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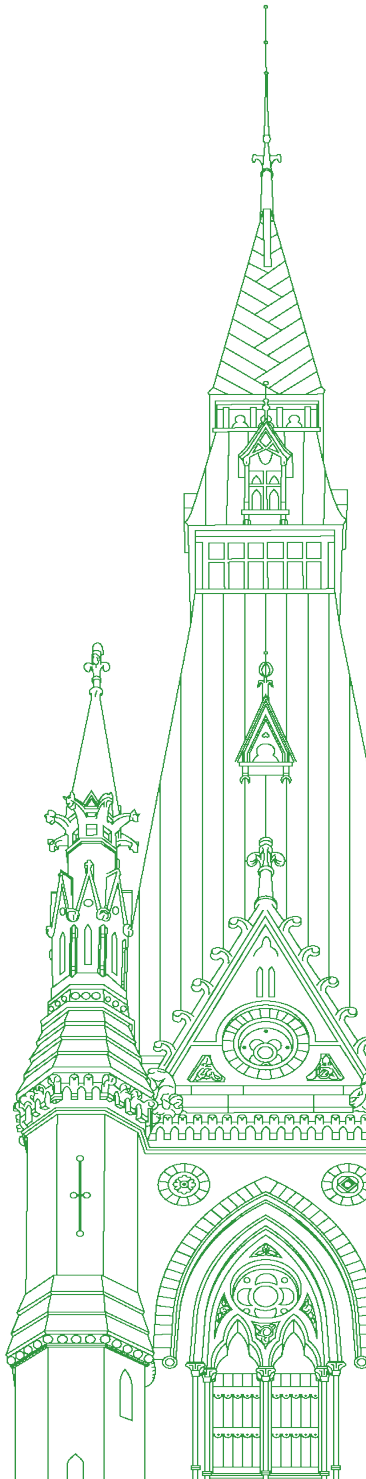

Chair: Ms. Marilyn Gladu

Standing Committee on the Status of Women

Monday, May 10, 2021

● (1830)

[*English*]

The Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): I call this meeting to order. Good evening and welcome to meeting number 33 of the House of Commons Standing Committee on the Status of Women. Today's meeting is taking place in a hybrid format pursuant to the House order of January 25, and the proceedings will be made available via the House of Commons website.

I would like to make a few comments for the benefit of the witnesses. Today our committee is continuing its study of midwifery services across Canada. If you're speaking, you're going to click on the microphone icon to activate it. I remind you that all comments should be addressed through the chair, and if you need interpretation, at the bottom of your screen you can choose English, French or the floor. When speaking, please speak slowly and clearly so that the interpreters can hear and interpret. When you're not speaking, your microphone should be on mute.

I'd like to welcome our witnesses. Each of you will have five minutes for your opening remarks, and then we'll go into our rounds of questions. We have Dr. Susan James with us tonight, and from the Association of Ontario Midwives, Jasmin Tecson, the president. From McMaster University, we have Kirsty Bourret, adjunct scientist at the McMaster Midwifery Research Centre.

Dr. James, we'll begin with you. You have five minutes.

Dr. Susan James (As an Individual): Thank you, Madam Chair and members of the committee.

I have been the director of the school of midwifery at Laurentian University for 20 years, and now, after a total of 22 years, the insolvency situation has caused me to be retired. I would like to focus on the role that the midwifery program has played in capacity building and then make some recommendations for going forward.

The first area is health human resources. The majority of current midwifery practices in northern Ontario did not exist before the midwifery program began. As noted in the first session, 60% of the midwives practising in these areas are graduates of the Laurentian program. Many students enter the program with the goal of joining existing northern practices or setting up new ones. For example, Mélanie Guérin entered the program in 1999, and in response to a question about setting up a practice in her home community of Hearst, a southern site director answered her, "There will never be practices in small communities like Hearst." This motivated Mélanie to spend every visit home networking with community members, and in 2005, she set up her practice.

Many northern communities still have no midwifery and, indeed, no maternity services. There are many professional provincial and federal actions that will be needed to realize the dream that every pregnant person should be able to birth close to home. These include new funding models, transportation issues, clean water and the improvement of Internet connections. A school of midwifery in a northern university is a very useful strategy for informing the population about midwifery and about choices that can be made related to childbirth, childbearing and other health situations.

One example of something that we created is a pelvic teaching program developed in 2002 to train midwifery, medical and nurse practitioner students, and hospital sexual assault nurses in sensitive, respectful and informative pelvic examinations, including pap smears. This program may be lost with the closure of the school, to the detriment of northern residents.

My next area is accessibility to education. Many of the northern students and graduates of the Laurentian program tell us that they would not a have done a degree in midwifery if they could not have remained in the north. Attention to the demographics of our applicant pool has lead us to accept direct from high school applicants every year, which helps to retain students.

The CNFS has assisted us with some resources for recruitment and scholarships for the program. The CNFS model is one that might be used for other aspects of a northern site for midwifery education.

My final area of capacity building is scholarship and research. Social science and humanities research about midwifery is common. There is a beginning collection of research by midwives to inform practice, but for the most part, this is not northern oriented. Midwifery is a nearly invisible research profession, not included in lists of professions within granting agencies or calls for proposals and research teams. Federal funding for midwives to conduct research in low income countries is available through the Canadian Association of Midwives, but similar opportunities for research in Canada's north are far less accessible.

My recommendations are, first, include health services in the responsibilities of FedNor. This may provide support for communities that can grow their economic picture when health services needed by residents of childbearing age are available locally. Second, build on the CNFS model to create federally supported but locally driven programs to address the needs of northern, indigenous, francophone, anglophone and racialized students. Third, support the development of a northern midwifery research institute. Possibly, this could be in conjunction with the Centre for Rural and Northern Health Research at Laurentian and Lakehead Universities.

Fourth, support the reintroduction of a school of midwifery in northern Ontario. This continues to need to support the educational and practice needs of northern, indigenous, racialized, francophone and anglophone populations. Fifth, and perhaps for the federal government most important, establish an office of midwifery within the federal government to coordinate and liaise with other departments and professions on questions related to the profession and health issues related to reproductive and sexual health.

● (1835)

Thank you very much, Madam Chair.

The Chair: Thank you.

Now we'll go to Ms. Tecson for five minutes.

Ms. Jasmin Tecson (President, Association of Ontario Midwives): Good evening, Madam Chair, and committee members.

My name is Jasmin Tecson. I'm a registered midwife, and I speak to you today as the president of the Association of Ontario Midwives, the largest regional association of midwives in Canada.

We are proud to be a part of a profession that is deeply valued by families, one that we believe is essential to improving health outcomes for pregnant people and their babies. Currently, there are approximately a thousand midwives in Ontario delivering about 18% of the babies in the province. We are autonomous primary care providers. Our midwifery education program, the first of its kind in Canada and respected internationally, confers a bachelor of health science in midwifery. Our comprehensive, rigorous training includes tests; commonly prescribed medications; care management of healthy, low-risk pregnancy and birth and postpartum; as well as emergency skills and assessment, and clinical care for healthy newborns.

Our model of care has proven to be a highly successful method for delivering perinatal care with strong clinical outcomes, exemplary client experiences and efficiency in the delivery of evidence-based care. Our model incorporates the development of a working relationship as well as a trust relationship. The support for informed choice that comes from this leads to levels of client satisfaction that are outstanding for a profession, from 97% to 100%. High levels of client confidence and support combined with continuity of care lead to lower rates of interventions and shorter hospital stays.

In 2019, the c-section rate for midwifery clients was 20%. In contrast, the provincial average was 29%. For midwifery clients who planned home births, the rate was an impressive 7%. By offering safe, skilled birth attendance at home or at birth centres, and follow up care postpartum in the community, Ontario midwives effectively reduce hospital admissions, further reducing health care costs and saving hospital resources for those who need it most.

These facts clearly make the case that midwifery is worth investing in. Yet, there is a price for midwives' dedication. Even without the additional stress of frontline work during a global pandemic, our profession suffers from the underfunding of our education programs, discriminatory pay and demanding work conditions that contribute to increasing burnout and the loss of skilled, dedicated professionals from attrition and disability.

The closure of the midwifery education program at Laurentian is devastating to Canadian midwifery. One third of the student midwives in Ontario were enrolled in the program. Its graduates have gone on to become leaders in regional midwifery associations across the country and in the National Aboriginal Council of Midwives. Closing the program ends bilingual midwifery education in Canada and essentially closes the door to Franco-Ontarians seeking midwifery education in their first language. The program made education accessible to a host of indigenous and northern students who otherwise would not have become midwives. The loss of this access point is a loss that will significantly impact the health of indigenous and northern communities.

Now, we have the risk of a reduced cohort of midwifery graduates who will care for tens of thousands of families in Ontario. The demand for midwifery across the province is great. Fewer graduates will mean that families who choose midwifery care will be unable to access it, far more so in the north.

In a 2015 analysis and report, the AOM made several recommendations for strengthening care in rural, remote and northern communities. The Laurentian program prepared midwives to work in such areas across Canada. Among the recommendations included are that women should have access to high-quality maternity care as close to home as possible. Local perspectives and needs should be taken into account in health care planning. The right to self-determination and culturally safe care must be upheld in indigenous communities. Training opportunities for new and experienced health providers need to be offered within these communities. Rural and remote midwifery funding frameworks must reflect the realities of practising in these areas.

With its integrated, person-centred approach throughout the provision of excellent perinatal care, midwifery is uniquely positioned to address social determinants of health such as gender, culture, race and access to health services. Midwifery in Canada is growing, but it needs coordinated efforts in policy and funding from provincial and federal levels for sustainability.

Thank you for your attention.

● (1840)

The Chair: Excellent.

Now we will go to Ms. Bourret for five minutes.

[*Translation*]

Ms. Kirsty Bourret (Adjunct Scientist, McMaster Midwifery Research Centre, McMaster University): Good afternoon, Madam Chair and honourable committee members.

I am here to talk about the concerns of francophone communities outside Quebec that feel aggrieved by the closure of the Laurentian University Midwifery Education Program. I thank everyone who has contributed to my testimony today.

I am a francophone midwife who grew up in northern Ontario, and I graduated from the Laurentian University Midwifery Education Program, where I have been a professor since 2007. I am one of the only francophone midwives outside Quebec to have earned a post-graduate degree.

Here is our main message: to enhance the education of francophone, indigenous and northern midwives, including midwives who identify as black or racialized, we must strengthen the integration of this profession at all levels of the public sector, across policies and health care systems.

The current closure of the midwifery education program has to do with the lack of understanding of midwifery by government and academic decision–makers. That underscores our recommendations at the federal level to increase the profession's impact across the country.

We want the committee to recommend to the province that: a midwifery education program be reinstated in northern Ontario; that it contain a francophone option; and that an indigenous midwifery education program be created in northern Ontario.

As for the federal government, we recommend that it create a position of chief administrator for midwives within the Public Health Agency of Canada and that midwives be included in decision–making wherever physicians and nurses are invited. We recommend investing in programs or creating programs at the federal level, such as the Consortium national de formation en santé, or CNFS, which improves the midwifery education capacity for northern and francophone communities. We recommend that those programs prioritize the education of indigenous and racialized midwives. Finally, we recommend supporting midwives' ability to complete their post–graduate studies, which enables them to be educators and researchers, in order to generate data for the profession and to increase the sustainability and impact of that profession over time.

The midwifery education program at Laurentian University has more than fulfilled its mandate to increase community services [*technical difficulties*] to monitor or increase our efforts. Those positive impacts will be cancelled out. Midwifery services in those communities, which are already difficult to obtain, will become inaccessible, and our families will suffer the consequences.

According to Mélanie Guérin, a midwife who graduated from Laurentian University, the communities of Hearst and Kapuskasing, which she has been serving for 15 years, are 95% francophone. Midwives who settle in small northern communities are rare, unless they come from there or from a similar community.

Pascale Alexandre, a student attending the Laurentian University Midwifery Education Program is a black francophone woman. She said she decided to become a midwife to help people in her community give birth in a context of cultural safety. According to her, eliminating the midwifery program's francophone component is an attack on black francophone minority groups and on people giving birth. She adds that, in a context where it is proven that racial discrimination has a negative impact on the provision of health care, reducing access for racialized and linguistic minority groups maintains that disparity, at best, and exacerbates it, at worst.

Carine Chalut, a client of the East Ottawa Midwives—a clinic that is almost completely francophone and whose midwives are Laurentian University graduates—says that she had francophone midwives for her three pregnancies and that having access to health services in her language was not only an advantage, it was a necessity. She adds that, when a woman is in a situation as vulnerable as that of giving birth, she cannot be expected to interact in a language that is not her mother tongue, as that puts her in a precarious, even dangerous, situation. She thinks it is important for francophone women to continue having access to that care in the language of their choice, as that is not only a matter of rights, but also of quality of care.

Although university education is a provincial responsibility, we feel that the federal government has a role to play in strengthening the impact of our profession. There are current examples of the federal government funding programs to improve the health staff through education and research programs. For instance, Health Canada has an official languages health program that funds the Consortium de formation en santé, the CNFS. Such programs can be implemented to improve the midwifery education capacity, especially in francophone, indigenous, black and northern communities, as well as in communities of colour.

In summary, the federal government has an opportunity to innovate and create structures that show an investment in midwifery through leadership, initial education and research in the field. That would increase our profession's capacity and impact.

Thank you.

● (1845)

The Chair: Thank you very much.

[*English*]

We will start with our first round of questions.

Ms. Sahota, you have six minutes.

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

Thank you to the witnesses for being here today and for your testimony.

Ms. Tecson, you spoke about the number of midwives who are registered in Ontario and the percentage of births through midwives in Ontario. Do you know of any regional differences across Canada? What are some of the factors that lead to these differences?

Ms. Jasmin Tecson: Unfortunately, the Association of Ontario Midwives doesn't collect data specifically for regions. What we do have through our managed program with the Ontario Ministry of Health are registrations with the college and funding via transfer payment agencies and registered practices.

In terms of regional considerations, we do know that it's challenging to have midwives set up practices in rural, remote and northern areas. Part of it is the concentration of midwives in urban centres in the southern parts of the province and the facilities and accessibility, quite frankly. It is a driving concern to consciously monitor and maintain the registration and practising of midwives in those areas.

Ms. Jag Sahota: Ms. James or Ms. Bourret, do you have anything to add to that?

Dr. Susan James: I can add a little bit to what Jasmin just said about the challenges of establishing practices in the north. This is a concern for students right from the time they begin the program throughout their placements and when they graduate.

Partially it's the funding model. It has added some wonderful improvements, but the funding model is basically fee-for-service. If you cannot generate enough clients for the midwife to make what would be an equivalent full-time salary or earnings in a southern placement or location, then it's quite possible that the midwife may not be able to stay there, particularly if she is the sole breadwinner for a family. Plus, she wouldn't necessarily have the ability to add in a second midwife to the practice to cover time off so that they can take vacations or take time off when they're ill. There is a locum program that can assist with that, but it isn't always possible to assist at the last minute and have somebody cover if they need that weekend off.

A funding model where we would expect...like in schools in the north, where you have small classrooms but the teachers are paid the same as teachers in a large urban centre with large classrooms. In fact they sometimes even get extra money for distance. Could it not be possible to develop funding models for supplements to funding models? If the Ontario government funding model is not sufficient, is this a place where something like FedNor might be able to help out to assist with the economic components of having midwifery right across the province?

● (1850)

Ms. Jag Sahota: Ms. James, you spoke about a midwife not being able to have or to retain enough clients, perhaps even having to move to another part of the country. Is mobility an issue? Is it fairly easy in terms of the rules around how you move? Are there different criteria in different regions of the country?

Dr. Susan James: The basis of registration from one province to the next is that there is an agreement that each province accept the same registration exam, which is done at a national level. The competencies for midwives have been developed at a national level. There are some small additions that various jurisdictions have added to the requirement to get registered, but usually something can be accomplished in writing a small examination or attending a workshop to add in the additional either competencies or knowledge of how the registration or regulations work in that particular area.

It is possible to move from one province to another. They can do that right from graduation, but particularly once a midwife has one year of experience, then cross-province or into territories is not that difficult.

Ms. Jasmin Tecson: If I may, I will add to the member's question. While there are fewer barriers around education for midwives to take their education credentials across the country, there are structural framework issues that need to be considered that can help or hinder a midwife's ability to set up shop. It's not simply a matter of moving to a location and hanging up a shingle.

Depending on where a midwife would like to practice, there are issues such as how midwifery is located. They're not always autonomous primary care providers working independently in a self-employed model similar to Ontario. In other regions, they are employees who are part of a health service or a health centre.

There are also issues in terms of where—

The Chair: I'm sorry, that's your time on this question.

We'll have to go now to Mrs. Zahid for six minutes.

Mrs. Salma Zahid (Scarborough Centre, Lib.): Thank you, Madam Chair. Thanks to all the witnesses for appearing before the committee today. Thank you for your time.

My first question is for Dr. James.

Do you think there are any opportunities for collaboration between the provincial and the federal governments that could potentially help your profession?

Dr. Susan James: I certainly have wonderful expectations and aspirations that there can be opportunities for collaboration. I have sat in on federal meetings in the last few weeks since we lost our program, as well as in provincial meetings. I have heard from representatives of every party, I think.

I think everybody is talking about the same thing. It's a matter of making sure there are ways that those collaborations can fit together. I think the reason both Kirsty and I have mentioned the CNFS as perhaps a model is that we have seen it work well.

When it first came to Laurentian, it mainly was interested in nursing, social work and maybe phys. ed., but over time we have also captured their interest. We created a proposal a few years ago where our francophone program would offer seats to students from other provinces where the other provinces would pay the grant part and maybe the student would pay the tuition part. They would be extra to our cohort of 30. We had provincial buy-in, we had federal buy-in and we had the individual potential student buy-in. Unfortunately, there was a change in the government at the time. Although the committee itself had found that we scored very highly on their priority list and we thought we may be going ahead with that, the funding to CNFS that year got cut and the program never actually happened.

I think that's an example of how the CNFS doesn't tread on provincial toes. It supplements provincial toes. I think we may be able to look at other possibilities for indigenous students, racialized students and for the north that would have the same kind of structure that's a partnership between a post-secondary institution and the federal government, but always with the co-operation of the provinces to make it work.

● (1855)

Mrs. Salma Zahid: Thank you, Dr. James.

I have one more question for you. As autonomous and primary health care providers, midwives are essential to the health care services.

How do the midwifery programs and the role of the midwives shape the health care system in Canada?

Dr. Susan James: That's a big question.

I think one of the first things that happened with midwives, as well as nurse practitioners—and I'll refer mostly to midwives because that's what I know best—is that this was the first time that some professionals in these two professions could work within the health care system as primary care providers, as autonomous, with hospital-admitting privileges in many provinces, an ability to prescribe medications and to order investigations without having to necessarily have permission from any other profession. It was a challenge within the health care system. We aren't doctors and we don't have to have doctors for certain situations where the client fits within the scope of practice of the midwife. The midwife then can carry on care without having to have permission that this client is able to come to a midwife—is able to stay with a midwife.

The scope of practice for the midwife is to know when things are coming outside of his or her scope and to move that client potentially into medical care. It may also be into care of a social services provider. We have created a partnership with physicians. We need them; they need us. It was a fairly significant challenge to the health care system to see health care providers who had that scope of practice, that level of responsibility, who weren't MDs.

Mrs. Salma Zahid: Thank you.

I think my time is up, or do I have some time?

I have one quick question for Ms. Tecson.

Can you tell us a bit about equity and access to midwifery?

Ms. Jasmin Tecson: I'm sorry, but I didn't hear the last part of your question.

Mrs. Salma Zahid: Can you tell us a bit about equity and access to midwifery?

Ms. Jasmin Tecson: The Association of Ontario Midwives has prioritized as one of its strategic goals addressing equity within the profession, with an awareness of racism, issues of a lack of diversity, and equity in the bigger health care system. Within the midwifery education program, that is also an area of specific focus.

Within how we work with our clients, especially in our "informed choice" model, we are able to spend more time with clients; an average of 30 minutes as opposed to the usual five minutes, which is the norm for a prenatal appointment. We are able to get to know a client to find out what is important to them culturally, individually, to provide the care that is most appropriate for their experience.

● (1900)

[*Translation*]

The Chair: Thank you.

Ms. Larouche, go ahead for six minutes.

Ms. Andréanne Larouche (Shefford, BQ): Thank you, Madam Chair.

I would like to begin by thanking the three witnesses. Ms. James, Ms. Tecson on and Ms. Bourret, your testimony is very precious. Thank you for being here today to talk about both the importance of the midwifery service and the importance of Laurentian University.

That is why, as a Quebecker, I would like to, on behalf of the Bloc Québécois, express our solidarity with Franco-Ontarians in terms of their growing struggle for their language's survival. I am thinking of young people and members of the northeastern Ontario francophone community, who deserve quality services without having to move to Ottawa or to Quebec.

For a number of years, we have been seeing an erosion of French-language education. Laurentian University was providing services by and for francophones. For us, that is crucial. In your opening remarks, you mentioned the importance of being able to receive services in your language at a stage as critical as giving birth.

Without further ado, I will ask my first question, but I want to remind you that I am also trying, as a Bloc Québécois member, to untangle all this because the university, education, health and midwives are the jurisdiction, as you mentioned—

The Chair: Sorry, could you please raise your microphone?

Ms. Andréanne Larouche: Of course.

I was about to say that, in Quebec, health and education programs are the responsibility of the province, as they come under provincial jurisdiction. So how can you work in collaboration with the federal government?

Ms. Bourret, you talked about the Consortium national de formation en santé. Can you tell us about potential collaboration with the federal government to ensure a better service and monitoring of midwives?

Ms. Kirsty Bourret: Thank you.

Once I answer your question, I will yield the floor to Susan James, who has much more experience than I do with the CNFS. She will be able to tell you in more detail about a potential collaboration.

In my experience, the CNFS is a very important program for health care providers. It provides subsidies and allows for collaboration among universities at the provincial level. It is intended for all health care providers.

I would not go as far as to say that we have been discriminated against at Laurentian University, but we initially had to re-explain to the federal government what a midwife is, what the profession consists in and what our needs are. In the beginning, it was a bit difficult for us to collaborate properly with the federal government. That is why we have discussed the possibility of raising awareness, either through the CNFS or by creating programs specifically aimed at increasing the number of francophone midwives.

The CNFS is used not only to increase the number of health care providers, but also to increase the capacity of the francophone profession, namely by subsidizing research on midwifery. As Dr. James said earlier, we don't have the capacity needed to do research on our own profession.

How can we explain the benefits of our work when we cannot measure them? The CNFS's programs are really important, as they support research. We assume that good collaboration would be possible, especially for midwifery and for francophone midwives.

I now yield the floor to Ms. James, so that she can explain to you in more detail how that collaboration works.

Thank you.

[*English*]

Dr. Susan James: I believe one of the ways that we have worked very effectively with CNFS as a federal organization and the university as a provincially funded organization is through wonderful communication and looking at where the sources of funding are for a particular request. For example, if it were a student who was really struggling with something about a placement—and this comes up all the time, because they have to move and find a place to live and buy food and travel around, etc.—we do get provincial money to help with some of that. However, sometimes a student will have additional needs, and, if they are a francophone student, they could ask CNFS if they have funding available to support them. CNFS will first ask what they have already done, what they have already looked at. Then, if that student still needs to have additional support, CNFS will look at what is in their budget that can help.

We've seen that for financial support of students. We've seen that in the program. For example, recently we were looking for more textbooks in French. The challenge for professions right around the world is that most things get written in English, and we want students to have the opportunity to learn by reading the required materials in their first language.

We were able to get some funding and additional support from CNFS. Not only did they give us the money to make it happen, but they also found the right people to do the translation. This was an electronic book, so we also needed really good IT support. We needed people who did that IT support who were francophone and who could understand what it was that we really needed for the francophone students to use that textbook well.

● (1905)

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

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

Ms. Lindsay Mathyssen (London—Fanshawe, NDP): Thank you, Madam Chair.

One of the things that we've seen over the recent period of time is that there was, for a long stretch, quite a lot of support, at least in Ontario, for midwives from the Association of Ontario Midwives. There was stable funding. That has been, as I understand it, cut, and you can correct me if I'm wrong, but in addition to that, midwives worked extremely hard to win a historic landmark within the Human Rights Tribunal of Ontario for pay equity. That is now being appealed. Could you talk about the impacts that has on your members, both financially and professionally, and how that impacts your members?

Ms. Jasmin Tecson: I would say that the impact has been extremely discouraging for midwives. Midwifery has been legislated in Ontario for 27 years, and for 17 of those 27 years, midwifery compensation was frozen even for the cost of living. To have a midwife with the clinical and emergency skills that we have who are available on call 24-7 for our clients the disrespect is incredibly disheartening.

To have that recognized by the Human Rights Tribunal of Ontario and the Divisional Court of Ontario was affirming, and yet it is deeply frustrating to have the provincial government challenge that, especially in light of the work midwives have put in on the front lines bridging care in the community so that families that are at a very vulnerable point in time can reduce their exposures during the pandemic.

To work as essential workers and yet not be recognized has led to burnout. It frustrates midwives that their compensation levels have led to them taking on higher caseloads than might be healthy, with that leading in turn to levels of mental and physical disability, which are a penalty for the entire profession.

Thank you for your question, because I feel this is an equity issue, where the health of birthing people and the health of those care providers, particularly those who are marginalized, is threatened because of the undermining of this female-predominant profession that serves them.

Ms. Lindsay Mathyssen: Thank you.

In this committee at the same time we're multi-functioning, doing a study on unpaid work and the additional work that women take on just naturally within the care professions as women and the imbalance or unfairness we see in the pay in those care professions. It seems as though midwives are no exception, unfortunately, to that.

You mentioned the additional stress because of COVID as well, and it's my understanding that because you were not recognized as essential services, midwives were neither provided with the pandemic pay nor PPE. Can you talk about the impacts on your profession that way, as well?

● (1910)

Ms. Jasmin Tecson: Yes, that's correct.

The federal government was good enough to provide funding for our province for pandemic pay. Unfortunately, in the divvying up of that pandemic pay, despite midwives meeting all of the criteria for essential workers who are eligible, they were not paid out, because within the gender bias of policy-setting, midwives were not included as an eligible category. Midwives are consistently treated as afterthoughts within the health care system.

The impact on midwifery practices was that they had to pay for additional staff, for changes to their facilities, and for personal protective equipment for themselves and their students out of their own operational budgets. For some practices, community members got together and sewed midwives' masks and made them gowns out of bedsheets.

To have that happen to a health care profession that has gone above and beyond and pivoted to meet the needs of the community is incredibly disheartening, and midwives definitely felt the insult. It definitely added to the stress and burden of the pandemic personally and professionally.

I just want to say that as far as sustaining and growing midwifery is concerned, midwifery cannot grow if it's stunted from the beginning by underfunding, or outright cutting of its educational programs. Further, it can't grow if it's starved by policies and compensation practices that don't value its workers. Their treatment around pandemic pay is entirely consistent with that.

Ms. Lindsay Mathyssen: You are, obviously, highly educated. Many of the students I spoke to were very concerned that they couldn't continue their education if they were to switch to the other two universities, because they would be put onto a pass-fail type of situation. How does that also impact your profession when you're stunted—and a bachelor's is incredible—when it stops there?

The Chair: Please provide a quick answer, in 20 seconds.

Ms. Jasmin Tecson: I would say that the cutting of the program—which was a success by all measures—is an example of what happens when decisions are made without consideration of the subtle impacts of gender bias. Ultimately, this slows the growth of a profession that already is growing slowly and is behind demand.

The Chair: That's very good.

Now we'll go to Ms. Shin, for five minutes.

Ms. Nelly Shin (Port Moody—Coquitlam, CPC): Thank you, Chair, and thank you to all the witnesses today for providing us with some wonderful insights about midwifery, especially in northern Ontario.

I wonder if you could speak to midwifery and how it relates to indigenous communities. Access to health care services may be challenging for many indigenous communities, which may force indigenous people to seek this care outside their communities. They have reported experiences of racism and violence while seeking health care, including sexual and reproductive health care outside their communities.

According to the National Aboriginal Council of Midwives, "Indigenous Midwifery care is a pathway that supports the regeneration of strong Indigenous families by bringing birth closer to home."

Could you describe the role that indigenous midwifery plays in the health and well-being of indigenous peoples and communities?

That question is for anyone.

Ms. Jasmin Tecson: I suppose I can start.

Susan and Kirsty, perhaps you can chime in, from working most directly with indigenous students.

My practice in downtown Toronto, even though I live in Scarborough, Ontario, is Seventh Generation Midwives. We work with an urban indigenous population, but we work with a model that grounds care fundamentally within a family unit and centres that within the bigger community.

For indigenous families, to receive care from an indigenous midwife who shares their world view and shares their understanding of what is essential in consideration of their whole personhood, their health and their location within their community makes a huge difference and minimizes the trauma that can be reenacted in their interactions within the health care system. It's affirming for the indigenous midwives practising, and definitely for the families, and resets the harm that has been caused generationally thanks to residential schools.

Perhaps Kirsty or Susan would like to add more.

● (1915)

Dr. Susan James: In the midwifery program at all three sites, right from the beginning in 1993, we have felt that it was important to ensure that indigenous applicants had an opportunity to have a space within the program.

At Laurentian, we have generally had a cohort of indigenous students in every year of the intake of our program. We attempt to not only support what it is that they feel they need from us to prepare them for practice in their communities, but we also want the other students who will be practising in northern Ontario, likely with at least some indigenous clients, and some practices will have high proportions of indigenous clients, to have an understanding so that each client doesn't have to try to interpret what it means to be indigenous to every midwife that she encounters in her health care.

Ideally, of course, we would like for our indigenous students to have an opportunity to have all their placements in indigenous practices and we do have procedures set up in our placement process to at least give them the first opportunity to get those placements when they are available.

We also know that the times are changing and it is time for there to be indigenous schools of midwifery. We know there is federal funding being put in place through FNIHB for the students to be able to create a school that is indigenous.

One of the things that may happen with a new northern school of midwifery is that instead of just re-creating the northern site of the consortium, perhaps we may have a new consortium that's something similar to what we have, but our partners might be maybe two or three indigenous schools of midwifery in northern Ontario. Maybe our partners will be with other places where francophone students want to study.

I'm getting off the indigenous topic here.

[*Translation*]

The Chair: Mr. Serré, you now have the floor for five minutes.

Mr. Marc Serré (Nickel Belt, Lib.): Thank you, Madam Chair.

I thank the three witnesses for their testimony.

I would like to put a quick question to the three witnesses, who will understand why I am bringing up this issue.

Lisa Morgan, who was a witness at the last meeting, said she was part of the tri-council.

[*English*]

Dr. James, were you part of the tri-council? We heard from Lisa Morgan. She participated in meetings at the tri-council.

I just want to know—yes or no—whether you were you part of that. I will tell you why afterwards.

Dr. Susan James: If you were talking about the tri-council with McMaster and Ryerson, yes. I was the director for 20 years. I've participated in many meetings of that consortium.

Mr. Marc Serré: Excellent.

Ms. Tecson, are you part of that tri-council?

● (1920)

Ms. Jasmin Tecson: I am not a member of the consortium. However, I was a member of the advisory council of the consortium when I was a student.

The consortium members are leaders within the midwifery education program not the professional—

Mr. Marc Serré: Excellent.

Madame Bourret, were you part of the tri-council?

[*Translation*]

Ms. Kirsty Bourret: Yes, I have been part of it since 2007 because I have been a professor at Laurentian University since then.

Mr. Marc Serré: Are McMaster University graduates sent across Canada? Laurentian University sends students to Nunavut and New Brunswick.

Does McMaster University send students across Canada or only to Ontario?

Ms. Kirsty Bourret: I cannot give you exact statistics. I can only talk about our graduates and the places they move to. I can say that the majority of graduates are Franco–Manitobans, Albertans or New Brunswickers.

Mr. Marc Serré: Okay.

[*English*]

Right now, Laurentian blew up the program. No francophones are getting services in September. Aboriginals are not going to get much service in September. Rural is blown up. It's dead; it's gone.

I'm trying to figure out.... I know we're talking about the federal government's role. I know we have the tri-council here that was submitting proposals to the provincial government.

Madam James, you talked about the CNFS. They do marvellous work, but they haven't proposed anything back to the federal government.

I dealt with

[*Translation*]

the Fédération des communautés francophones et acadienne, the Association des collèges et universités de la francophonie canadienne, and the Société Santé en français.

[*English*]

These are all organizations.

My question for Ms. Tecson is this: How do we try to coordinate a plan? Right now the provincial government has zero plans for midwifery other than just giving it to McMaster and Ryerson.

How do we try to coordinate our efforts? I thank Lindsay Mathyssen for bringing this motion forward here. How do we try to coordinate efforts to get a plan, so that we could have the federal government at the table with proposals?

Right now there have been no proposals submitted. I wanted to see if you could help to try to steer us in the right direction here with some recommendations to the federal government.

Ms. Jasmin Tecson: I would say as a starting point it would be valuable to reach out to the Ministry of Health, which manages the Ontario midwifery program, and to the Ministry of Colleges and Universities in Ontario. Work with them to develop a cohesive plan that looks long term.

At the federal level, it helps to have midwifery recognized even just as a job category because it's not. If the federal government starts with a clear position on midwifery with goals and targets for how they would see midwifery positioned to support birthing people across Canada, that vision can translate down as an expectation to provincial governments for setting their policies and programs.

Mr. Marc Serré: Dr. James, you mentioned earlier that you were at the table with the CNFS. You were at the table with the provincial government—the Wynne government prior. They were making some movement. Now it's gone.

I'm trying to get a handle here on understanding how we get together, if we don't have a willing provincial partner at the table. We have to get the provincial government to outline that there's an issue. I know it's difficult right now with the court situation at Laurentian. The court has made it a worst-case scenario. How do we get to sitting down with the provincial government?

The Chair: I'm sorry. That's the end of your time.

Mr. Marc Serré: Oh, that went so fast.

The Chair: I hate to interrupt before the answer.

[*Translation*]

Ms. Larouche, you have the floor for two and a half minutes.

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

Once again, I thank the three witnesses. I will try to be quick.

Ms. Bourret, I would like to come back to the program's closure. Correct me if I am wrong, but there were only 30 spots for 300 applications last fall. If that is not the reason the program is closed, why do you think it is?

Ms. Kirsty Bourret: I think the discussion is the same on the provincial side, and I think the answer is the same when it comes to what can be done on the federal side. I think it is just a matter of a lack of awareness and understanding of the role midwives play in Canada and in the provinces. With proper understanding of the potential contribution of midwives at Laurentian University, it would be difficult to justify abolishing a program. Gender equality is also involved. We have discussed this already with a minister. I generally think that we are given less importance because we are involved in a female occupation.

I want to come back to Mr. Serré's question. At the federal level, it's a matter of not only helping provinces better recognize the role midwives play, but as Ms. Tecson said, the role of midwives should also be better recognized by the federal government. I work on Global Affairs Canada's programs that strengthen midwifery on a global scale. The first thing we do is raise awareness at the federal level in order to integrate midwifery at the administrative level. That is why Ms. James and I asked that a position of federal chief administrator for midwives be created, to have an office that manages anything to do with midwifery.

Global Affairs Canada funds all sorts of innovations abroad, and it could not have that same innovation here, in Canada. That makes no sense. We must work together to innovate well on the federal side to integrate midwifery, which will also strengthen its integration at the provincial level afterwards.

● (1925)

[*English*]

The Chair: Very good.

We'll go to Ms. Mathyssen for two and a half minutes.

Ms. Lindsay Mathyssen: Thank you.

One of the things the Canadian government has a responsibility for doing is to enforce the Canada Health Act. Within that, of course, is reproductive services being available to women across Canada equally and fairly. Certainly the role of midwives has the ability to expand. For example, in Hamilton, Ontario, they are working with other doctors, ensuring that they have medications available so that women who need access to reproductive services can get them.

Can one of you, or all of you, quickly talk about expanding that role of midwives to ensure that women have that equal access under the Canada Health Act to reproductive services and health services?

Ms. Kirsty Bourret: I have to jump in and speak here, because this is an area of interest of mine.

It's important to point out that it actually isn't an expansion of our role. In Ontario it is, but when you look at our global definition of midwifery, we have it within our scope to provide all sexual and reproductive health care, which includes contraception, which includes access to abortion. This is something that's well known and that we are trained to do.

Again, around the world, I am working with Global Affairs Canada to ensure that midwives have the capacity to do this within their scope, which means increasing access to sexual and reproductive health care, especially in very, very remote and rural areas. We've been arguing for that for a really long time. While in Ontario it might look like an expanded scope, really the vision of midwifery at the national level is to be able to provide these services across Canada.

You know, this will have a huge impact on our ability to impact this issue around our overall lack of access to contraceptive and reproductive health care, especially with indigenous and other populations that are at a disadvantage. I think there is an opportunity here to have this discussion and to raise awareness of midwives' capacity to function in that way.

The Chair: Very good. I think we'll leave it there.

To our witnesses, thank you for your excellent testimony and helping us with our study.

We will briefly suspend while we do sound checks for our next panel.

● (1925)

_____(Pause)_____

● (1930)

The Chair: I want to welcome our witnesses for our second panel of our study on midwifery services across Canada.

From the Canadian Association for Midwifery Education, we have Kim Campbell, the chair—not the former prime minister, but an expert in her field—and from the Canadian Association of Midwives, Alixandra Bacon, the president.

Each of you will have five minutes to make your remarks.

We'll start with Ms. Campbell.

Ms. Kim Campbell (Chair, Canadian Association for Midwifery Education): Thank you very much.

Madam Chair, thank you for the opportunity today to provide evidence, through an education lens, regarding midwifery and the impact of the Laurentian University program closure.

I'm representing the Canadian Association for Midwifery Education, as we said, which is a not-for-profit organization of midwifery educators. Our mission is to promote excellence in midwifery education. We do this through setting and maintaining standards for curricula—

[*Translation*]

Ms. Andréanne Larouche: Madam Chair, I have a point of order.

I apologize, Ms. Campbell, but I cannot hear what you are saying, as there is no interpretation.

[*English*]

The Chair: Yes.

The Clerk of the Committee (Ms. Stephanie Bond): You don't actually have to hold it so close to your mouth, Ms. Campbell. We'll do another sound check.

Ms. Kim Campbell: Okay.

Testing. Can you hear me okay?

The Clerk: I would just leave it there and not push it close, because it distorts the audio.

We'll try the best we can and we'll let you know if we have to interrupt. Please resume.

The Chair: Go ahead.

Ms. Kim Campbell: I'm going ahead here.

I wanted to tell you that we are the accrediting agency for midwifery education, and one of our goals is to maintain the standards of curriculum and scholarship as well as supporting continuing development of midwifery faculty and programs. Currently, we are also exploring the ways in which we can support the indigenous midwifery education programs that currently exist and are being developed.

Before Laurentian's closure last month, Canada had seven baccalaureate midwifery education programs in five provinces. Combined, they admitted just over 150 individuals into a highly competitive stream each year, where approximately 10% of all applicants are given an offer of admission. Upon graduation, these new midwives will have spent over 2,500 hours in supervised clinical practice and exit the education program ready to provide primary care, meeting the sexual and reproductive health care needs of women, trans and non-binary people.

Midwifery is the international standard supported by the World Health Organization for primary maternity care. Professional midwifery is the most cost-effective primary maternity care for health care payers, and 85% of pregnant people can complete their pregnancy and birth safely with only midwifery care. We have an obstetrical primary care provider crisis in many communities across Canada, and midwives see themselves well prepared to fill this need.

As you may know, I think you probably heard that midwives attend about 20% of births in Ontario per year and 26% of births in British Columbia. Those are the two largest midwifery-represented provinces. The loss of a program threatens the production of enough midwives to replace midwifery retirement or those promoted into leadership work. Ontario also educates midwives for the provinces and territories without sufficient midwives in practice to have their own educational programs such as Atlantic Canada and the far north. That need, combined with educating midwives for Ontario, cannot be managed by two midwifery programs in the south.

We must also highlight that we lack sufficient midwifery providers who represent the diversity of our communities across the country. Birth is a psychosocial health event that proceeds most normally when the culture of the primary provider matches that of the birthing family. Therefore, diverse provider backgrounds, including indigenous and French-speaking midwives, are essential to culturally safe care.

Students should be able to study midwifery close to their home communities. Having students move south to large urban centres for midwifery education places an unnecessary burden on families when they plan to live and work in the north. Students may learn and perform less well when separated from their community supports, and program attrition is linked to such barriers and stressors.

As a collective, the midwifery education program has recognized the urgent need to address inequities and facilitate diversity within our programs to support a safe and inclusive environment for indigenous, Black and people of colour within the student cohorts. We also know that the populations that suffer Canada's highest perinatal morbidity and mortality are found in our northern, indigenous and racialized communities.

When there are insufficient maternity community obstetrical services, the birthing units close. Pregnant people must travel, sometime significant distances, to receive care. This intersects with multiple social determinants of health. Researchers from the University of British Columbia have reported the negative impact on birth outcomes when obstetrical services close and people must travel from their communities to give birth. Several universities are instituting processes to remove barriers for indigenous applicants and others to join midwifery education programs.

Education programs that reduce barriers to enable inclusivity of folk, who, due to racism and colonization, have experienced systemic trauma, violence and oppression, is essential to support equity underserved populations. Closing Laurentian University's midwifery program, a program that helped meet those gaps, imperils those communities.

I also need to stress that midwives continue to struggle for recognition, and it is exhausting to continue to have to do so. At the federal level, there are barriers to midwives. Notwithstanding the long indigenous and settler history of midwives' roles in Canadian history, the first new midwifery wasn't regulated in Ontario until 1994. Now, 27 years later, midwifery is regulated or is in the process of being regulated in all provinces and territories in Canada.

In the current health care climate, there is a pressing need to support capacity building. Midwives should have pathways in leadership and service at the federal level. Unfortunately, there's lack of access to research awards and representation at the table where policy is forged.

Many midwives will graduate from a four-year degree with a debt burden of $90,000 to $100,000. However, if they work in rural and remote communities, they do not benefit from the federal education loan forgiveness programs that their colleagues in nursing and medicine enjoy.

Midwifery is a gendered profession, and we serve a gendered population. Laurentian provided education to future midwives who serve indigenous, francophone and northern and remote communities.

● (1935)

It has been said by others that you can assess the health of a nation by how it treats its indigenous peoples. Limiting the education of health professionals who can ably serve these communities does not reflect very well on us.

Thank you very much for the time to allow me to speak to you today.

The Chair: That's very good. Thank you so much.

Now we'll go to Ms. Bacon for five minutes.

Ms. Alixandra Bacon (President, Canadian Association of Midwives): Thank you, Madam Chair.

The Canadian Association of Midwives and the National Aboriginal Council of Midwives are the organizations representing midwifery in Canada. Our vision is equitable access to excellent sexual, reproductive and newborn midwifery services for everyone. Our focus to achieve this is on advocacy, midwifery association strengthening in Canada and abroad, and promoting excellence in clinical care.

Midwives are involved in 11% of births in Canada and play a vital role in the provision of equitable, accessible, culturally safe and high-quality health care, when and where people need it the most. Evidence shows that midwives working in the continuity of care model decrease pre-term birth, stillbirth, epidural use and instrumental birth. Canadian midwives also decrease rates of cesarean birth, hospital admission and readmission, and shorten hospital stays. All of this saves the system money.

For birthers of low socio-economic status, midwifery has been shown to reduce the prevalence of small for gestational age and pre-term birth when compared with physician care. Similarly, Canadian evidence shows birthers who are substance using or who have mental illness also experience improved outcomes when cared for by midwives, but access to midwifery care is constrained by a lack of awareness.

We know, as Kim has mentioned, that there's an inverse relationship between perinatal outcomes and distance travelled to care. Canadian midwives, however, have a long history of providing care closer to home, particularly in Inuit, indigenous and remote communities.

The UNFPA's state of the world's midwifery report was released on May 5, the International Day of the Midwife. For the first time, it includes a Canadian report showing that our workforce of 2,000 midwives amounts to only 0.5 midwives per 10,000 individuals. This is an inverted ratio of midwives to physicians compared to most high-income countries, and indeed, most other countries in the world.

Our sexual, reproductive, maternal and newborn child health workforce theoretically may exceed need; however, in reality, many communities do not have their needs met due to inequitable distribution of providers, as well as scope of practice restrictions.

The report also points to a potentially inefficient skill mix within the workforce, which may contribute to overmedicalization of childbirth or too much too soon in urban areas, and too little too late in rural areas, each contributing to higher cost to the system and poorer outcomes for Canadians. Given the improved outcomes and cost savings, the case for increasing the proportion of midwives involved in births is sound. However, if Canada wanted to adopt a midwife-led perinatal care system, we would need to increase the number of midwives to 9,000 by 2030.

What the state of the world's midwifery report doesn't take into consideration are the factors that threaten the future of the midwifery workforce in Canada. These include, as have been mentioned by previous witnesses, a shortage of midwives to meet the demands of Canadian birthers; a failure to address the needs of indigenous midwifery and fulfill the TRC call to action number 23; gender discrimination manifesting as a scarcity of midwifery leadership in administration and governance; inequitable pay,; lack of provincial or territorial funding; and a stagnation of growth in some jurisdictions due to health system arrangements and/or a lack of professional autonomy. These factors culminate to ultimately result in significant levels of burnout for the midwifery profession.

The closure of the Laurentian University MEP, Canada's only bilingual and tri-cultural MEP, further threatens the stability, diversity and equity of our workforce.

We call upon the federal government to co-operate with provincial and territorial governments to support the relocation of the Laurentian program to a northern university that can support its bilingual and tri-cultural mandate; expand investment in indigenous midwifery and focus on creating diverse pathways to education, including community-based education for indigenous students; extend federal student loan forgiveness to midwives working in underserved, rural and remote communities; add midwifery as a primary health care provider as defined by the Treasury Board of Canada, to facilitate midwives eligibility to work in federal service jurisdictions; create senior midwifery leadership positions, including a chief midwifery officer within Health Canada; and invest in CAM's capacity-building work with Canadian midwifery associations and invest in midwifery research and advanced education and leadership training for midwives.

Thank you.

● (1940)

The Chair: Excellent.

Now we're going to start our rounds of questioning with Ms. Shin for six minutes.

Ms. Nelly Shin: Thank you. I'd like to thank the witnesses on this panel for sharing their information and giving us more insight and understanding of midwifery in Canada.

Alix, you mentioned that 11% of births in Canada involve midwives. I like the terms, just to quote you, “culturally safe” health care and “improved outcomes”. I'd love to hear testimony from both witnesses on any situations or scenarios you were directly involved in or that you're aware of where culturally safe health care in the context of the work of midwives really did improve the outcome. Could you give us an example in the indigenous community and another example in a racialized community?

● (1945)

Ms. Alixandra Bacon: I can speak to a somewhat sad example. In my practice very recently we had an indigenous birth-giver who was pregnant with her fifth child. She had had two previous losses. Her eldest child was severely disabled and in a wheelchair with a feeding tube and required 24-7 care, and she found herself in the very sad circumstance of experiencing another second trimester loss at 18 weeks. It was what we call a “missed miscarriage”. She had to be induced to prevent complications associated with this and it was extremely important to her that she received care that was holistic as well as culturally sensitive.

To provide this care I connected with an indigenous doula to assure my patient that she could have culturally competent support. I looped in spiritual care to better understand her requests. For example, she wanted a cedar wrapping of the baby as part of a ceremonial burial, so we coordinated on that to ensure that it would occur. We connected to make sure that she would have child care so she and her partner could be together for the birth of their child, while their eldest and their other children could be well taken care of, and we helped to facilitate a traditional burial with an elder from her community.

That would be my example.

Kim, would you like to share one?

Ms. Kim Campbell: I have one that's more uplifting but maybe not as impactful as what you had happen, Alix.

I work in a community birth program in Surrey that serves new Canadians. There's a large immigrant population there and we have access to translation services through the Fraser Health Authority, and we have many people whose first language is not English, or who speak very little English at all. One particular person had come from a French-speaking African nation, and though I didn't speak any French, we were able to get an interpreter for them, and we got a community member who became a doula and provided doula services to them. We did absolutely everything and looked after all of her wishes. She came from a traumatic background. She had come from a country that had experienced war and violence, and she was exceptionally traumatized. She had PTSD and we facilitated a beautiful spontaneous birth because we set the stage for what she needed.

Ms. Nelly Shin: Thank you so much. I really love the sense of dignity that you're bringing through these very specialized forms of care.

My question now has to do with COVID-19 and how it has impacted midwives and how it has affected hospital births versus births in the homes of the pregnant mothers.

The question is for both witnesses and maybe we can start with Alix.

Ms. Alixandra Bacon: Thank you so much for your question.

I think that midwives have really stepped up in the time of COVID-19 to sustain their services and to offer new services, including advocacy for people who are birthing to receive respectful care and the support they need.

To give you an example, at times in the pandemic there were birthing people who were denied the presence of a support person in labour, and midwives advocated to ensure that the birthing people could have the appropriate support, which we know the evidence supports in showing reduced rates of Cesarean birth and other interventions.

In my place of work, people can bring in their partner or they can bring in a certified doula. We are masked, although the birthers aren't necessarily wearing masks when they're pushing. They're not able to bring in their families to visit them afterwards anymore, and extended families are no longer able to be present for the births. There have been, in certain jurisdictions, restrictions on home births that were made very hastily, and I'm very pleased to say that the midwifery leadership advocated strongly for home birth to be reinstated. As I believe Ms. Tecson alluded to earlier, one of the strengths of midwifery during this pandemic has been that we offer care out of hospital which relieves the pressure on acute care settings, as well as keeping healthy people away from sick people in acute-care settings.

Midwives have also expanded their offerings to include COVID testing and COVID immunizations, and to provide care for those who found themselves unattached to their primary care provider, because, at the beginning of the pandemic, many family physicians closed their practices. Midwives didn't have that luxury of waiting to figure things out. We hit the road and ensured that people continued to receive the care they required.

● (1950)

The Chair: Very good.

Now we'll go to Ms. Dhillon for six minutes.

Ms. Anju Dhillon (Dorval—Lachine—LaSalle, Lib.): Thank you very much, Madam Chair.

I'll start with Ms. Bacon. You had a very heartbreaking story about what can sometimes happen. I'd like to ask you about this. Following the closure of the midwifery program at Laurentian University, there will be a disproportionate impact on indigenous students. What are the consequences of a decrease in the number of indigenous midwives across Canada, in your opinion?

Ms. Alixandra Bacon: We cannot afford to have a decrease in indigenous midwifery. In fact, we need to be focusing all of our investments on growing the workforce of indigenous health care providers to fulfill our...Truth and Reconciliation Commission and the UN Declaration on the Rights of Indigenous Peoples. This will be devastating.

We've seen Joyce Echaquan, and we're hearing the call for Joyce's principle out in British Columbia, where I'm located. We've recently looked at the “In Plain Sight” report. The impact of racism on indigenous families is devastating, and it's unacceptable. We cannot afford to lose any of our indigenous midwifery practitioners. In fact, at this time we need to be funding and innovating so that we can increase the number of indigenous midwives available to provide culturally safe care where and when it's needed.

Ms. Anju Dhillon: Thank you very much.

Ms. Campbell, would you like to add something to that.

Ms. Kim Campbell: I agree with Alix. There are so many examples I can recount where my lack of understanding and knowledge of their culture and their community has had such a detrimental effect, I think, in not being able to meet their needs. That's not just indigenous people, but many people. I think we need to increase diversity in all areas. With regard to indigenous...absolutely, I hands down agree with Alix.

Ms. Anju Dhillon: Thank you.

Ms. Campbell, how many bilingual midwifery programs are offered in Canada, and what is the number of student applicants in comparison with the space offered for these programs?

Ms. Kim Campbell: Right now there's only one program in Canada that offers French-language instruction, and you have to be a resident of Quebec to attend it. It's at the University of Quebec at Trois-Rivières—it's Sherbrooke, rather. It's limited to people who live in that province, so with the closure of Laurentian, there is no other francophone instruction available.

The second part of your question was...?

Ms. Anju Dhillon: What number of spaces are available to those who are applying to these positions?

Ms. Kim Campbell: They have 24 seats a year at UQTR that they admit to, and they would all be French-speaking people. Those would be the only seats available in Canada for French-language instruction for those people living in Quebec.

Ms. Anju Dhillon: So you believe there is a serious need for more spaces and more....

Ms. Kim Campbell: Yes, but we have a bit of a dilemma right now.

Alix spoke a bit about the burnout that midwives are experiencing. COVID has certainly contributed to that, but lack of pay equity and resources have also had a significant impact on the workload that midwives have been experiencing.

You need preceptors to train midwives. I mentioned that there are 2,500 hours of clinical time spent in the midwifery program, where students are placed with midwife providers to learn how to practise, just like medicine and nursing does.

When we burn out midwives, they're not able to find the energy and the time to teach. We've experienced a significant drop in our preceptors in B.C., and I know that has been felt in Ontario, in Alberta, and it's been reported in Quebec. We have significant issues with preceptor burnout.

We need more midwives. However, the University of British Columbia was offered an expansion to our program, and we had to say we could not at this time bring more students in because we couldn't place them.

● (1955)

Ms. Anju Dhillon: My God.

Ms. Bacon, I have a question for you.

You've done considerable work in sexual health education. Can you share with us how midwifery services support the provision of sexual and reproductive health care in Canada?

Ms. Alixandra Bacon: Thank you so much.

This is an area where midwifery is greatly underutilized, as Dr. Bourret alluded to earlier.

It is within the scope of a midwife to provide cervical cancer screening, to be providing contraception, including the placement of intrauterine devices and the new Implanon contraceptive insert. It's in our scope of practice to be testing and treating for sexually transmitted and blood-borne infections.

However, in some jurisdictions, this is with an advanced scope of training. It is not accepted in all jurisdictions. There are also constraints, in that we are limited to providing this care, in most cases, though not all, to people who are pregnant or in the first three months postpartum.

This is an area where midwives could be providing a much larger role and having a bigger impact in helping to meet that unmet need for contraception in Canada, for long-acting, reversible contraception in particular, and that culturally safe component of care.

There are pilot projects, in Ontario in particular, such as the MATCH program, where midwives are working with delegation of function to be able to provide these services to people outside of that child-bearing year, as well as to provide abortion services. These are areas where we can expand.

[*Translation*]

The Chair: Thank you very much. Your time is up.

We will go to Ms. Larouche.

Ms. Larouche, go ahead for six minutes.

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

I thank Ms. Campbell and Ms. Bacon for joining us today and for reminding us of how important of a role midwives play in women's reproductive health. They are also reminding us of the important role of the program that has been abolished at Laurentian University for francophone communities in Canada, indigenous communities and northern communities.

You explained that those communities must be served in their language, that they have unique needs and that the program was important to them.

Ms. Bacon, you also talked about inequitable pay, health system underfunding or an unfair service allocation. You also talked about the importance of investing more in midwife associations.

Ms. Campbell, you talked about the fact that midwives were underpaid, and you also talked about income inequality and the lack of resources.

At a time when the pandemic has exacerbated problems, midwives and health care staff are exhausted. It is important for the government to reinvest in health transfers to enable Quebec and the provinces to in turn reinvest in their health system. That would obviously impact midwives.

I would like you to talk to us about the importance of having a vision now. We should not wait until after the crisis to give money back to the health system and to provide means to help midwives and other underpaid professions.

As you have both discussed the issue of funding, perhaps Ms. Campbell could start. We will then hear from Ms. Bacon.

[*English*]

Ms. Kim Campbell: There are several initiatives that could be undertaken if the scope of practice were enhanced to help make better use of the funding we have. Right now we have siloed health care systems, and midwives who have capacity to provide a more comprehensive service could be bulked into a team delivery system, for example, so that funds would.... Actually, you may not have to find more money. You could just be more creative in the use of the monies you have. However, right now we have a bit of a double-dipping system, and we have to refer to other providers to duplicate care when we actually have the competency and the skills to do it. That costs consumers money.

I think if there were midwives in leadership positions, they could potentially bring their lens to the discussion, but we can't even, at this time, be at the table for some of these discussions because we're not recognized.

● (2000)

Ms. Alixandra Bacon: I'd like to build on what Kim had to say. It is important not only to fairly compensate midwives, but also to integrate midwifery into the health care system. Otherwise, we will see situations like we see in some of the provinces and territories that are using the employment model, where there's complete stagnation in growth. We are asking impossible things of the provinces and territories where there are four midwives. Those midwives are expected to practise clinically and represent midwifery in regulation, in associations, at all of the committees and in research. It's an unacceptable burden to put on a small group of health care providers.

The Canadian Association of Midwives has identified, as one of our three key pillars, focusing our efforts on strengthening midwifery professional associations. We've had huge success with this and being able to impact the health rights and well-being of women and girls in our association-strengthening work abroad. However, we do not currently have the funding to provide those same supports to see that midwifery is integrated and midwives are put in positions of leadership here at home in Canada. We would like to see a partnership that provides midwifery capacity building to associations in the provinces and territories and to the National Aboriginal Council of Midwives so we can do the capacity building and create a more sustainable system.

[*Translation*]

Ms. Andréanne Larouche: Exactly.

I want to come back to the Laurentian University Midwifery Education Program and to its importance in improving the recognition of that profession and in ensuring succession for midwives in francophone and indigenous communities.

Ms. Campbell, could you tell us some more about the importance of the program and about the connection between succession and the recognition of the profession?

[*English*]

Ms. Kim Campbell: Perhaps the best way to deliver an education program that reduces barriers for participation is to distribute it to the communities. We're trying it in British Columbia. We're distributing programs to the communities so that students are coming together as a cohort to learn over small periods of time. Then they're going back to their home communities, or to communities close to where they normally live, to continue their education there.

We know that when we educate people in their communities they stay in their communities, and that when we bring people to the south, they sometimes don't go back, or they can't succeed in the program because they have lost the support of their family. We had an indigenous student come into our program many years ago who experienced so much trauma and grief from the effects of social determinants of health that it was too overwhelming for her to stay. Had we been able to be more flexible in our program and offer something that was more unique to meet her needs, there would have been a different outcome. I think there are so many different things we could be doing better.

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

Ms. Lindsay Mathyssen: Thank you so much.

You both spoke about specific stories that you had heard or that you had seen directly from a lot of your clients. When we talk about "vulnerable populations", there is so much that could mean. I think a lot of women using a midwife do so for religious or cultural purposes. They don't have trust in the system and don't want to enter an institution like a hospital.

Obviously when midwives enter a home, there's a very different type of service. Can you talk about the importance of them for a group or culture impacted by an institutional reality that doesn't fit with what they need for birthing?

Ms. Kim Campbell: Can I go first, Alix?

I'll take that on. I serve a population in the Fraser Valley that holds deep religious beliefs, one of which involves the non-interventional approach. They choose to birth at home and, because of their strong beliefs, won't accept any interventions that others would consider life-saving.

Through our embarking on relationships with some of the people in that community, they have come to trust us as listening to them and supporting them and advocating for them at every turn and asking them what we can do for them to help them meet their life goals. It's always an honour to be asked into someone's home to support them at the most intimate time of their lives. It's very important that we continue to do that, so offering home birth services and offering people care where they want it and when they need it is integral to an informed choice and a culturally sensitive care model.

● (2005)

Ms. Alixandra Bacon: Thank you, Kim.

I think there's enormous benefit to the continuity-of-care model that midwives have as well as to our fee structure. The continuity means that we're working in small groups. Care is provided by anywhere from one to four midwives in most cases, although there are some very innovative group and collaborative practices. This means we really have a chance to build the relationship and build trust with our clients. The person you meet antenatally is the person who will be present at your birth. There are no strangers. That's very important to people, particularly when we are providing trauma-informed care.

I can think of examples. I care for many Muslim birthers in my community. It's very important to them that there be no men involved in their care, and in a home birth situation, we can control the environment and ensure that they are receiving care from an all-female team, for example, if that's important to them.

In the case of queer families, I've provided home birth for queer families in which one of the parents is transgender and is very concerned about the discrimination they might face during a birth in the hospital. A home birth has been a way to provide them with safe and respectful care in which the correct pronouns are used and the family can really celebrate the birth without having to defend their human rights.

Ms. Lindsay Mathyssen: Thank you.

Basically what we're talking about in terms of that institutionalization of medicine, the colonialization of medicine as we know it and as maybe someone like me would feel more comfortable with is that it certainly doesn't cover what's required.

Ms. Bacon, you said that a lot of the services you provide are not accepted in all jurisdictions. That speaks to that institutionalization. Can you maybe expand on what you meant by that?

Ms. Alixandra Bacon: I think that while we do have Canadian midwifery competencies that are standardized and we do write a national exam, you do see small variations from jurisdiction to jurisdiction in the scope of practice, and those relate somewhat to regulations. Depending on the body involved in setting the midwifery regulations, there can certainly be politics and, I would say, gender discrimination and maybe some territorialism that's at play in determining who gets to provide what services.

The great irony is that we have Canadians who have unmet needs for sexual and reproductive health care, whether that's trans-inclusive care or access to long-acting reversible contraception or terminations, and yet at the same time due to the somewhat siloed nature of care, we have conversations about protectionism and about how one health care provider cannot steal a piece of the pie from another health care provider.

I think it's very important that we're breaking down silos and that we're providing care that's really family-centred care and based on the needs of the individuals receiving it. If we focus on that shared goal of meeting those needs, I believe we'll come to better solutions.

Ms. Lindsay Mathyssen: I know you're going to cut me off, Madam Chair, so I'll give you the rest of my time.

The Chair: Oh, how wonderful.

We'll go to Ms. Sahota, for five minutes.

Ms. Jag Sahota: Thank you, Madam Chair.

I'd like to thank the witnesses for being here today.

My colleague Ms. Shin asked you about how COVID has impacted the practice of midwifery and whether there's been a change in the number of births since the pandemic happened.

Ms. Bacon, you answered that. I'm just wondering if Ms. Campbell has anything to add to that.

Ms. Kim Campbell: I mentioned that it's also been exhausting for our teachers. The midwives are so consumed with the extra work that goes into keeping safe: maintaining their safety and ensuring the safety of the people they're caring for and the colleagues they work with and their families. There are midwives who aren't living at home because they feel it's unsafe to come into their home environment. They're living in a segregated space so they can keep their families safe. It's just too much to take a student into, so the impact of COVID on the education program has been devastating.

We have concerns right now—I guess I can say this—about the ability to provide enough placements for our second-year students at the University of British Columbia. Right now, we're reconfiguring the way we're delivering our programs so that we can meet the learning objectives, but we're being very creative in how we do it. This is the first time that we've had to do something like this.

● (2010)

Ms. Jag Sahota: Thank you.

Did you have anything to add, Ms. Bacon?

Ms. Alixandra Bacon: I did want to add to and build on that to say that the Midwives Association of B.C. has been conducting research on burnout in their population. They found that, over COVID, the proportion of B.C. midwives who reported moderate to high work-related burnout has increased from 45% in 2017 to 77%. That has resulted in the proportion of midwives who've made plans to leave the profession: It more than doubled in the same time period. Twenty per cent of midwives in British Columbia now are considering taking steps to leave the profession.

Ms. Kim Campbell: Can I add something to that?

Ms. Jag Sahota: Go ahead.

Ms. Kim Campbell: There are 25 vacancy calls in Fraser Health for midwifery positions, and that has never happened—ever. We've lost 25 midwives in one community where there were 100.

Ms. Jag Sahota: You both spoke about this, but I think it was more Ms. Bacon who spoke about the C-sections and hospitalization admissions being low when there are midwives involved. What are some of the contributing factors for that ? That's actually quite interesting.

Ms. Alixandra Bacon: Kim, do you want to take this one first. I know it's your wheelhouse.

Ms. Kim Campbell: You bet. It is my wheelhouse. That's the evidence-informed practice for midwifery care.

We have evidence that supports the fact that the role of the midwife contributes to several decreases in interventions, caesarean sections being one of them. We think it's the continuity of care. We think it's the relationships we build and the trust and the comfort that people have when they're with someone they know. It's quite simple: It lets their body do the work. Anxiety stops that, so when you create a soft landing spot and a safe place for people, the body does what it needs to do. It's very simple. That's it.

Ms. Alixandra Bacon: I would add that midwives picture birth as a normal life event. We do not pathologize birth. Also, we've learned the art of watchful waiting.

There's the cliché of midwives knitting in the corner, but it's for a very good reason. If we're knitting, we're not intervening needlessly. I think that's a real unique midwifery skill set that contributes to the decreased caesarean rates, as well as the time with our clients to make sure they're really well informed and prepared for what to expect in a birthing process.

Also, they have that continuous support in labour. We don't just sweep in at the end and catch a baby. We are with them from the onset of active labour until an hour or two after they birth, and that means that sometimes I might spend 14 hours straight with someone in supporting them. I believe it's that quality time that we spend one-on-one that makes the difference.

Ms. Jag Sahota: You've just said that you can spend up to 14 hours with someone. Do you come up with specific solutions for the clients depending on their needs and accommodate them? Let's say they're a high-risk client. Does the care start earlier than it does for others and end later as well? How is that managed?

Ms. Kim Campbell: I can jump in a bit here.

We have a system of risk assessment and we make sure that we individualize the care to meet the risk and the needs of the person. We always have our antennae up. We're always checking the environment. We're always situationally aware, and we pivot constantly.

The Chair: Very good.

Now we'll go to Ms. Sidhu for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair.

Thank you to all the witnesses for being with us, and thank you for your testimony.

My question is for Ms. Campbell.

What is presently being done to support the retention of midwives across Canada?

Ms. Kim Campbell: Thank you very much for the opportunity to answer that. The answer is, not enough. We have an exodus of midwives, a hemorrhage of midwives from the profession.

We're trying to negotiate system changes. We have very little flexibility in how midwives can work. Some of the working teams are requiring midwives to do team model care, call care. There's no way to use your competency and skills if you can't get up in the middle of the night, or you have a chronic care family member you have to look after or you have some unique issue with your health. There are sometimes no half-time positions for midwives to take. Depending on how the model is funded, the overhead can be crippling.

It's not sustainable in many of the places in the country as it's run right now. We have significant issues.

● (2015)

Ms. Sonia Sidhu: How do you think the two levels of government can better collaborate when it comes to the midwifery program? Do you have examples from other federated countries?

I would ask both of you to speak on that.

Ms. Kim Campbell: Alix, maybe you can speak to that with your ICM focus right now.

Ms. Alixandra Bacon: Absolutely.

I think it's critical that we see a national federal-level midwifery office, with a chief midwifery officer, whose role it would be to liaise with the ministers of health, advanced education—education federally and across the provinces and territories—to facilitate these sorts of conversations.

Ms. Sonia Sidhu: Ms. Bacon, you were talking about the impact of midwifery on rural communities.

Are there any international policy approaches to midwifery that are better serving rural families?

Ms. Alixandra Bacon: Actually, Canada along with Australia, I think, are really leading the way in terms of evidence, looking at rural midwifery practice. What we haven't seen are the investments that follow the evidence.

We know that midwives are more likely to go to rural areas; they're more likely to stay in rural remote areas. In terms of the percentage of people they can keep close to home for birth, midwives can maximize the percentage of people who can stay in their home community without having to travel, in comparison to other health care providers.

The evidence is there, and Canada and Australia lead in this evidence. You can look up the rural birthing index work by Jude Kornelsen.

What we need to see are investments that follow that evidence. In particular, this is going to look at salaried models of care and expanded scope, which are going to be essential to this.

These areas have care that's low volume, but that doesn't necessarily mean it's low input. You can spend an incredible amount of time, particularly when the midwife is replacing the role of several health care providers. The midwife in a rural remote community may also be serving as an ultrasonographer. They may also be the lab tech, drawing blood samples. They might be the infant hearing screener, the lactation consultant.

They're providing an enormous value. But we need to be investing. We need to look at alternate models of care. As well, as I mentioned, we need to be getting that Treasury Board distinction that would facilitate midwives working in federal jurisdictions, because several of these rural and remote areas, such as on reserve, fall under federal jurisdiction.

Ms. Sonia Sidhu: As a quick follow-up, Ms. Bacon, each year, 40,000 women in Canada travel outside of their communities to give birth, due to a lack of services in rural Canada.

How are different provinces across Canada addressing this gap?

Ms. Kim Campbell: In B.C., there are two provincially funded programs that are looking at trying to sustain rural obstetrical programs, by providing mentorship, providing access to training that's close to home, building confidence and building the competence in providing emergency services. They've individualized eight communities in B.C. as part of their rural obstetrical program, which is funded, unfortunately, through the Doctors of BC. However, they've been very inclusive, including midwives and nurses in their training platforms. We're hoping that increases capacity and impacts the communities to keep those providers there.

It's difficult to stay in a community if you lose or you start.... There's a critical mass, and if you take away one key player, the whole house of cards can fall down. They're trying to build a system. There are people who feel they want to stay there because they feel well supported and well funded to do so.

The Chair: That's very good.

[*Translation*]

We now go to Ms. Larouche for two and a half minutes.

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

I thank you once again, Ms. Campbell and Ms. Bacon, for your testimony, which sheds some light on the profession for us.

Ms. Bacon, I would now like you to talk to us about the importance of Laurentian University in francophone education outside Quebec and even its importance, as you mentioned, in terms of the disparity in midwifery services between rural and urban communities.

I would like you to talk about Laurentian University's role in that respect.

● (2020)

[*English*]

Ms. Alixandra Bacon: Thank you.

Yes, I am very concerned about the closure of Laurentian University because of its unique mandate. Laurentian University was the only bilingual midwifery education program in Canada, and the only French language midwifery education program accessible to non-residents of Quebec.

Its loss will be felt profoundly across the country in francophone communities. It also happened to be the only northern university-based midwifery education program—and, to be frank, rural care, remote care, northern care are specialty kinds of care. You can't fly just any midwife into a rural community and assume they will have this unique and expanded full-scope skill set to be able to provide care in these areas.

We are very concerned to see that northern specialty lost, and in particular I am deeply saddened to hear of the loss of the program that was the first in Canada to openly welcome indigenous students. So many of Canada's indigenous midwifery leaders were trained at Laurentian University and that was because they openly and explicitly welcomed indigenous students.

Again, indigenous care, as well as an educational program that's tailored to meet the needs of indigenous students and to set them up for success, is a key focus if we're going to meet our commitments to UNDRIP and the TRC.

The Chair: That's very good.

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

Ms. Lindsay Mathyssen: Thank you.

I just wanted to use my final time on postpartum care. You've touched on it a bit but we haven't heard a significant amount about your postpartum care and what that means to women and the services that are provided—the difference in care that it provides.

Ms. Alixandra Bacon: I think you see Kim and me smiling because you have touched on what is perhaps the biggest selling feature of midwifery care. We look after birthers and their babies until approximately six weeks postpartum—or at least we're compensated in my jurisdiction to six weeks, and care for them of up to 12 weeks, so there is that continuity of care. In the first week postpartum, those visits happen in the house. We do not expect you to pack yourself and your new baby into the car and drive to our office at five days postpartum, and we're coming the very next day. We will see you each day that you're in hospital, if you are in hospital, until you are discharged, and your very first day after discharge we're coming to you at home.

I can tell you both as a midwife and as a mother that if you are hoping to breastfeed, it is not as easy as it looks. It is extremely difficult, and your success is dependent upon receiving care early on. If I had had to wait until day five postpartum, my son would not have been fully breastfed or perhaps been a child who was not breastfed at all.

That is a place where our care really shines. It's also where we really have an opportunity to impact families as a whole in recognizing and responding, for example, to family-based violence or child neglect. We are very privileged to be able to enter people's homes and it really deepens the trusting relationship and is one of the most beautiful and heartfelt parts of our work.

Ms. Kim Campbell: It is the favourite part of my job.

Ms. Lindsay Mathyssen: I'll gift my 30 seconds.

Thank you, Madam Chair, and thank you to the witnesses.

The Chair: Thank you.

I think we're going to leave it there, because I have a couple of things that we have to clear up.

I want to thank the witnesses for excellent testimony. You've helped us with our study, and thank you also for your service to all the women in the country.

For the committee, I need to get approval for the budget to do this study. It's $2,550 for all of the headsets, etc., that we need for the study. Can I have approval from the committee for that?

Some hon. members: Agreed.

The Chair: Very good.

The other thing is that you need to have your dissenting reports on our pay equity study submitted in both languages by this Friday.

Tomorrow we will be completing our study on sexual misconduct within the Canadian Armed Forces. On Thursday we're going to start, and hopefully finish, our consideration of the report on women's unpaid work. That's what's on our agenda.

Don't forget that tomorrow we meet at 11 until 1 o'clock, and Thursday is from 6:30 until 8:30. Is it the pleasure of the committee to adjourn?

Seeing that it is, we'll adjourn.