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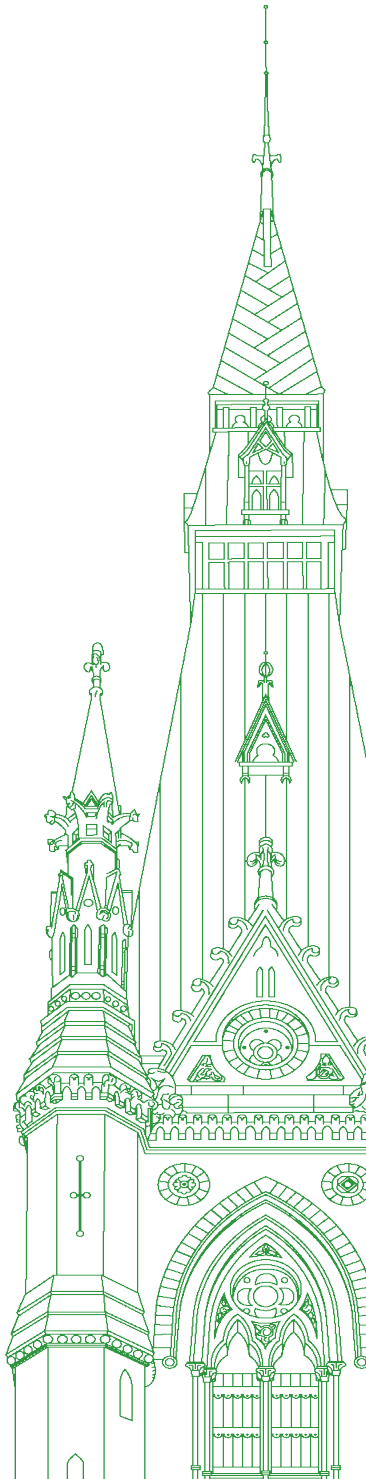

Chair: Ms. Marilyn Gladu

Standing Committee on the Status of Women

Thursday, May 6, 2021

● (1100)

[*English*]

The Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): I call this meeting to order.

Welcome to meeting number 32 of the House of Commons Standing Committee on the Status of Women. Today's meeting is taking place in hybrid format, pursuant to the House order of January 25, 2021, and the proceedings will be made available via the House of Commons website. The webcast shows the person speaking rather than the entire committee.

Today our committee is beginning its study on midwifery services across Canada.

For the benefit of the witnesses, when you want to speak, you can click on the microphone icon to activate your mike, and your comment should be addressed through the chair. Interpretation is available. If you look at the bottom of your screen, you can select the language you prefer. When speaking, please speak slowly and clearly for our interpreters. When you're not speaking, your mike should be on mute.

Now let me welcome our witnesses who are joining us for our first panel. They'll each have five minutes for their opening remarks.

We have Lisa Morgan, who is a registered midwife. We also have Tom Fenske, who is the president of the Laurentian University Staff Union.

Lisa, we'll start with you. You have five minutes.

Ms. Lisa Morgan (Registered Midwife, As an Individual): Thank you.

My name is Lisa Morgan, and last Friday I was the director of the school of midwifery at Laurentian University. Today, I come to you as Lisa Morgan, registered midwife, after 14 years as tenured professor at Laurentian.

I speak today not as one voice. I also bring the voices of Dr. Kirsty Bourret and Dr. Karen Lawford, who are francophone and indigenous midwives and scholars, as well as a group called SOS, Save Our Sages-Femmes, a group of francophone, indigenous and northern stakeholder midwives who come from across Ontario.

Throughout the world, midwives provide essential, cost-effective, person-centred health care services. Investing in midwifery globally could save 4.3 million lives annually by 2035. In Ontario, midwives deliver nearly 20% of all babies as a regulated, funded and insured health profession. We are autonomous primary care providers, and we're in high demand across Canada and across Ontario. In many instances, midwifery clinics cannot keep up with this demand.

Unfortunately, Laurentian University unilaterally decided to close its school of midwifery, effective April 30, 2021, and all faculty contracts were cancelled. In a communiqué to students on April 12, university president Robert Haché stated that the midwifery program was cut due to low enrolment.

The midwifery program has been full ever since its inception in 1993. This year, there were over 300 applicants for the 30 available seats. We are financially viable because midwifery education programs are envelope-funded by the provincial government, with additional student tuition contributing to overhead.

The school of midwifery at Laurentian University was one of only six midwifery schools in all of Canada—there are only five now—the only francophone midwifery school outside of Quebec, as the Quebec midwifery school does not admit anyone who is not a resident of Quebec, and the only bilingual midwifery school in the country.

We provided focused northern indigenous programming, which attracted indigenous midwifery students from across Canada. Since 1993, over 400 midwives have graduated from Laurentian, and 25% of these midwives are francophone. In fact, 60% of midwives working in northern Ontario are Laurentian graduates, and 60% of these graduates are francophone or provide services in French. As well, 20% of Laurentian's graduates are also members of the National Aboriginal Council of Midwives. This demonstrates a critical contribution to reproductive services in northern Ontario, and that Laurentian was more than meeting its mandate to increase services in northern francophone and indigenous communities.

Closing the program will substantially negatively impact northern Ontario women and birthing people and their families, and it accentuates an already sparse health care human resource environment.

The francophone midwifery program in Ontario is essential to the continuity of a francophone workforce. Francophone midwifery outside Quebec needs to serve the 744,000, or 5%, of the total population of Ontario. Studying exclusively in French is a right in order for the students to achieve linguistic, cultural and social well-being and competency. Receiving services in one's mother tongue is crucial and increases the quality and the safety of the care.

Currently in Ontario, the lack of French services persists, with 50% to 55% of francophones having little or no access to health services in their mother tongue. In addition, the francophone minority intersects with indigenous, black and persons of colour. Francophone visible minorities are mostly clustered in central and eastern Ontario and 16% of francophones identify as visible minorities. As with visible minorities in the general population, they live primarily in central and eastern Ontario.

I'd like to hold up l'Hôpital Montfort in Ottawa as a unique example, with its obligation to maintain the French language, embody French culture, foster solidarity with the Franco-Ontarian minority and protect the Franco-Ontarian community from assimilation. In order to achieve its objectives, it must hire francophone midwives. Of the 25 midwives who maintain privileges at l'Hôpital Montfort, greater than 60% are graduates of Laurentian University's midwifery program.

We do not believe the only locations for midwifery education should be in the universities of southern Ontario. We appreciate that Ryerson and McMaster stepped forward in a crisis and they're doing their best to support our current students, but this can only be short term.

● (1105)

Historically, decisions about the location of the third midwifery school were careful to consider the values of decentralization. There were concerns expressed about two out of the three schools being located within one hour of each other. We are now in a position, 28 years later, of having only these two closely located schools available for midwifery education in Ontario.

Ontario needs a bilingual midwifery education program. It's critical for indigenous, francophone and northern communities. We need more midwives, not fewer.

[*Translation*]

We are, and will continue to be, the indigenous and francophone midwives of northern Ontario.

[*English*]

The Chair: Now we will go to Mr. Fenske.

You have five minutes.

Mr. Tom Fenske (President, Laurentian University Staff Union): Thank you.

Thank you, Lisa.

Lisa has been doing a great job leading that program.

I don't have a lot of speaking notes. I was heavily involved through the CCAA process as the president of the staff union.

When it comes to midwifery programs, there's a lot of confusion. There are a lot of questions unanswered. You heard from Ms. Morgan that the enrolment has been exactly what it's supposed to be. It has hit its target every year.

What we are very confused about is the actual building of barriers in 2021. We feel like this is a situation where, because of a decision that has been made.... These decisions that were made through this process were about dollars and cents. The functionality of the institution, or the functionality of servicing women in the north, was not part of this discussion, and it should have been.

If you look at some of the midwife programs in the north.... I was lucky enough for two of my children to have midwives, and I was even luckier that I had the same two midwives both times. Xavier was the last baby that one of them, Meghann, delivered. She went up north to work in Timmins. I think it's called the Boreal Midwifery Practice, and both of the people who work there in Timmins are Laurentian graduates, to my knowledge.

If the program wasn't based here in Sudbury at Laurentian University, would there be a practice in Timmins? I don't think there would be. That's the precise reason that having a midwifery program down south is fantastic, but it does not service the north. There is a significant number of indigenous students and francophone students.

You will see that we have an indigenous learning centre. In that centre, there are specific rooms that are designed just with a phone and a booth. That's because indigenous students feel disconnected because they are not in their communities. The idea that you would now ask indigenous students to go to southern Ontario is going to create significant barriers, barriers that were supposed to be, over years, brought down.

When you look at the system, and I'm sure Ms. Morgan would talk much better about it than I would, you see there's a lottery to get into the program. There's a separate lottery specific for francophone and indigenous students. That's about taking down barriers. That's about making sure that people have access to the things they need to have access to in the north. A decision like this in 2021.... I am baffled by the idea that we would be moving away from servicing northern Ontario, which this decision has done.

We've asked several times why this is happening. For other programs they would give us the reasons they made those decisions, but there was nothing they could tell us about the midwifery program. We kept saying this is an envelope of funding. It hits a target every year. It's a good program. It's servicing the north. How is this on the list of programs to be cut? The only real excuse they gave us was that the funding could dry up one day, and then they'd be stuck with people.... They wouldn't be in a CCAA process where, as you know, there are a lot of things you can do. If you exit people out of the institution, there is no severance, or it's caught up in a claims process.

My concern is that they took advantage of a point in time. They ignored northern Ontario by doing so and created a massive barrier for this specific program that really does, if you heard Ms. Morgan, significantly service the north.

● (1110)

The Chair: Very good.

Ms. Sonia Sidhu (Brampton South, Lib.): On a point of order, Madam Chair, the staff did not receive good sound quality. Can you check with the clerk?

The Chair: Could the clerk check with the interpreters? Staff are not getting good sound for translation.

Is it good? Okay. We'll continue.

We'll start our first round of questioning with six minutes each, beginning with Ms. Shin.

Ms. Nelly Shin (Port Moody—Coquitlam, CPC): Thank you, Madam Chair, and thank you to the witnesses today for being here on such quick notice.

The whole topic of midwifery is quite unfamiliar to some people. Having never had children myself, I would love to learn more about it. I understand that it's a very valuable part of the birthing process, and an option that has been available.

How is midwifery regulated in Canada? I would like to understand that.

Ms. Lisa Morgan: It's done province by province. We have regulatory colleges, and we have the College of Midwives of Ontario that regulates our graduates. We've recently launched a national accreditation program for midwifery schools, so now there is that national oversight around the quality of the program.

The schools in Ontario were visited for accreditation over the last year and a half, and a member of the college of midwives was present, as the regulators want to keep a close eye on accreditation as well. We have a very defined scope of practice. Midwifery exists almost everywhere.

P.E.I. and Yukon are kind of pulling things together and have made recent announcements, so I think that shortly we will have midwifery across Canada.

Ms. Nelly Shin: That's wonderful. Thank you.

You mentioned, Lisa, that Ontario has 20% of the babies delivered by midwives and that midwives are instrumental in saving many lives. Could you speak to what that looks like?

Ms. Lisa Morgan: As midwives, we do really good work in serving vulnerable populations, with the time we can take and the way we work with our social networks around us. During my many years of practice, teens were a group that I served well. My practice was Cambridge Midwives, where 15% of our midwives' clientele were Muslim and specifically needed female caregivers. We really tried to reach refugees, immigrants and the hard-to-reach.

We do have the evidence to say that we are doing a good job. We have good outcomes. We have lower intervention rates with equally good outcomes, and we've been found to be cost-effective in the system. Every 28 years in a health care system feels new, but 28 years has allowed us to gather the data that shows we're doing a good job and reaching the people we need to reach.

Ms. Nelly Shin: Could you provide some data? You may have already said it and I missed it, but overall across Canada, how many births annually...? Perhaps you might be able to provide some data for that and also data specific to Ontario.

● (1115)

Ms. Lisa Morgan: Those are numbers that I'm not prepared with right in front of my hands as I'm sitting here. It's 20% of babies in Ontario. It's not the highest in the country. In B.C., midwives are delivering 25% and have probably exceeded that by now, whereas in provinces with smaller numbers of midwives, of course, that number could be quite a bit lower. I think that nationwide the number is probably at about 12% of babies across Canada delivered into the hands of midwives.

Ontario is where the first midwifery program launched in 1993. Like I said, with us gone, there are only five remaining. When we talk about our ability to deliver babies across Canada or serve the needs of vulnerable populations, it depends on building that workforce. We have a lot of apprenticeship within the degree—two and a half of the four years are spent in clinical practice—and we're one-on-one apprenticing with a midwife to learn our skills through a lot of that time.

The growth of this profession is in the sustained support we need in order to grow the midwifery workforce and to be able to then grow the percentage of babies that midwives are able to deliver. I will comment that 85% of pregnancies are low risk. Reproductive health care in general could be delivered by midwives. In doing only 20%, there's a huge margin that we could be serving. As we know, more and more, family doctors are leaving maternity care or obstetrics, and midwives have been there in the last 28 years to fill that gap.

Ms. Nelly Shin: Thank you so much.

I have another question. How has COVID-19 impacted your clientele?

Ms. Lisa Morgan: It's made the work of midwifery harder, but it has introduced that choice for people who want choice of birthplace. There are people who did not feel that during this—

Ms. Sonia Sidhu: I have a point of order, Madam Chair.

The Chair: Go ahead, Ms. Sidhu.

Ms. Sonia Sidhu: Madam Chair, the French translation is coming in on the English channel.

The Chair: Both are coming at the same time now.

Ms. Nelly Shin: I wonder if Lisa could start again from the top, because it was speaking in—

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Excuse me, Madam Chair, but I couldn't hear the interpretation at all.

[*English*]

The Chair: The translation is not working.

Can the clerk take a look? We'll suspend briefly, and you won't lose your time, Ms. Shin.

● (1115)

_____(Pause)_____

● (1115)

The Chair: We'll pick up with Lisa.

Ms. Lisa Morgan: The question was on the effect of COVID on midwifery clients. It introduced more choice. We are the only care providers delivering babies at home, and we have the evidence to show that it is a safe choice. It was a choice made by increasing numbers of people as they were giving birth during this pandemic, which brings to light the importance of having an alternate care provider to be able to provide care in a different way under varying conditions.

I will say for the midwives, though, that not being essential workers made the pandemic quite difficult. No PPE was paid for or supplied by the government and they could not afford PPE for our students either, so we had to supply our students with all their PPE for their placements, which added thousands of dollars of cost to our program budgets this last year as well.

The Chair: We will go to Ms. Hutchings for six minutes.

Ms. Gudie Hutchings (Long Range Mountains, Lib.): Thank you to both of the witnesses for being here for this incredible conversation.

I'm from Newfoundland and Labrador, and I think it was 2018 that my province recognized midwifery. I come from a very rural riding, as my colleagues hear me say all the time. We're promoting mental health, telehealth and rural health, but you can't really deliver a baby over the Internet, so the uptake and the interest are incredible.

I have a story. I have a nephew and his wife who live probably two hours from any major hospital, and when she was due—and again she was a safe pregnancy—they had to move into a community where she was able to be closer to a hospital.

How do you think midwifery services contribute to women's mental health throughout their pregnancy and delivery? I know that my niece-in-law was totally stressed that they had to pack up and move and go to a place. They were looking for a midwife in the area where they live, but one wasn't available at that time.

I'd love to have your thoughts on that.

● (1120)

Ms. Lisa Morgan: Certainly that is our dream. That's what the Canadian Association of Midwives would say: a midwife in every community. We know we're most successful when we train people from the community to return to the community and when we remove people from community for as little time as possible, when clinical training can be done within the community that person plans to serve.

You mentioned one aspect, having that caregiver close by for checkups, visits or support, but it's also for the connections. It's called continuity of care when you develop a relationship with the person you're caring for. We are on a pager 24-7, and those calls, those mental health concerns, those check-ins that you can do with your midwife if you're not well.... We pay really particular attention postpartum. We care for the mother-baby diet until six weeks postpartum. We're talking to the family about postpartum depression. We're talking to that person about reaching out to us and about the supports that we can help with.

We also know that some of that mental health stuff around pregnancy and postpartum is around emergencies, processing and lack of information, so we really try to do a good job with debriefing the birth, why what happened happened and what questions we could answer. We also know that goes a long way in terms of reconciling what happened and what needed to happen, because we have the evidence to say that good births are not really about that unmedicated normal vaginal birth that goes straightforward. It's about that person feeling involved in the decision-making. There are good Caesarian sections. You just have to understand the reasons, have your questions answered and have that relationship and that trust.

When we talk about mental health, I think that goes a long way.

Ms. Gudie Hutchings: Tom, I'm just going to ask a quick question of you.

There was a great article in Maclean's in October of last year saying that midwifery is in demand, but increasing school program capacity isn't easy.

How can we best support and advocate for the midwifery programs moving forward?

Mr. Tom Fenske: I think there should be full recognition of the value they bring. Maybe I'll give you a personal story. When my eldest, Madeline, was born we had family members who were a little skeptical. They were not as comfortable with midwives, and we were figuring it out because it was our first child. That skepticism melted away when the midwife, I think it was Nicole, came to our house and sat on the bed and spent an hour debriefing us—here is what you need to do—and answered all our questions. At the time my mother-in-law was in the house and there was complete confusion around the idea that the midwife would come to the house and that we would see her again in two days, that she was coming back.

That kind of knowledge and that intimate relationship that is built, getting that information out there and helping people understand, it's such a.... The whole experience involved.... They used to host an annual party before COVID and everyone would show up. You would see all these families and all their children running around Fielding park. That advocacy of helping is the whole story of the midwifery program and what midwives can bring, and using the people who do it is probably the best way of approaching it.

Ms. Gudie Hutchings: Thank you. We need to move beyond just having a pamphlet in a doctor's office and do some work and support in that area.

I think I have a little time left, Madam Chair.

Lisa, what are the challenges facing midwives today? We just touched on one—the acceptance of a generation, we'll say. I know my mother would have said the same thing, if I had wanted to. I looked at it but I did hypnotherapy, because there wasn't a midwife around.

What are the main challenges and what recommendations do you have to help address those challenges?

Ms. Lisa Morgan: Burnout is probably the biggest challenge, and we're seeing that now. A recent study said two-thirds of B.C. midwives were considering leaving. There was some participation of Ontario midwives, but burnout is certainly an issue.

There has been austerity in the health care system as long as midwifery has been around. There was a hard fight through the Human Rights Tribunal for Ontario midwives to achieve pay equity, and we are in appeal again still. Other pressures like paying for PPE or not being considered essential certainly contribute to the burnout.

● (1125)

The Chair: That's your time on that question.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

I'd like to begin by thanking the two witnesses for having come to testify before the committee this morning. They've shown us why midwives are important.

On behalf of the Bloc Québécois, I'd like to express our solidarity with northern Ontario francophones. Our political party unanimously adopted a motion expressing the House of Commons' concern over the crisis that has shaken the world of Franco-Ontarian post-secondary education. I'll read the motion:

> That the House express its concern about the closure of 28 French language programs and the layoff of some 100 professors at Laurentian University in Sudbury;
>
> That it reiterates its solidarity with the Franco-Ontarian community; and
>
> That it recalls the essential role of higher education in French for the vitality of the Franco-Canadian and Acadian communities.

It's an important motion, introduced in the House by the member for La Pointe-de-l'Île.

It's a shocking situation. I'd like to hear what the two witnesses have to say about this, and about how the Laurentian University crisis and the status of the midwifery program are linked.

I'll ask Mr. Fenske to begin, and then Ms. Morgan could continue afterwards.

[*English*]

Mr. Tom Fenske: Yes, if I understand the question correctly, it's the barriers that have been created. To have people from northern Ontario have to go to southern Ontario to learn these programs.... That's the whole reason we have a medical school in the north. It's to service the north, to branch out and stay in the north. For a lot of people, where they do their schooling and where they practise and do their internship is where they are going to stay. Our concern is that there is this barrier that was taken down years ago, and that barrier is being recreated. I feel that would be the biggest impact, if I understood the question correctly.

[*Translation*]

Ms. Andréanne Larouche: Exactly, Mr. Fenske. I understand that it was a significant barrier, and linked to what we are discussing today.

Ms. Morgan, you spoke about the impact of austerity in the health care field and about the importance of reinvesting in health systems in Quebec and the other provinces in order to avoid the need for austerity measures and difficult choices. You mentioned just how crucial it was for the federal government to send a clear and strong message about the fact that our health care system needs help, particularly to get us through the crisis.

You both spoke about some of the problems encountered with personal protective equipment during the COVID-19 crisis that led to additional expenses. You raised the importance of increasing health transfers. The Bloc Québécois' position on this is clear. Transfers should increase to 35%. After all, the federal government contributed as much as 50% to health care systems in the past, and then gradually reduced the transfers to 22%, forcing the governments of Quebec and the other provinces to make difficult choices, which are being felt even today, particularly for midwives.

[*English*]

Ms. Lisa Morgan: I think there needs to be recognition that it takes money to grow a program. To grow a health cadre—to bring back a workforce that was eliminated for 100 years—is going to take investment and it's going to take more than four years or any change in parties. Twenty-eight years, as I said, is kind of a short period in terms of the health profession. We need continued commitment to investing in the growth of this profession so that we have people to deliver the babies who need to be delivered.

In addition to Tom's comments, I want to make an example of this year's list. We admit 30 students a year. We couldn't admit our students to our program this year, but Ryerson and McMaster agreed to admit the 30 students on Laurentian's behalf. Fifteen students will be going to Ryerson and 15 will be going to McMaster.

We did our selections for our offer list the same way we always do. We're mandated to look at indigenous, francophone and northern applicants first. Last year, 60% of our applicants came from this list of people. This year, I'm proud to say, 70% of the successful applicants to our program are indigenous, northern and francophone—21 out of 30. Ten of those successful applicants were francophone.

Since they only have a choice between McMaster and Ryerson, neither of which will be teaching the program in French, those 10 francophone applicants have to be contacted to find out if they are able to study in English. If they cannot study in English at a university level, they'll have to turn down the offer for the midwifery program.

When you say “long term”, this is already starting. This September, we're going to be training fewer francophone midwives. We also don't know whether our indigenous and northern applicants will be choosing McMaster or Ryerson. I do wonder how many of these students, from the 70% on our offer list, will actually end up registered at Ryerson or McMaster.

● (1130)

The Chair: We'll now go to Ms. Mathyssen for six minutes.

Ms. Lindsay Mathyssen (London—Fanshawe, NDP): Thank you, Madam Chair, and thank you to the witnesses.

You had actually just been talking about equality of official language access in terms of services.

As a member of Parliament, I've come back to studying French. Trying to convey something in a conversation about anything is always a struggle. I think, Tom, you also mentioned this.

Can we briefly talk about how important this is in terms of Canada being a bilingual nation and the rights involved in having access to health services for women? Can we talk about the importance of women having access to these services in their first language, especially at a time when they are stressed out and have difficult questions to ask?

Mr. Tom Fenske: I can start but I'm sure Ms. Morgan will have a lot more to say than I will.

We have a university in northern Ontario and we have an indigenous learning centre so that people can feel comfortable. They have to feel comfortable and there is a trust component. When you can speak in the language of your choice, your trust level is a lot higher. If you and the person you are dealing with are able to communicate with each other, you can learn. You're immersing yourself.

A lot of times it's a new city but you're still getting some sense of your home community. You have to transfer it over. If you're going to southern Ontario and there's no francophone program, you're going to be outside the realm of what you know, what you've grown up with and what you've gone to school with.

What's frustrating to me is when the university talks about seeing if they can transfer students into different programs. Well, you know, students don't go to school to be midwives and then be transferred into nursing. They want to be midwives. Now those barriers have been created—you've heard this, Ms. Morgan—so they have to make a choice. That choice is about not training in the language of their choice versus wanting to be a midwife. That's a horrible choice to have to make.

Ms. Lisa Morgan: I'll add a fine point to my answer, and that is imagining someone in labour.

[*Translation*]

Take me, for example. I can speak French fairly well, but not when I'm sick.

[*English*]

If we put that woman in labour, what can we even compare that to? Then to be expected to receive services in a second language and communicate in a second language.... Also, there are the choices throughout pregnancy and postpartum, choices about the infant. Very complicated discussions have to ensue to make those informed choices, and to expect that in someone's second language....

The other thing I want to add on to this is that it's not just a francophone issue but also indigenous. There's the ceremony around birth, and this is so community-dependent. It's so important that we train midwives from those communities to serve those communities, and they can only learn to serve those communities in those communities. I think it puts an even finer point on how important that relationship is and that congruency is.

● (1135)

Ms. Lindsay Mathyssen: Thank you. That's very important.

There have been a lot of conversations and there's a lot of confusion around what's going to happen next. I know that students and staff are both lost in that and are not really sure where they're going.

You mentioned that the university came forward and that the president said that they cut the midwifery program because there wasn't enough funding. However, we know that's not true because there is envelope funding from the province. Your tri-council comes together and ensures that the program is going forward collectively together and that the envelope funding is taken care of.

They also said that there wasn't enough enrolment, and we know that that's not true as well.

Also, going forward, the province said that it was going to save this program and that there will be a northern midwifery program, except it said only temporarily. The minister made this grand announcement, but when it got back to the actual ministry officials, they said that there were strings attached.

Can you talk about that, the impact that's had and where you're sort of left in all of that confusion?

Ms. Lisa Morgan: As a terminated faculty member and ex-director of the school, I have no role. I'm unemployed with no severance. I'm not connected. How do I have any say on where a third school would be or on anything about midwifery at this point?

I'm sorry. I kind of lost your question a little bit there. What was the question? It was about weighing in on this announcement.

Midwifery is a very small world. There aren't unemployed midwifery faculty. We all have jobs, except for the ones who were just recently let go from the school. Who is setting up a school and where? Who are they talking to? If they're not consulting with me or my faculty, I'm not sure who they're talking to. I have no details on that at all, and I was the director of the northern francophone and indigenous school of midwifery. If there are any decisions or any conversations being had, I am not privy to them, nor do I know anybody who is.

The Chair: All right.

We'll go now to Ms. Wong for five minutes.

Hon. Alice Wong (Richmond Centre, CPC): Thank you, Madam Chair.

I thank both witnesses for appearing today to brief us and educate us about the importance of a midwifery service in our nation.

During my time.... You know, I've never given birth to any children. In Asia when I was born, actually, midwives were very important. I was delivered by a midwife. That is why I have fond.... Well, I don't have fond memories because I was then a baby, but my mom used to praise the midwife for helping to have a healthy girl born to the family, so that was important in Asia in those days.

That probably leads to my next question. I think the professor did mention the importance of her students' service to cultural groups. Can you expand on that?

Ms. Lisa Morgan: It touched a bit on indigenous or francophone—from language to spiritual—but we also know there is a recognition part as well.

We have been engaging in our anti-racism work, looking at our school itself and at our graduates, and recognizing that we need Black midwives, midwives of colour. There is that recognition of what you can grow up to be, as a Black girl, when you see a Black midwife. There is also that connection to the racism that is in our health care system and that understanding and advocacy.

Like I said, there are vulnerabilities on so many levels and they're intersecting, as we all know, so training midwives who are able to best serve the communities where they work is overall what we're talking about.

Midwifery is in a transition phase right now. We are looking at our very white profession and understanding that we are not in the best position to care for all the people who need to access our services, so we're pushing even harder.

Laurentian has had this mandate, always—northern, francophone and indigenous—and it's expanding that mandate to Black and persons of colour. Inclusivity is really where we're at right now in health care.

● (1140)

Hon. Alice Wong: Thank you very much.

You said just that you don't have a voice anymore because you are no longer counted as faculty.

That leaves the question to Tom, who is now the president of the faculty union.

I have a fond memory of my own union, when I was faculty at the university college and then a polytechnic university in B.C. I definitely know the importance of the union. Now they are the voice to speak for and represent retired members or members of the faculty.

Tom, can you expand more on the importance of your role in bringing the voice of the faculty to the university?

In B.C., for example, very often when the ESL program is cut or whatever, it is because of funding. This time, it's not because of funding. Can you expand more on that and what you see is the challenge here?

Mr. Tom Fenske: I would just clarify that I am the president of the staff union. However, I feel it would be the same for the faculty unit. I hesitate to speak on their behalf, but I would say that it is complete confusion.

Arguments can be made for different programs—and I don't think that's something we would want to get into—but with regard to this program, it does not make sense. You have a program that can successfully recruit. It's funded with an envelope. It's needed in the communities that it serves. It's everything you should be looking for at a university. It's checking all of the boxes.

It's not a program where you're concerned about the funding. It's only growing. It's growing in Canada, in Ontario. We're left with complete confusion as to why this happened.

I know that if the university came to our union, or if they came to LUFA, the faculty union, I am sure there could be significant conversations to have that program remain here. However, that's not happened.

The Chair: Now we're going to go to Ms. Dhillon for five minutes.

Ms. Anju Dhillon (Dorval—Lachine—LaSalle, Lib.): I believe my colleague, Mr. Serré, will be taking my place.

[*Translation*]

Mr. Marc Serré (Nickel Belt, Lib.): I'd like to thank our two witnesses.

My questions will be for Ms. Morgan. If I have any time remaining, I'll get back afterwards to the midwifery program.

I'd like to thank you, Mr. Fenske, for the work you have been doing. These are difficult times. People have been calling what happened on April 12, "Black Monday at Laurentian University". The situation is affecting the community and the university.

[*English*]

It was a bombshell. No one expected this and this is wrong.

I am going to focus on Ms. Morgan.

Thank you so much. I want to get a bit of an explanation. The midwifery program was set up—the tri-council of McMaster, Ryerson and Laurentian—about 28 or 30 years ago, and the intent was to focus on rural, indigenous and, obviously, the francophone aspect. Now we've completely blown that up. We're sending students back to southern Ontario, where Ryerson and McMaster are one hour apart. It doesn't make any sense. I want you to explain a bit about that.

Also, I read somewhere that Laurentian had an additional cost for the bilingual program of around $200,000 or so. From your experience, can you confirm what the additional cost was to Laurentian? Was the split in revenue one-third to each institution? Was Laurentian receiving any additional dollars for the francophone, indigenous and rural aspects?

Ms. Lisa Morgan: I think the financial aspect is really important to address. The envelope was equally split three ways between Laurentian, McMaster and Ryerson, but only Laurentian was required to offer the program in two languages with that very same amount of money.

We recently made a request about a month ago to MCU that we needed an increase in funding at all three sites, but Laurentian particularly needed some additional funding to be able to offer the second language. Our translation costs are about $20,000 a year and our faculty costs for teaching in all four years of the degree adds up to $200,000, so I was making a request for an extra $220,000 to fund being able to offer the program in two languages.

It also points to the disadvantages Laurentian has had for so many years, with the expectation that it be delivered in two languages for the very same money as delivering it in one language. We could not ever get any traction that this wasn't fair and there should be more consideration given. Every single course had two streams, a French stream and an English stream. There was a doubling up right through it for no extra money, but we did it. As I mentioned, all our salaries are covered by our envelope entirely.

In terms of the only two schools, I think I said it in my remarks, there are just two schools less than an hour apart training midwives for all of Ontario. In our classrooms, our courses, we put a real focus on rural, remote and northern in everything we did. They will be receiving the same urban midwifery education as any other student at McMaster and Ryerson, without that special aspect on the teaching.

● (1145)

Mr. Marc Serré: I'm happy, Ms. Morgan, you submitted that to the tri-council for additional dollars, but are you aware if the province has acknowledged this? Has the province even approached the federal government? I see you're nodding no, so there hasn't been any request from the province to the federal government.

I wanted to ask also about out of province. You said earlier that you, Laurentian, take on students from outside Ontario at about 10%, like New Brunswick. My understanding is that every midwife in New Brunswick has been trained by Laurentian. You also have it in Nunavut, and they go back to their communities.

You mentioned earlier that Quebec has a midwifery program, but they don't accept any students outside of Quebec. No francophones are allowed to go to Quebec. I just wanted to confirm that. Hopefully, our Bloc Québécois member could support this, seeing the role that Laurentian is playing in accepting francophones from all across Canada, but Quebec doesn't play a role there. I just wanted to clarify that, please.

Ms. Lisa Morgan: The university in Trois-Rivières, Quebec, yes, they graduate about 20 midwives a year. Quebec needs those 20 midwives. In their application process, you must be a resident of Quebec to apply to the midwifery program in Quebec, so what you're saying is true. When there are francophone midwives wanted in other parts of Canada, they have historically made arrangements with Laurentian to purchase seats in the Laurentian program. As you mentioned, the three New Brunswick midwives staffing the clinic there were all trained at Laurentian through that provincial government arranging for seats in our program in Ontario.

I was in discussions—

The Chair: That's your time.

Madam Larouche, you have two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

Once again, I'd like to thank our two witnesses, Mr. Fenske and Ms. Morgan, for their testimony this morning.

As I said earlier, I'd like to begin, as a member of the Bloc Québécois, by expressing my support for and total solidarity with francophones everywhere outside Quebec. We support those affected by what happened at Laurentian University, and in particular the midwives.

We know that there are more than 250 midwives in Quebec and that there were approximately 43 [*Inaudible—Editor*]. The case has certainly drawn a lot of attention.

I'd also like to have your comments about some of the things that were said in an article published in Le Devoir. For example, it said that the cutting of the program looked like retaliation against a female profession, and that it had been condemned by observers of the midwifery community.

In the same article, Marie-Pierre Chazel, a Montreal woman who received pre- and post-pregnancy monitoring care from midwives, said that it was really an attack on women.

What do you think? Is this retaliation? Does the work of midwives get enough recognition?

[*English*]

Ms. Lisa Morgan: It feels like both. I think you've said that it's a female profession that's under crisis, females serving females. We're talking about women's health care here, which is chronically underfunded, recovering often from previous cuts.

Like I said, we were recently engaged, or I should say still engaged, with the Human Rights Tribunal of Ontario about pay discrimination based on gender. It's been going on for many years and has cost us a great deal of money out of pocket. Each of us midwives has to contribute to those legal bills. It's very political. It feels very difficult. It's historically feeling unsupported. The profession can feel quite unsupported, and that certainly translates into the midwifery program as well.

When a cut happens like this, that none of us can understand or justify, “misogyny” is a word that's been used.

● (1150)

The Chair: Now we'll go to Ms. Mathyssen for two and a half minutes.

Ms. Lindsay Mathyssen: Thank you so much.

We talked a little bit about—or Tom, I think you mentioned—the CCAA. It's never been used against a public institution, and the New Democrats were very concerned that it would be used not only, as a start, against a public institution such as a university but could expand further.

Can you talk about your experience and the experience of your members once Laurentian was granted CCAA protection?

Mr. Tom Fenske: Sure. It was two months of hell. I don't know whether I'm allowed to say that word, but I did. It was dollars and cents. I wasn't Tom Fenske; I was just an FTE, a full-time employee, a number.

It was just a head count procedure to try to get as many people out the door as possible, and midwifery offers the perfect example of why you can't use it in the public sector. It's not a private industry. It's a public sector institution that serves the public. If this were something that could be used in the public sector, there would have been carve-outs and a conversation around “No, wait, this is a program that services the north, that services indigenous and francophone women”, but it didn't and it doesn't care.

This process doesn't care. It's cold, run by lawyers from Toronto, and it was.... In any argument that you can make that was sound, it was as though you were talking to a wall. It was “Get people out the door. Salary, benefits...we need to reduce those, so get as many people out the door....”

Right now the university is scrambling, because they have cut too deep, too far, and people are.... I've received two emails today about people who had to go on sick leave. You're walking through a war zone where there are things all over the place and you don't know what's what. I couldn't even tell you what my department's name is right now, because that's being figured out.

That's part of the problem. If this were something that could be used in the public sector, then midwifery would still exist, because everybody recognizes why it needs to stay at Laurentian and why it needs to stay in the north.

The Chair: Very good.

I think we have time for one more question for the Conservatives and one more for the Liberals, so we'll go to Ms. Sahota.

Ms. Jag Sahota (Calgary Skyview, CPC): Thank you, Madam Chair.

Thank you to the witnesses for being here.

I'm going to echo what my colleague Ms. Nelly Shin said about our finding out a lot of information about this program, right here today, and from learning quite a bit. I've heard some background from my grandmother, who grew up in India, where this was the main method, if that's the right word, used by people in small villages, for example, or even the bigger cities back when she was younger. All of her kids were born with the help of a midwife.

Lisa, you spoke about ethnic communities and focusing on bringing in people from different cultures. I'm wondering: Is there a difference in the students who apply for this program and taking the services of midwives into ethnic communities?

Ms. Lisa Morgan: This is exactly what we're seeing. We're seeing many people dream about being a midwife who may not have dreamt of it before. We had a real intention in having these mandated populations and creating midwives for these communities.

Many of the news stories over the last couple of weeks since the school was closed have featured some of our Black midwifery students working in Ottawa, francophone students and indigenous students who are coming forward and fighting hard for this program. This was a dream that they dreamt and are realizing, and they see the need to serve their own communities. It is a beautiful, growing thing that was taking shape here, and it feels really that it has been cut off at the knees.

● (1155)

The Chair: Now we'll have a final question from the Liberals. I'm not sure which of my Liberal friends will ask it.

Monsieur Serré.

[*Translation*]

Mr. Marc Serré: Thank you, Madam Chair.

[*English*]

Ms. Morgan, you mentioned that you have always, for 30 years, been dealing with the provincial government on this. It's clearly a provincial jurisdiction, but I want to ask you what you feel the federal government could do, what its role is when we talk about inclusiveness, when we talk about francophone and indigenous populations.

Right now, we haven't received anything from the province over the last 30 years or even recently. If we don't receive anything from the province, what recommendations do you have for this federal committee for the role of the federal government to support you and the program?

Ms. Lisa Morgan: I do understand that the federal government has been hesitant to speak because universities are a provincial matter, but when we talk northern, francophone and indigenous, I do not see that as a provincial matter, particularly when we talk about indigenous nations that [*Technical difficulty—Editor*] provincial boundaries. When we talk about training midwives for the north, we're not talking about just Timmins. We mean Nunavut and northern Quebec. The same skills you need to provide health care in a low-resource setting apply to all of those settings. Francophone is national...one of the two official languages.

Particularly for the northern, indigenous and francophone, I think it's imperative that the federal government step in, as these are groups that are disenfranchised. They need that additional support and advocacy. That is needed for midwifery right now. I don't think it's confined to a provincial matter when we really think specifically about what the mandate of our school was.

The Chair: I think that's an excellent place to leave it for this panel.

I want to thank our witnesses for doing an excellent job today.

We're going to suspend momentarily while we do the sound checks for the second panel.

● (1155)

_____(Pause)_____

● (1200)

The Chair: I want to welcome our witnesses for the second panel.

We have Angela Recollet from the Shkagamik-Kwe Health Centre. We also have with us Buffy Fulton-Breathat, who is a registered midwife with the Sudbury Community Midwives.

I'll introduce Naomi when she comes along.

Each of you will have five minutes for your opening remarks.

We'll start with Angela. You have five minutes.

Ms. Angela Recollet (Chief Executive Officer, Shkagamik-Kwe Health Centre): I won't go into my introductions. I have to say that everybody here in the north is completely disheartened with the state of our community university. I held my post at Laurentian from 1994 to 2010, so I've been witness to several successes of our community-led and community-driven institution.

As a status Indian, if you will, we've had.... I heard our previous witnesses speak about the mandate of Laurentian University having indigenous, francophone and anglophone affairs, but in fact that tricultural mandate began with us as indigenous people. Just so you're aware, I do not like the term “indigenous”. I am Anishinabe, and this is Anishinabe territory.

We were very adamant about making Laurentian University a tricultural university and honouring the original people of this territory. We had to fight extremely hard to make that a reality.

As you can see, I am uncertain as to why the state of affairs at Laurentian has gotten to where it has. As an indigenous woman, as an *anishinaabekwe*, we are consistently under a microscope of accountability. We have to identify to the cent every penny that we spend, with full detail. To allow the university, an institution that is run systemically, to have such disgraceful unaccountability is just beyond somebody of my stature when it comes to leading Anishinabe affairs in this community. We have to continuously write 60-plus pages of proposals, whether it's the provincial government or the federal government, to identify simple access to services for indigenous people in this country that you now call Canada. For simple $60,000 requests, it's 60 pages to identify and prove why we require these services.

I'm going to stop about the disgrace of the university and the fact that both provincial and federal governments allowed this to happen the way it did. I think everybody has accountability.

I want to talk about the inequities of the north and the south that continue to happen to this day. I'll speak from many different lenses, first, obviously, as an Anishinabe woman, and second as a citizen in these territories. I will not get into a disagreement with the northeast and the northwest. That happened many moons ago, when we established the Northern Ontario School of Medicine. I'll speak directly to midwifery in just a moment, because I have several recommendations.

I'm a grandmother of five. We have always accessed midwifery. Prior to colonial practice and colonization and Canadian and Crown policy, we depended solely on our midwives. Our indigenous midwifery is a time immemorial practice and has been honoured and respected to this day. Obviously, with Crown policy and practices like the Indian residential schools...and even today that hasn't disappeared. It has just evolved into child welfare systems. Everybody needs to take a hard look at that, because they're still taking our children.

Prior to any of that contact, our midwifery was absolutely honoured. This was the fact of our life. This was our cycle of life. Without our midwives, we wouldn't exist in the harsh terrains that we once resided in. I'm a huge supporter of midwifery. In fact, with the Shkagamik-Kwe Health Centre, we are one of 10 aboriginal health access centres in the province of Ontario and the only one of their kind in what you now call Canada.

In the last decade, we strived to negotiate with the province and established a very reciprocal, respectful relationship to ensure that it's a partnership and we don't have the province dictating to us on what has to be and what can't be. We work together to find resolve. We have now expanded our sector to approximately 28. That includes the aboriginal health access centres, aboriginal community health centres and now the indigenous interprofessional primary health care teams, along with indigenous family health teams and aboriginal midwifery.

The 10 AHACs were a pilot—

● (1205)

The Chair: I'm sorry. That's the end of your five minutes. We'll have to get your recommendations when we come to the rounds of questions.

We'll go to Buffy for five minutes.

Ms. Buffy Fulton-Breathat (Registered Midwife, Sudbury Community Midwives, As an Individual): Hi there.

I'm a practising midwife. I'll be working full time again this summer delivering babies in the Sudbury area. I'm a former faculty member and a graduate. I'd like to speak on the impact this has had both on the women and the students who benefit from midwifery education and midwifery services in the north.

In 1993, when the decision to have a site in the north for midwifery education was made, it had a huge impact not only on the availability to the learners who wished to become midwives but also on the women of the north. The location of the program in Sudbury meant that a midwifery practice started in Sudbury. We've now delivered over 7,000 babies through our midwifery practice. That practice was founded by the midwifery faculty at the university. It also provided a firm foundation for midwifery to spread across the north.

I know this has already been addressed with your previous speaker, so I don't want to go over it or belabour it too much. I've provided Monsieur Serré with a graphic. The practices in Attawapiskat, Kenora, Thunder Bay, Sault Ste. Marie, New Liskeard, Temiskaming and Hearst are populated by northern graduates. Having a site in the north is tremendously important for the retention of these graduates.

I can speak to that personally. My mother left the north for education. She stayed in southern Ontario. I returned to the north. I've worked in Attawapiskat; I've worked in Sudbury. I've committed my professional practice to the north, which is a consistent theme among students who are educated in the north.

The year 2020 was the international year of the midwife. Perhaps it was foreshadowing that Laurentian University did nothing to celebrate the international year of the midwife and our program. That's my personal bias.

My point is that midwives matter. Midwives matter in women's health care. We're recognized for our ability to work well in low-resource settings. As was said by one of your previous witnesses, we have no hesitancy in attending people in their homes. I can speak to my own midwifery practice. During COVID, our out-of-hospital birth rate has been 50%. People have been afraid to enter hospitals. Midwives service that portion of the pregnant population. Nobody else does. Nobody else will attend people in their homes. The impact of having a known care provider provide you with 24-hour care and to have access to them by phone or pager is immeasurable.

In addition, I just wanted to speak to the fact that several of my former clients are now midwives. They became my students, which was amazing. They were empowered by their birth experience to elevate their education, to realize their potential and to contribute to the well-being of the people in their communities.

I think it's a particular strength of midwifery and of our northern program that we have a specific mandate to incorporate francophone, indigenous and northern students into our learning population, because these are the people who are experts in their own communities and they return to their own communities to provide those services.

That's all I wanted to say. Thank you.

● (1210)

The Chair: That's very good.

I see that Naomi Wolfe is here. Welcome to our committee. Let's do a sound check and then we'll give you five minutes for your opening remarks.

If you want to start your remarks.... It sounds like there's a little feedback or something.

Ms. Naomi Wolfe (Registered Aboriginal Midwife, Shkagamik-Kwe Health Centre): Angela and I are in the same room and I was on the line trying to connect to get logged on with one of your IT support people.

My name is Naomi Wolfe, and I am a registered midwife at Shkagamik-Kwe Health Centre. I have been practising midwifery for over [*Technical difficulty—Editor*] years and—

The Chair: We're having a little technical difficulty with the Internet connection. I think the IT technician will reach out in a minute. We'll suspend until we can get it fixed.

● (1210)

_____(Pause)_____

● (1210)

Ms. Naomi Wolfe: I am Anishinabe. I come from Brunswick House First Nation, which is in northern Ontario. I have lived in the north my whole life.

I actually trained as a midwife in southern Ontario, which is the opposite of what we were saying. The reason is that I wanted a foundation of midwifery from our perspective as first peoples of this land, so I trained as a traditional midwife at Six Nations of the Grand River Territory [*Technical difficulty—Editor*].

● (1215)

The Chair: Yes, we'll have to suspend. We're losing you again.

Let's have the technician take a look at it. I do apologize. This is the challenge of Zoom in this current time.

● (1215)

_____(Pause)_____

● (1215)

The Chair: We will hear from you, Naomi. Thank you for your perseverance. We want to hear your testimony.

Ms. Naomi Wolfe: One more time.... Here we go.

I already gave a bit of introduction and context on how I came to midwifery and my personal story, and why I feel midwifery in the north needs to remain in the north.

My biggest recommendation obviously is that we need to maintain midwifery education in the north. I think we also need to rethink the way we deliver midwifery education from an indigenous perspective and how the model of midwifery care works in our indigenous communities. There have been multiple studies done and master's and theses on how this needs to be an expanded interdisciplinary care model and that midwives play a huge role in bridging and supporting the gaps in health care in our northern communities.

Midwives have been filling this responsibility, without all of the recognition that we should have been receiving and the support we should have been receiving this whole time, to improve morbidity and mortality rates in our northern communities. This has always been perceived or labelled as a temporary solution, when it's actually the gold standard solution that we have midwives in the north who are educated and trained in the north, particularly in our first nation communities, so that we have our babies being born at home in the community with the safest care possible.

My number one recommendation is that midwifery education stays in the north, that we find a way to offer midwifery education that is interdisciplinary and focuses on indigenous ways of learning, thinking and doing, and that it's led by our communities and our leaders in a way that is reflective of the needs of our communities.

● (1220)

The Chair: Super.

We now go into our first round of questioning then for six minutes with Ms. Sahota.

Ms. Jag Sahota: Thank you, Madam Chair.

Thank you to the witnesses for being here today.

Like I said to the last panel, we're learning a lot about midwives and the role that they play, so I'm going to continue on with my questions around that. My question is for Buffy.

You spoke about being a midwife and now having students. What is it like? When do you guys get involved, at what level and at what stage? How is the continuity of care provided throughout pregnancy and when does it really end? We spoke about mental health issues, helping with that. I'm sure you're not just midwives; you're also acting as their counsellors, their support in many ways. I'm just wondering if you can speak to that, please.

Ms. Buffy Fulton-Breathat: Our role in people's care commences at conception, so as soon as people find out they're pregnant, they're welcomed into our midwifery practice. Most people meet their midwife at seven or eight weeks of pregnancy, and then we maintain that involvement until six weeks postpartum. Our mandate is to care both for mothers and newborns until six weeks postpartum.

Yes, you're right, it does involve more than just the provision of hands-on care. It's a unique relationship. Without going beyond our scope of practice, we're not counsellors; however, we do end up being advocates for assisting our clients to find services, particularly during COVID when there has been a significant impact on people's mental health and their feelings of safety around where they're giving birth, who's taking care of them, how many people are they being exposed to, all of those pieces.

I think midwifery has serviced very well by having a small team of one or two midwives taking care of somebody, as opposed to saying it's shift change and this is the next nurse who's going to take care of you, or it's shift change and this is the next obstetrician who's going to take care of you.

Ms. Jag Sahota: That's interesting when you said it's a couple of midwives. How does that work? Within the same area, will you find two midwives who are going to be there? There are not going to be changes like from one midwife to the other, to the third one, to the fourth one. I'm just trying to get a sense of how...because you'll get to learn a lot about the household, the health of the mother, the child and all that, which requires having the same midwife, or one or two of them, to be involved.

If you can speak to that, how is that determined? What is the normal course of that?

Ms. Buffy Fulton-Breathat: You're speaking to continuity of care. Because I cannot be available 24 hours a day, 365 days a year, our clients are assigned a team of two midwives. When I was working full time as a faculty member, I had a team of three midwives to ensure I could teach the learners and still have a known care provider available to the person. At the outset of care, people are assigned their team of midwives, who will rotate and whom they'll meet to ensure that they have developed a relationship and they know the person they're paging at 4 a.m. when they're going into labour.

We're minimizing the number of people involved and ensuring a continuity in that relationship from conception to postpartum.

● (1225)

The Chair: I believe Ms. Wolfe also has a response.

Ms. Naomi Wolfe: I wanted to echo why the need for midwifery expansion in the north is so important, because Buffy talked about these teams of midwives and not having the ability to provide 365-day-a-year care. In our communities, that is happening with midwives who don't have the support or the bodies or the extra midwives to support them in that.

For example, I work and live in an urban centre where there are many other midwives, but I am the only indigenous midwife practising out of my practice, so I provide 365-day care, around-the-clock care. If I am physically not able to be present, then I'm at least reachable for our clients so that I can send them in the right direction for the care they need.

If we don't have more midwives, this happens. We have a midwife in Elliot Lake who is very similar. There are many midwives in smaller, more rural parts of our community that don't have multiple midwives to support them in that work. That's again why it's so important that we have more midwives trained in the north.

Ms. Jag Sahota: You both spoke about how COVID has increased at-home births and the comfort level that clients feel when they can give birth at home as opposed to going to the hospital. Have you also seen an increase in diverse communities, ethnic communities, where they're getting more comfortable using the services of midwives?

Anybody can answer.

Ms. Buffy Fulton-Breathat: I was just pausing to see if Naomi was going to speak.

Certainly in Sudbury we have noticed that. One of the things we track through BORN, the Better Outcomes Registry and Network, a statistical database, is the ethnicity of the clients for whom we care. As we make inroads into particular ethnic communities we discover, through word of mouth, that trust relationship gets enhanced and built.

Certainly, yes, we have noticed a difference. With Laurentian having a strong international student program, the international students were one of the areas where we noticed a big impact.

The Chair: Very good.

Now we'll go to Monsieur Serré for six minutes.

[*Translation*]

Mr. Marc Serré: Thank you, Madam Chair.

I'd like to thank the three witnesses for their commitment to the program, to northern Ontario, and to indigenous people.

My first question is for Ms. Recollet.

Could you tell us more about your recommendations, given that you never had the opportunity to finish your comments about this matter?

Ms. Angela Recollet: Thank you, Mr. Serré.

I'm sorry, but I don't speak French.

[*English*]

I think you were asking me if I have recommendations on how we can retain the midwifery program in the north. Is that what you asked me?

Mr. Marc Serré: That's correct.

Ms. Angela Recollet: Not bad, eh? I've been hanging around with you too long, or not long enough.

I have several recommendations. You all heard my opening remarks about my passion and compassion for this territory and more importantly, my corporate history with Laurentian University, and several developments, one of which is the Northern Ontario School of Medicine. Again, we are completely disheartened and we have taken on mass advocacy to lobby with government partners. The Northern Ontario School of Medicine was founded upon a tri-cultural relationship in the north with Goyce Kakegamic, Geoff Hudson and Dr. Augustine amongst many grassroots native people, along with our chieftains to ensure that we were creating a school in the north that remains in the north and that we provide expertise to the learners to break down the systemic racism in the health care system by identifying, recruiting and retaining aboriginal people and increasing their success rates in medicine to ensure that we can provide a platform of care for our people by our people.

We have been pushing to ensure that NOSM remains an accrediting body, which it already is, and maintains its degree-granting status. I will not fight with Thunder Bay and Sudbury and have the argument of northeast and northwest. That argument began in 1997, and I want to believe that we established a solution-based approach to ensuring that the medical learners had a vast geography to learn in.

I'm still uncertain how on earth they could have allowed funding that was specific to midwifery to be spent and not accounted for. I also note that other universities in the province of what you now call Ontario are trying to get dibs on our midwifery program, and I am completely against that. This midwifery program, just like NOSM, was created in the north by the north and needs to remain in the north.

I would strongly support and I plead with all of you for your influence to ensure that there is some accountability to retain Laurentian but, more importantly, if there's a way, to make NOSM degree-granting and to make midwifery its own school with its own authority and accountability process, partnered with NOSM.

● (1230)

Mr. Marc Serré: Thank you for those recommendations.

Ms. Fulton, 20% of births happen with a midwife. I don't understand why that number's not higher. I had two of my girls with midwifery. Can you go into the details a bit more about the biases? No one understands why this was cut by Laurentian University. No one understands this. Was there a bias within the medical profession, within the university, with the minister of health?

Why was this program cut and why don't we as a society utilize midwifery more often as continuing care?

Ms. Buffy Fulton-Breathat: To start with the utilization, we are underpopulated as midwives to service the demand, in fact, and about 40% of people in Ontario who wish to have the services of a midwife don't get the services of a midwife. Those are the numbers that the Association of Ontario Midwives put forth. Out of every 10 women who ask for midwifery services, six get it and four do not.

I can speak to my own practice. We have 90 women on a wait-list for the months of July and August alone for our little practice. That's 90 women who will not get the services they're requesting as a consequence of the lack of availability of care providers. Now, that's not a consistent demand around the calendar.

Normally, we do have wait-lists, but the only way that we're going to grow midwifery, address those wait-lists and address those four out of every 10 people who are seeking midwifery and don't get the care is to have a program that, one, is situated around the province—not focused in the GTA—and that, secondly, permits graduates to maintain at the same level we have or at an expanded level.

As has previously been said, right now what limits our capacity to grow is the availability of preceptors: those midwives and graduates who supervise the learners. We do have some self-imposed limits. That's why only a hundred students are taken in across the consortium each year. However, we had just started to address unique ways of expanding this, such as, for example, not recognizing provincial borders for students who are coming from other provinces, because Laurentian really was educating the country, not just Ontario.

As was previously said, all the midwives in New Brunswick graduated from Laurentian. We regularly take in students from the Northwest Territories, from the Yukon and from all across the country, because there were only six schools of midwifery. Now there are five.

The Chair: Very good.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Ms. Andréanne Larouche: Thanks very much to the three witnesses, Ms. Fulton-Breathat, Ms. Recollet and Ms. Wolfe, for their testimony, and in particular their contribution to midwifery.

I'd like to do what I did when we received the previous group of witnesses. You mentioned the importance of having a university outside of Toronto in northern Ontario. I'd like to mention that because we, the Bloc Québécois, naturally give you our full support. My colleague from La Pointe-de-l'Île has made himself clear on this matter, and has shown his full support for the cause.

The situation is extremely shocking and deplorable. We know that the francophone communities cannot really do without university programs in French. It's therefore absolutely essential to do something. You referred to how important this university was for midwives across Canada, and for the francophonie outside the province, because while this university has a strong presence in Ontario, it also serves people in New Brunswick, the Yukon and elsewhere.

I'd also like to point out that this whole incident is being monitored very closely in Quebec. We already have our own legislation on midwifery services. We have a legal and regulatory framework that is supervised by the Ordre des sages-femmes du Québec.

What do you think about the fact that there is a university in northern Ontario with outreach all over the place, even in Témiscamingue, and that it has to handle the relationship with Ottawa? In Quebec, we already have legislation and an association for midwives.

I'd like to hear your comments on this.

Would you like to begin, Ms. Fulton-Breathat?

● (1235)

[*English*]

Ms. Buffy Fulton-Breathat: I'm not entirely certain that I'm understanding the question you're asking.

[*Translation*]

I apologize, but my French isn't very good.

[*English*]

Are you asking how the association is integrated to ensure that French-language services are provided across the province?

[*Translation*]

Ms. Andréanne Larouche: Yes, and I'd also appreciate it if you could speak to us about the extent to which the university is needed to perform such a role. Don't forget that Quebec and the provinces also have a role to play. Many of the aspects involved in midwifery services, such as university education and health, come under provincial jurisdiction.

[*English*]

Ms. Buffy Fulton-Breathat: At the provincial level, I think the most important thing is to continue to support midwifery practices and their growth and their expansion, because these are the sites that become the areas for learners to refine their skills while they're still undergraduates. That hasn't been an issue. The Ontario government has actually committed to funding every graduate midwife—who then become the future preceptors of our learners.

There is still much of northern Ontario that is not serviced by midwifery. I named about nine practices in northern Ontario, and those are the only nine practices. It's highly limited. There are many communities that are lacking midwifery services right now, so it's essential that we continue to have 100 or more graduates to populate those areas to allow people to be provided services in their first language, in their chosen language, whether or not that is English or French, and that we have a program that allows learners from those communities to be educated in their first language.

Ms. Angela Recollet: *Meegwetch*, Buffy, for your remarks.

If I can chime in, Madam Larouche.... Again, I didn't have my translation on, but I caught some of what you were asking.

I do want to share really quickly.... The relationship in Quebec—I guess my question is a rebuttal back to you—is your relationship with the Cree nation. The Cree nation in northern Quebec is a very vibrant community that has taken a very political stance in ensuring that relationships happen, specifically with leadership—in the past with Matthew Coon Come and the hydro dams to ensure that there's revenue-sharing with resources. They've been able to sustain their educational cultural identity, along with their health authorities, to ensure that Cree midwives are happening.

It is not the same as soon as you cross one side of that James Bay border; it's a very different reality. We are now working directly with the Ministry of Health and Long-Term Care, which has been critical, as I was stating in my earlier opening remarks, for the importance of indigenous midwifery in what we now call Ontario. As I was stating, the Shkagamik-Kwe Health Centre is one of two aboriginal health access centres that received specific aboriginal midwifery funding, and the province itself is coming back to expand our program here in the north to ensure that we can continue to recruit and retain aboriginal midwifery.

That is not the case if we lose our midwifery school. Our school is critical to ensuring that we continue to expand this service. Even Sudbury.... It's disgraceful to say that we're in the north. When we talk about the north from an indigenous perspective, we're going into fly-in communities that still don't have access to clean water, so we can't even provide midwifery because they don't even have access to clean water.

● (1240)

The Chair: Ms. Wolfe would like to make a comment.

Ms. Naomi Wolfe: I just want to echo a little bit what Buffy was saying: that communities should be able to access education and care in their languages. You also asked about some accountability structures. I can think of an example where a community midwife from Quebec had strict limitations placed on her ability to open and set up practice because she was not francophone-speaking. However, her community is Algonquin and English-speaking, and nobody in her community would require access in French. Because of the regulations in how midwifery care is delivered in Quebec, there were significant roadblocks and challenges to her being able to set up a practice and provide care in her community.

I would probably imagine that similar things are happening for midwives who are wanting to work in their northern communities and Cree is their first language.

The Chair: Now we'll go to Ms. Mathyssen for six minutes.

Ms. Lindsay Mathyssen: Thank you, Madam Chair.

We heard in this panel and the last, as well, about the importance of the relationship that women have with their midwives, and that is a special relationship because it is fully about trust. Delivering in the best of situations is very stressful—not that I've done this yet but so I've been told by many friends.

To have services in your own language, to be able to be serviced in ways that are culturally appropriate and culturally sensitive.... Could the witnesses talk about the importance of that, in addition to—and I know that Ms. Recollet and Ms. Wolfe are in more of an urban centre—the special needs for northern remote, as you also mentioned before, communities and women having access to those culturally sensitive, traditional knowledge-based practices with indigenous or aboriginal midwives?

Ms. Angela Recollet: Naomi, would you like me to go first on this?

Ms. Naomi Wolfe: Yes.

Ms. Angela Recollet: We're not just going to talk about Ontario and Quebec. We need to talk about what you now call Canada as a whole.

I'll give you an example. With the Inuit nation, those mothers, those expectant mothers, have to be displaced from their communities and their families, with only one individual to accompany them as a support system, and have to travel hours and hours, sometimes 40 hours, in order to get to a nursing station to have a non-Inuit or non-native practitioner provide care that is unsafe, lacking cultural bias to their birthing right. That in itself has to be recognized. A solution-based policy would be to provide access in our traditional territories. We do not want to be displaced anymore, and that goes from coast to coast to coast when it comes to our circle of life.

Even here in an urban setting, as you're asking, it wasn't by choice that we were located to urban settings, but I can say that 80% of the indigenous population in what we now call Canada has been displaced to urban settings so that they can have the same access to care that all of you on this call have.

We continue to have to fight for this, to reclaim who we are as indigenous people in these first territories with limited access to resources and constantly needing to justify why we require it. Right from birth to death, this is our ongoing struggle and our ongoing education that we need to provide to newcomers, to government officials, to everyday people walking down the street, to break down what you've learned and provide you with a different education so you know the true history in Canada.

Ms. Lindsay Mathyssen: One of the calls to action from the Truth and Reconciliation Commission, number 16, was a call for post-secondary institutions and the creation of the understanding that culturally sensitive and inclusive programs that are indigenous-led but also in the indigenous languages be provided.

With the direct closure of Laurentian University's indigenous midwifery program, do you see that as obviously contradictory?

● (1245)

Ms. Angela Recollet: Of course, and in fact, I just want to share some history. This is far prior to the Truth and Reconciliation Commission's 94 calls to action.

These recommendations happen and we're continuously having to repeat history, and it goes back to the the Royal Commission on Aboriginal Peoples in what you now call Canada. These same recommendations were heard then, and we're still having to tell our story now.

With the RCAP recommendations, we established the AET strategy. The aboriginal education and training strategy was established in 1989-90 and incorporated in 1991. Laurentian University was a recipient of that AET strategy, and that strategy included the recruitment, retention and increased success rates of aboriginal people in post-secondary education. That included colleges and universities, and that also included the reclamation of our languages.

I can speak to this very eloquently because I was the one who was leading it. We strived to ensure that the reclamation of our cultural identity was celebrated and that it was recognized, just as the francophone population demands success and demands that they have authority to deliver their programs, their education. The problem is that we're working in your system, in your institutions, and you're still not recognizing our form of education, our form of governance, our language, our culture, our birthing right, our inherent right to take care of our own people.

That will always be an issue and we will continue to have these conversations, and I hope to goodness that when my five grandchildren are at my stage of life, they're not having to continue to educate other citizens in what you now call Canada.

You can see my passion about this.

The Chair: Yes.

Ms. Wolfe had her hand up.

Do you still want to say something?

Ms. Naomi Wolfe: I did. I wanted to be very clear that you mentioned that Laurentian had cut its indigenous midwifery program.

It was not an indigenous midwifery program, and that definitely would be one of my recommendations moving forward. That is at the core of how, for a huge.... I realize that we also need to support our francophone students as well, but Laurentian did a very poor job at that, and this is an opportunity, now that this has happened, to do a much better job at this being indigenous midwifery by indigenous midwives and community, and that is at the core of how that education is going to be delivered to indigenous communities.

Angela talked a little bit about the north. We need to really be able to support expansion of care in the north and have appropriate care providers so that women can stay in the north and there is a trained birth attendant regardless of.... When we put these labels of scope and practice that there are appropriately trained providers in communities who can do prenatal care and education to help our communities be healthier so that they can stay in community to have their babies....

If there are births happening in community, and we have the right skilled people there to be able to deliver these babies in safety, we can improve the morbidity and mortality of our communities, starting with pregnancy and childbirth.

The Chair: I wonder if, in the time remaining, the committee would be okay with each party having a question, since this was Ms. Mathyssen's motion. Is that okay? Very good.

We'll go then to Ms. Wong.

Hon. Alice Wong: Do I have one question or five minutes?

The Chair: You have one question.

Hon. Alice Wong: After listening to all the witnesses, instead of closing the program, in fact, it should be expanded because there's such a great need.

I also heard about national accreditation. I think that's a great idea, because in order to.... That would be for the rest of the nation, as well, but of course, our focus is on Laurentian right now. The degree-granting status is very important, so I'd like to ask the panellists to comment on that part.

Ms. Angela Recollet: Buffy, do you want to take the lead here?

● (1250)

Ms. Buffy Fulton-Breathat: Sure.

I was going to comment on that and say that, in whatever new entity a third site becomes, wherever that may be, one of the things that we had already identified as really important was that we do have a true tri-cultural mandate. Even if we were still confined to 30 spaces, make sure that's one-third English, one-third French, one-third indigenous learners as the population, recognizing that there are different ways of knowing.

One of the things that we were confined by at Laurentian, because of a hiring freeze, was our ability to hire full-time faculty who identified as being experts in indigenous knowledge. We recognize that. It was something that we couldn't address, so I think that would be really important going forward, hopefully expanding beyond the number 30 with the ability to have out-of-province placements, recognizing the provincial boundaries as being permeable, as being a colonial entity.

I don't want to step into that too much. It's not my area of expertise, but at the same time, it's really important that we stop confining this to being just an Ontario issue, because midwifery is a national issue.

[*Translation*]

The Chair: Thank you.

Over to you now, Mr. Serré.

Mr. Marc Serré: Thank you, Madam Chair.

As we don't have much time left, I'd like to focus on one point.

[*English*]

To all the witnesses, please, if there's anything that you want to submit in writing afterwards, please do so.

I want to ask Angela and Naomi: Can you explain a bit about, when we look at midwifery, the aboriginal community, which is where it started, and the ceremony of birthing? Can you provide some education here to the committee about that, please?

Ms. Angela Recollet: Naomi, you can go ahead here.

Ms. Naomi Wolfe: I'm trying to follow exactly what it is that you're asking. Is it how we deliver services in a way that's reflective of our traditional practices?

Mr. Marc Serré: Yes.

Ms. Naomi Wolfe: I think number one is knowing the history and the context of where people come from in their particular story or situation, and how their home or their community or family has moved through that trauma that they've been through. Also, it's recognizing the diversity of our communities in terms of how we share and learn and bring babies into the world in a way that is traditional to us, and what that looks like. I think it's just being genuine in the care that we're providing and understanding the historical context, and then the knowledge about those ceremonies and that commitment.

We always say, we know when we're walking this road that there's so much we need to learn. We need that openness to continue to learn those stories and to support families, in parenthood and childbirth, to have the birth that is reflective of what their community knows and where they've come from. In order to do that there has to be an understanding of their history and their specific community.

At Shkagamik-Kwe we have a whole traditional team. All of our clients access both midwifery and physician OB care when and if needed, and vice versa. Those with high-risk pregnancies also have access to traditional support and midwifery care so that we can normalize birth and make it a safer experience for families.

That's very much the role that I take on at Shkagamik-Kwe. I look after every woman who comes through that door so they're not turned away from midwifery care, they're not turned away from having care, like Buffy talked about. Their practice has to cap. We don't do that. Anybody who comes in has the support of the midwife, our obstetrician or our nursing, our traditional team and program.

We land in this urban centre, and we come from all different parts of Turtle Island. Wherever they come from, we are supporting the knowledge and the stories of each individual family, and how we can help them have the safest birth in terms of, obviously, medical safety, but also safety in terms of how they give birth to and care for their little one.

[*Translation*]

The Chair: Thank you very much.

Ms. Larouche, you have time to ask one question.

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

Once again, I'd like to thank the witnesses for being here with us today.

I already mentioned my support for the cause at issue concerning Laurentian University, and for francophones, and I'd like to reiterate my support, and the support of the Bloc Québécois, for the Cree communities and all the other indigenous communities. Quebec has forged a special relationship with indigenous communities, and I feel that it's important to move in this direction.

The relocation and closing of this program would have a disastrous impact on indigenous families in the region, and midwifery services are particularly important for indigenous families. If I have understood you correctly, this is what we should remember from your testimony.

I'd like all three of the witnesses to make brief comments about this.

● (1255)

[*English*]

Ms. Angela Recollet: Thank you for your question.

I think we'll just reiterate what we've already stated. When it comes to your leadership in what you call Quebec, your partnership and the reciprocal respect that is required to continue and to evolve with Cree nations—Algonquin nations—within Quebec is paramount to ensuring that the systemic racism that happens in the health care system, and not just in Quebec but right across what you now call Canada.... Everyone needs to stop racism in its tracks. We're human beings. We require the same humanity that everyone in what you now call Canada has.

Going back to midwifery, first of all, the school has closed. Let's be clear on that. This, right now, is our lobbying and our advocacy and our pushing back to both provincial and federal governments to ensure that individuals in what you call the north—but again, Sudbury and Thunder Bay are certainly not northern communities....

We're looking at indigenous communities that are fly-in, that don't have road access, that don't have access to clean water. That is why it's paramount for us to ensure that midwifery programs developed in the north stay in the north. We require every effort from every individual who is in a decision-making position to advocate, to lead and to ensure that the midwifery program remains here and that we collectively identify solutions and what those look like.

You can't make those decisions without us. It requires us to lead this. We know our territories. We know our population base, and we partner with one another. We respect our francophone partners as equal partners just, as you've heard from Buffy, as they recognize us.

That, however, is still not the case in mainstream society. Systemic racism is very much alive. It continues on a daily basis. We see it in hospitals. If you had a true, regulated degree-granting institution in which the midwifery school were recognized to have an equal part in authority with those three tri-cultural places in what you now call Canada, then we collectively could break down some systemic barriers.

The reason Naomi, once an aboriginal midwife, chose and then began her registered midwifery program was so that she could have access to hospital privileges. Right now, aboriginal midwifery does not have access to hospitals. There are many systems that we need to break down to recognize that western education and governance does not hold the monopoly on knowledge. It does not hold the monopoly on how we provide service—

The Chair: I'm sorry to cut you off, but we're running out of time, and I want to give Ms. Mathyssen the chance to ask the last question.

Ms. Lindsay Mathyssen: I wanted to hear, actually, the end of that. I think I'll give my time for that, if you want to continue.

The Chair: You can continue, then, Angela. Thank you.

Ms. Angela Recollet: Thank you, Lindsay.

Again, this is not western and Crown governance, Crown policy does not hold the monopoly. We have a multicultural platform here. I see many women who come from very different territories in *Shkaakaamikwe*, which in the Anishinabe language means “Mother Earth”.

You all have your land that you are responsible for, that you retain. You've had the access to retain your language, your culture and your identity. We as indigenous people deserve those same rights. That is what I plead for, to ensure that when we're making decisions, they do not always reflect the Crown's and the government's way of systemically removing our indigenous right, our language, our culture and who we are as a people, but that they celebrate that we are the original peoples of these territories.

We don't own these lands. We're simple custodians. We deserve the same access that everybody on this panel has been given the right to.

I'll leave it there. *Meegwetch*.

The Chair: *Meegwetch*.

Ms. Wolfe, you may have a final comment.

Ms. Naomi Wolfe: I just want to expand a little bit on what Angela was saying. Even just delivery of care and education in care need to be expanded. It needs to be an expanded model of midwifery care outside the confines of the limitations that provincial regulatory bodies put on it. The delivery of care in our northern communities needs to be reflective of the demographic of women who are there and of how midwives can provide that care. We need training and more collaborative care models and expanded scope so that we can improve the quality of care in our northern communities as well.

● (1300)

The Chair: I want to thank the witnesses for your testimony today as well as all the work you do to help women.

For the committee, I just want to let you know.... You had me look at the calendar with the analysts and the clerk to make sure that we could achieve all the things from our committee that we wanted to achieve. In order to do so, we have to add one meeting somewhere.

The options are that we could add a meeting next Monday night from 6:30 to 8:30, or we could add one in the break week in our normal slot, on Thursday from 11 a.m. to 1 p.m.

I would ask for some advice about which you would prefer.

Ms. Hutchings.

Ms. Gudie Hutchings: Thank you, Madam Chair.

Did we look at adding an hour or two to the other meetings?

The Chair: There was no flexibility to be able to extend any of the meetings. They're very tight. They wouldn't allow it.

These were the options they provided. Otherwise, we'd have to get rid of something on our list.

Ms. Gudie Hutchings: Then I'll go for the Thursday of the constituency week, but it's up to the others. I'm flexible.

The Chair: Monsieur Serré.

Mr. Marc Serré: Yes, I'm flexible, but if I had a choice, it would be Monday night versus Thursday.

The Chair: Perhaps I could get a show of hands. How many would prefer the Monday night?

I think more people prefer the Monday night. We'll do it on the Monday night, May 10. There will be an extra meeting between 6:30 and 8:30.

I want to remind you as well that this Thursday's meeting is also from 6:30 to 8:30. I don't know why they want to run so late, but there you are.

Thank you for your time today. Is it the pleasure of the committee to adjourn?

Ms. Gudie Hutchings: Madam Chair, is that eastern time? I just want to make sure that we're all on the same—

The Chair: Yes. It's eastern standard time.

Ms. Gudie Hutchings: Perfect.

The Chair: It's the pleasure of the committee to adjourn, so we will. I'll see you on Thursday.

Thank you.