **A. EDUCATION REQUIREMENTS** | | | | | | | | | | |
| MIDWIFERY EDUCATION REQUIREMENTS | Graduation from midwifery education program approved by CMBC<br>**OR**<br>assessed through a process approved by the CMBC to be substantially equivalent in education and competencies to a graduate of a midwifery education program approved by the CMBC. | Graduation from a recognized school of midwifery within 2 years prior **OR** completion of an approved refresher program within 1 year prior **AND** Completion of a baccalaureate level degree **OR** within first 2 years of registration, completion of specified courses at first year university level, with 70% grade in each course. | Graduation from a midwifery education program approved by the SCM<br>**OR**<br>Completion of an assessment process approved by the SCM on the ability to perform the entry-level competencies of midwifery. | Graduation from an education program based on core competencies approved by CMM<br>**OR**<br>Completion of an assessment process approved by the CMM on the ability to perform CMM core competencies. | Graduation from Ontario's midwifery education program, or equivalent.<br><br>(International applicants must successfully complete the International Midwifery Pre-registration Program.) | Graduation from Quebec's midwifery education program at Trois-Rivières (UQTR)<br><br>(International applicants - for diploma recognition and equivalency, the Regulation respecting diploma and training equivalence standards for the issue of permits by the OSFQ, 2007 G.O.Q. 2, 2453 | Graduation from a university-level midwifery program, with a degree, diploma or certificate (or equivalent). | Completion of a Canadian baccalaureate-level midwifery education program. Must have graduated in the last two years prior to application.<br>**OR**<br>Completion of equivalent program. Must have graduated in the last two years prior to application. | Graduation from a baccalaureate-level midwifery degree program<br><br>(International applicants – completion of a competency assessment program or a bridging program approved by Council during the previous 2 years). | Completion of an approved midwifery educational program or completion of an approved assessment process in the year previous to applying for license in Nunavut. |
| **B. REGISTRATION EXAM REQUIREMENTS** | | | | | | | | | | |
| CANADIAN MIDWIFERY REGISTRATION EXAM (CMRE) | Yes | Yes | No*<br><br>*Written and clinical exams required for registration in any other Canadian jurisdiction. | No*<br><br>*Currently under legislative review – expected to become mandatory* | No*<br><br>*Currently under legislative review – expected to become mandatory* | No | Must be registered (unrestricted) and in good standing as a midwife in a Canadian province or eligible for (unrestricted) registration as a midwife in a Canadian province. | Yes | Yes | Successful completion of the CMRE or full registration in another jurisdiction in Canada (CMRE not required if jurisdiction did not require it on initial registration). |
| **C. JURISDICTIONAL REQUIREMENTS** | | | | | | | | | | |
| | Must review orientation material about the practice of midwifery in BC and pass BC-specific jurisprudence exam. | Must have membership in the Alberta Association of Midwives. | Must attend orientation session about the practice of midwifery in Saskatchewan. | Must attend orientation session about the practice of midwifery in Manitoba. Must intend to practice within 3 months of application for registration. | Must have membership with Association of Ontario Midwives.<br><br>International applicants are first registered as supervised midwives. | | Must be registered (unrestricted) and in good standing as a midwife in a Canadian province or eligible for (unrestricted) registration as a midwife in a Canadian province. | | Must be registered as a midwife in another province/territory during the previous 5 years. Must be without restrictions imposed on her certificate of registration from any other province/territory. | Completion of a traditional midwifery learning module (module currently under development). Must be licensed in Nunavut to practice). |

| D. CLINICAL EXPERIENCE REQUIREMENTS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **British Columbia** | **Alberta** | **Saskatchewan** | **Manitoba** | **Ontario** | **Quebec** | **Northwest Territories** | **Nova Scotia** | **New Brunswick** | **Nunavut** |
| **TOTAL BIRTHS ATTENDED AS A MIDWIFE** | 60 | 60 | 60 | 40 | 60 | | Depends on jurisdiction which established eligibility for registration in the NWT | 40 (or 1125 hours) in last 5 years **OR** 12 (or 450 hours) in last 1 year. | 60 | 50 |
| **BIRTHS ATTENDED AS A PRIMARY MIDWIFE** | 40 | 40 | 30 | 20 | 40 | 40 | Depends on jurisdiction which established eligibility for registration in the NWT | 40 (or 1125 hours) in last 5 years OR 12 (or 450 hours) in last 1 year. | 40 | 40 |
| **BIRTHS ATTENDED WITH CONTINUITY OF CARE[1]** | 30 | 30 | 10 | 3 | 30 | 10*<br>*For graduates of UQTR. International applicants and those trained outside of Quebec should contact the OSFQ. | Depends on jurisdiction which established eligibility for registration in the NWT | | | |
| **BIRTHS ATTENDED AS A MIDWIFE OUT-OF-HOSPITAL** | 5 as primary midwife | 10 as primary midwife | 0 | 0 | 10 including 5 as primary midwife | | Depends on jurisdiction which established eligibility for registration in the NWT | Experience required | | |
| **BIRTHS ATTENDED AS A MIDWIFE IN HOSPITAL** | 5 as primary midwife | 10 as primary midwife | 0 | 0 | 10 including 5 as primary midwife | | Depends on jurisdiction which established eligibility for registration in the NWT | Experience required | | |
| **CURRENCY[2]** | All above experience must have been in the last 5 years. | All of the above experience must have been in the last 5 years, and 10 births as primary and 10 births with continuity of care must have been in the last two years. | 10 births must have been attended as a primary midwife in the last 2 years. | 10 births must have been attended as a midwife in the last two years. | All above experience must have been in 2 of the last 4 years. | | Depends on jurisdiction which established eligibility for registration in the NWT | See above | All above experience must have been in the previous 2 years. | 10 births attended as a primary should have occurred within the last two (2) years prior to application for licensure. |
| **OTHER** | | Must have maintained competencies by actively practising midwifery | 75 antenatal, 50 postpartum, and 50 newborn exams | 75 antenatal and 75 postpartum exams | | | Depends on jurisdiction which established eligibility for registration in the NWT | Experience in the following areas: Provision of the complete course of antenatal, intrapartum, postpartum and newborn care as a primary midwife **AND** Primary responsibility for the management of labour and birth in both hospital and out-of-hospital settings. | | |

| E. ADDITIONAL REQUIREMENTS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **British Columbia** | **Alberta** | **Saskatchewan** | **Manitoba** | **Ontario** | **Quebec** | **Northwest Territories** | **Nova Scotia** | **New Brunswick** | **Nunavut** |
| **LANGUAGE FLUENCY** | Yes, English | Yes, English | Yes, English | Yes, English | Yes, English or French | Yes, French | No, must provide information on the languages written and spoken | Yes, English | Yes, English or French | Yes, English |
| **NEONATAL RESUSCITATION** | Yes | Yes | Yes | Yes | Yes, without intubation*<br>**(waiting for legislative changes re intubation)* | Yes | Yes | Yes | Yes | Yes |
| **CARDIOPULMONARY RESUSCITATION** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

[1] Each province/territory has its own policies regarding what experience is counted towards continuity of care requirements in their own province/territory.
[2] The term 'currency' refers to clinical experience requirements that must have taken place in a given time period prior to application for registration.

| E. ADDITIONAL REQUIREMENTS Cont'd | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **British Columbia** | **Alberta** | **Saskatchewan** | **Manitoba** | **Ontario** | **Quebec** | **Northwest Territories** | **Nova Scotia** | **New Brunswick** | **Nunavut** |
| **OBSTETRICAL EMERGENCY SKILLS** | Yes | Yes | No | No | Yes | Yes | No, for registration, but Yes, for credentialing (A registered midwife cannot work in the NWT unless credentialed also.) | Yes | Yes | Yes |
| **FETAL HEALTH SURVEILLANCE** | Yes, certification in the 2 years prior to registration | | | | | | No, for registration, but Yes, for credentialing (A registered midwife cannot work in the NWT unless credentialed also.) | | | |
| **REGISTRATION FEES** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **PROFESSIONAL LIABILITY INSURANCE** | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes, if not a Government of Nunavut employee |
| **LEGAL AUTHORIZATION TO WORK IN CANADA** | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| **DISCLOSURE & REMEDY**[3] | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | | Yes |
| **PROOF OF GOOD CHARACTER**[4] | Yes | Yes | Yes | Yes | Yes | Yes, for those who come from outside Quebec | Yes | Yes | Yes | Yes |
| **CRIMINAL RECORD CHECK** | Yes | Yes | Yes | Yes | No | No | No | Yes | Yes | No |

| F. NEW REGISTRANT/SUPERVISION REQUIREMENTS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **British Columbia** | **Alberta** | **Saskatchewan** | **Manitoba** | **Ontario** | **Quebec** | **Northwest Territories** | **Nova Scotia** | **New Brunswick** | **Nunavut** |
| **NEW REGISTRANTS' POLICY** | Must work with an established midwifery practice or experienced midwife for 6 months or 20 births, and have a mentor relationship with an established practice for 12 months. | Must work with an established practice for the first 3 months of registration, and be mentored for a further 9 months | Applicants who have attended fewer than 20 births as a full practicing member must have a mentor. | Minimum of 6 months supervision for all new registrants that have not practiced as a midwife in Canada. | Must work with an established practice/experienced midwives for 1 year full time (minimum 30 primary births) and attend all births with them. | No | | | Policy in development | 1) New graduates must work with an experienced midwife who has a full license for a one year period |
| **SUPERVISED PRACTICE** | "Conditional" registration category exists for applicants with discrete gaps in clinical experience numbers or competencies. This allows applicants the opportunity to practice legally under supervision until 'general' registration requirements are met.<br><br>A "Conditional –Remedial" registration category has been proposed for when supervision is required as a result of complaints or disciplinary proceedings. | "Restricted" registration category exists for applicants with discrete gaps in clinical experience numbers or competencies. This allows applicants the opportunity to practice under supervision until full registration requirements are met. Applicants may be eligible for 'temporary' supervised registration prior to completing the full assessment process and while waiting to take the next available exams. | "Restricted" membership may be available to applicants who do not meet the eligibility requirements for full practicing membership. Applicants practice under supervision in accordance with a plan approved by the Council to meet full practising requirements. | "Supervised" registration category exists for applicants with discrete gaps in competencies. This allows applicants the opportunity to practice under supervision until gaps are met. | "Supervised" registration category exists for application with discrete gaps in clinical experience numbers or competencies. This allows applicants an opportunity to practice under supervision until full registration requirements are met. Graduates of the IMPP who do not meet the clinical experience requirements of the Registration Regulation may obtain this experience during their period of supervised practice. | For midwives returning after an absence of active practice longer than 3 years, there is a process to come back into practice. For others, a permit is issued after they are declared competent (during clinical clerkship). For midwives from France who have practiced continuity of care, there is a special track - a restrictive permit for 6 months, and will be supervised. | | "Provisional" registration category exists for applicants with discrete gaps in clinical experience numbers or competencies. This allows applicants the opportunity to practice under supervision until full registration. All supervision requirements are met. All supervision requirements must be completed within one year or less. | Policy in development | 2) Applicants who are not new graduates but do not meet the required birth numbers on application will have conditions placed on their license until birth numbers have been met. |

[3] Disclosure of information relevant to safe and ethical practice of midwifery, including any criminal or professional proceedings (professional misconduct, incompetence, or lack of fitness to practice) initiated against the applicant; status of an proceedings at the date of the application; outcome of any proceedings, including terms of any citation, penalty or sentence. Also, disclosure of any denial of registration by a professional regulatory authority.

[4] Written statements from sources acceptable to the provincial/territorial regulatory authority, attesting to the applicant's honesty, trustworthiness, good judgment, ethics, integrity and/or professional behaviour and reputation.

Data gathered from Table 1 of CIHI:
HCP Provincial Profiles (2016): Data Tables

Midwives in Ontario

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 656 | 5 | 99.8 |
| 2015 | 678 | 5 | 99.8 |
| 2016 | 711 | 5 | 99.8 |

Midwives in Quebec

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 157 | 2 | 100% |
| 2015 | 155 | 2 | 100% |
| 2016 | 221 | 3 | 100% |

Midwives in Selected Provinces/Territories

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 1,242 | 4 | 99.9 |
| 2015 | 1,273 | 4 | 99.9 |
| 2016 | 1,424 | 4 | 99.9 |

Midwives in Nova Scotia

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 10 | 1 | - |
| 2015 | 10 | 1 | - |
| 2016 | 10 | 1 | - |

Midwives in Manitoba

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 55 | 4 | 100% |
| 2015 | 52 | 4 | 100% |
| 2016 | 52 | 4 | 100% |

Midwives in Saskatchewan

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 16 | 1 | 100% |
| 2015 | 11 | 1 | 100% |
| 2016 | 15 | 1 | 100% |

Midwives in Alberta

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 84 | 2 | -- |
| 2015 | 94 | 2 | -- |
| 2016 | 111 | 3 | -- |

Midwives in British Colombia

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 237 | 5 | 100% |
| 2015 | 247 | 5 | 100% |
| 2016 | 273 | 6 | 100% |

Midwives in Territories

| Year | Count | Per 100, 000 pop | Female (%) |
|---|---|---|---|
| 2014 | 25 | 21 | 100% |
| 2015 | 26 | 22 | 100% |
| 2016 | 31 | 26 | 100% |

No Data:
Prince Edward Island
Newfoundland and Labrador
New Brunswick