SOCIAL JUSTICE CURRICULUM AND MIDWIFERY EDUCATION

TRANSFORMING THE ONTARIO MIDWIFERY EDUCATION PROGRAM THROUGH SOCIAL JUSTICE CURRICULUM: A MODIFIED DELPHI STUDY

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TITLE: Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study

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Lay Abstract:
This study aimed to define ‘social justice’ in the context of Canadian midwifery education, determine specific social justice content to be included in Ontario Midwifery Education Program (OMEP) curriculum, and identify social justice-based Canadian midwifery competencies (CMCs) set out by the Canadian Midwifery Regulators Council (CMRC). This work was completed through consensus-building methodology that included focus groups, interviews, and surveys.

A definition that aligned participants' interpretations of the term social justice was developed. A key finding was that participant-identified social justice content that dealt with ‘legal and economic structures’, and ‘policy and health service structures’ did not have any corresponding CMCs, suggesting that those respective structural competency categories may be underdeveloped in Canadian midwifery curricula. These findings suggest that the OMEP is undergoing a shift in its understanding of social justice knowledge and praxis. It is recommended that the OMEP adopt innovative social justice teaching methods and concordant curriculum to propel the program into novel territory for health professions education.

Abstract:
Introduction: Social justice education aims for transformative, liberatory, democratic classrooms and curriculum. From inception, the Ontario Midwifery Education Program (OMEP) has included curriculum that reinforced key principles of Ontario midwifery, including informed choice, continuity of care and choice of birthplace. Despite the social justice underpinnings of these principles, the OMEP has not formally defined social justice in the context of midwifery education or formalized a social justice-based curriculum linked to the Canadian Midwifery Competencies (CMCs) set out by the Canadian Midwifery Regulators Council (CMRC).

Methods: A modified Delphi design was utilized that involved focus groups, interviews, two rounds of surveys and a member checking session. Participants were recruited through purposeful and snowball sampling. Open coding was used to analyse qualitative data and identify themes, and quantitative data was analyzed using descriptive statistics.

Results: Three key findings were elicited. First, qualitative data was used to articulate a definition of 'social justice' in the context of midwifery education based on the OMEP's social justice values, goals, and actions. Second, 86 social justice-based elements (grouped in three thematic areas) and 32 social justice-related CMCs were identified which gave way to 26 corresponding learning outcomes and 6 program level learning outcomes. Third, it was noted that the thematic categories, 'legal and economic structures', and 'policy and health service structures', were not captured in any of the 32 CMCs suggesting the need for a paradigmatic shift in social justice education in midwifery.

Conclusion: Recommendations to the OMEP are: 1. develop social justice curriculum using constructive alignment and social justice education pedagogies, 2. incorporate social justice curriculum throughout the program to be a global exemplar, and 3. add additional competencies to the existing CMRC's roles-based framework to support structural competency education. Future work could involve the development of a Canadian midwifery education framework that centres social justice pedagogies and curriculum.

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List of Abbreviations

CMC – Canadian Midwifery Competencies
CMRC – Canadian Midwifery Regulators Council
OMEP – Ontario Midwifery Education Program
PGM – People of the Global Majority
CDC – Curriculum Development Committee
TA – Thematic Analysis
MEP – Midwifery Education Program
HPE – Health professions education
ILO- Intended learning outcome
TLA – Teaching and learning activity
AE – Assessment and evaluation
SJE – Social justice element
SME – Subject matter expert
KI – Key Informant

Chapter 1 – Introduction

In this chapter, the controversial nature of the inception of the Ontario Midwifery Education Program (OMEP) and its 'unintended' participation in structural oppression of its partners[1] is dissected to provide context to the study's topic of social justice in midwifery education. Structural oppression as it relates to midwifery, denotes the exclusion and erasure (systemic discrimination) of people of the global majority[2] (PGM) and marginalized partners (students, clients, preceptors, midwives, faculty, instructors etc.) at the individual, community, and societal levels. This oppression was operationalized through a culture of white supremacy (i.e., centering of whiteness), a side-effect of the second wave feminist movement that galvanised the resurgence of midwifery in Ontario. Next, I discuss events that occurred in 2020 that sparked the development of this study. Then, I examine the foundations of social justice education, specifically, the teachings of Paulo Freire and bell hooks among others. Their approach to transformative pedagogies and distinction between *how we teach* and *what we teach* will carry through this thesis. Then I introduce a curriculum development concept and tool titled constructive alignment which guides the work of this study. Lastly, I close the chapter by presenting the research question and objectives.

1.1 The Inception of the Ontario Midwifery Education Program

Understanding landscape of midwifery in Ontario, pre- and post-legislation, and the subsequent development of its education program is essential to appreciate why this study's results are pivotal to midwifery partners and health professions education (HPE) at large.

The (re)conception of midwifery in Ontario was seeded within the milieu of second wave feminism. This sociopolitical movement, which concentrated on challenging the states' patriarchal and capitalist control of women's sexuality, fertility, and experiences of violence, armed lay midwives and consumers to set a goal of imbedding midwifery into the Ontario healthcare system for the benefit *all women*.(1,2) Interestingly, a phenomenon of second wave feminism was the

[1] The term 'stakeholder' has been replaced with the term "partner(s)' throughout this document. The term 'stakeholder' is a common corporate term for partners. But has negative connotations to many Indigenous Peoples. When land acquisition was happening, this term referred to the allotment of land to settlers. Settlers were given wooden stakes to claim their plot of land prior to any treaty or land negotiations with Indigenous Peoples. It is more appropriate to refer to Indigenous Peoples as partners rather than stakeholders. Indigenous Peoples are not stakeholders; they are Aboriginal rights holders whose rights are protected under the Constitution of Canada. https://www2.gov.bc.ca/gov/content/governments/services-for-government/service-experience-digital-delivery/web-content-development-guides/web-style-guide/writing-guide/writing-guide-for-indigenous-content/terminology

[2] People of the Global Majority (PGM) is an interchangeable term with Black, Indigenous, People of Colour, however it points out the demographic inaccuracy of the euphemism "minority" and can feel more empowering as it unites people from around the world who are struggling against white oppression. (Rosemary Campbell-Stevens https://www.linkedin.com/pulse/global-majority-we-need-talk-labels-bame-campbell-stephens-mbe)

misconception that it prioritized the struggles of *all women* when in fact it centered the interests of white, middle-class, heterosexual, able bodied women who had power and privilege in many spheres of influences. (3) At that time, the homogenous group of midwives and consumers assumed that the needs and wants of *all pregnant women* were universal i.e., all pregnant women wanted access to midwives and choice in their care plans. On the surface, this goal seemed reasonable however, in reality, pregnant people who were marginalized due to their socially constructed identities and lack of power and privilege, faced multiple oppressions that affected their access to, and treatment within the healthcare structures and systems. These multiple oppressions can be explained by the concept of 'intersectionality'. Kimberlé Crenshaw, lawyer, academic and one of several theorists of critical race theory, articulated that there are multiple intersections of oppressions faced by PGM who belonged to several socially constructed identities. (4) For example, a woman who is disabled and racialized will not only face societal oppression based on gender, but also on their disability and racialization. In retrospect, many grandmothers of midwifery, while well intentioned, perpetuated structural oppression through a culture of white supremacy where their own positions of power and privilege obstructed their ability to recognize intersectional experiences of PGM and other marginalized partners. This structural oppression and culture of white supremacy plagued the subsequent development of legalization, regulation, and education.

As a result of efforts to legalize midwifery in the province of Ontario, the profession became a formally regulated health profession in 1991. (5) In her book, *Obstructed Labour*, Sheryl Nestel discusses the inequities that occurred during the regulation of midwifery. This discussion is beyond the scope of this paper but is important to acknowledge as another aspect of midwifery that was influenced by the exclusionary effects of second wave feminism and white supremacy.

The decision to embed the Ontario Midwifery Education Program (OMEP) within the institution of academia as an undergraduate bachelor's degree rather than within community colleges as a diploma was controversial. Eventually, with the advocacy of the Association of Ontario Midwives and ensuing support from the Minister of Health Elinor Caplan, an education subcommittee was appointed in 1989 to lead the development of an midwifery education program (MEP).(5) The Curriculum Development Committee (CDC) was an interdisciplinary group that consisted of midwives, physicians, nurses, and consumers who were faced with a mandate to "describe in detail the essential component of midwifery education in Ontario". (5) Through contentious debate about issues of accessibility (5,6), maintenance of the apprentice model (5), and the need to create legitimacy in the profession (5,6), the Ontario Midwifery Education Program (OMEP) was born. It eventually consisted of three undergraduate programs housed at McMaster University, Toronto Metropolitan University (formally Ryerson University) and Laurentian University. These three programs constituted the consortium and their doors opened in 1993.(5) In the spring of 2021, the program at Laurentian University was closed and the consortium is currently operating with only two sites. Ultimately, the decision to situate the MEP as an undergraduate university degree was one of compromise; it ensured student access from high school, and it positioned itself for legitimacy with other healthcare professions. (5) Nevertheless, subsequent curriculum decisions

perpetuated an exclusionary culture of white supremacy that exacerbated systemic discrimination and structural oppression of PGM and marginalized partners.(6)

There is limited research published on the development of the OMEP's curriculum. A recent study focusing on the experiences of resilience among racialized students in the OMEP shed light on the effects of the exclusionary white supremist culture within the OMEP and profession. Shamkhi, Ramlogan-Salanga, and Darling demonstrated that the culture of white supremacy within the OMEP played a major role in shaping negative experiences for racialized students.(7) Specifically, white-centered curriculum intensified experiences of erasure, exhaustion, objectification and silencing.(7) Participants (current and past OMEP students) articulated their frustration with being taught content that was developed by white women for white women to learn and to eventually apply to white women clients. (7) Furthermore, when content based on 'Other' was presented, it was left to racialized or marginalized students to "teach to the white students" furthering the feelings of exhaustion and objectification. Moreover, when injustices were witnessed or experienced in the classroom, and white solidarity dominated, racialized students had to choose to either engage the conflict or stay silent in an effort to protect themselves mentally and/or physically.(7) As a racialized registered midwife myself, who was also educated within the OMEP, is currently an instructor at the McMaster MEP, and a co-investigator in the above mentioned study, I can corroborate that the OMEP curricula and the majority of the faculty explicitly and/or implicitly centered whiteness. Over the past two decades, these unexamined actions and inactions of the OMEP have caused harm to me and my peers who identify as PGMs and/or marginalized. Our community experience represents the symptoms of systemic discrimination within the education program that eventually manifest into chronic disease as professionals. Assefa et al. reiterated the negative effects of racism, systemic discrimination and the exclusionary culture that exists beyond the OMEP. (8) Their study reports that 86% of respondents experienced racism in their work as a midwife and 87% reported witnessing another midwife or midwifery student being a target of racism. (8) Recommendations from this research include but are not limited to raising awareness about racism in the profession and increasing diversity in midwifery.(8) While this research is seminal, our lived experiences are proof enough that there is work to be done to reconcile the missteps of the past. We are all looking forward to building a transformative OMEP.

The structure of OMEP has largely remained the same since its inception. The four year undergraduate program originally ran year round and could be completed in three calendar years, but it was changed after a few years so the summer terms after the first two years are off. (5) Other than this change, much of the program remains very similar to its original form. It has also stayed true to the essence of the apprentice model by constructing both pre-clinical "classroom" curriculum and clinical "field" experience supervised by midwifery preceptors. (5) Over the past two-years while this study was in progress, the OMEP has undertaken efforts to identify, addressed through consultation with partners, and implement initiatives that challenge the culture of white supremacy and exclusion. These projects continue to be evaluated for quality improvement. However, a systematic evaluation of the curriculum has not been initiated.

Lastly, an area for future research lives in the unpacking of the experiences of PGM and marginalized clients with respect to their interaction with midwives, midwifery preceptors and students of the OMEP. This niche area of research remains unexamined across Canada, however, there is a vein of research that speaks to the importance of quality care for racialized clients. The Birth Place Lab in the Faculty of Medicine at the University of British Columbia has recently studied the power of racial and/or cultural representation for clients of colour as a mechanism to supports autonomous decision making and relationship building between themselves and healthcare providers. According to the Birth Place Lab's recent study titled Giving Voice to Mothers, almost all respondents (2700 people from all 50 United States) prioritized two factors when aiming for quality perinatal services: 1. Building trusting relationships with their healthcare providers and, 2. Finding providers who understand their values.(9) Specifically, "women of colour including Black and Indigenous women, talked about the importance of being able to choose a provider who shares their culture".(9) Alarmingly, "all perinatal service users of colour reported lower overall rates of respect, privacy and dignity, than White women".(9) One in seven women (17%) indicated that they would like to find a midwife or doctor who share their heritage, race, ethnic or cultural background, however of those women, 69% Black women, 4% white women, and 49% Latina women had difficulty finding a concordant healthcare provider. (9) These results indicate the importance of racially or culturally concordant care and the gravity of PGM and marginalized populations' representation in healthcare *and* education.

1.2 The Year of Resistance and Uprising

The summer of 2020 was a period that could only be describe as cataclysmic. The pandemic was escalating, and death tolls were rising locally and globally. Health inequities of underserved populations were quickly becoming undeniable. The public was starting to comprehend their own mortality as they witnessed illness and death on social media, at their workplace and even within their own families. On May 25, 2020, this unrest was worsened when Mr. George Floyd in Minneapolis, Minnesota was killed by police officers. These events sent shock waves into society which have since forced the masses to critically examine society's values, structures, and systems.

During the summer of 2020, racialized midwifery students from across the province called on the OMEP consortium to address a comprehensive list of factors contributing to systemic racism in the MEP[3]. This included a call to review and revise the MEP curriculum. In response, the McMaster MEP has developed a statement on equity, diversity and inclusion that articulates a commitment to anti-racist and anti-oppressive pedagogy and has developed an EDI action plan that includes reviewing and revising its curriculum. This revision is where my study is situated.

[3] Internal MEP document, not published

1.3 Social Justice in Education: Genesis

According to the Oxford English Dictionary, the term "social justice" was first recognized in 1824 within the context of philosophy and politics.(10) Currently, the definition states: "justice at the level of a society or state as regards the possession of wealth, commodities, opportunities, and privileges". Depending on the lens applied to this definition (e.g., theoretical, political, everyday life, etc.), social justice can remain ambiguous. Moreover, there is continued debate specifically within the realm of health professions as to what this term means to each profession independently. (11–15) In the case of midwifery, a global scan of the literature resulted in no definitions.

In education, social justice discourse in North America can be traced back to the work of George Counts (1932)[4] and John Dewey (1859-1952) as they both called for teachers and society-at-large to build a new social order and reform education.(16) Specifically, they believed that through education society could develop a more democratic, just, free, and peaceful world. (17) There are countless Indigenous, Black, and racialized educators who have spent their lives delivering education in their own communities based on their own epistemology. Those same educators would have also challenged the educational standards though indirect methods. These education heroes have not been recognized or mentioned in the history books or academia, however, their efforts, courage, and tenacity deserve explicit recognition and acknowledgment. Today, the contemporary works of Paulo Freire, bell hooks, Maurianne Adams, Lee Anne Bell and many others have helped refine the goals of social justice in education. As Adams explains, "[s]ocial justice education pedagogy is based upon a set of principles and practices for teaching about oppression and social justice".(18) Paulo Freire's 1970 book, Pedagogy of the Oppressed, while controversial for its perceived classism, challenges oppressed people to awaken their consciousness to fully understand their oppression in hopes that they will be agents of their own change. (19) His idea of conscientizaçao or conscientization, becoming aware of one's existence through dialogue and praxis is one key component of social justice education. The second contemporary theory is bell hook's engaged pedagogy which calls for progressive, holistic and transformative education for both the student and teacher. (20) In essence, social justice in education is not only what we teach, but how we teach it; something the OMEP must consider given its genesis and legacy.

1.4 Constructive Alignment & Curriculum Design

Health professions education (HPE), as a discipline on its own, has examined issues of population health and population education over the past 80 years. (21) Cate et al. has reiterated that HPE's future trajectory will continue to investigate issues such as competency-based and time variable education; simulation and artificial intelligence; as well as a specific focus to engage in global collaboration and exchange, and team-based and community-based care. (22) It is my assertion

[4] Counts GS. Dare the school build a new social order. United States of America: Southern Illinois University Press; 1932.

that if HPE programs aim to produce providers who uphold evidenced-based biomedical practice that is both anti-oppressive and anti-racist, then the integration of social justice education (*how we teach*) and social justice-based curriculum (*what we teach*), will undoubtably play a role in this predicted trajectory of HPE.

The question remains however, how does HPE programs move from the educational rhetoric of lecturing students to value social justice as part of their training, to a place where educators can create transformative learning spaces that foster actionable teaching and learning in the classroom? In other words, how do we educate in a socially just manner that inspires students to want to be socially just in their practice as future healers? In 1949 Ralph Taylor proposed a framework, *Basic principles of Curriculum and Instruction*, that has since been adapted and popularized by John Biggs as an outcomes-based education framework called 'constructive alignment'. (23) Biggs' framework focuses on student learning that is self-directed because teachers are posed as facilitators rather than lecturers of specialized knowledge. (24) Furthermore, this framework forces teachers to design the course 'backwards'; meaning that teachers need to shift their thinking to 'what are the end goals of the course?' versus 'what do I want to teach based on my own knowledge base?' Coincidentally, constructive alignment aligns with creating a socially just classroom through its student-centred approach to teaching and learning.

Constructive alignment consists of three interlinked components: first, the creation of intended learning outcomes (ILOs), followed by the construction of concordant teaching and learning activities (TLAs), and finally the development of suitable assessments and evaluations(AEs). (24) Educators are tasked to determine what it is that they would like students to be able to do by the end of the course or program, i.e., through the development of ILOs. Second, the TLAs must be developed to encourage students to form their own interpretation of the content being taught and aim to meet the requirements of the ILOs. Third, the AEs, be they formative or summative, must appropriately determine if the student has met the ILOs. This framework requires adjustments to the way that content is taught, what activities are being used and how evaluations occur; consequently, this approach initially takes time to develop and a trial-and-error approach is required for ultimate success. (24)

1.5 Research Question & Objectives

The purpose of this research was to explore the incorporation social justice curriculum into the OMEP to better prepare students to serve Ontario's diverse population in respectful and culturally appropriate ways and provide curricular guidance in light of these findings.

The research question was: What elements of social justice curriculum should be included in the Ontario undergraduate midwifery education program?

The objectives of the study were:

1. To define "social justice" in the context of Canadian midwifery education.
2. To identify social justice elements in the context of Canadian midwifery.
3. To develop intended learning outcomes (ILO) and compare them to the 2020 Canadian Midwifery Competencies (CMC).
4. To generate normative recommendations for the Ontario Midwifery Education Program regarding the integration of social justice curriculum.

This was a two-phased study. The first phase aimed to define social justice in the context of Canadian midwifery education. This goal was to help inform the OMEP about *what to teach*. Currently, the literature does have a few exemplars discussing the process of identifying and integrating social justice curriculum in medical schools, particularly the Geisel School of Medicine at Dartmouth. (25) Their stepwise approach has informed this work and study design. Unfortunately, a search of the literature did not reveal any examples of social justice curriculum identification or integration in midwifery education programs worldwide. Furthermore, the CMCs developed by Canadian Midwifery Regulators Council (CMRC) were recently revised and incorporate elements of social justice, affirming that there is a requirement to address social justice and by extension health equity as a profession nationally. (26) The second phase of this study aimed to engage in the first stage of constructive alignment, developing learning outcomes and mapping the CMCs to see if there is alignment. This will inform future work concerned with completing the constructive alignment framework by developing teaching and learning activities (TLA), and assessments that support an OMEP that is inclusive, liberatory, and transformative.

Chapter 2 – Theoretical Framework

In this chapter, I discuss the concept of structural competency theorized by Metzl and Hansen. I then elaborate on their paradigm shift and suggested framework for incorporating this into health professions education. Lastly, I discuss how structural competency connects the objectives of my study.

2.1 Structural Competency

This research study rests on the foundational footings of the theories of both Freire and hooks, specifically their principles of transformative and liberatory education (i.e., how we teach). While this discourse on transformative pedagogy is part of the social justice education scholarship, my study will be focusing on what we teach. To do this, this research also builds on Metzl and Hansen's theory of structural competency. Structural competency "redefines cultural competency in structural terms". (27) It challenges HPE programs to teach their students to recognize that beyond the implicit and explicit discernments that occur during one-on-one interactions with clients in the clinical space, there are also structures in society that contribute to clients' overall health and wellness.

Metzl and Hansen define structural competency as:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or disease (e.g., depression, hypertension, obesity, smoking, medication 'non-compliance', trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matter as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definition of illness and health.(27)

Furthermore, Metzl and Hansen define "structure" as multidimensional. Structures, in their context, imply

> buildings, energy networks, water, sewage, food and waste distribution systems, highways, airline, train and road complexes and electronic communications systems that are concomitantly local and global, and that function as central arteries. [Additionally,] structures can represent the hidden agendas of diagnostic and bureaucratic systems that encompass biomedical interactions. (27)

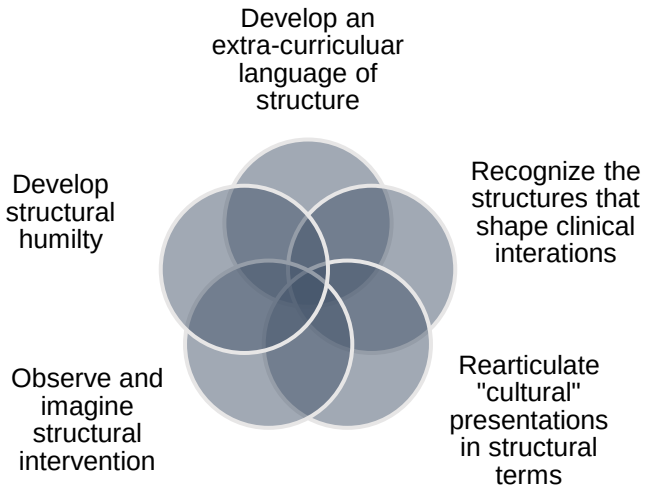
Lastly, they recognize that structures can also be located in the language used and attitudes presented which act as facilitators or barriers to overall health outcomes. (27) Essentially, structures can be both tangible configurations and non-tangible forces that society has deemed "necessary" for the sustainability of itself. For many, it is the exposure to societal structures, such as the

Canadian residential school system, or the Children's Aid Society, that contribute to health disparities. This concept will be further developed in the Chapter 5.

In addition to defining structures, Metzl and Hansen discuss what "competency" means in their formulation of the term. They emphasize that competency is not the mastery or expertise of any one area of socially constructed identity knowledge (i.e., religious competency, gender, and sex competency, etc). Instead, it is the ability to continually study the nuances of these constructs and how they interact with structural forces. Moreover, competency requires humility when examining how structures dominate and reinforce stigma which influence health inequities and result in poor health outcomes. (27)

The paradigm of structural competency has been placed in a theoretical framework that includes five intersecting skill sets (refer to Figure 1). The first skill set is "recognizing the structures that shape clinical interactions" and it is based on identifying "how physical, and socio-political forces impact medical decisions". (27) The second skill set, "developing an extra-clinical language of structure", requires an expansion of thinking about structures beyond the medical definition. This necessitates discussion with other disciplines to understand their interpretations of structures. The third skill set, "rearticulating 'cultural' presentations in structural terms" is based on the ability to reformulate clinical presentations with terms and concepts gathered from the interdisciplinary discourse mentioned previously. Skill set number four involves "observing and imagining structural intervention" that motivates learners and clinicians to recognize that structures that influence health are time specific, in that they tend to be created or dismantled when convenient to dominant society. The fifth and final skill set, "developing structural humility", is all encompassing and a continual process. Interestingly, this skill set reminds us that structural competency is not a panacea and instead it requires critical reflection to understand its limitations.(27)

Figure 1: Metzl & Hansen's Structural Competency Framework



2.2 Paradigmatic Shifts: Structural Competency & Midwifery Education

The refocusing of the OMEP's culture, pedagogy, and curriculum to align with its professional bodies' position statements endorsing a more inclusive, equitable, and socially just profession is where structural competency is situated.(26,28,29) Metzl and Hansen's structural competency paradigm and subsequent theoretical framework pushes the MEP to enhance their own critical thinking regarding social justice organizationally and educationally. This is reiterated by Kahlke and Eva in their discussion of critical thinking paradigms whereby they stress the importance of not only maintaining excellence in biomedical pedagogies of HPE but also incorporating humanist perspectives, and social justice approaches. (30) The definitions of 'critical thinking' have remained profuse in higher education, where a juxtaposition exists involving a 'reductionist' approach of, 'interpretation, analysis, evaluation, inference, explanation, and self-regulation' or a subjective approach that necessitates emotional connections and relationship building. (30) Kahlke and Eva's study revealed that when applying a social justice approach to critical thinking, health professions educators (and related students) must acknowledge the role biases play at the individual and societal levels. Meaning that these biases, if not challenged, can limit health care provider actions and as a result, patient access to resources. Furthermore, understanding the influence of social systems (i.e., power and privilege attributed to dominant white society) strengthens health care providers' ability to think critically about individual client cases.(30) Overall, HPE programs, (administrators, faculty, and students) need to integrate a flexible approach to critical thinking by engaging in reflection, discussion, action, and conflict. The last category of 'conflict' is usually where the "unarticulated assumptions about important topics" (30) come to light for educators and policy makers. These are the issues that are typically unnoticed due to the predominance a white supremacist organizational culture therefore, integrating structural competency throughout the OMEP is essential to fully engage in social justice pedagogy.

Returning to the inception of the OMEP and the profession in Ontario, midwifery is one of the few 'medical' professions that is, for the most part, supporting healthy individuals who are facing a natural physiological change in their own body or in someone close to them. As a result of this natural state of being, midwives are not seeking to pathologize clients' pregnancies, instead midwives are guiding clients through, with evidence, a natural metamorphosis. In other words, Midwives are "with women" (pregnant people) as opposed to "medicalizing women". Moreover, if our model of care is so vastly different compared to medicine, why would our education model not also differ from that of medicine? Midwifery education needs to rethink its curriculum to purposefully build social justice curriculum that is continuous throughout the program and does not centre whiteness. Through constructive alignment, (i.e., intended learning outcomes, teaching and learning activities and assessments and evaluations) social justice curriculum should support social justice pedagogy of liberatory education and experiential praxis leading midwifery education into its own new pedagogical paradigm.

2.3 Social Location & Personal Bias

It is important to me to identify myself within the context of this research study. As a racialized, cis-gender, heterosexual person who continually finds myself straddling the duality of existing with and without power and privilege, I approached this study with critical self-reflection and reflexivity. This study has forced me to confront the struggles that I have faced as an former OMEP student, as a clinical preceptor, and eventually as an instructor within the program. During the past 15 years in the OMEP, I have helplessly witnessed the oppression faced by Indigenous, Black, racialized, and underrepresented students in both pre-clinical and clinical courses. I have watched them (us) fail due to a misalignment of teaching pedagogy, white-centred curriculum, systemic discrimination, and a lack of racial representation. They (we) have been forced to be resilient in a manner that is more aligned with code switching[5] rather than approaching the learning in their (our) own way. Code switching exacerbates imposter syndrome[6] which produces insecurities that develop into an overall lack of confidence. The pervasive exclusionary culture of white supremacy within the OMEP produces classrooms that are made for the dominant culture to succeed; it has historically not been a space for inclusion or safety.(7) Through memo writing, journaling, and discussion with my peers, my biases have been challenged and I have worked through them. I have learned that my life experiences have been the backbone to my progression as a researcher, an educator, Registered midwife, and life-long learner. My experiences continue to influence my ontological and critical epistemological approaches to my work and have sharpened my awareness of my implicit and explicit biases.

[5] Code switching = adjusting one's style of speech, appearance, behaviours, in a way that optimized the comfort of others in exchange for fair treatment. (Harvard Business Review 2019)

[6] Imposter syndrome = a collection of feelings of inadequacy that persists despite evident success, feelings of chronic self-doubt or fraudulency. (Harvard Business Review 2008)

Chapter 3 – Methodology & Methods

In this section I present background information about Delphi study designs and describe my adaptations to Sitlington and Coetzer's approach to the modified Delphi. Next, I review my application of Braun and Clarke's six phases of thematic analysis to the study in micro and macro levels. Then, I discuss participant inclusion and exclusion criteria and recruitment methods. This is followed by a description of the steps of my approach to the modified Delphi including a literature review, three Delphi rounds that consisted of focus groups, interviews, and surveys, and lastly a member checking session.

3.1 Modified Delphi Study

In the 1950s Norman Dalkey of the RAND Corporation, created the (classic) Project Delphi for the purpose of forecasting.(31,32) The premise of the classic Delphi is to gather the opinions of experts or an "Advice Community" through a systematic and iterative process using several rounds of quantitative surveys to obtain consensus on a given issue. (31–33) Two and a half decades later, Linstone and Turoff further developed the Delphi process by acknowledging the variations of the classic Delphi structure. (34) They along with other scholars, advise that Delphi studies in general, undertake four unique phases. First, the topic of interest should undergo discussion where each participant has an opportunity to voice their opinion. Second, the group of participants develop a common understanding of the topic. Third, if any disagreements were identified, further discussion would be required. Fourth, participants would evaluate results and provide final feedback. (34–36) Since the mid-1970s, the Delphi has continued to evolve by moving away from paper-and-pencil based survey administered through postal services to internet-based e-Delphi platforms. (37,38) The use of online platforms has permitted researchers to access a larger pool of experts, reduce turnarounds time for the construction of surveys and analysis, and has enhanced participant anonymity and security through the use of online privacy policies and cyber security measures. (37)

The Delphi study design is appropriate in circumstances where the problem may benefit from collective subjective judgements, those who need to contribute to the problem have very diverse backgrounds and expertise, the mixed range of expertise needs to be maintained to avoid domination by one group, and logistics are an issue due to distance, time and/or cost. (33–35) Based on these guidelines, a Delphi was suitable for this study for multiple reasons: social justice content is multifaceted and ambiguous and therefore requires the opinions of many to define and refine, and this approach allowed me to seek the opinions of intersectional experts; it supported the inclusion of nursing, social work and medical experts to broaden the data collection; pandemic restrictions required a format that would facilitate remote participation; and the asynchronous nature of an online Delphi allowed participants to complete the surveys at their convenience.

The classic Delphi has been utilized by several disciplines such as education, business, and healthcare. (35,39,40) Each discipline has incorporated modifications to the classic Delphi to meet their study's needs. Some of the modifications have included changes to the sample size and/or

number of survey rounds, and incorporating qualitative options in the surveys. (35,41,42) In the field of education, Sitlington and Coetzer's modified Delphi study design which focused on curriculum development included three rounds of mixed methods surveys with experts who were recruited through a process of purposeful and snowball sampling.(35)

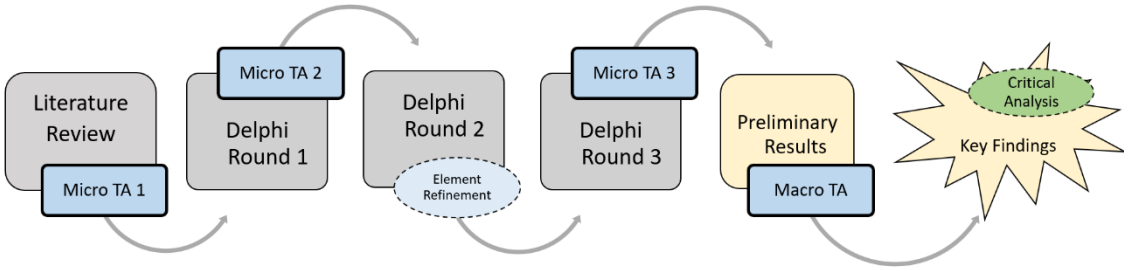
My methodology reflected the majority of Sitlington and Coetzer's design, however I added three adaptations. First, I created a MS Power Point presentation summarizing data collected from the literature review and shared this with participants prior to round one's brainstorming focus groups and interviews. I continued to use this presentation to guide questioning during round one focus groups and interviews. Social justice in general is a topic tends to either create silence or spark several tangential conversations, therefore using the Power Point presentation helped keep participants on track. The second adaptation occurred after round two's survey. I decided to remove SJEs that achieved consensus rather than the SJE that did not achieve consensus. I did this because the elements that achieved consensus met the objective of the study and therefore did not need to be assessed a second time. I also wanted to give participants a second chance to review the elements that had not reached consensus and present the newly suggested SJEs from the first survey. The third adaptation involved my return to Linstone and Turnoff's "member checking" at the close of the study to confirm my analysis as opposed to Sitlington and Coetzer's check in with participants about their experience with the Delphi process. This adaptation was chosen due to the objectives of my study as I wanted to know if participants agreed with my final analysis.

3.2 Thematic Analysis

I used Braun and Clarke's approach to Thematic Analysis (TA) to guide my qualitative analysis.(43–46) Braun and Clarke explain that qualitative analytic methods can be divided into two camps: those that are tied to a particular theoretic or epistemological position e.g., grounded theory or discourse analysis or, those that are essentially independent of theory and epistemology and can be applied across a range of theoretical and epistemological approaches.(44,46) The TA applied in my study rests in the second camp. As a critical constructivist researcher, I have approached my TA in a manner that "examine[s] the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society". (44). To guide the process of coding and theme creation, I used Braun and Clarke's six phase process recursively. See Appendix 1 for a description of the TA process.

In my study, Braun and Clarke's TA process was applied in a non-linear way. In other words, I applied the six phase process at micro and macro levels at various stages of the modified Delphi process. For example, micro-TA occurred at three points: post-literature review, post Delphi round 1, and post Delphi round 3 (second survey). Macro TA occurred at the end of the Delphi rounds once all of the SJEs had been identified and the entire data set was able to be re-examined to generate a thematic 'map' of the analysis (phase 4). (44) Details of how each micro and macro-TA were conducted are discussed in this chapter while the results are discussed in the related sections in Chapter 4. Refer to Figure 2 for a visual representation of the stages of my TA.

Figure 2: Stages of Thematic Analysis



3.3. Participants

A modified Delphi study design promotes gathering experts to brainstorm ideas; however, caution must be given to avoid homogenous expert groups as they can perpetuate hegemonic thinking. (35) Furthermore, as Dupree discussed, 'expert' status is one that is steeped in implicit and explicit biases that align with colonialist dogma, and white supremacy.(47) This is especially true when "experts" continue to be academics or professional white males, who hold power and privilege within their discipline and society at large. In midwifery, as discussed earlier, the dominant prototype of 'experts' i.e., leaders, educators, midwives, and students, remain white women who espouse power and privilege and are products of midwifery and society's structures of oppression. To counter this, my study involved a purposeful decision to recruit a heterogeneous group of experts that represented experts and lay-experts. (48)

Through purposeful and snowball sampling I recruited experts who had a significant depth of social justice content knowledge and reflected various social identities, positionalities, and lived experiences. I utilized snowball sampling to reach more participants in groups that proved more difficult to recruit such as nurses. Of note, despite best efforts I was unable to recruit any nurses for the study.

I invited both Subject Matter Experts (SMEs) and Key Informants (KIs) to participate in my research. Subject matter experts were academics or clinicians with expertise in social justice in health professions education, and KIs were, as a group, considered midwifery partners (i.e.,

midwifery students, clients, midwives, and midwifery educators). This is not to be confused with members of the midwifery periphery such as staff at an Association, College, or non-governmental organizations (NGOs), etc.

3.3.1. Inclusion criteria/exclusion

Subject Matter Experts consisted of academics and/or practitioners in midwifery, nursing, social work, or medicine. I aimed for a minimum of 5 participants from each profession. Inclusion criteria for SME were: 1. Having published academic or alternative literature on the topic of social justice in health professions education in Canada or the United States of America; or 2. Currently teaching or having taught a social justice course in their own discipline at a Canadian university at the undergraduate level; or 3. Practicing midwifery, nursing, social work, or medicine in Ontario with a clinical focus related to social justice. Professionals outside of these four disciplines (midwifery, nursing, social work, and medicine) were excluded.

Key Informants consisted of: 1. Current Ontario midwifery education program senior students in level 4 and/or recent graduates (≤June 2019 graduate); or 2. Canadian midwives who are known in the midwifery community as social justice leaders or advocates; or 3. Ontario midwifery clients who had experienced a full course of midwifery care in the past two years (June 2019-2021) and were discharged from care[7]; or 4. Canadian midwifery education program faculty and/or sessional instructors who were currently teaching or had published literature on social justice content;

Exclusion criteria for KIs were: current Ontario midwifery education program students who were enrolled in levels 1-3; midwives who had not practiced in Ontario; midwifery clients who were still in care or had not completed a full course of care; and midwifery education program faculty and/or sessional instructors outside of Canada.

3.3.2. Rational regarding participants

There has been very little consensus in the literature about the preferred size of an expert panel. (31,35,39,41) On average, expert panels can range from 5-60 individuals.(32,33,35,41) The OMEP has less than 5 faculty/sessional instructors who are considered subject matter experts in the field of social justice, therefore I planned for the initial brainstorming sessions to also include 5-10 educators within the disciplines of nursing, social work, or medicine. These disciplines were chosen because nursing, social work and midwifery are considered part of a list of the "caring professions", an anecdotal group of professions known to care for those who are ill or in need of support with complexities in their lives. (49) Medicine was included because midwifery works closely with this core medical profession, and it has its own influences on the midwifery profession.

[7] Full course of care includes prenatal, antenatal (birth) and 6 weeks postpartum care

3.3.3 Recruitment

I sent a standardized email for initial recruitment which included an information letter and consent form to ten people from each category of participant with the goal of recruiting 50%. I chose these recruitment goals for two reasons, one, given the stresses of the pandemic on health care students and workers, I did not set my recruitment much higher, and two, knowledge of 'social justice' content is niche and many people do not consider themselves an expert despite their clinical experience, education and lived experiences. Each communique described why they were being contacted (i.e., their individual connection to the subject matter), the time requirement, and the levels of participation. (Refer to Appendix 2 for details). I ended my solicitation for participants after three email attempts. Participants were reminded that they could withdraw from the study at any point via a notification by email.

Once participants consented to join the study, a first step was the administration of a demographic survey. (See Appendix 6). I administered the demographic survey in round one and two only as the participants changed in those rounds and not in the third. The McMaster web-based platform, REDCap, was used to create, deliver, collect, and store the demographic survey as well as the Delphi surveys. This platform is "[a] secure web application for building and managing online survey and databases".[8] The purpose of the demographic survey was to confirm that the participants represented diverse and intersectional populations, and it acted as a tool to confirm inclusion/exclusion criteria. (41)

3.4 Literature Review

Typically, Delphi studies begin with a brainstorming session with SMEs and there is minimal to no preparatory material provided. (32,34) Due to the depth and breadth of the research question, and the desire to provide SMEs with context for their thinking, the first adaptation I made to Sitlington and Coetzer's study design was the completion of a literature review including grey literature gathered from Canadian midwifery education programs prior to the first Delphi round.

I conducted a literature review using the following search strategy: ((midwifery or nursing or medicine or medical or social work) adj3 (education or undergrad* or baccalaureate)).ti,ab,kf. AND (curriculum*).ti,ab,kf. AND (social* adj3 (just* or responsib*)).ti,ab,kf. Databases that were accessed included the Cumulative Index to Nursing and Applied Literature (CINHAL), Ovid (Medline EPUB and other non-index citations), Medline(R) Daily (1946 to Present), EMBASE (1974 to April 24, 2021), Web of Science, Education Research Information Centre (ERIC) on Proquest (1966-April 24, 2021).

[8] https://mctr.mcmaster.ca/

My inclusion criteria were studies that were: 1. from undergraduate midwifery, social work, nursing, and medical programs in any country, 2. presented in English, 3. discussed and/or listed social justice content or curriculum, and 4. were peer-reviewed or grey literature. Grey literature included content from the websites of midwifery education programs in Canada and the USA, regulatory bodies of health professions, and professional associations. Items that were excluded were literature from professions not previously listed, as well as descriptions of social justice workshops or standalone sessions, and any items that was not in English.

I scanned each article for social justice theoretical frameworks or theories and discrete curriculum elements. There were times where common social justice elements were easily identified because the authors deemed them as such, however this was not always the case. I retained terms/elements that I was unsure of their context or meaning but were identified as social justice content by the authors as I also knew that in round one, participants could decide the elements relevance. During the literature review process, I noted the context in which the elements were referred to so that they could be listed more than once if their meanings were diverse. I edited the cumulative list to eliminate removing any duplicates or synonyms. This process was managed in MS Excel where I gathered a cumulative listing of SJEs that were organized by author(s), year of publication, type of study, country of publication, discipline of study (nursing, medicine, social work, midwifery), element, theory, notes/context.

Micro thematic analysis began in the literature review. I engaged in a micro-TA process when I started to identify SJEs, i.e., phase one of Braun and Clarke's TA process. Once I had completed the literature review, I began phase two of the TA process. Braun and Clarke acknowledged various methods for coding, including the use of low-technology such as highlighters and post-it notes to help identify segments of data. (44) I grouped (coded) elements based on their context. For example, the term 'cultural safety' could be referred to as the actions of a healthcare provider (Individual) or a strategic goal (Community). In phase three I further organized the SJEs into categories. In phase four, these categories were further refined into preliminary themes. Lastly in phase six, I created a MS Power Point presentation for participants to review the refined list of SJEs organized by preliminary themes. (See Appendix 4). The results of the micro-TA, including the creation of the categories and preliminary themes of the literature review, are found in section 4.2.1.

The second approach to gathering SJEs was to approach other Canadian MEPs to understand what they were currently teaching in their programs with regards to social justice. I began with an informal email addressed to the directors of each Canadian midwifery education program excluding McMaster University (which was where this study was based). I asked the directors to provide me with any recent course syllabi or outlines that they (or their faculty/instructors) believed represented social justice curriculum. In an effort to support self-identification of social justice curriculum, I did not provide inclusion or exclusion criteria to the directors. Once documents were received, I applied the same scanning technique used in the literature review to identify ideas, topics, frameworks that were related to social justice. If there was uncertainty, I used unit or weekly titles and subtopics listed in the documents as a guide to identify social justice elements. I repeated the

micro-TA process during this data collection. These SJEs were eventually sorted into the same categories, then into the preliminary themes.

Once the literature review was completed, I created a MS Power Point (PPT) presentation of the collected data. Social justice elements that were identified from Canadian MEPs were highlighted in red font to distinguish them from SJEs found in the literature. I distributed the presentation via email to SMEs one week prior to engaging in the first round of the modified Delphi to allow participants an opportunity to review the material before their focus group or interview. (See Appendix 4 for the PPT presentation). I also provided copies of the PPT slide deck to SMEs for the purpose of their own note making. The power point presentation remained the same for all participants and the process I took for the building of the power point was described to participants during the focus groups or interviews.

3.5 Round One: Interviews and Focus Groups

Round one involved focus groups and interviews with SMEs. I gave participants the choice of how they would like to participate by using the MS Bookings platform. The focus group and interviews were scheduled for 60 and 30 minutes respectively, with flexibility to extend as needed. Both the focus groups and interviews were brainstorming sessions that were semi-structed with open-ended questions. (See Appendix 3). I conducted these sessions on the secure McMaster University Zoom platform. Audio recordings and transcripts were captured contemporaneously on the same platform. I used Excel software to manage the data, and saved it on MacDrive, a secure server that is password protected. I used open coding to identify SJEs, concepts and/or themes. I collated and added the SJEs to the preliminary list of elements identified through the literature review.

One of the study's objectives was to develop a definition of social justice in the context of Canadian midwifery education. As a result, participants were asked to view definitions of social justice from nursing, social work, medicine, and midwifery in the PPT presentation. (See Appendix 5 for Discipline Specific Definitions). Subject Matter Experts were asked open ended questions regarding these existing definitions. (See Appendix 3 for the Interview Guide). Micro-TA was conducted specifically for this portion of the focus groups and interviews to capture the themes surrounding participants responses. These results are discussed in section 4.3.

3.6 Round Two: Initial Survey

In round two I asked the SMEs who remained and the new KIs (now collectively referred to as participants) to complete a survey in which they were asked to prioritize the list of SJEs compiled based on round one. Participants were also asked to provide free text suggestions for SJEs that were not present. The surveys were conducted online using REDCap Software.[9] I used a 7-point Likert scale, with a priori positive consensus set at 70% or more of the experts scoring $\geq$6, and negative

[9] Refer to Appendix 2 for details.

consensus set at 70% or more of participants scoring ≤2. I collated the responses on MS Excel and used the results to inform the final survey in round three. Surveys were open for 14 days and there was an additional 20 days for turnaround for the final survey.

3.7 Round Three: Social Justice Elements & Canadian Midwifery Competencies Survey

In the final round, I removed SJE that had obtained consensus from the initial survey (round two). This second adaptation to Sitlington and Coetzer study design was made due to differing end-goals of each project. Sitlington and Coetzer study requested participants to select top-10 items from a list of over 30 items, therefore there was no need to remove items as the Delphi progressed.(35) On the other hand, I was building a list of items (elements) based on participants' assessments of the level of priority (low to essential). I added new elements that were suggested by participants in the initial survey (round two) to the final survey (round three) if they were not synonymous with another term. The last micro-TA occurred after round 3 was completed where I coded any new elements in the same way that I coded the original elements during the literature review stage.

At the macro-TA level, I collated the micro-TAs and engaged in a final round of thematic analysis. This time I was searching for common ideas/themes with the elements regardless of their individual context. This led to a regrouping of all terms and the development of new broader themes (pink post-it notes) that related to social justice curriculum in general.

In addition to the list of SJEs, I added the 2020 CMCs from the CMRC to the survey. I asked participants to identify any competencies that reflected social justice skills, knowledge, or judgement. I set a priori positive consensus at ≥95% participants scoring ≥6 on a 7-point Likert scale, and negative consensus at ≥95% participants scoring ≤2. I increased the level of consensus in this section of the survey to provide greater refinement of the competencies.

In general, Delphi studies can reach data saturation when "the research question is answered" i.e., consensus is reached when theoretical saturation is achieved, or sufficient information has been exchanged. (33) Furthermore, in heterogenous samples, 3 or more Delphi rounds are considered sufficient. (33). Lastly, as Sitlington and Coetzer stated, "too many rounds can lead to respondent fatigue".(35) Given these parameters, data saturation was met after the second survey (round three) thus I did not conduct a third survey (fourth round) as I originally planned.

3.8 Building sample learning objectives and program level outcomes

During the macro-TA process, I was concurrently developing sample learning objectives based on the finalized SJEs. I used Chatterjee and Corral's definition of a learning objective as "clearly written, specific statements of observable learner behaviour or action that can be measured upon completion of an educational activity".(50) I constructed the learning objectives using Bloom's

Revised Taxonomy, focusing on the higher level cognitive and affective domains, i.e., evaluate and create, and organization and characterization, respectively. (51–53) This process of creating sample learning objectives was repeated to create program level learning outcomes that related to the McMaster MEP's Degree Level Expectations. These Degree Level Expectations were set by the Ontario Council of Academic Vice-Presidents' Undergraduate and Graduate Degree Level Expectations.(54) The McMaster MEP Degree Level Expectations were used as an exemplar for the OMEP.

Lastly, I mapped the participant identified social justice-based CMCs to the sample learning objectives. This process involved my independent judgement as a registered midwife clinician and the results of the micro-TA. My mapping was corroborated during the member checking session.

3.9. Defining "Social Justice"

One of the objectives of this study was to create a definition of social justice in the context on Canadian midwifery education. During the literature review, definitions were identified from nursing, social work, medicine, and midwifery. (See Appendix 5). These definitions were presented in the PPT slide deck to SME in round one. During the focus groups and interviews, open ended questions were posed to participants for their input. The goal of round one with regards to defining social justice was to get a sense of the need for a midwifery specific definition and possible SJEs that could be used to construct it. A micro-TA was performed after round one on the qualitative data collected in round one. SJEs specific to the definition that obtained consensus during subsequent Delphi rounds were used in the final construction of the definition.

4.0 Rigour & Member checking

Rigour can be thought of as, "the researcher's responsibility to ensure that procedures have been adhered to and confounding factors eliminated [where possible] to produce dependable results". (55) Hasson and Keeney report that several authors "believe the term trustworthiness is more appropriate than reliability and validity to gauge the effectiveness and appropriateness of a Delphi study". (41,55) Trustworthiness involves establishing credibility, dependability, confirmability, and transferability. (55) Hasson and Keeney maintain Engles and Kennedy's (2007) method of producing creditability through ongoing iteration and feedback given to participants during each round of Delphi and through the final member checking. Thus, my last adaptation to Sitlington and Coetzer study design was the member checking session. Sitlington and Coetzer focused on collecting feedback from the participants regarding their experience with the Delphi process itself rather than on the results of the study. (35) According to Candela, "member checking provides a way for the research to ensure the accurate portrayal of participant voices by allowing participants the opportunity to confirm or deny the accuracy and interpretations of data, thus adding creditability to the qualitative study". (56) In my study, I emailed participants with draft tables of my final analysis which included categorization of the SJEs, sample learning objectives, program level objectives and their related themes. (See Table 6). The definition of social justice was omitted due

to time constraints. Participants were given seven days to provide feedback on the document via email. All requests for clarification were responded to within one week of receipt of the original email.

Dependability can be achieved by including a wide range of experts in the study. As described in section 4.1, the process included a range of participants with diverse perspectives. I further corroborated the dependability of my findings through the demographic survey of all participants. Lastly, Hasson and Keeney recommend that "confirmability can be addressed by maintaining a detailed description of the Delphi collection and analysis process whilst transferability can be established through the use of verification of the application of the Delphi findings". (55) In order to achieve confirmability I employed Charmaz's technique of memo-writing to highlight emergent reflections and monitor progress, essentially creating an audit trail.(33,42,57) Based on the research process and the participants, the findings of my research are likely to be transferable across Canada. It is beyond the scope of this research to consider transferability beyond Canada.

Chapter 4 – Results

This chapter presents the results of the modified Delphi. I discuss the diversity of the participants by reviewing the result of the demographic survey. Next, I discuss the quantitative results of each Delphi round as well as any related qualitative data. Descriptions of the micro and macro thematic analyses are also provided where applicable. Lastly both the qualitative and quantitative data that led to the creation of a novel definition of 'social justice' in the context of midwifery education is discussed.

4.1 Participants and Demographic Survey

Seventy-five people were contacted via email requesting their participation. Thirty-eight people agreed to participate, while 39 declined or did not respond at all. The demographic survey can be viewed in Appendix 6 and the characteristics of all participants are shown in Table 1.

Table 1: Characteristics of Participants

Participant Roles	**Round 1 (SME) n=22**	**Round 2 (KI) n=36**
Ontario Midwife (>2 years since graduation)	4	6
Midwifery educator (Faculty/sessional instructor at OMEP)	6	11
Current senior midwifery student	0	4
Recent Midwifery Education Program graduate (graduated 2019, 2020 or 2021)	0	3
Midwifery consumer (experienced prenatal, antenatal/birth and 6 weeks of postpartum care AND discharged from midwifery care)	0	6
Midwifery sector stakeholder (AOM, CMO, NACM)	3	0
Other professional (nursing, medicine or social work)	8	6
Participant Race/Ethnicity		
Asian - East (e.g. Chinese, Japanese, Korean)	1	4
Asian - South (e.g. Indian, Pakistani, Sri Lankan)	5	3
Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	2	2
Black - African (e.g. Ghanaian, Kenyan, Somali)	3	3
Black - Caribbean (e.g. Barbadian, Jamaican)	2	6
Black - North American (e.g. Canadian, American)	0	3
First Nations	1	1
Indian - Caribbean (e.g. Trinidad & Tobago with origins in India)	1	1
Indigenous/Aboriginal - not listed here	0	0
Inuit	0	0
Latin American (e.g. Argentinean, Chilean, Salvadoran)	0	0
Métis	0	1
Middle Eastern (e.g. Egyptian, Iranian, Lebanese)	0	2
Pacific Islander (Tongan, Fijian, Samoan)	0	0
White - European (e.g. English, Italian, Portuguese, Russian)	6	9
White - North American (e.g. Canadian, American)	4	5
Mixed heritage (e.g. Black - African & White - North American)	0	2
Not listed	1	0

Born in Canada	n=21	n=36
Yes	9	22
No	11	14
Prefer not to answer	1	0
Age (years)	n=21	n=36
18-24	0	1
25-34	2	11
35-44	8	13
45-54	5	4
55-64	6	6
65+	0	1
Sexual Orientation (multiple options available)	n=21	n=36
Bisexual	3	6
Gay	0	0
Heterosexual	11	21
Lesbian	0	0
Pansexual	0	2
Queer	5	6
Prefer not to answer	2	1
Gender (multiple options available)	n=21	n=36
Non-binary	2	3
Man	1	0
Woman	18	33
Transgender	n=21	n=35
Yes	0	1
No	20	33
Unsure	1	1
Illness (multiple options available)	n=21	n=36
Chronic Illness	4	4
Learning Disability	1	0
Mental Illness	3	5
Physical Disability	0	1
Sensory Disability (i.e. hearing or vision loss)	2	0
Not listed	13	0
None	0	25
Do not know	2	0
Prefer not to answer	0	2
Highest level of education completed	n=21	n=36
Highschool diploma	0	1
College degree or diploma	0	1
Bachelor's degree (undergraduate)	6	15
Master's degree	7	12
Doctorate	8	7

Current enrollment in Ontario Midwifery Education Program	n=0	n=4
X University, formally Ryerson University	0	1
McMaster University	0	3
Route of Entry into Midwifery (not a current student)	n=13	n=20
Graduate of the Michener Preregistration Program	0	1
Graduate of the Ontario Midwifery Education Program (RU, MU, LU)	9	12
Graduate of another Canadian Midwifery Education Program	0	2
Indigenous Midwifery Education Program or apprenticeship	0	0
Graduate of the International Midwifery Preregistration Program	1	1
Other	3	3
Not applicable	0	1
Geographic region of practice	n=16	n=19
Rural	1	2
Remote	0	0
Urban	12	11
Mixed	3	1
Not applicable	0	5
Type of clinical practice	n=19	n=19
Team practice with 2-4 midwives	3	6
Team practice with more than 4 midwives	1	5
Interprofessional/collaborative care	1	0
Exclusively locum	1	0
Not applicable	11	6
Other	2	2

Subject Matter Experts comprised of four groups: Ontario Midwives (n=4), Medicine or Social Work (8), Midwifery sector stakeholder (n=3), Midwifery Educator (n=6). Key Informants comprised of an additional three groups: Midwifery consumer (n=6), recent MEP graduate (n=3), current Ontario MEP senior student (n=4). Midwifery partners (Midwifery consumers, recent graduates of the MEP and current senior students) were invited to participate in rounds two and three only. Participants self-identified their race and/or ethnicity based on the list of populations provided. The racial majority was white European, followed by Black Caribbean and South Asian. There were several populations that were not represented in any rounds of the Delphi, specifically Inuit, Indigenous/Aboriginal not listed, Latin American, and Pacific Islanders.

In round one, 22 subject matter experts (SMEs) were expected to participate in either focus groups or interviews, however only 19 attended these brainstorming sessions. Twenty-one SMEs completed the demographic survey prior to attending brainstorming session. In round two the demographic survey was required again as new participants joined the study and some SMEs withdrew. A total of thirty-eight participants completed the demographic survey. Round two had thirty-six participants and two withdraws; round three has an additional four withdraws. Attrition is common in Delphi's due to lag time between rounds. This occurred between round two and three

and I chose not to add new participants to maintain sample size. Total attrition for the study was seven participants. See Table 2 for a summary of participants in each round.

Table 2: Summary of Participation and Attrition (n)

Total Participants n=39	**Expected**	**Actual**	**Attrition**
Round 1 (SMEs)	22	19	-3
Round 2 (SMEs & KIs)	38	36	-2
Round 3 (SMEs & KIs)	36	34	-2

In round one, most of the SMEs (eleven) were born outside of Canada however in round two the results were the opposite. The age range of participants was 18-65 years old. Regarding gender and sexual identity, most participants in both rounds were heterosexual women, however there were also participants who identified as bisexual, pansexual, queer, non-binary, man, and transgender unsure. Regarding illness or (dis)ability, the majority stated they did not have an illness while others reported, chronic illness (n=4), mental illness (n=5) and physical disability (n=1). Overall, the participants' level of education ranged from high school diplomas to doctorates. The main route of entry into midwifery was through the OMEP. Most midwife participants reported practicing in urban or mixed geographic regions, with only a few in rural or mixed settings. The range of professional practice arrangements included small groups of 2 to ≥4, some working with interprofessional teams, however the majority indicated that this section did not apply to their current working structure. The majority of current midwifery students were from McMaster University.

Regarding years of experience, the median range was 12-13 years as practitioners, researcher and/or educator. As a midwifery practitioner the median range of experience was 8-8.5 years. As a clinical preceptor the median range experience was 5-6 years between rounds. Of note, participants had an opportunity to list their years of experience in multiple options therefore the total for all categories will be larger than the expected total sample size. (See Table 3).

Table 3: Years of Experience of Participants

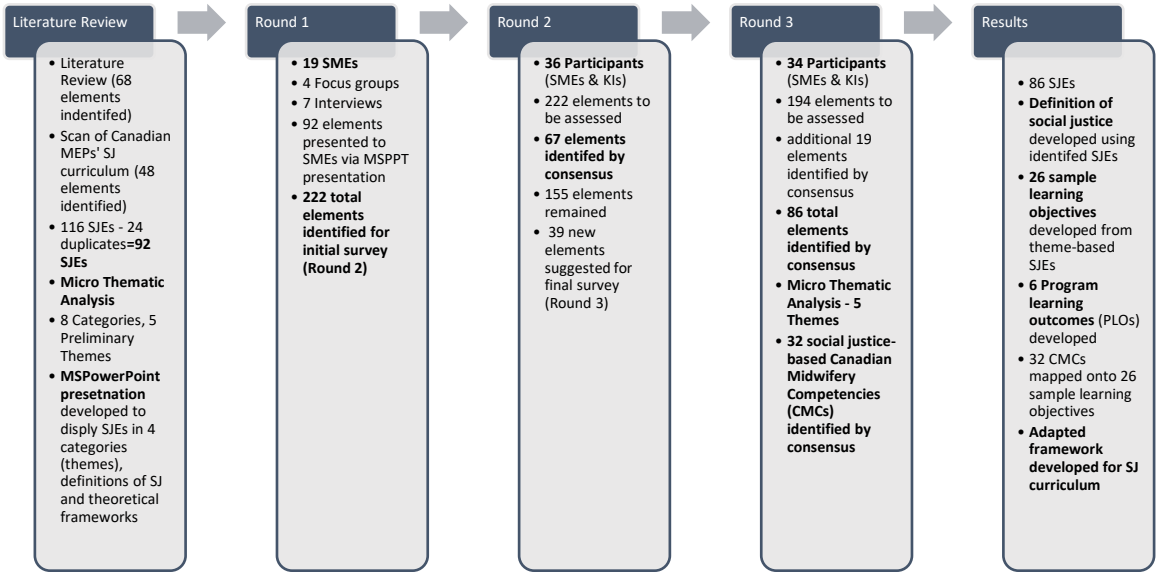
Round 1: Years of Experience of Subject Matter Experts	**n**	**Range (yrs)**	**Median (yrs)**
Practitioner, Researcher, Educator	16	<1-37	13.5
Midwifery Practitioner	17	<1-37	8
Clinical Preceptor	11	3-19	6
Round 2: Years of Experience of Subject Matter Experts & Key Informants	**n**	**Range (yrs)**	**Median (yrs)**
Practitioner, Researcher, Educator	26	<1-36	12
Midwifery Practitioner	16	<1-36	8.5
Clinical Preceptor	9	2-34	5

4.2 Literature Review

The literature review produced 216 studies that were imported for screening. There were 69 duplicates which were removed. There were 113 studies that were deemed to be irrelevant, leaving 75 full text studies to be assessed for eligibility. Upon further review, 51 of these studies were excluded due to the following issues: wrong topic, graduate level curriculum, wrong profession, not program level curriculum (i.e., workshops or limited seminars). There were 24 studies that were reviewed in detail. The publication dates of the articles ranged from 2003 to 2021. The majority of the papers were from the United States of America (19), followed by Canada (3), United Kingdom (2), and South Africa (1). Medicine was the discipline that dominated, with 13 articles, followed by nursing (8), midwifery (2), and social work (1). Most of the documents were in the form of reports or commentaries, followed by case studies. Sixty-eight social justice elements and 11 theoretical frameworks were identified. There were several elements that were repeatedly mentioned indicating that these were items that were common across the health professions education. In order of frequency, the top five elements were: 1. Solidarity with the underserved (n=19), 2. Reflection/ reflexivity/self-awareness (n=13), 3. Social determinants of health (n=10), 4. Advocacy (n=10), 5. Power and Privilege (n=9).

The second data gathering process involved the Canadian MEPs. The University of British Colombia, Mount Royal University (Alberta), University of Manitoba, and Toronto Metropolitan University (Ontario, formally Ryerson University) responded to the request for social justice-based course outlines or syllabi. The one French MEP, Université du Québec à Trois Rivières Baccalauréat en pratique sage-femme also submitted documents; however, they were in French and therefore were excluded from this analysis. Four MEPs have introductory social justice courses which are offered in level one while others have a variety of courses such as Introduction to Midwifery the Profession, as well introductory Indigenous midwifery courses. There were forty-eight SJEs identified in the curriculum materials from the Canadian MEPs. The 116 elements identified in the literature review and data gathering were cross referenced and duplicates or synonyms were removed. In total there were 92 social justice elements remaining. See Figure 3 for an overview of the modified Delphi study including the number of participants, development of SJEs, points of thematic analysis and results.

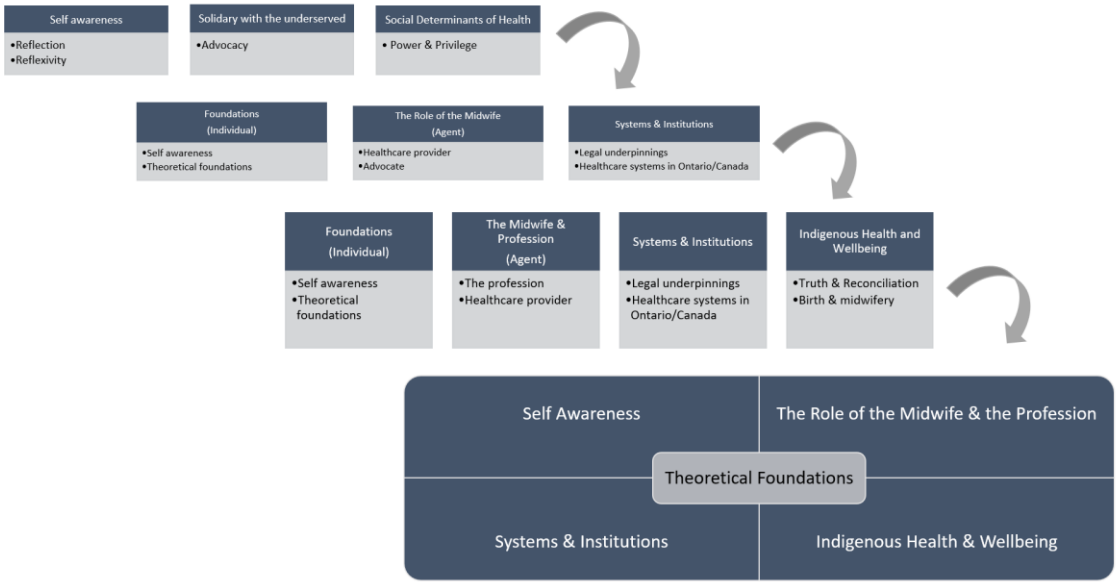
Figure 3: Modified Delphi Process & Summary Results



4.2.1 Micro-Thematic Analysis 1

Phase one of Braun and Clarke's TA process, (see Appendix 1) I noted that during the literature review there were several SJEs that continued to appear in the literature. I also began to understand that the context of the SJEs was essential in the organization of the terms. The context of the SJEs helped me create initial codes as per phase two. The top five elements, as mentioned in section 4.2 inspired my first iteration of 'categories'. I had tried to organize SJEs into these categories, but soon realized that they were not fitting well. Essentially their context was not aligning with the category's context. Many SJEs were both a noun and verb that had a different expectation based on subcategories. The SJE could be used to explain phenomenon (e.g., microaggressions given or received) or situate and experience (e.g., critical race theory as a client or midwife). In phase four, I spent time reviewing themes. Figure 4 displays the several iterations of preliminary themes during all stages of thematic analysis. In row three of Figure 4, the themes and subcategories were used to display the SJEs to SMEs in round one. As phase six suggests, I presented this TA in a PPT presentation to SMEs as a starting point for discussion in round one. (See Appendix 4 for the presentation slide deck)

Figure 4: Iterations of preliminary SJE themes



4.3 Round one

In round one there were 19 SMEs who attended one of four focus groups or seven interviews. Focus groups comprised of 2-4 SMEs and me as the interviewer. Subject matter experts were presented with the 92 social justice elements identified through the literature review and asked to either add or delete elements. After assessing qualitative results, an additional 130 new elements were identified.

4.3.1 Micro-Thematic Analysis 2

Another round of micro-TA occurred after round one. In phase one, all focus groups and interviews audio recordings were transcribed from the secure McMaster Zoom platform. Each transcript was reviewed with the audio recording to clarify any poorly transcribed passages. A MS Excel document was created to aid transferring the coded transcribed data. Page one of the Excel document was organized by focus group or interview and by SME. Question posed in the sessions were listed on the opposing axis.

Open ended questions and responses were thematically analyzed separately from questions about discrete SJEs. Full quotes were copied verbatim into the corresponding SME and question boxes in the Excel document. After reviewing all the comments/quotes for each question, any key ideas or statements were highlighted and added to a column at the end of the question row. These final

overarching ideas were coded based on common ideas, context, or words. Subsequently preliminary themes were created. This process continued for each of the four open ended questions posed.

Page two of the Excel document mimicked the organization of focus groups and interviews, and corresponding SMEs. On the opposing axis, the SJE terms displayed in the PPT presentation were also listed. If participants made a comment to keep, remove or replace a term, this was noted. Any new SJE were listed in a separate row named "Elements added by participants". I reviewed all the SJE's and kept all newly suggested elements and removed any duplicate or synonymous terms.

The themes developed during the literature review remained for the most part, however as phase four suggests, I did review the sub-categories and found that some were removed as they were identified by SMEs as discrete SJE's. Other sub-categories also shifted to themes. For example, the subcategory of Self Awareness replaced the theme of Foundations, and the subcategory of Theoretical Foundations became its own theme. It became clear after round one that the context of some SJEs were directly related to 'individuals' understand of SJE concepts (nouns) and the 'individuals' responsibility to enact the knowledge (verb), hence the first newly named theme, Self-Awareness. The next theme merged into one, 'the role of the midwife and the profession', as the perspective of the learner shifted from 'self' to 'professional self'. The third revised theme was Systems and Institutions; as midwives we work in structured systems, through policy and culture, and these systems operationalize society's values, beliefs that are exclusive. As such, Midwives are well positioned to learn and challenge inequities. The fourth theme revised theme was Indigenous Health & Wellness, and the fifth theme became Theoretical Foundations which was initially a subcategory of Foundations.

4.4 Round two

In round two, the first Delphi survey was initiated. There were 36 participants (SMEs and KIs). Two hundred and twenty-two SJEs were presented in the five revised categories: 1. Self-awareness, 2. The Profession and the Role of the Midwife, 3. Systems & Institutions, 4. Indigenous Health & Wellbeing, 5. Theoretical Frameworks. Sixty-seven SJEs met positive consensus criteria and were removed from the initial list. An additional 39 SJEs were suggested by participants and added to the next Delphi survey.

4.5 Round three

In round three, 34 participants returned to complete the final Delphi survey. Two participants did not return for unknown reasons. In addition to the 67 elements identified in round 2, another 19 were identified in round three for a total of 86 final SJE. (See Table 4 for a list of the final SJEs). Note, while participants were asked to rank their level of priority of the SJEs based on a 7-point Likert scale, I have chosen to display the tables as percentage of consensus because of ease of reading the results. Refer to section 3.6 for definitions of positive and negative consensus.

Table 4: Final List of Social Justice Elements (n=86)

Category 1: Self-awareness	**Consensus %**	**Mean (s)**	**STD**	**VAR**
Discrimination domains (racism, sexism, ableism etc.)	91%	6.7	0.6	0.4
Indigenous and Black bodies	91%	6.6	0.6	0.4
Anti-oppression	89%	6.4	0.7	0.5
Historical/generational trauma	89%	6.4	0.8	0.6
Oppression	83%	6.2	1.1	1.2
Whiteness, white superiority, white supremacy	81%	6.2	1.3	1.7
Critical consciousness (self-reflection/reflexivity)	80%	6.3	0.8	0.6
Islamomisia, homomisia etc - ('misia' = hate of)	80%	6.2	1.2	1.3
Equity vs. equality	78%	6.1	1.1	1.1
Humility	78%	6.1	1.0	1.0
Forced sterilization of marginalized bodies	75%	5.7	1.1	1.3
Inclusion	74%	5.9	1.2	1.5
Interactional justice (people who are affected by decision are treated with respect and dignity)	74%	5.8	1.3	1.7
Othering	74%	5.9	1.3	1.8
Privilege, power	74%	6.2	1.2	1.3

Category 2: The Profession and the Role of the Midwife	**Consensus %**	**Mean (s)**	**STD**	**VAR**
Anti-oppression action	91%	6.3	1.1	1.3
Anti-racist action	91%	6.3	1.1	1.3
Provide trauma-informed care (historic, intergenerational, intimate partner violence etc)	86%	6.4	0.8	0.7
Gender and sexual diversity and trans care	83%	6.4	0.8	0.7
Accessibility/Access	82%	6.3	1.0	1.0
Communication	82%	6.1	0.9	0.8
Structural competence (understanding how systems affect the health of people)	79%	6.2	1.1	1.3
Lack of diversity in the profession	78%	6.0	1.2	1.5
Cultural safety	77%	5.9	1.4	1.8
Obligation to the underserved	77%	6.1	1.0	1.0
Mitigating health disparities	76%	6.0	0.8	0.6
Poverty racism and exclusion	76%	6.3	0.8	0.7
Respectful care	75%	6.0	1.0	0.9
Histories of Indigenous Midwifery	74%	6.1	1.3	1.7
Community centred care	71%	5.9	1.0	1.0

Category 3: Systems & Institutions	**Consensus %**	**Mean (s)**	**STD**	**Var**
Uninsured Clients (Regional policies)	86%	6.3	0.6	0.8
Uninsured services in Ontario	86%	6.3	0.9	0.7
Truth and Reconciliation Commission of Canada	83%	6.3	1.7	1.3
OHIP and OMP Funding for non-insured residents in Ontario	80%	6.1	1.0	0.9
Parenting and the intersections of class and race	77%	6.2	0.8	0.6
Abortion Services	74%	5.9	1.3	1.6
Child Welfare System	74%	5.8	1.3	1.7
The Indian Act	74%	6.1	1.0	1.0
The Midwifery Act (1991)	74%	6.1	1.0	1.1
OCAP	73%	6.1	1.2	1.4
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	70%	6.0	1.2	1.4
Non-Insured Health Benefits (for Indigenous people with "status"	70%	6.1	1.3	1.7

Category 4: Indigenous Health & Wellbeing	**Consensus %**	**Mean (s)**	**STD**	**VAR**
Indigenous midwifery	100%	6.8	0.4	0.2
Colonialism, white supremacy, settlers	97%	6.6	0.7	0.4
Decolonizing Indigenous midwifery	97%	6.4	1.1	1.3
Ongoing genocide	91%	6.4	1.1	1.2
Colonialism	90%	6.5	1.2	1.4
Engagement with Community Leaders and Elder	89%	6.1	1.2	1.4
Indigenous health (history and present day)	88%	6.5	0.7	0.5
Intergenerational trauma	88%	6.4	0.9	0.8
Indigenous Birth Centres	86%	6.4	0.8	0.7
Missing and murdered Indigenous women and girls (Calls for Justice)	86%	6.3	1.2	1.3
Birth and evacuation policies	83%	6.2	0.7	0.5
Calls to Action (health)	83%	6.2	0.8	0.7
Indigeneity, identity and community	83%	6.3	0.9	0.8
Role of CAS in Indigenous child apprehension	83%	6.1	1.4	1.9
Cultural competency, cultural humility, cultural safety	82%	6.3	1.1	1.3
Effects of residential schools	80%	6.2	1.2	1.5
The role of southern midwives in northern midwifery	77%	5.9	1.3	1.7
Responsibilities of treaty settlers	77%	6.1	1.4	1.9
White supremacy	77%	6.1	1.3	1.7
Indian hospitals	76%	6.0	0.9	0.8
Evacuation policies	74%	6.0	0.9	0.8
Land back	71%	5.8	1.6	2.6

Category 5: Theories & Frameworks	**Consensus %**	**Mean (s)**	**STD**	**VAR**
Anti-Colonial Indigenous Theories	94%	6.7	0.6	0.3
Reproductive Justice	91%	6.4	1.0	1.0
Critical Race Theory	86%	6.5	0.9	0.8
Disability Justice	83%	6.4	0.9	0.8
Anti-Oppressive Theory & Praxis	82%	6.4	0.9	0.8
Indigenous Frameworks and methodologies	80%	6.1	1.3	1.8
Intersectionality	80%	6.3	1.2	1.4
Queer Theory	74%	6.1	0.9	0.8

Participants were also (re)introduced to the 2020 Canadian Midwifery Competencies set out by the CMRC. (58) Participants provided their assessment of which CMCs pertained to social justice. Of the 80 CMCs, 32 were identified as social justice based. (See Table 5 for a list of the social justice-based CMCs).

Table 5: Social justice-based Canadian Midwifery Competencies (2020)

Primary Care Provider	Definition
A1	Collects the client's comprehensive contextual health history
C1	Develops a care plan, in partnership with the client, based on evidence, balancing risks, and expected outcomes with client preferences and values
C4	Evaluates response to the care plan in collaboration with the client and revises it as necessary
D5	Provides responsive counselling and education, and recommends appropriate resources
D8	Provides a safe birthing environment within all applicable settings
E1	Recognizes the human rights of clients seeking care
E2	Supports clients to address determinants of health that affect them and their access to health services and resources
F3	Recognizes abuse and intimate partner violence and applies an individualized trauma-informed care approach
F6	Provides sexually transmitted infections counselling, diagnosis, and treatment, as appropriate
Advocate	Definition
AD1	Recognizes and responds to the impact of the client's life experiences, including historical, social, and cultural influences on childbearing and early parenting
AD2	Fosters an environment of respect and autonomy as determined by the client
AD3	Encourages and facilitates the client's own research and knowledge gathering, honouring other ways of knowing and doing
AD4	Respects, promotes, and supports the client's rights, interests, preferences, beliefs and culture
AD5	Demonstrates cultural safety and humility by respecting diversity and individual differences and attending to power differentials inherent in health care delivery
AD7	Recognizes and takes action in situations where client safety is actually or potentially compromised

AD9	Advocates for health equity, particularly for vulnerable and/or diverse clients and populations
AD10	Advocates for the use of Indigenous health knowledge and healing practices for Indigenous clients consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada
Communicator	Definition
COMM2	Applies a person-centered approach characterized by empathy, respect, and compassion in order to foster trust and autonomy
COMM4	Provides the client and family members with accurate and complete information to assist them in making informed decisions about their health care, treatment choices and symptom management
COMM5	Utilizes effective communication skills (e.g. attentive and respectful listening, feedback, open-mindedness, non-verbal cues and behaviours) with the client and their family to clarify perceptions and understanding, negotiate a care plan and resolve conflicts
Collaborator	Definition
Coll1	Engages with other health care providers and community-based services to plan and deliver care that meets the client's needs
Coll2	Shares information in a collegial manner with colleagues and other health care professionals as needed to improve client safety and optimize health outcomes
Coll3	Recognizes inter-professional and intra-professional conflict, striving for consensus among those with differing views
Coll4	Negotiates overlapping and shared responsibilities by respecting one's role, responsibilities and scope of practice and those of other health care professionals (e.g. when identifying the most responsible provider)
Professional	Definition
PROF4	Identifies ethical issues when providing care and responds using ethical principles
PROF6	Recognizes and responds to unprofessional conduct and competence among midwives and other health care professionals
PROF7	Recognizes and observes personal and professional boundaries and limitations in order to provide safe, respectful and ethical client care, and seeks support when needed
PRO10	Identifies and mitigates safety risks to the client, family, and health care providers
PROF12	Ensures client safety is maintained when students are involved in providing care
PROF14	Promotes and adheres to anti-racism policies that guide recognizing, reporting, documenting and responding to racism in the health care system, including anti-Indigenous racism
Lifelong Learner	Definition
LL5	Is aware of one's own personal biases, values, beliefs and positional power and acts to reduce bias and dismantle racist beliefs and systems
Leader	Definition
LEAD3	Promotes a culture of safety by participating in and facilitating activities that emphasize client and midwife safety
LEAD5	Recognizes the value of and engages in mentorship for peers and students (e.g., support, guide, educate and role model)
LEAD6	Provides constructive and respectful feedback to promote learning and professional growth among students and peers
LEAD8	Recognizes and responds to racism, including anti-Indigenous racism, with accurate information, respectful corrections, and a constructive and collaborative approach to systemic change

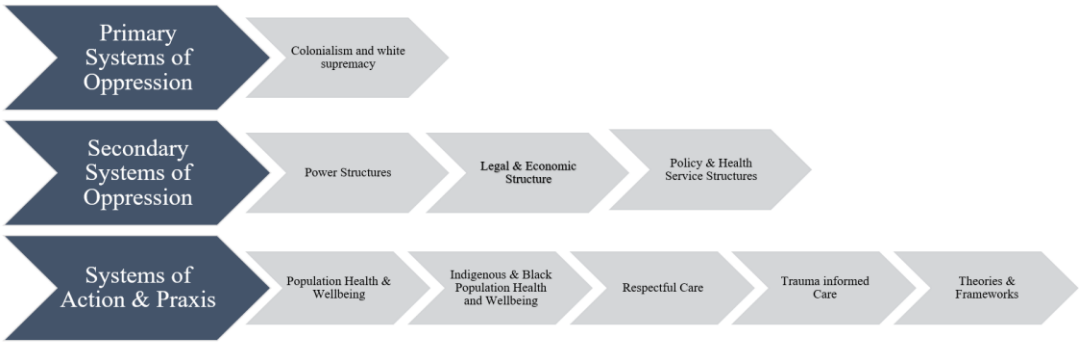
4.5.1 Micro-Thematic Analysis 3

In round three a final micro-TA occurred focusing on the qualitative data gathered in round 1 and the definition specific SJEs confirmed in round 3. A description of this micro-TA is found in section 4.7.

4.6 Macro-Thematic Analysis

When approaching the final TA of this study Braun and Clarke's TA six phase process guided my approach. (See Appendix 1). First, the final 86 SJEs were transferred to post-it notes of the same colour (green). Colour coded dots were placed on each SJE post-it note to indicate its association with one of the five preliminary themes (phase four). These SJE's were then grouped initially by commonality, meaning, SJE's that were the same word were grouped together. Naturally these words tended to create patterns, for instance the SJE 'Indian Act' was grouped with the 'Midwifery Act' both SJEs represented legislative documents. This process continued despite the context of SJEs and their placement in preliminary themes. To aid in my thinking about the macro-TA, I placed a draft version of the definition of 'social justice' on the wall as well as a diagram of Metzl and Hansen's theory of Structural Competency for reference. These groupings of SJEs represented the entire data set which allowed me to create a larger thematic map as suggested in phase four. It became apparent that there were three overarching themes and several sub-categories that aligned with Metzl and Hansen's theory, but also, there was a unique vision for Canadian midwifery education that was linked to the draft definition of social justice. The overarching themes were: 1. Primary systems of oppression, 2. Secondary systems of oppression, 3. Systems of action and praxis. These were further divided into subcategories: 1a. Colonialism and white supremacy, 2a. Power structures, 2b. Legal and economic structures, 2c. Policy and health services structures, 3a. Population health and wellbeing, 3b. Indigenous and Black population health and wellbeing, 3c. Respectful care, 3d. Trauma-informed care, and 3e. Theoretical frameworks. (See Figure 5 for the thematic map).

Figure 5: Thematic Map of Analysis



The next stage in the analysis was the development of twenty-six corresponding sample learning objectives and the development of 6 overarching program level learning outcomes. This process was managed on MS Excel. I listed all the newly formed themes and SJEs under each subcategory in one column and I aimed to create the sample learning objectives in the adjacent column. This process is described in section 3.8. Once these were established the 32 social justice-based CMRC competencies were mapped on to these sample learning objectives to assess alignment. Through this process, gaps were identified with the social justice-based CMCs within section 2b (learning objective 6-8) and 2c (learning objective 10 & 11). Lastly, six overarching program level learning outcomes were developed that are a starting point for applying constructive alignment to the curriculum development process. Refer to Table 6 for a breakdown of the results of this analysis.

Table 6: Program Level Learning Outcomes and Midwifery Competencies

PRIMARY STRUCTURES OF OPPRESSION	COLONIALISM & WHITE SUPREMACY	Program Level Learning Outcome		**1.Challenge colonial and white supremacist systems that oppress and contribute to pregnancy, birth, postpartum and newborn health disparities of Indigenous, Black, racialized, and underserved populations.**		
		Sample Learning Objectives		1.Explain how colonialism and white supremacy has contributed to health disparities of Indigenous, Black, and racialized peoples historically and currently nationally, provincially, and locally.	2. Reflect on ways in which white supremacy, white superiority, and whiteness impacts ones' daily practice.	3. Question and critique the roles and responsibilities of treaty settlers in the promotion of Indigenous health and wellbeing.
		Canadian Midwifery Competencies		A1, C1, E1, E2, AD1, AD2,PROF14,LEAD8	C1, C4, E1, AD1, AD2, AD3, AD4, AD5, AD7, AD10, COMM2, COMM4, COMM5, PROF4, LL5, LEAD3	C1, D8, E1, E2, AD4, AD5, AD7, AD9, AD10, COMM2, COMM4, COMM5, LL5, LEAD8
		Social Justice Elements	Cat 1: Self-Awareness	Colonialism, white supremacy, white superiority, whiteness, oppression		
			Cat 2: The Profession & the Role of the Midwife	White supremacy, Lack of diversity in the profession		
			Cat 3: Systems & Institutions	*None identified*		
			Cat 4: Indigenous Health & Wellbeing	Colonialism, The role of southern Midwives in northern regions, Responsibility of treaty settlers, Ongoing genocide		

SECONDARY STRUCTURES OF OPPRESSION	POWER STRUCTURES	Program Level Learning Outcome		**2. Cultivate methods of critical self-reflection to examine the ways in which one's practice challenges systems of oppression.**	
		Sample Learning Objectives		4. Analyze the meaning, impact, and roles that power structures influence the ways in which midwives practice the profession and engage health care systems.	5. Practice challenging personal power structures that interfere with providing equitable midwifery care.
		Canadian Midwifery Competencies		C1, C4, E1, E2, F3, AD1, AD2, AD3, AD4, AD7, AD9, AD10, COLL1, COLL2, PROF4, PROF6, PROF7, PROF10, PROF12, PROF14, LL5, LEAD3, LEAD8	AD1, AD2, AD4, AD5, AD9, AD10, COMM2, COMM4, COMM5, PROF4, PROF6, PROF7, LL5, LEAD5, LEAD6, LEAD8
		Social Justice Elements	Cat 1: Self-Awareness	Othering, Discrimination domains, Oppression, Islamonisa (anti-Muslim hate), Privilege and power, Equality vs. Equity, Bias awareness, Microaggressions	
			Cat 2: The Profession & the Role of the Midwife	*None identified*	
			Cat 3: Systems & Institutions	*None identified*	
			Cat 4: Indigenous Health & Wellbeing	*None identified*	

SECONDARY SYSTEMS OF OPPRESSION	LEGAL & ECONOMIC STRUCUTRES	Program Level Learning Outcome		**3. Develop practices that continually scrutinize visible and invisible structural barriers that contribute to health inequities of underserved populations.**			
		Sample Learning Objectives		6. Interrogate how national and regional legislation impacts the delivery of midwifery services.	7. Interrogate how national and local legislation influence the health and well-being of marginalized populations.	8. Examine and reflect on the variety of economic structures that influence global midwifery.	9. Support the rights of Indigenous Peoples nationally and globally with special consideration for pregnant people and their newborns.
		Canadian Midwifery Competencies		*None identified*	*None identified*	*None identified*	AD10
		Social Justice Elements	Cat 1: Self-Awareness	*None identified*			
			Cat 2: The Profession & the Role of the Midwife	*None identified*			
			Cat 3: Systems & Institutions	Indian Act, Midwifery Act			
			Cat 4: Indigenous Health & Wellbeing	UNDRIP			

SECONDARY STRUCUTRES OF OPPRESSION	POLCIY & HEALTH SERVICE STRUCTURES	Program Level Learning Outcome		**3. Develop practices that continually scrutinize visible and invisible structural barriers that contribute to health inequities of underserved populations.**		
		Sample Learning Objectives		10. Examine the ways in which global, national, and local policies influence the health outcomes of pregnant people, their support networks and communities.	11. Critique how national and local health-based services impact the provision of midwifery care and the subsequent effects they have on the health and wellbeing of underserved populations.	12. Examine the historic and present-day effects of services related to health care on Indigenous and Black population health.
		Canadian Midwifery Competencies		*None identified*	*None identified*	E1, AD5, AD10, LEAD8
		Social Justice Elements	Cat 1: Self-Awareness	*None identified*		
			Cat 2: The Profession & the Role of the Midwife	*None identified*		
			Cat 3: Systems & Institutions	Uninsured services (regional policies), OHIP and OMP funding for the uninsured, child welfare system, Abortion services, Uninsured services in Ontario, Uninsured health benefits for "status“ Aboriginal people		
			Cat 4: Indigenous Health & Wellbeing	Evacuation policies, Birth and evacuation policies, Role of CAS on Indigenous child apprehension, Indian hospitals, Indigenous birth centres		

STRUCTURES OF ACTION AND PRAXIS	POPULATION HEALTH & WELLBEING	Program Level Learning Outcome		**4.Advocate for equitable access to, and provision of, midwifery care at various systems levels.**		
		Sample Learning Objectives		13. Recommend the ways in which midwives can mitigate health disparities for underserved populations	14. Exhibit inclusive and intersectional approaches to address population health disparities.	15. Establish practices that address health disparities of underserved populations.
		Canadian Midwifery Competencies		A1, C1, C4, D4, D8, F3, AD1, AD2, AD3, AD4, AD9, AD10	A1, D8, AD1, AD2, AD3, AD4, AD5, AD9, AD10	A1, C1, C4, D5, D8 E1, E2, F3, F6, AD1, AD2, AD3, AD4, AD5, AD7, AD9, AD10
		Social Justice Elements	Cat 1: Self-Awareness	*None identified*		
			Cat 2: The Profession & the Role of the Midwife	Mitigating health disparities, poverty, racism, and exclusion, obligation to the underserved		
			Cat 3: Systems & Institutions	Parenting and the intersection of race and class		
			Cat 4: Indigenous Health & Wellbeing	*None identified*		

STRUCTURES OF ACTION AND PRAXIS	INDIGENOUS & BLACK POPULATION HEALTH & WELLBEING	Program Level Learning Outcome		**5.Demonstrate anti-oppressive actions in the provision of midwifery with a particular focus on cultural safety, humility, and inclusive communication skills.**			
		Sample Learning Objectives		16. Examine and the histories of Indigenous Midwifery nationally, provincially, and locally.	17. Describe ways in which regulated midwifery will support the sovereignty and growth of Indigenous midwifery.	18. Exhibit ways in which and settler midwives will support the sovereignty and growth of Indigenous midwifery.	19. Develop methods to centre the wellness of underserved populations.
		Canadian Midwifery Competencies		AD1, AD3, AD4, AD5, LL5, LAED8	AD9, AD10, LL5, COMM2, COMM3, COMM4, COMM5, PROF14, LEAD8	AD1, AD2, AD3, AD4, AD5, AD7, AD9, AD10, COMM2, COMM4, COMM5, COLL1, LL5, LEAD8	AC1, C1, C4, D5, E1, E2, F3, F6
		Social Justice Elements	Cat 1: Self-Awareness	Black and racialized Peoples, Uninsured people			
			Cat 2: The Profession & the Role of the Midwife	History of Indigenous midwifery			
			Cat 3: Systems & Institutions	TRC, Black and racialized Peoples, Uninsured people			
			Cat 4: Indigenous Health & Wellbeing	Indigenous Peoples and Communities, Indigenous midwifery, Indigenous health past and present, Indigeneity, Identity, and community, TRC Calls to Action – health, MMIGW Calls for Justice, Decolonizing Indigenous MW, Engagement with community leaders and Elders, Land back,		

STRUCTURES OF ACTION AND PRAXIS	RESPECTFUL CARE	Program Level Learning Outcome		**5.Demonstrate anti-oppressive actions in the provision of midwifery with a particular focus on cultural safety, humility, and inclusive communication skills.**		
		Sample Learning Objectives		20. Demonstrate respectful care with a focus on cultural safety, humility, and inclusive communication skills.	21. Incorporate methods to practice critical consciousness.	22. Establish anti-oppressive actions in the provision of midwifery.
		Canadian Midwifery Competencies		A1, C1, C4, D5, D8, E1, E2, F3, F6, AD1, AD1, AD2, AD3, AD4, AD5, AD7, AD9, AD10, COMM2, COMM4, COMM6, COLL1, COLL2, COLL3, COLL4, PROF4, PROF6, PROF7, PROF10, PROF10, PROF12, PROF14, LL5, LEAD3, LEAD5, LEAD6, LEAD8	LL5, LEAD 3, LEAD5, LEAD6, LEAD8	A1, C1, C4, D5, D8, E1, E2, F3, F6, AD1, AD1, AD2, AD3, AD4, AD5, AD7, AD9, AD10, COMM2, COMM4, COMM6, COLL1, COLL2, COLL3, COLL4, PROF4, PROF6, PROF7, PROF10, PROF10, PROF12, PROF14, LL5, LEAD3, LEAD5, LEAD6, LEAD8
		Social Justice Elements	Cat 1: Self-Awareness	communication, critical consciousness (self-reflection etc), inclusion, humility, interactional justice, anti-oppression		
			Cat 2: The Profession & the Role of the Midwife	Respectful care, Cultural safety, communication, community centred care, accessibility/access, gender & sexual diversity and trans care, anti-oppressive action, anti-racist action,		
			Cat 3: Systems & Institutions	*None identified*		
			Cat 4: Indigenous Health & Wellbeing	cultural competence, humility, and safety,		

STRUCTURES OF ACTION AND PRAXIS	TRAUMA INFORMED CARE	Program Level Learning Outcome		**5.Demonstrate anti-oppressive actions in the provision of midwifery with a particular focus on cultural safety, humility, and inclusive communication skills.**		
		Sample Learning Objectives		23. Describe how trauma-informed care can be applied to the provision of midwifery care.	24. Demonstrate trauma-informed care in prenatal, antenatal, and postpartum care.	25. Establish a practice of trauma-informed care.
		Canadian Midwifery Competencies		COMM5, COLL1, COLL2, COLL3, COLL4, PROF4, PROF6, PROF7, PROF10, PROF10, PROF12, PROF14, LL5, LEAD3, LEAD8	COMM4, COLL1, COLL2, COLL3, COLL4, PROF12, LL5, LEAD3, LEAD8	COMM2, COMM4, COMM5, PROF4, PROF6, PROF7, PROF10, PROF12, PROF14, LL5, LEAD3, LEAD8
		Social Justice Elements	Cat 1: Self-Awareness	Indigenous and Black bodies, forced sterilization of marginalized bodies, historical/generational trauma, provide TIC (historic, intergenerational and IPV)		
			Cat 2: The Profession & the Role of the Midwife	provide TIC (historic, intergenerational and IPV)		
			Cat 3: Systems & Institutions	*None identified*		
			Cat 4: Indigenous Health & Wellbeing	Effects of residential schools, intergenerational trauma,		

STRUCTURES OF ACTION AND PRAXIS	THEORIES & FRAMWORKS	Program Level Learning Outcome		**6.Integrate anti-oppressive and equity-based theories to praxis**
		Sample Learning Objectives		26. Demonstrate the ability to apply theoretical knowledge and client-centred respectful care principles to diverse populations in various midwifery settings.
		Canadian Midwifery Competencies		A1, C1, C4, D5, D8, E1, E2, F3, F6, AD1, AD3, AD4, AD5, AD9, AD10, COMM2, COLL1, LEAD 3, LEAD 8
		Social Justice Elements	Cat 1: Self-Awareness	Ownership, Control, Access, and Possession (OCAP), Reproductive Justice, Critical theories, Indigenous theories, Critical Race Theory, Intersectionality, Queer theory, Disability Justice, Anti-oppressive praxis
			Cat 2: The Profession & the Role of the Midwife	Ownership, Control, Access, and Possession (OCAP), Reproductive Justice, Critical theories, Indigenous theories, Critical Race Theory, Intersectionality, Queer theory, Disability Justice, Anti-oppressive praxis
			Cat 3: Systems & Institutions	Ownership, Control, Access, and Possession (OCAP), Reproductive Justice, Critical theories, Indigenous theories, Critical Race Theory, Intersectionality, Queer theory, Disability Justice, Anti-oppressive praxis
			Cat 4: Indigenous Health & Wellbeing	Ownership, Control, Access, and Possession (OCAP), Reproductive Justice, Critical theories, Indigenous theories, Critical Race Theory, Intersectionality, Queer theory, Disability Justice, Anti-oppressive praxis

4.7 Definition of Social Justice

Defining social justice in terms of Canadian midwifery education is paramount as this definition determines where the curriculum is situated. The literature search identified no definitions of social justice in midwifery education worldwide. The OMEP has an equity statement that provided a starting point for discussion. To provide comparators, professional definitions from nursing, social work and medicine were used to inform discussion in round one. See Appendix 5 for discipline specific definitions of social justice. These definitions were presented to SMEs during their focus groups and interviews in round one. Using a micro-TA approach, three common themes were identified in round one: 1. Language is powerful, 2. Be Clear, Be Explicit, and 3. Tool for advocacy and accountability.

Language is Powerful

Regarding power of language, one SME cautioned against using some specific terms because they can cause unintended harm, while another stressed the importance of syntax. Social justice is not just something that is discussed, it is an action, and for students and health care providers, its about praxis.

> Terms like Marginalized, disadvantaged, and vulnerable; having 'exceptional needs' should be nuanced in the definition so not to further oppress those populations…There's many ways to talk about how people think about the term social justice, such as a theoretical framework (like a noun), or you can talk about it as a practice framework (verb). (SME1)

Be clear, be explicit

One SME discussed the importance of understanding and defining the nuances of social justice. Specifically, the need to be clear about what one means when referring to social justice; this is especially true when teaching. Another SME noted that there comes a time to say what we mean even if we know the topic of social justice is ever changing. The implicit nature of social justice is not enough, making it explicit is the priority.

> [With] Social [justice], you need to have some sort of shared, especially to teach something, you need to have some sort of shared understanding of what you're teaching. Those definitions are a commitment to social justice, and if you're going to commit to something, it has to be clear what you're committing to, and it has to be clear that there has to be some sort of shared understanding of what that means or else there's confusion…If you fundamentally believe that social justice is promoting equality, then you're going to have a very different understanding of social justice, than I do, if I think it means … promoting equity. (SME 6)

> Social justice is continually evolving and not everyone will agree with it. But, at this moment in time, it is implicit if it's not named, I mean, what you're choosing to include or not include, or how you're going to do the curriculum, there is an implicit understanding of SJ, so make it explicit. So at some point you need to put a stake in the ground. The implicit assumptions [of the curriculum become] explicit and there is a shared understanding of what this curriculum is trying to do. (SME 6)

> I think it's helpful to have a definition, you know people throw around language a lot, and there's not a shared understanding, so I think it's really helpful to be clear, "This is what we mean by Social Justice." And it also offers a vision. You know we need to be clear where we're trying to get and what we're trying to prevent. (SME11)

> We get also caught up in this idea that social justice has to meet everything and encompass everything and be the be all and end all of what we're doing, and I don't think that's the case. (SME 2)

Tools for advocacy and accountability

The idea that the definition can also act as an advocacy and accountability tool was mentioned several times during round one. These two SMEs discussed the value of a definition in ways that were all encompassing. Social justice is not just fodder for curriculum development, it is a culture, and a value system, and action-oriented:

> Yes, I think we do need a definition, one that is clear that operationalizes it because there's so many misconceptions. One that doesn't end up oppressing the very same people, it was meant to help because some of those same equity seeking groups will be instructors, preceptors and so, ironically, they may be the ones that are tasked to do the impossible. It needs to be something that when it's applied to all of our existing policies - whether it's hiring, or how we supervise students, or how we manage placements, or how we admit students - that it provides access to resources and opens up the way to resources and helps to mitigate against existing systemic barriers and push against those systemic barriers. (SME 12)

> I think the definition is important from an advocacy standpoint, in terms of not only the students but also like clinicians and instructors to hold the MEP accountable, right, so then you have something to quote to say you know we affirm a responsibility to foster an anti-oppressive environment. I think it's important to be like this is what you're saying, but also creating that accountability is so important. (SME 13)

In addition to the qualitative comments provided by the SMEs, the Delphi rounds also produced a list of sixteen definition specific SJEs. See Table 7 for a list of the elements.

Table 7: Key Elements for the Definition of Social Justice

Key terms	Consensus %	Mean (s)	STD	VAR
Racism	89%	6.4	0.9	0.8
Addressing inequities	83%	6.3	0.8	0.7
Anti-oppression	83%	6.4	1.0	1.0
Reproductive justice	83%	6.3	1.0	1.1
Uncovering & understanding power structures	81%	6.2	1.2	1.4
Anti-racism	81%	6.3	0.9	0.8
Root causes of disparities	78%	6.1	0.9	0.7
Colonialism	77%	6.0	1.4	2.0
Equity	75%	6.0	1.2	1.4
Reducing barriers	75%	5.8	1.3	1.7
Systemic oppression	75%	6.2	0.8	0.7
Homophobia/transphobia	74%	6.0	1.3	1.6
Privilege	74%	5.7	1.7	3.0
Access to services/opportunities	71%	5.9	1.3	1.7
Accountability	71%	5.9	0.9	0.8
White supremacy	71%	5.9	1.4	2.1

The process for developing the definition for social justice was one that was iterative. I used the three themes that were identified in the qualitative TA as the foundation of the definition and the 16 SJEs to develop a draft definition. This initial version was revised several times as I continued to work through other aspects of the study such as the three micro-TA processes, my own experiences as a past midwifery student and clinician, as well as my knowledge as an instructor in the program. It is important to note that there is a body of evidence that exists within the culture of racialized and underrepresented midwifery in Ontario that has not been investigated in traditional academic ways, however it is known amongst us what social justice is and how midwifery should be advocating for it. This deep feeling and wanting is congruent with participants' ideas and as such, the final definition of social justice in the context of Canadian midwifery education is as follows:

Social justice, in the context of midwifery education is grounded in the principles of reproductive justice, anti-oppression, an obligation to the underserved, and professional accountability in both teaching and learning.

The process of social justice in education is ongoing and includes the critical examination of systems of oppression such as discrimination domains, privilege and power, colonialism, and white supremacy, coupled with persistent critical self-reflection and reflexivity. This work equips educators and learners to continuously identify root causes of structural and health disparities and incorporate purposeful praxis. A socially just midwifery education program aims to graduate midwives who are committed to mitigating systemic barriers and addressing inequities for birthing people and their support networks within local communities, Canadian health care systems, and society at large.

I presented the above version of the definition of social justice as a trial during a poster presentation at the McMaster Midwifery Research Symposium in March 2022. (59) There were no objections to the definition. Unfortunately, a limitation of this definition is that I did not include it in the member checking documents due to time constraints. Initially, the member checking session was going to be offered via Zoom for an open discussion of all aspects of the study, however this was not feasible at the time.

Chapter 5 – Discussion

In this chapter, I provide a summary of the three key findings and discuss their contributions to the literature. I compare the construction and implementation of social justice curriculum between midwifery, nursing, social work, and medicine with a specific focus on structural competency. Next, I discuss the connection between constructive alignment and social justice curriculum construction for the OMEP. Lastly, I propose an adaptation to Metzl and Hansen's theory of structural competency.

5.1 Key findings

Social justice curriculum has been incorporated into HPE in many ways, however this study extends the literature in three key ways: First, this study is the first to define and identify 'social justice' content for Canadian midwifery education. Second, the results indicate that the faculty within the OMEP needs to reconceptualize social justice curriculum using constructive alignment to build a transformative curriculum that is based in structural competency. Third, I propose an adaptation to Metzl and Hansen's theory by extending the definition of structures to make explicit the most prolific system of oppression which is colonialism and white supremacy.

A definition of 'social justice" in the context of Canadian midwifery is novel. At the outset of this study, it was clear that without a clear and explicit foundation, attempting to situate SJEs into an existing curriculum would prove to be difficult. Since the OMEP's inception, second wave feminism's 'social justice principles' of the advocating for *all* women have been both overtly and covertly incorporated in its curriculum. The hidden curriculum involved centering whiteness the classroom, through the content that is taught, the materials that are referenced, and the assessments that are chosen, as well as through the policies and structure of the OMEP.(7) It was the people of the global majority (PGM) and marginalized partners who bore the brunt of exclusionary harm. Defining social justice is a way to be explicit about what "we" (i.e., midwifery partners) value and want to champion. It sets a standard that can be incorporated into curriculum and expectations regarding professional conduct. It also holds education programs and their educators accountable to meeting a minimum standard of socially just curriculum. Based on the definition created in this study, the minimum standard is quite high, and the definition places an onus on the faculty, staff and sessional instructors of the OMEP and their counterparts at other Canadian MEPs to adhere to the words of our collective partners.

A reconceptualization of the OMEP's social justice curriculum is a very large undertaking. It will take years to develop as it is a subject area that has many nuances that are constantly evolving. There will be a requirement for educators and administrators to learn and embody socially just education principles and practices which will undoubtably lead to many missteps along the way. Training and praxis in humility, grace, and compassion is crucial for 'success'. This is not an impossible challenge for the OMEP faculty and staff, rather it is an opportunity to foster a new

paradigm of Canadian midwifery education and to reconcile with partners regarding the OMEP's legacy of structural oppression caused by the exclusionary culture of white supremacy. When reflecting on this study's results, one must acknowledge the prominence of Indigenous health and wellbeing that is centred by truth and reconciliation. As a way of healing, restorative justice calls on all parties affected by an incident to come together to address issues of concern through facilitated dialogue, perspective-taking and storytelling. (60,61) The OMEP faculty and staff needs to speak their truth by acknowledging their role in causing harm to Indigenous, Black, and racialized and marginalized students while also providing a safe space for those same students to share their experiences. There cannot be any reconciliation without truth; there cannot be an expectation of students to be socially just practitioners without the academy modeling this same socially just pedagogy. The McMaster MEP took this first step in 2021 by offering an apology to partners and making space for discussion publicly and privately with faculty. As an ongoing effort to speak the truth, the OMEP consortium should consider participating in a restorative justice process with its current and past students.

This study was able to identify SJEs that once thematically analyzed, resulted in three major categories: primary structures of oppression, secondary structures of oppression, structures of action and praxis. (See Figure 5). It became clear that the SJEs, regardless of their specific context, characterise symptoms of a larger systemic disease, namely colonialism and white supremacy (i.e., primary structures of oppression). (62,63)The subsequent SJEs reflect social hierarchies, economic and legal systems (i.e., secondary structures of oppression). And finally, the remaining SJEs reflect the actions that must occur to combat both primary and secondary structures of oppression. This analysis suggests that the OMEP's social justice curriculum should concentrate on a structural/systems approach, specifically Metzl and Hansen's theory and framework of structural competency. (See Figure 6).

Globally, midwifery education programs have not produced much research on the integration of a comprehensive social justice curriculum, let alone any research that emphasises structural competency. Previous publications identify the need to integrate content such as ethics (41), cultural safety (64), and the importance of cultural concordance (65). In Ontario, the OMEP has for decades offered a few courses that incorporate social justice content, but as mentioned earlier, has not been standardized across the consortium. One possible reason for this lack of standardization is that each OMEP site has tailored their content to their region and demographic of students and public population. (66) For example, at Laurentian University, an MEP that was recently been closed in 2021, provided Francophone and Indigenous specific courses; Toronto Metropolitan University (formally Ryerson University) and McMaster University have first year social justice and Indigenous health courses and have informally incorporated content into second- and third-year courses. Additionally, the OMEP sites have established Indigenous, Spanish-language, Black and Racialized specific placement opportunities in an effort to create culturally supportive spaces for learning. (66) Furthermore, there have been recent efforts to train preceptors to support students who engage in these unique placements. (67) Recognizing that the OMEP is still relatively new in

comparison to other HPE programs, there has been a concerted effort build a program and curriculum that includes social justice, but there has been little published about these efforts.

When examining comparator HPEs, social justice curriculum has been manifested in a variety of formats. With respect to structural competency, a scoping review conducted in 2022 indicated that while students benefit from this training it remains difficult to teach. (68) In medicine, there are a few exemplars of the integration of social justice curriculum which range from constructing an entire curriculum to developing individual courses that broaden critical thinking. In particular the Geisel School of Medicine at Dartmouth, Lebanon, New Hampshire created a plan to address social justice curriculum. (25) In 2013, this medical program aimed to "develop education goals and objectives,… create topic outlines, and embed key concepts in both experiential learning and core biomedical curriculum".(25) Their comprehensive study predated Metzl and Hanson's theory of structural competency, but was already alluding to the concept, stating, "given the high prevalence, significant medical impact, and sociopolitical complexity of these and other nonmedical elements, providing medical students with training in how these factors influence human disease is vital".(25)

Since 2013 there have been many iterations of social justice curriculum, within medical schools. One in particular has incorporated structural competency in a unique way: curated in partnership with McMaster Univeristy Department of Family Medicine and the McMaster Museum of Art in Hamilton Ontario, The Art of Seeing™ is a singular program that uses a novel approach. This is a visual literacy program that is designed to enhance empathy, perception, and resilience and to support the professional growth and self-care of its participants through learning to look at visual art. (69) This program is unique in that it indirectly gets medical students to be reflective rather than reactionary when they initially view the art; they are tasked to slow down and view the nuances before making a final interpretation. These exercises are meant to be analogous to patient encounters. Future clinicians are tasked to consider what systems/structures have affected the patient "upstream" now that they are "downstream" and ill.

Nursing's history is quite similar in some respects to midwifery. Scholars have noted that both disciplines can trace their roots of oppression to a patriarchal health care systems and an ongoing struggle to gain control of their education systems. (70) Nursing education has evolved from Barbara Carper's original patterns of knowing (1978) to a more recent reimagination by Chinn and Kramer's (2008) emancipatory knowing, i.e., social justice praxis. (70,71) Chinn and Kramer's 'way of knowing' is a "call to action to advocate for social justice in a system that continues to permeate inequities and oppression among the masses". (71) Emancipatory knowing focuses on becoming aware of social issues that affect patients and taking the next step in creating action, not only for the patient but for society as well. (71) Gholar et. al's scoping review was able to locate one social justice curriculum program housed at Israel's Jerusalem's College of Technology, namely, the TOLERance Model for nursing. It incorporates five aspects of learning, Theory, Observations, Learning from patients, Engagement, and Research which are

accomplished through learning activities such as case studies and patient simulations. While this program shows promise, it still recognizes that teaching and evaluating structural competency remains challenging. (68,72)

Social work was the third comparator profession that I examined. While not considered a health profession, it closely works with midwifery, medicine, and nursing. Structural competency is implicitly built into social work curriculum and the profession as a whole. Downey et. al remark that as a practice and pedagogy, structural competency resonates with National Association of Social Work's principles of empowerment, social justice, and advancing human dignity. (73,74) No publications of social work curriculum that specifically focuses on structural competency were identified. Downey et al., however, focus on the importance of interprofessional training as it has the potential to promote a more meaningful collaboration between disciplines and breakdown hierarchical pressures. They suggest by arming multiple healthcare professionals with common structural-based terminology, communication between providers will be strengthened, and theoretically the wellbeing of clients will be positively affected. (75)

5.2. Constructive alignment

Curriculum design over the past 150 years has moved from memorization and performance, to behaviorism (Thorndike), to cognitivism (Taylor), to constructivism (Dewey, Vygotsky, Biggs). (76) Constructivism, specifically Vygotsky's social constructivism, posits that we all learn from social interactions which guide us in our understanding of new knowledge and which helps create our vision of the world around us. (77) This philosophy is well positioned for the subject of social justice as the topic is vast yet very personal for many learners. Many midwifery students will lean on their lived experiences to make sense of the social justice knowledge that they will be challenged to navigate. Biggs' framework of constructive alignment is the approach used to apply theory arising from constructivism to the process of curriculum design. The development of social justice curriculum for the OMEP is necessary and complex: using constructive alignment to aid in its development will ensure the end goals are met in a systematic way.

Constructive alignment consists of three interlinked phases of curriculum development: intended learning outcomes (ILO), teaching and learning activities (TLA), and assessments and evaluations (AEs). The scope of this study was to engage in the first phase which is the creation of intended learning outcomes (ILOs). The six program level learning outcomes that were developed align with the McMaster MEPs pre-existing list of program level learning outcomes which are mapped onto the undergraduate degree level expectations set by the Ontario Universities Council on Quality Assurance.(54) (See Table 6) . As a starting point, the OMEP faculty and sessional instructors will be able to apply the constructive alignment's 'backward approach' of determining what students should know by the end of a course, that is, specific SJEs can be scaffolded throughout the four-year program with an increasing level of complexity with the eventual aim of achieving CMRC competencies. This approach will begin to dismantle the exclusionary culture of white supremacy that was both covertly and overtly enabled at the inception of the OMEP.

The other two phases of constructive alignment, the creation of TLAs and AEs, are beyond the scope of this project. However, as a starting point, the OMEP faculty and sessional instructors will need to consider non-traditional ways of teaching and evaluating its students when it comes to social justice content. How does the OMEP faculty and sessional instructors teach the connection between settler colonialism and a colonized client's medical complication of gestational diabetes for example? One activity would be to learn the art of asking clients' questions that do not further oppress. This skill would be initially scaffolded with foundation knowledge regarding the effects of the residential school system and/or generations of malnutrition (food insecurity). This skill of asking culturally safe history taking questions requires practice in a safe environment, and as such, patient simulation or peer-to-peer discussion may be the classic methods to "test the waters". However, an initial in-person session with a racialized or marginalized standardized patient or peer could be traumatic or oppressive to both participants. One adaptation may be to offer an online simulation instead where anonymity and safety can be maintained. This approach will allow students to gradually build confidence when faced with understanding and practicing structural competency. Regarding AEs, be it summative or formative, the OMEP faculty and sessional instructors should provide space for growth and feedback for students. Shifting the definition of successful learning from a marks-based system to a holistic community learning system better aligns with social justice education pedagogies of Freire and hooks. Hunt and Chalmers list several transformative and democratic AEs; in-class multiple choice with 'clickers' and with 'confidence ratings', portfolios, presentations, posters, case studies, reflective journals, annotated bibliographies, artifacts and more. (76)

It is important to note that constructive alignment is not a panacea. It is simply a curriculum tool that shifts the responsibility of teaching and learning to *both* the educator and student by walking together through learning process. As Freire and hooks propose, a transformative classroom is one where learning is student-focused, democratic, and liberatory. Constructive alignment facilitates *how we teach* social justice education while simultaneously supporting *what we teach*.

5.3. Structural competency

Metzl and Hansen's formalization of structural and systems awareness by health care providers and allied workers is relatively new (<10 years) and therefore it continues to require time for it to be incorporated fully into HPE and then reproduced in praxis. In this section, I discuss how the OMEP curriculum developers should utilize Metzl and Hansen's 5-point framework to situate the work of incorporating structural competency along with lessons learned from two exemplars from Vanderbilt University and an interdisciplinary group of academics, students, and health practitioners from California. Furthermore, based on the thematic analysis of this study, I propose an adaptation of Metzl and Hanson's theory that expands the conception of structural influences on human health.

Metzl and Hansen's framework discussed in Chapter one, (see Figure 1), is the starting point for OMEP's integration of structural competency. The five core competencies should be approached as skills, knowledge, and attitudes that are holistic but also specific to midwifery. For example, competency 2 (developing an extra-clinical language of structure) may include the use of gender-neutral language at all levels of communication, oral and written, which can be reflected in program policies, course syllabi, evaluations, etc. This significant act of allyship, inclusion, and humility counters the historical exclusion of gender non-conforming or trans individuals who seek pregnancy related care. (78) By incorporating specific inclusive vocabulary into students' lexicon throughout the MEP, they will be better equipped to name inequities present in systems and structures that manifest in the lived experience of clients.

There are two seminal structural competency-based programs that can be used as exemplars for the OMEP. The first is Vanderbilt University's pre-health major in medicine, health, and society (MHS). At this institution, they restructured their program to incorporate structural competency by identifying central curricular concepts and skills related to structural competency, and developing and employing an evaluation instrument, the Structural Foundations of Health, to establish student baselines with content and skills. (79) The development of this instrument included demographic questions, and a variety of open and closed questions that were focused on health disparities, advertisements (for pharmaceuticals), and professional preparation and was piloted, and then administered to graduates. (79) The OMEP faculty should also consider building an evaluation tool to assess students' knowledge with structural competency as part of curriculum revision.

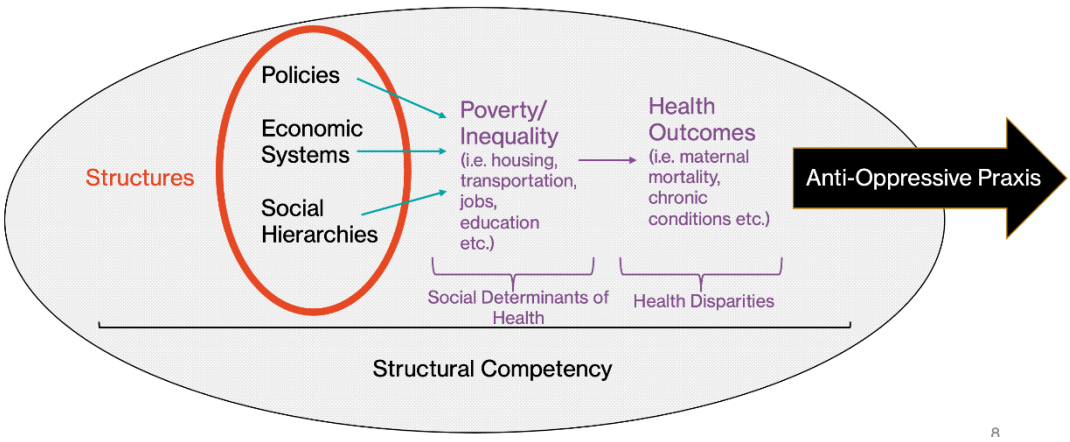
The second program, which is an interdisciplinary program at the graduate level, was created over a span of three years (2014-2017) in San Francisco, California. Neff et al. created an open access curriculum that consists of several modules, reading lists, training slides, participant workbook, post-training surveys, and facilitator guidelines. (80) This curriculum states that it outlines processes that address in actionable ways, structurally driven health care disparities of vulnerable populations. (80) The study's outcomes revealed that practitioners felt overwhelmed and helpless when introduced to the content. Therefore they made a shift in how the content was presented to display the application of structural competency in and beyond clinical contexts. (80) They found that participants were able to reframe their understanding of patients moving away from blame to empathy. Lastly, the training reminded participants why they entered the health professions field, that is, the desire to help and heal. (80) They also noted that they have since revised their curriculum to better meet disciplinary needs, for example, perinatal cases for the reproductive health professions. (80) The OMEP faculty and sessional instructors have an opportunity to learn from this seminal work and building on what has been created here could save several years of development.

5.3.1 Theory of Structural Competency: An Adaptation

Metzl and Hansen's definition of structures is overarching as it includes social, economic, political systems as well as covert biomedical cultures, diagnostics and bureaucracies that silently shape health of populations. It is the latter half of the definition where I focus my adaptations. Metzl and Patty's 2017 study at Vanderbilt University reported that after completing the program of study, students were able to recognize "social determinants and cultural foundations of health" however, "they struggled to address race [and class] when the subject appeared to be white". This statement suggests that there is an unconscious bias that white people are exempt from poor social determinants of health. This is alarming for two reasons: 1. the educators who created the curriculum did not recognize that the most harmful of all structures to PGMs and underserved populations are colonialism and white supremacy, and 2. as a result of the curriculum, students who engaged in the curriculum "simply reproduced the very structural language and methods for which they were rewarded in their course work…". (79) thus replicating the hidden, white-centred approach to HPE.

In Figure 6, I have proposed an adaptation to Metzl and Hansen's theory of structural competency. I have added a grey oval that encompasses the core words used to describe the theory of structural competency. This oval, while large, is also subtle and does not draw attention. In fact, once could say that it is neat, pleasing to the eye, and it helps visually focus attention on the core concepts displayed in the centre. This grey oval is analogous to the structure of colonialism and white supremacy. To become structurally competent, healthcare providers will need to understand the "hidden rules of the game" before they can learn the strategies to navigate and "succeed". In Table 6, the first group of SJE, sample learning objectives, competencies and program level learning outcomes focus on theme one, Primary Systems of Oppression: white supremacy and colonialism. It is here where OMEP faculty, staff and instructors should ground their curriculum development. Curriculum, assessments, policies, and practices should be examined to identify how the Primary Structures of Oppression are embedded within, and once identified, they should be challenged to find equitable pathways for rebuilding the OMEP. The second adaptation to the original figure is the large black arrow on the right of the oval that states 'Anti-oppressive Praxis & Action'. This arrow indicated the need to not only to become structurally competent, but to also act out the ways in which change should occur. Engaging in the social, economic, political, and hidden structures is part of clinical work that health care providers must engage in to challenge and dismantle systems of oppression. These adaptations require further analysis and will be the future of my work.

Figure 6: Adaptation of Metzl and Hansen's Theory of Structural



In Chapter 2, section 2.2, I referred to Metzl and Hansen's definition of structure. Specifically, it is in their second sentence that I would propose an elucidation. They state, "structures can represent the hidden agenda of diagnostic and bureaucratic systems that encompass biomedical interactions". (27) The 'hidden agendas' are the primary structures of oppression. Metzl and Hansen further allude to the primary structures of oppression by stating, "Essentially, structures can be both tangible configuration and non-tangible forces that society has deemed "necessary" for the sustainability of itself". (27) Again, these tangible configurations and non-tangible forces have been deemed necessary for the purpose of maintaining power and privilege in the hands of dominant society. Structural competency based on my adaptations to Metzl and Hansen's theory along with the results of this study is as follows:

> Structural competency is the trained ability to acknowledge and understanding how the primary structures of oppression, which are white supremacy and colonialism, have been purposefully codified, covertly and overtly, throughout the fabric of society. The codification can be found in the secondary structures of oppression that include social, economic, and political systems, and are constructed to optimize the maintenance of dominant society's power and privilege. The outcomes of these constructed systems influence the health and wellbeing of underserved populations upstream, resulting inequities and poor health outcomes downstream. Through the utilization of the structures of action and praxis, healthcare providers must actively challenge oppressive systems and structures, both tangible and intangible, to rebuild an equitable healthcare system and society.

5.4. Limitations

There are a few limitations found in this study. This study set out to examine the literature on social justice curriculum at the undergraduate level in midwifery, nursing, medicine, and social work worldwide. Understanding that there are different terms used to describe 'social justice' it is possible that the search strategy used could have missed undergraduate curriculum that existed but is described using other ways. Over the past three years, 'social justice' curriculum in many HPE programs have been developed concentrating on specific areas of interest within a social justice framework. For example, programs have chosen to focus on 'cultural safety', or 'health equity', or 'service-work', as part of their social justice curriculum. As HPE programs continue to develop their curricula, these specializations may evolve to include a broader inclusion of social justice content. Another limitation of literature review was the exclusion of any social justice curricula that was at the graduate level. Many MEPs and HPEs around the world are graduate programs and therefore may have been missed in the literature search.

The study's inclusion criteria included nurses as a comparator health care profession and education program. Despite purposeful and snowball sampling, I was unable to recruit any nurses. This was discouraging since the literature review produced several studies of interest from nursing education programs. There were a few factors that played into their absence, including the stresses of the pandemic and lack of time, unavailability due to sabbaticals, and feeling a lack of significant expertise in the area of social justice education. Future investigations into this topic will certainly benefit from engaging with nursing literature, faculty, students and practitioners.

Chapter 6 – Conclusion

This modified Delphi study has contributed to the literature a definition of 'social justice' in the context of Canadian midwifery education, identified SJE for midwifery curriculum development, and produced program level learning outcomes to direct course-based learning in the OMEP. Through the process of mapping the IOLs to social justice-based CMCs, gaps were recognized pertaining to structural competency that the OMEP faculty, staff and sessional instructors will have to address to produce a comprehensive social justice-based curriculum.

In the words of Audre Lorde, "the master's tools will never dismantle the master's house". This is where the real challenge lies for the OMEP and Canadian midwifery education. The MEPs have been situated within the academic institution requiring them to follow hegemonic "rules". Knowing that the academic institution itself has been built using the 'master's tools' (i.e., colonialist frameworks and white supremist values to protect the power and privilege of the dominant society) the OMEP faculty and sessional instructors will need to incorporate 'innovative tools' in their ways of teaching, learning, and assessing students that will challenge the status quo. Building and delivering social justice education requires innovative thinking and the use of constructive alignment to aid in providing direction in curriculum development; but ultimately, it will be the courage of teachers and learners that will build the 'new house' of socially just healthcare.

Recommendations to the OMEP faculty, staff and instructors include the development of a social justice curriculum focusing on structural competency while also embedding social justice pedagogies throughout the program. Additionally, the OMEP must plan and implement course and program evaluations that involve students, teachers, and other partners, as this will hold the OMEP faculty, staff and instructors accountable to its values, mission, and vision of an equitable and inclusive education program.

Future work will involve the development of a Canadian midwifery education framework that centres social justice pedagogies and curriculum.

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Appendix 1: Braun and Clark's Phases of Thematic Analysis

Phases	Description of the process
1. Familiarize yourself with your data:	Transcribe data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting feature of the data in a systemic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Review themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix 2: Initial Recruitment, Information and Consent Letters

Initial Recruitment email
(HIREB Approval July 27 2021 Version 3, Project #13719)

Hello XX,

My name is Claire Ramlogan-Salanga and I am a Registered Ontario Midwife, sessional instructor in the McMaster University Midwifery Education Program (MEP) and a student in the McMaster University Master of Science in Health Education program. I am the principal investigator of a research study entitled, Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. The research team includes my supervisor Dr. Liz Darling RM, PhD, and committee members Dr. Audrey Campbell and Dr. Lawrence Grierson, PhD.

In the summer of 2020, racialized midwifery students from across the province called on the Ontario Midwifery Education Program (MEP) consortium to address a comprehensive list of factors contributing to systemic racism in the MEP. This included a call to review and revise the MEP curriculum. An initial area of that curriculum that requires focused attention is social justice. While there is a plethora of information about social justice in education, there is very little discussing this topic in the context of midwifery. The results of this research will be used to guide the Ontario MEPs in transforming their curriculum to better reflect student and society's needs.

I am contacting you because (insert one of the lines below) and as such, I am asking if you would consider participating in this study as a key informant and/or subject matter expert.

1. You were referred to me by one of your colleague or midwife or midwives or instructors.
2. You are highly recognized in academia/midwifery community for your work in social justice curriculum development
3. You are an educator in the Canadian/Ontario Midwifery education program and are recognized as an expert in social justice content.

As a subject matter expert your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require a minimum of 30 minutes to a maximum of 2.5 hours of your time over a four-month period (depending on your level of participation). The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse and intersectional population. Next, you will receive a link to a video-based literature review to that will provide you will a summary of social justice elements, themes, and definitions which you can take time to review before attending a focus group or individual interview. You will have a choice to either attend a focus group or schedule an individual interview

with me to help establish the baseline social justice elements and themes, these results will support the construction of the first-round survey. The focus group/interview will be conducted via Zoom and audio recorded to aid in analysis. The transcripts will be anonymized and stored on a secure server that is password protected. Transcripts will be accessible only by the research team. The results of the first round will be analyzed and refined for the second and third survey. Lastly, there will be an optional member checking session for participants to review the results of the entire process. Your participation in rounds one, two and three (surveys) are not mandatory but is highly desired.

If you choose to remain in the study as a subject matter expert, you will be participating in the three rounds of 30-minute surveys over a two-three month period. The surveys will have both quantitative and qualitative questions which allows you to add your own suggestions and thoughts throughout the survey. The surveys will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys.

OR

As a key informant your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require 1.5-2 hours of your time over a three-month period. The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse population. The first survey will include an initial list of social justice elements and themes for your consideration. There will be an opportunity for you to add your own suggestions and thoughts throughout the survey. The survey's will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys. I am requesting that you participate in all three rounds. Lastly, there will be an optional member checking session for participants to confirm the results of the entire process.

I have attached an information package that includes more detailed information and a consent form on page 4 for you to review. If you are interested in participating in this study, please return the signed consent document by DATE. If you have any questions, please feel free to email me. Should you not be interested in participating but know someone who might be interested or well suited to this study, please let me know by email either way. I will follow up with you a maximum of two times after this initial email.

Thank you for your time and consideration,

Claire Ramlogan-Salanga RM

Follow up email #2 (SME & KI)

Good morning,

On XX date I emailed you an invitation to participate in my study, Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. My name is Claire Ramlogan-Salanga and I am a Registered Ontario Midwife, sessional instructor in the McMaster University Midwifery Education Program (MEP) and a student in the McMaster University Master of Science in Health Education program. I am the principle investigator and the research team includes my supervisor Dr. Liz Darling RM, PhD, and committee members Dr. Audrey Campbell and Dr. Lawrence Grierson, PhD.

In the summer of 2020, racialized midwifery students from across the province called on the Ontario Midwifery Education Program (MEP) consortium to address a comprehensive list of factors contributing to systemic racism in the MEP. This included a call to review and revise the MEP curriculum. An initial area of that curriculum that requires focused attention is social justice. While there is a plethora of information about social justice in education, there is very little discussing this topic in the context of midwifery. The results of this research will be used to guide the Ontario MEPs in transforming their curriculum to better reflect student and society's needs.

I am contacting you because (insert one of the lines below) and as such, I am asking if you would consider participating in this study as a key informant and/or subject matter expert.

1. You were referred to me by one of your colleague or midwife or midwives or instructors.
2. You are highly recognized in academia/midwifery community for your work in social justice curriculum development
3. You are an educator in the Canadian/Ontario Midwifery education program and are recognized as an expert in social justice content.

As a subject matter expert your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require a minimum of 30 minutes to a maximum of 2.5 hours of your time over a four-month period (depending on your level of participation). The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse and intersectional population. Next, you will receive a link to a video-based literature review to that will provide you will a summary of social justice elements, themes, and definitions which you can take time to review before attending a focus group or individual interview. You will have a choice to either attend a focus group or schedule an individual interview with me to help establish the baseline social justice elements and themes, these results will support

the construction of the first-round survey. The focus group/interview will be conducted via Zoom and audio recorded to aid in analysis. The transcripts will be anonymized and stored on a secure server that is password protected. Transcripts will be accessible only by the research team. The results of the first round will be analyzed and refined for the second and third survey. Lastly, there will be an optional member checking session for participants to review the results of the entire process. Your participation in rounds one, two and three (surveys) are not mandatory but is highly desired.

If you choose to remain in the study as a subject matter expert, you will be participating in the three rounds of 30-minute surveys over a two-three month period. The surveys will have both quantitative and qualitative questions which allows you to add your own suggestions and thoughts throughout the survey. The surveys will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys.

OR

As a key informant your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require 1.5-2 hours of your time over a three-month period. The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse population. The first survey will include an initial list of social justice elements and themes for your consideration. There will be an opportunity for you to add your own suggestions and thoughts throughout the survey. The survey's will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys. I am requesting that you participate in all three rounds. Lastly, there will be an optional member checking session for participants to confirm the results of the entire process.

I have attached an information package that includes more detailed information and a consent form on page 4 for you to review. If you are interested in participating in this study, please return the signed consent document by DATE.. If you have any questions, please feel free to email me. Should you not be interested in participating but know someone who might be interested or well suited to this study, please let me know by email either way. I will follow up with you a maximum of two times after this initial email.

Thank you for your time and consideration,

Claire Ramlogan-Salanga RM

Follow up email (SME):

Welcome to Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. I am thrilled that you have decided to join this project!

Thank you for submitting your completed consent form. Based on your consent form, you have chosen to participate in _____. (initial focus group/interview only OR initial focus group/interview and three rounds of surveys) If you change your mind at any point, please let me know via email.

Next, please fill in the doodle poll (insert link) to indicate your availability for the initial focus group no later than ____. I will be in touch with a date, time and zoom link to get us on our way! If none of the suggested dates work for you or you would rather have an individual interview, please provide me with two-three preferred 30 minute time slots for me to confirm with you.

Thanks again for your time and effort.

Claire Ramlogan-Salanga RM

Follow- up email (KI):

Welcome to the Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. I am thrilled that you have decided to join this study!

Thank you for submitting your completed consent form.

As a Key Informant, you will be participating in three rounds of surveys. These surveys will occur a two weeks apart, and you will be able to complete them at your leisure. Please notify me as soon as possible if you are not intending to participate in any of the survey rounds.

Thanks again for your time and effort. I will be in touch on DATE with more instructions.

Follow up email- missing consent form:

Welcome to the Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. I am thrilled that you have decided to join this study!

Before I can have you officially join this study, I require your signature on the consent form. I have attached the information letter and consent form (on page 4) to this email. Please sign and return the form as soon as possible.

Last Follow up email (SME & KI) #3:

Good day,

This will be my last attempt to contact you for this study. My name is Claire Ramlogan-Salanga and I am a Registered Ontario Midwife, sessional instructor in the McMaster University Midwifery Education Program (MEP) and a student in the McMaster University Master of Science in Health Education program. I am the principal investigator of a research project entitled, Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study. The research team includes my supervisor Dr. Liz Darling RM, PhD, and committee members Dr. Audrey Campbell and Dr. Lawrence Grierson, PhD.

In the summer of 2020, racialized midwifery students from across the province called on the Ontario Midwifery Education Program (MEP) consortium to address a comprehensive list of factors contributing to systemic racism in the MEP. This included a call to review and revise the MEP curriculum. An initial area of that curriculum that requires focused attention is social justice. While there is a plethora of information about social justice in education, there is very little discussing this topic in the context of midwifery. The results of this research will be used to guide the Ontario MEPs in transforming their curriculum to better reflect student and society's needs.

I contacted you XX days ago because (insert one of the lines below) and as such, I am asking if you would consider participating in this study as a key informant and/or subject matter expert.

1. You were referred to me by one of your colleague or midwife or midwives or instructors.
2. You are highly recognized in academia/midwifery community for your work in social justice curriculum development
3. You are an educator in the Canadian/Ontario Midwifery education program and are recognized as an expert in social justice content.

As a subject matter expert your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require a minimum of 30 minutes to a maximum of 2.5 hours of your time over a four-month period (depending on your level of participation). The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse and intersectional population. Next, you will receive a link to a video-

based literature review to that will provide you will a summary of social justice elements, themes, and definitions which you can take time to review before attending a focus group or individual interview. You will have a choice to either attend a focus group or schedule an individual interview with me to help establish the baseline social justice elements and themes, these results will support the construction of the first-round survey. The focus group/interview will be conducted via Zoom and audio recorded to aid in analysis. The transcripts will be anonymized and stored on a secure server that is password protected. Transcripts will be accessible only by the research team. The results of the first round will be analyzed and refined for the second and third survey. Lastly, there will be an optional member checking Zoom session for all participants to review the results of the entire process. Your participation in rounds one, two and three (surveys) are not mandatory but is highly desired.

If you choose to remain in the study as a subject matter expert, you will be participating in the three rounds of 30 minute surveys over a two-three month period. The surveys will have both quantitative and qualitative questions which allows you to add your own suggestions and thoughts throughout the survey. The surveys will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys.

OR

As a key informant your participation in this modified Delphi study is highly valued as your understanding of the subject area is unique and you bring an intersectional lens to the project. This project will require 1.5-2 hours of your time over a three-month period. The modified Delphi will begin with your participation in a short demographic survey that will help me confirm that the participants in this study represent a diverse population. The first survey will include an initial list of social justice elements and themes for your consideration. There will be an opportunity for you to add your own suggestions and thoughts throughout the survey. The surveys will be housed in McMaster's REDCap secure survey platform. The content will be password protected and only accessible by the research team. The results of the first-round survey will be analyzed and refined for the second and third rounds of surveys. I am requesting that you participate in all three rounds. Lastly, there will be an optional member checking Zoom session for all participants to review the results of the entire process.

I have attached an information package that includes more detailed information and a consent form on page 4 for you to review. If you are interested in participating in this study, please sign and return the consent document by DATE. Should you not be interested in participating but know someone who might be interested or well suited to this study, please let me know by email either way. I will follow up with you a maximum of two times after this initial email.

Thank you for your time and consideration,

Information Letter & Consent

Participant Information and Consent
Title of Study: Transforming the Ontario Midwifery Education Program through social justice curriculum: a modified Delphi study
Principal Investigator: Claire Ramlogan-Salanga, RM, B.Comm, B.HSc
Supervisor: Dr. Liz Darling RM, PhD
Committee Members: Dr. Audrey Campbell, Dr. Lawrence Grierson PhD.
Funding Source: No funding

Claire Ramlogan-Salanga is a Registered Midwife in the province of Ontario, sessional instructor at the McMaster Midwifery Education Program and a student in the Master of Science in Health Education program at McMaster Univeristy. This project has no funding.

Invitation to participate in research
The goal of the proposed research is to define social justice in the context of Canadian midwifery, as well as identifying the elements of social justice concepts and competencies that can be incorporated into the Ontario Midwifery Education Program (MEP). This modified Delphi study has three phases: the first phase involves gathering a group of key informants to build a list of social justice elements that support or refute the content of the literature review; the second phase involves recruiting subject matter experts who will provide opinions on these elements through three rounds of surveys; phase three involves a member checking session where all participants will be able to view the researcher's interpretations of the findings. Final analysis and application of the results to the MEP curriculum will be completed as part of my thesis and can be viewed during the public defence in July 2022. Participation in this research is voluntary, and there are no negative repercussions should you choose not to participate.

Why is this study being done?
In the summer of 2020, racialized midwifery students from across the province called on the Ontario MEP consortium to address a comprehensive list of factors contributing to systemic racism in the MEP. This included a call to review and revise the MEP curriculum. An initial area of that curriculum that requires focused attention is social justice. While there is a plethora of information about social justice in education, there is very little discussing this topic in the context of midwifery. The results of this research will be used to guide the Ontario MEPs in transforming their curriculum to better reflect student and society's needs.

How many participants will be in this study?

There will be 12-15 key informants and 25-30 subject matter experts in this study. As part of the Delphi process, I am seeking a diverse range of "experts"[10] from the following areas: current Ontario midwifery senior students and/or recent (<2 years) graduates, Ontario Midwives, Canadian MEP Faculty, Ontario midwifery clients who have been discharged from care and have completed a full course of care[11] and health care professionals in the fields of nursing, social work and medicine who have taught, or published material regarding social justice content.

What will happen to participants in this study? (Subject Matter Expert)
If you consent to participate in this study as a SUBJECT MATTER EXPERT, the following will occur:

- You will be contacted by phone or email to arrange a date and time for a focus group or individual interview based on your availability.
- You will receive a link to complete a short demographic survey before participating in the Delphi process.
- If you choose to participate in an individual interview it will last approximately 30 minutes; focus groups will last approximately 60 minutes. With your permission, interviews/focus groups will be audio recorded for later transcription and analysis.
- Before you attend the interview or focus group, you will be provided with a link to a video presentation summarizing the literature review of social justice elements and themes as well as current definitions of social justice. You will be asked to critique these lists and definitions during the focus group or interview.
- Your participation can end at this point, however if you are interested in continuing in the study as a key informant please read below.

Further optional participation as a KEY INFORMANT includes:

- Three rounds of surveys that will further refine the social justice elements, themes, competencies, and definition. You will have an opportunity to add your suggestions or thoughts in the surveys.
- There will be three rounds of surveys, 2 weeks apart, which will take 30 minutes each to complete.
- The surveys will be open for 10 days to complete on your own time.
- You will be given a personal link and ID number to access the surveys which will allow you to return to unfinished surveys.
- The surveys will consist of both open text and 7-point scaled questions.

[10] "Expert" is defined as a person who has completed a terminal degree in social justice-based education and/or has experience in midwifery education, research, or practice; as well as those with lived-experience as a midwifery consumer.
[11] Full course of care: prenatal, antenatal (birth) and six weeks postpartum care.

- At the end of the study, you will be invited via email to participate in member checking session to review the researcher's interpretation of the survey's findings. This is an optional session.
- Your participation is voluntary and can be ended at any point by letting the principal investigator know via email.

Are there any risks?
There are no foreseeable risks associated with participation in this study. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. Below I describe the steps I am taking to protect your privacy.

Are there any benefits?
This research will not benefit you directly. Participation in this research may directly benefit midwifery students, and indirectly midwives and midwifery consumers in the future, as the findings will be used to transform the Ontario MEP's curriculum. All participants will be invited to a presentation of preliminary findings once analysis of the collected data is underway.

Will I be paid to participate in this study?
Participants will not be paid to participate in this study.

Will there be any costs to me in this study?
There are no costs associated with participating in this study.

What will happen to my personal information?
Every effort will be made to protect your confidentiality and privacy. Your name or any information that would allow you to be identified will not be used. You will be assigned a code and only the researcher will have access to the information linking your name to the data provided in your interview. Although the researcher will not share any identifiable information obtained in group interviews, other participants of the group might not follow this rule. During the focus group, the researcher will remind participants that the discussions that occur during that time should remain confidential and private and that every effort will be taken to deidentify personal stories should they be shared by participants. For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board and this institution and affiliated sites may consult your research data for quality assurance purposes. However, no records that identify you by name or initials will be allowed to leave the research office. By signing this consent form, you authorize such access. Direct quotes may be used for the final manuscript, but any associated identifiers will be removed. The information you provide will be kept on a computer and will be protected by a password. Once the study is complete, an archive of the data without identifying information will be maintained for a period of 3 years, after which point the data will be destroyed.

This study will use the McMaster licensed version of the Zoom platform to conduct the focus group(s) and/or interview(s), which is an externally hosted cloud-based service. A link to their privacy policy is available here: https://zoom.us/privacy. Additionally, the surveys will be conducted online using the McMaster licensed version of REDCap, a secure, web-based platform hosted at McMaster Univeristy. A link to their privacy policy is available here: https://projectredcap.org/software/mobile-app/privacypolicy/. Please note that whilst these services are approved for collecting data in this study by the Hamilton Integrated Research Ethics Board, there is a small risk with any platform such as this of data that is collected on external servers falling outside the control of the research team. If you are concerned about this, we would be happy to make alternative arrangements for you to participate, perhaps via telephone. By signing this consent form, all focus group participants agree not to make any unauthorized recordings of the content of a focus group session (or the surveys) using Zoom or any other third-party device or application. Note the researcher cannot guarantee that all participants will refrain from recording the session. Please talk to the researcher if you have any concerns.

Can participation end early?
Your participation in this study is voluntary. If you decide that you no longer want to participate in the study, you can withdraw for whatever reason, even after signing the consent form. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will not be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still participate in the study. Please email or provide other written documentation to the researcher if you intend to withdrawal.

If I have questions about this study, who should I call?
If you have any questions, please contact Claire Ramlogan-Salanga RM, McMaster University

Claire Ramlogan-Salanga
ramlogac@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB) under project #13719. The HIREB is responsible for ensuring that participants are informed if the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair of the Hamilton Integrated Research Ethics Board at 905.521.2100 x 42013.

CONSENT STATEMENT

I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

Please indicate you level of participation:

- Initial focus group only (Subject Matter Expert)
- Initial focus group (Subject Matter Expert) and three rounds of surveys (Key Informants)

_____

Name Signature Date

SIGNATURE OF INVESTIGATOR:

In my judgment, the participant is voluntarily and knowingly giving informed consent, and possesses the legal capacity to give informed consent to participate in this research study.

_____

Name of Investigator Signature of Investigator Date

Appendix 3 : Semi-Structured Focus Group or Interview Guide

(HIREB Approval July 27 2021 Version 2, Project #13719)

The following is a semi-structured interview guide that will be used for focus groups or individual interviews with key informants.

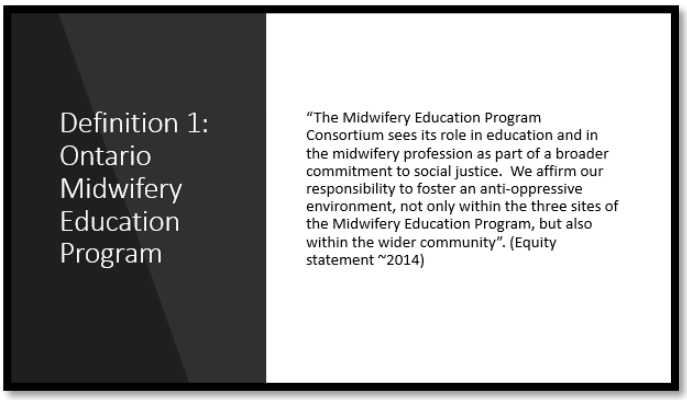
Preamble: Thank-you very much for taking the time to participate in this interview/focus group. Last week I had sent each of you a summary of the finding from the literature review of elements of social justice curriculum and definitions of social justice from midwifery, nursing, social work and medicine. In that presentation there were XX elements, XX themes, and XX definitions identified. Today we are here to discuss each of those topics and decided if there are any other elements/themes or definitions that should be added or deleted from the list. The results of this focus group/interview will be collated and will build the first round of the Delphi survey.

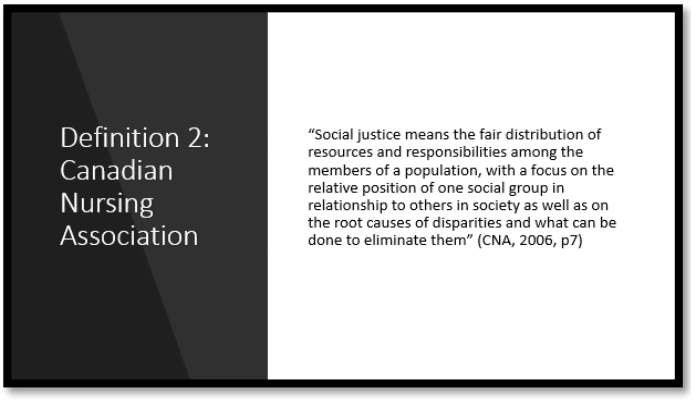
As with any focus group/interview, if you do not want to continue to participate, please let me know via the chat or you can excuse yourself from the meeting. I will follow up with you as soon as possible. This focus group/interview will be audio recorded only for note taking purposes. The Zoom recording and transcripts will be kept on a secure server and will be password protected. The only people who will have access to today's discussion will be my supervisor, committee members and myself. As a reminder, this focus group is confidential, and I ask that participants do not share what is said here with others outside of this space including personal stories or client or student examples. This focus group will take 60-90 minutes OR This interview will take 30-60 minutes to complete. Does anyone/Do you have any questions at this time?

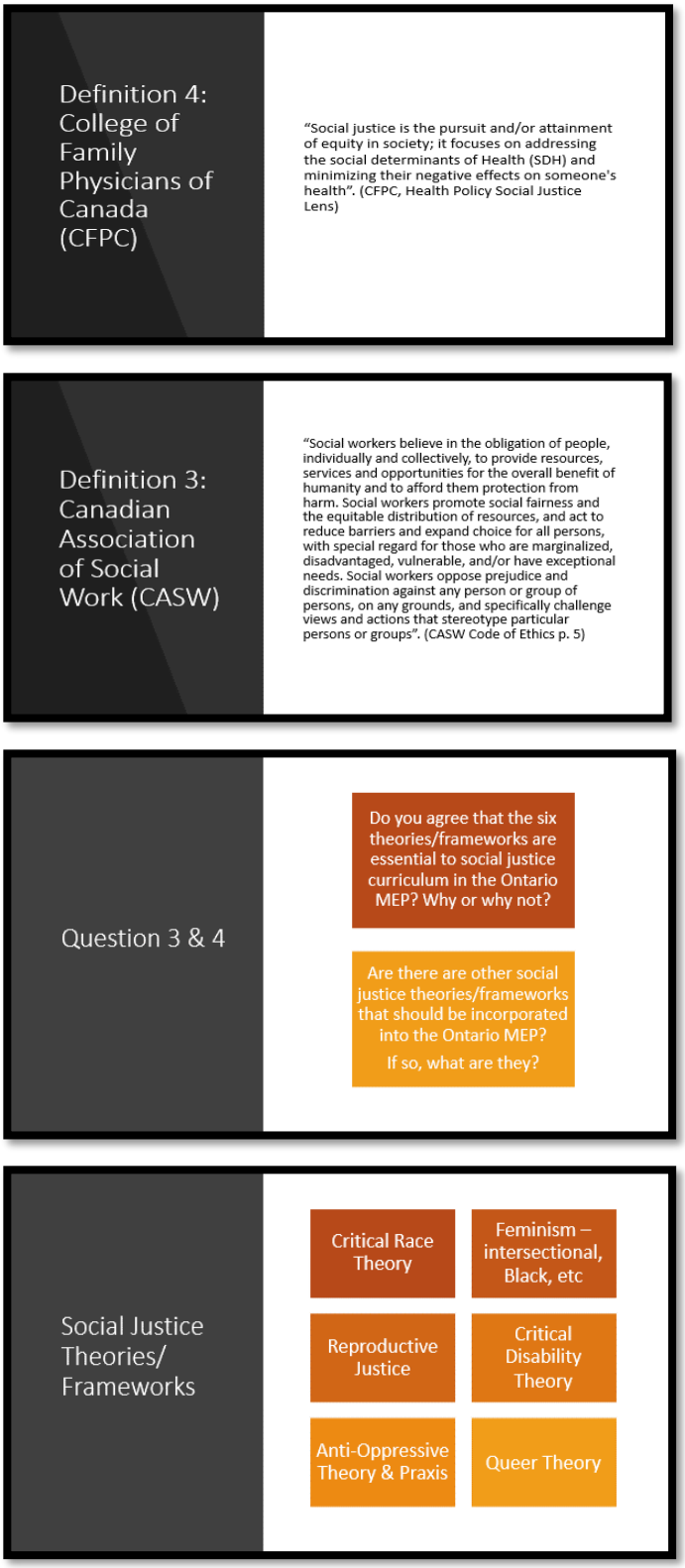
1. Based on the XX# definitions of social justice found in the literature, what version do you think best suits the Canadian Midwifery context?
    a. For the version you did like, can you explain why?
    b. If there are no versions that you like, were there any aspects that you did like/dislike?
2. Do you think midwifery should have a different definition of social justice than the other "medical" professions? If so, why?
    a. Do you have a suggestion for a Canadian midwifery-based definition?
3. There are XX# of elements identified through the literature review and I have placed them into XX# of themes, let's work though <u>each</u> theme and see if we can brainstorm ideas to further clarify, add or delete social justice elements.
    a. Does everyone agree with _____ theme? If not, why? What would you change the theme to instead?
    b. Does everyone agree with the elements listed within this theme? If not why? What would you change/add/delete?
4. (At the end, after going through all of the themes) Is there anything that we did not cover that you think is an important element of social justice education for midwifery students?

Thank you for all your input today. For those of you have chosen to continue with the subsequent rounds of the Delphi as a subject matter expert you will be hearing from me in XX weeks to begin that phase of the study. For those of you who have completed their participation in the study today, thank you again for helping to shape midwifery education in Ontario. I wish you all the best.

Appendix 4: Literature Review MS Power Point Presentation



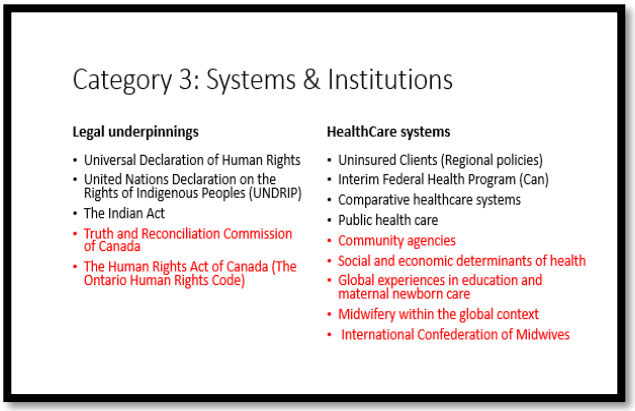



Definition 4: College of Family Physicians of Canada (CFPC)
"Social justice is the pursuit and/or attainment of equity in society; it focuses on addressing the social determinants of Health (SDH) and minimizing their negative effects on someone's health". (CFPC, Health Policy Social Justice Lens)
Definition 3: Canadian Association of Social Work (CASW)
"Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm. Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs. Social workers oppose prejudice and discrimination against any person or group of persons, on any grounds, and specifically challenge views and actions that stereotype particular persons or groups". (CASW Code of Ethics p. 5)
Question 3 & 4
Do you agree that the six theories/frameworks are essential to social justice curriculum in the Ontario MEP? Why or why not?
Are there are other social justice theories/frameworks that should be incorporated into the Ontario MEP?
If so, what are they?
Social Justice Theories/ Frameworks
Critical Race Theory
Feminism – intersectional, Black, etc
Reproductive Justice
Critical Disability Theory
Anti-Oppressive Theory & Praxis
Queer Theory


Categorization of ALL social justice elements
Foundations (Individual)
• Self awareness
• Theoretical foundations
The Profession & Midwife (Agent)
• The profession
• The Midwife
Systems & Institutions
• Legal underpinnings
• Healthcare systems in Ontario/Canada
Indigenous Health and Wellbeing
• Truth & Reconciliation
• Birth & Midwifery


Category 2: The Profession & the Midwife
Midwife
• Person-centred care
• Ethics
• Cultural safety
• Humility
• Outreach (service work)
• Teamwork and collaboration with other HCPs
• Praxis (critically reflective thought and action)
• Provide trauma-informed care (including historic trauma, IPV)
• Structural competence
• The pregnant body: images, body, sexuality
• Pandemic & health inequities (covid)
• Prenatal testing and reproductive technologies
• Solidarity with the underserved
• Building trust and listening to clients
• Cultural learning/openness/bridging
• Mitigating health disparities
• Leadership
• Providing choice
• Greif & Loss
• Professionalism
• Gender and sexual diversity and trans care
• Poverty and exclusion
• Social determinants of health
• Perinatal substance use & care of targeted populations
• Fetal alcohol spectrum disorder
• FGM/FC


Category 2: The Profession & the Midwife
The profession
• History of midwifery in the Canadian context
• Tenets of midwifery
• Regulatory standards of midwifery
• Professionalism
• Lack of racial representation in the profession
• Ethics


Category 3: Systems & Institutions
Legal underpinnings
• Universal Declaration of Human Rights
• United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
• The Indian Act
• Truth and Reconciliation Commission of Canada
• The Human Rights Act of Canada (The Ontario Human Rights Code)
HealthCare systems
• Uninsured Clients (Regional policies)
• Interim Federal Health Program (Can)
• Comparative healthcare systems
• Public health care
• Community agencies
• Social and economic determinants of health
• Global experiences in education and maternal newborn care
• Midwifery within the global context
• International Confederation of Midwives


Category 4: Indigenous Health and Wellbeing
Truth & Reconciliation
• Indigenous health (history and present day)
• Calls to Action (health)
• Knowledge and narrative
• Indigeneity, identity and community
• Effects of residential schools
• World view
• Colonialism, white supremacy, settlers
Birth & Midwifery
• Decolonizing Indigenous midwifery
• Cultural competency, cultural humility, cultural safety
• Birth and evacuation policies
• Sexualities
• Allyship
• Indigenous midwifery


NEXT STEPS
For those of you who are staying on as subject matter experts, you will be contacted in November for the first round of Delphi surveys
For those of you are not remaining on with the study, thank you for your time and effort. You input into this project has been invaluable.

Appendix 5: Discipline Specific Definitions of "social justice"

Source	Discipline specific definition of "social justice"
(OMEP Equity statement ~2014)	"The Midwifery Education Program Consortium sees its role in education and in the midwifery profession as part of a broader commitment to social justice. We affirm our responsibility to foster an anti-oppressive environment, not only within the three sites of the Midwifery Education Program, but also within the wider community".
(Canadian Nursing Association, 2006, p7)	"Social justice means the fair distribution of resources and responsibilities among the members of a population, with a focus on the relative position of one social group in relationship to others in society as well as on the root causes of disparities and what can be done to eliminate them"
(Canadian Association of Social Work, Code of Ethics 2005, p5)	"Social workers believe in the obligation of people, individually and collectively, to provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm. Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs. Social workers oppose prejudice and discrimination against any person or group of persons, on any grounds, and specifically challenge views and actions that stereotype particular persons or groups".
(The College of Family Physicians of Canada, Health Policy Social Justice Lens, Feb 2018)	"Social justice is the pursuit and/or attainment of equity in society; it focuses on addressing the social determinants of Health (SDH) and minimizing their negative effects on someone's health".

Appendix 6: Demographic survey

Questions	Responses
Personal identifying code	__-___-___
Which of the following best describes your role in this study? [dropdown menu]	1 = Ontario Midwife (>2 years since graduation) 2 = Midwifery educator (Faculty/sessional instructor at OMEP) 3 = Current senior midwifery student 4 = Recent Midwifery Education Program graduate (graduated 2019, 2020 or 2021) 5 = Midwifery consumer (experienced prenatal, antenatal/birth and 6 weeks of postpartum care AND discharged from midwifery care) 6 = Midwifery sector stakeholder (AOM, CMO, NACM) 7 = Other professional (nursing, medicine or social work) 8= None of the above
[branching logic, if….	NEED TO MAKE LOGIC RULES 1 continue, including blue & dark green boxes, but not pink 2 continue, including blue, dark green & orange boxes, but not pink, grey, orange or green 3 continue, including green, but not blue, pink, grey or orange 4 continue, including blue & dark green boxes but not pink, grey orange or green 5 continue, including pink box, but not blue, grey, orange or green 6 continue, including blue and grey boxes, but not pink, orange or green 7 continue, including dark green & orange boxes, but not blue, pink, grey or green 8 Unfortunately you are not eligible to participate in this study. The principal investigator will contact you shortly to review your results. Thank you for your time.
Were you born in Canada? [dropdown menu]	1 = Yes 2 = No 9 = Unsure 99 = Prefer not to answer
[branching logic, if NO to the previous question...] If no, what year did you arrive in Canada? [dropdown menu]	[Insert years from 1930 to 2020]
What is your age? [dropdown menu]	1 = 18-24 2 = 25-34 3 = 35-44 4 = 45-54

	5 = 55-64 6 = 65+ 99 = Prefer not to answer
Which of the following best describes your racial or ethnic group? [dropdown menu]	1 = Asian - East (e.g. Chinese, Japanese, Korean) 2 = Asian - South (e.g. Indian, Pakistani, Sri Lankan) 3 = Asian - South East (e.g. Malaysian, Filipino, Vietnamese) 4 = Black - African (e.g. Ghanaian, Kenyan, Somali) 5 = Black - Caribbean (e.g. Barbadian, Jamaican) 6 = Black - North American (e.g. Canadian, American) 7 = First Nations 8 = Indian - Caribbean (e.g. Trinidad & Tobago with origins in India) 9 = Indigenous/Aboriginal - not listed here 10 = Inuit 11 = Latin American (e.g. Argentinean, Chilean, Salvadoran) 12 = Métis 13 = Middle Eastern (e.g. Egyptian, Iranian, Lebanese) 14 = Pacific Islander (Tongan, Fijian, Samoan) 15 = White - European (e.g. English, Italian, Portuguese, Russian) 16 = White - North American (e.g. Canadian, American) 17 = Mixed heritage (e.g. Black - African & White - North American) 18 = Other(s): Please specify:_____ 98 = Do not know 99 = Prefer not to answer
What is your gender? I recognize that gender is often complex and has multiple dimensions. However, for the purpose of statistical analyses, please select only ONE option you feel best describes your gender. [dropdown menu]	1 = Woman 2 = Man 3 = Intersex 4 = Non-binary 5 = Two-Spirit 6 = Other (Please specify): _____ 9 = Unsure 99 = Prefer not to answer
Do you identify as trans or transgender?	1 = Yes 2 = No 9 = Unsure 99 = Prefer not to answer
What is your sexual orientation? I recognize that sexual orientation is often complex and has	1 = Bisexual 2 = Gay 3 = Heterosexual 4 = Lesbian 5 = Pansexual

multiple dimensions. However, for the purpose of statistical analyses, please select only ONE option you feel best describes your sexual orientation. [dropdown menu]	6 = Queer 7 = Two-Spirit 8 = Other (Please specify): _____ 9 = Unsure 99 = Prefer not to answer
Do you have any of the following? Please check ALL that apply [multi-select checkboxes]	1 = Chronic Illness 2 = Developmental Disability 3 = Drug or Alcohol Dependence 4 = Learning Disability 5 = Mental Illness 6 = Physical Disability 7 = Sensory Disability (i.e. hearing or vision loss) 8 = Other (Please specify): _____ 9 = None 98 = Do not know 99 = Prefer not to answer
What is your highest degree or level of education you have completed? [drop down menu]	1 = some high school 2 = College degree or diploma 3 = Bachelor's degree (undergraduate) 4 = Master's degree 5 = Doctor of Philosophy (PhD) 6 = Trade school 7 = Alternative education 9 = unsure 99 = Prefer not to answer
How many times have you experienced midwifery care as either a client or support person?	##
How many years have you been working in a midwifery stakeholder organization?	## years
How many years have you been a practitioner, educator and/or researcher?	## years Not applicable

If you are a current senior midwifery student, what Ontario midwifery education program are you enrolled at?	1 = Ryerson "X" University 2 = McMaster University 3 = Indigenous Education Program 4 = Other
What was your route of entry into the profession of midwifery	1 = Graduate of the Michener Preregistration Program 2 = Graduate of the Ontario Midwifery Education Program (RU, MU, LU) 3 = Graduate of another Canadian Midwifery Education Program 4 = Internationally Educated Midwife 5 = Indigenous Midwifery Education Program or apprenticeship 6 = Graduate of the International Midwifery Preregistration Program at RU 7 = other 8 = not applicable 99 = Prefer not to answer
For how many years have you been a practicing midwife?	## years
Are you a clinical preceptor	1= Y 2 = N 99 = Prefer not to answer
[branching logic, if YES to the previous question...] How many years have you been a clinical preceptor?	## years
What is your current practice arrangement?[12] [dropdown menu]	1 = Solo practice 2 = Team practice with 2-4 midwives 3 = Team practice with more than 4 midwives 4 = Interprofessional/collaborative care 5 = Exclusively locum 6 = not applicable 6 = Other (Please specify): _____
Does your current practice serve a rural or remote catchment area?	0 = No 1 = Yes 2 = not applicable
Do you serve a marginalized population as a	0 = No 1 = Yes 2 = not applicable

[12] Adapted from Stoll and Gallagher 2019 and Megregian et al. (2021)

practitioner, educator, researcher?	