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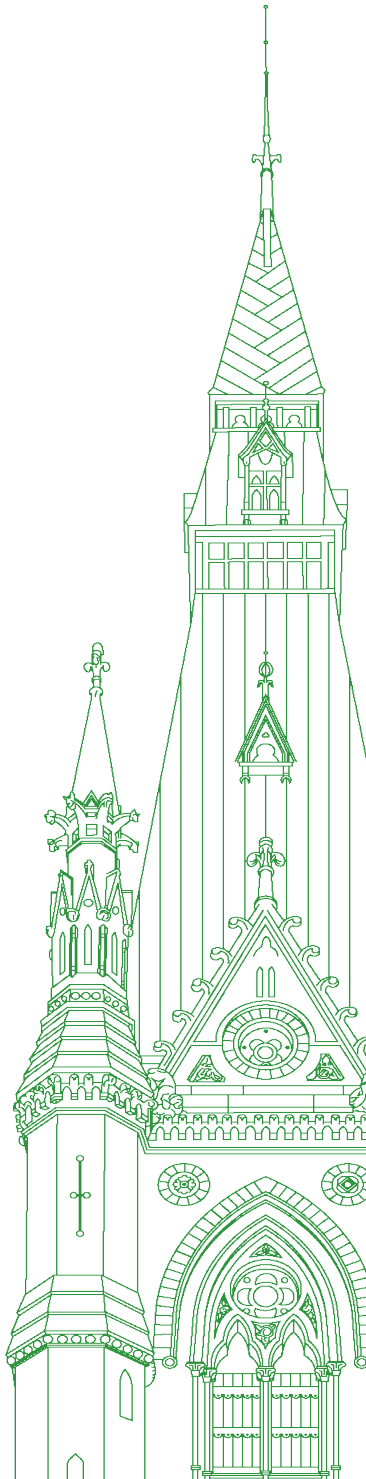

Chair: Ms. Marilyn Gladu

Standing Committee on the Status of Women

Tuesday, May 25, 2021

● (1100)

[*English*]

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

Welcome to meeting number 36 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, 2021. Our committee is studying midwifery services across Canada.

Witnesses, I will recognize you by name. All your comments should be addressed through the chair. If you need interpretation, there is a button at the bottom of your screen where you can choose either your favourite language or the audio from the floor. When you're speaking, please speak slowly and clearly for the interpreters. When you're not speaking, your mike should be on mute.

Now I'd like to welcome our witnesses, who will each have five minutes for their opening remarks.

We have, from Laurentian University, Robert Haché, president and vice-chancellor, and Marie-Josée Berger, provost and vice-president, academic. From the Association of Ontario Midwives, we have Ellen Blais, director, indigenous midwifery.

We'll begin with Robert for five minutes.

Mr. Robert Haché (President and Vice-Chancellor, Laurentian University): Thank you very much, Madam Chair.

Good morning, everyone. *Aaniin*.

[*Translation*]

Good morning, I'd like to thank the committee for inviting me to participate today. The committee's work in examining critical issues such as women's health, support and care for certain groups of women, women's labour issues and challenges faced by women living in rural communities, for example, is essential.

I am pleased to speak to you today from Laurentian University in Sudbury, in Northeastern Ontario, located on the 1850 Robinson-Huron Treaty territory and on the traditional lands of the Atikamekseng Anishnawbek and Wahnapitae First Nations.

Earlier this year, Laurentian University faced a devastating choice: close the university's doors or declare insolvency and set down the path of the Companies' Creditors Arrangement Act to ensure the university's survival. It was an extremely difficult choice and the consequences were significant. We were at an impasse where decisions had to be made to ensure our long-term future, and one of those decisions was the termination of our midwifery program.

[*English*]

Although midwifery and *sage-femme* programs have been a point of pride for Laurentian University and indeed an area of need for the province, it has been a very expensive program to deliver relative to other programs. Indeed, it has actually been two programs, one in French and one in English, with a total of 30 students across both programs, and with faculty and support duplicated for each program.

With revenues capped well below the cost of the delivery of the programs, in a situation in which decisions needed to be made to restore the financial viability of the university, it was no longer possible for Laurentian to continue to offer these programs. To accommodate midwifery students, Laurentian has been working with the other programs in the province and is communicating options to help students make informed decisions about their academic future to ensure that they complete their degree. Further, the total number of midwifery training positions in the province will not change, as the Laurentian slots are being redistributed across the other programs in the province.

Laurentian's efforts are firmly trained on the future: on what comes next, on rebuilding and on excelling in our mandate of educating the future leaders of our global communities. We remain deeply committed to our bilingual and tricultural mandate, offering strong programs in French and English and with indigenous content and program options across faculties.

● (1105)

[*Translation*]

Laurentian University will continue to provide post-secondary pathways for our North's first-generation learners, for francophone and Indigenous students, for those located in remote areas or impacted by societal challenges, to the children and grandchildren of our nearly 70,000 alumni and to all those discerning individuals who choose to pursue higher education.

[*English*]

I would like to thank the committee again for the invitation to appear before you this morning and applaud the important work that you are doing for the people of Canada.

Thank you. *Merci*. *Meegwetch*.

[*Translation*]

The Chair: Thank you very much.

Ms. Blais, you have the floor for five minutes.

[*English*]

Ms. Ellen Blais (Director, Indigenous Midwifery, Association of Ontario Midwives): Thank you. *Shekoli*. Good morning.

I'm speaking to you today from Wasauksing First Nation near Parry Sound.

Thank you, committee members, and thank you, Madam Chair. I am honoured to have the opportunity to have a few minutes to share with you some words about the value of indigenous midwifery to the health and wellness of indigenous communities.

My name is Ellen Blais, and I hold the position of director of indigenous midwifery at the Association of Ontario Midwives. I am a graduate of the midwifery education program at Ryerson University, and I am from the Oneida Nation of the Thames.

I would like to share the name I was given that connects me to my spirit. In the Oneida language my name is Kanika Tsi Tsa, which means Little Flower. I was born through the waters of Many Flowers, who was born through the waters of She Who Carries Flowers, my maternal grandmother. My identity comes from a place of dislocation from the moment I was born, being taken away at birth by child welfare from my culture and my roots. The story of indigenous midwives is inherently related to dislocation as well, up to and including the closure of the Laurentian University midwifery education program.

Sadly, my story is shared by many. Although indigenous people make up about 4%-5% of the population of Canada, in many jurisdictions well above 60% of our population are in the care of the state. Since indigenous midwives are often present at the birth of indigenous babies, they work hard every day to intervene in these destructive practices and are providing excellent clinical care to every indigenous family they are working with. However, there are far too few of us to sustain this kind of work into the future.

I have three recommendations that I will now share, and then provide you with real-life contexts of why these recommendations are relevant.

First, we need a commitment from the federal government to build capacity for indigenous midwifery programs and services by developing a funding strategy to ensure indigenous midwifery is core funded.

Second, we need a commitment from the federal government to provide a mechanism to hire midwives and to provide housing and infrastructure for midwives in first nation and indigenous communities.

Third, we need a commitment from the federal government to provide funding for indigenous midwifery education, so that individual communities can support broader initiatives or create their own midwifery education programs that are relevant to the community, self-governed and community-responsive.

To connect the theme of dislocation, the history speaks for itself. The colonization of indigenous lands and resources also involved the forced removal of our children by the state to be placed in residential schools, now replaced by the current child welfare system. The medicalization of childbirth, along with policies embedded in the Indian Act, pushed indigenous midwives to the side and extinguished their work.

Without these overwhelming forces, midwives would have stood strong to keep birth in our communities. Midwives would have held our babies close and would never have allowed infants and children to be taken out of their mothers' arms. The anti-indigenous racism that is so prevalent in our health systems would not have been allowed to develop exponentially, to the point where indigenous people die from lack of culturally safe care.

In addition, the closure of Laurentian University has left a huge gap in providing midwifery education in the north, and with that, access for midwifery education for indigenous students and the growth of indigenous midwifery in northern communities.

Allow me one moment to ask you a few questions to illustrate my story.

If you have had children, imagine yourself when you were preparing for childbirth, or maybe even preparing for the birth of your grandchild. What were your hopes and dreams for your birth? Where were you going to have your baby? Most likely, you were thinking about your home, your family and your community.

Now replace your thoughts with these. Imagine yourself getting on a plane alone about four weeks before your baby is due. You wave goodbye to your family and hope that they will be okay. You arrive in a small rural or remote community thousands of kilometres away, where you know no one. You live in an unfamiliar place and you wait four lonely weeks until your baby is born. At birth, there is no family, no home and no community. You get back on a plane and you go home all alone with your baby in your arms, with no support.

This is what indigenous people have had to do for generations. It is a harmful and hurtful practice. Where is the sound of the newborn baby's cry? We have only silence. What does that mean for the health and wellness of your community? What has been lost?

● (1110)

In conclusion, access to indigenous midwives is imperative for the health outcomes of indigenous communities. Please consider these recommendations. We are tired of holding this up on our own. We know that to bring back birth is to bring back life. We know how to do this. We are strong, we know what we need, and we are brilliant.

I will conclude with a final ask by sharing a quote from the Women Deliver Indigenous Women's Pre-Conference.

> We ask the government of Canada to measure the health and wellness of Indigenous women, girls and gender diverse people as an indicator of the health and wellness of the entire nation.

Thank you. *Yawʌ'kó*

The Chair: *Meegwetch,* Kanika Tsi Tsa.

Now we'll go to our first round of questioning. We're going to begin with Ms. Sahota for 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. Blais, you touched on diversity a bit. I'm wondering if either you or the other witnesses can speak to the reception. How is midwifery received by other groups of different ethnicities? How about LGBTQ communities? What's the reception in terms of the program? How many different ethnic groups or LGBTQ individuals sign up for this program? Do these ethnically diverse groups or LGBTQ communities use midwifery services for the births of their children?

Ms. Ellen Blais: I'm most expert in the indigenous communities, of course, but based on my experience of living down in Toronto, there are many practices that serve specifically and very specially LGBTQ2QS communities. We have a very diverse population of clients who have midwifery care. It's diverse, as you can imagine. Also, the indigenous communities themselves are very diverse. There's no such thing as a pan-indigenous approach to indigenous midwifery.

To answer your question, yes, it's a very diverse client population.

Ms. Jag Sahota: Mr. Haché, do you have anything to add to that?

Mr. Robert Haché: Not really. I can't comment on the services that are used. I don't have the figures before me in terms of the distribution of visible minorities and so forth within the midwifery program.

Ms. Marie Josée Berger (Provost and Vice-President, Academic, Laurentian University): Maybe I can add a few words, Madam Chair.

What is very important is that at the midwife program, we ask students to identify themselves. If I look at some of the numbers I have—I don't have all the numbers—I see that in the program right now, there are five students who identify themselves in terms of their diversity. When we address some of the specific assumptions about the program as it is, we have students identify themselves as indigenous, as francophone, but also as gendered. They are identified as she or he; it depends.

During the course of the program, most of the professors take into account inclusion and diversity in delivering the different aspects of the program.

● (1115)

Ms. Jag Sahota: Thank you.

This is to any or all the witnesses who can maybe shed some light on what role midwives play in Canada's health care system, and more specifically in the indigenous communities.

Ms. Ellen Blais: I can speak for the indigenous communities.

We have about 130 indigenous midwives across Canada right now. This is why we are hoping that the federal government will consider additional funding for education and for programs and services in our communities. We are part of the health care system of Canada. We fully integrate within the health care system, providing services with birth at home, in the community, in birth centres and in the hospital. We work on all those levels of the health care system.

In terms of indigenous people, as I said before, we have about 130 indigenous midwives working across Canada, and about 30 specifically in Ontario. They work fully integrated with the health care system as well.

I hope that's helpful.

Ms. Jag Sahota: Thank you. My time is up.

The Chair: You have one more minute.

Ms. Jag Sahota: I have one more minute? Okay.

Maybe I can pose the same question to you, Ms. Berger.

Ms. Marie Josée Berger: I think it's very important to note that this program at Laurentian is part of a consortium. There are three universities—Ryerson, McMaster and Laurentian—and they work together to prepare the programs. For most of the courses, the reflection and the critical thinking and everything are delivered are as part of the consortium. We prepare the students by having them look at different aspects. One of them is geography and the special population groups, including aboriginal and francophone.

As well, because of the trends in the program, some of the programs are offered part time and some full time in order to give the opportunity to students to complete them, depending on where they are, such as in the north or in remote areas. We accommodate them. It's part of the consortium work.

[*Translation*]

The Chair: Thank you.

Mr. Serré, you have the floor for six minutes.

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

I thank the witnesses very much for coming here today to discuss a very important topic for our community. I am a graduate of Laurentian University, as are my father and daughter, and the news on April 12 when the court proceedings ended shook the community to its core. I myself was extremely disappointed and frustrated at programs being terminated at Laurentian University, which also saw its image become tarnished. I am still very proud of the university, but I'm having trouble accepting the process.

I know I don't have a lot of time, Mr. Haché, but we need to regain the community's trust. Today in committee we are specifically looking at the midwifery program.

[*English*]

Mr. Haché, we've heard repeatedly that there's an urgency to keep the midwifery program in northern Ontario. It's been our pride for the last 28 to 30 years because it's rural focused and it's in northern Ontario, with strong partnerships with Laurentian and Lakehead and a focus on indigenous studies, and it's the only bilingual program in Canada. Can you confirm today what efforts are being made to support this program to stay in northern Ontario?

Mr. Robert Haché: This was an extremely difficult decision for Laurentian. Entering the process, and everything that has happened since we entered the process, was extremely difficult. We do absolutely recognize the impacts on communities and on individuals. None of this was done lightly.

Very simply, as I referenced in my opening remarks, Laurentian did not have a choice. It was either follow this process or close the doors three months ago on January 1. We chose the path that provided the university with a chance, but we had to do some very difficult things to try to bring the university financially in order. It had gotten to a point where we were insolvent and would otherwise have had to close our doors. We went through an exercise that looked at all of our programs on the English side and on the French side to identify those areas and those programs that would help support a financially viable university going forward and those programs that were just unaffordable and could not be maintained going forward. It's truly unfortunate, but the midwifery programs were clearly programs that cost us more to deliver than we received in revenue.

● (1120)

Mr. Marc Serré: Monsieur Haché, we heard clearly from witnesses that the midwifery program with the tri-council will now be McMaster and Ryerson, which are an hour apart, with very little rural experience, very little indigenous experience and very little French experience.

I don't know if there have been conversations, but there's a natural fit here to have NOSM deliver the program. There's Collège Boréal here in northern Ontario. Have you considered these options? Are there conversations with Laurentian and the Minister of Colleges and Universities to have the midwifery program remain in northern Ontario in partnership with NOSM and/or possibly Collège Boréal?

Mr. Robert Haché: We've had many conversations with the Ministry of Colleges and Universities and with the Ministry of Health, which provides support for the program as well.

The program, as you heard, is part of a consortium, and the steps that have been taken have been to close the programs at Laurentian and to transfer the students and the student positions—the slots that were previously held at Laurentian—to Ryerson and McMaster. The total number of training positions will continue in the province, but they will be redistributed to the existing consortium partners.

This was done in the best interest of the students, notwithstanding other initiatives that might be possible in the future to create new consortium partners or programs. It was done simply because of the situation we were in and having to deal with students who were continuing clinical placements into the summer and who needed to have certainty for the fall. This was judged by all to be the most appropriate solution for the students who are currently in the program and for the program going forward.

Mr. Marc Serré: The students here in September are going to a McMaster or Ryerson program, but are there any conversations with the provincial government to ensure that these students remain in northern Ontario? Time is of the essence here.

McMaster doesn't have any experience, as I said, in a rural context. It doesn't have experience with indigenous or francophone services, so how can this committee and the federal government support Laurentian or support the province? We need a proposal from either Laurentian or the province to support the midwifery program staying in northern Ontario. What can we do to help?

Mr. Robert Haché: Thank you.

First let me indicate that the students who are in the program will be attending virtually in the fall, so they will not need to physically move to attend the program.

In addition, all of the clinical placements that happen in the north will continue to happen in the north. We did work very carefully with Ryerson and McMaster to ensure that clinical placement opportunities would continue to be available in the north going forward for students who are in the north.

For the students in the francophone program, there will be French language opportunities to allow them to complete their program and to complete their training in French. All of that is being built in and provided as a result of the transition that is occurring.

[*Translation*]

The Chair: Thank you.

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

● (1125)

Ms. Andréanne Larouche (Shefford, BQ): I'd like to thank the witnesses, Ms. Berger and Ms. Blais, as well as Mr. Haché, for being with us today and reminding us just how important the midwife issue is.

Mr. Haché, you just addressed the issue with my colleague Mr. Serré and talked about the solutions in place. In your opening remarks, one thing you mentioned was redistributing students elsewhere in Canada. You talked about two colleges as well as other possibilities and future agreements.

In your opinion, would student redistribution adequately address the growing need for midwives across the country?

Could you tell us more about this student redistribution?

Mr. Robert Haché: Thank you for the question.

Students have been redistributed throughout the province of Ontario, which has a total of 90 spots for training midwives. Previously, these spots were distributed across the three institutions offering the program.

The 30 positions assigned to Laurentian University have been redistributed to McMaster University and Ryerson University. This leaves the total of 90 training spots intact.

It is an excellent program for people who want to study in the field. We always have many more applications for the training than we have spots available. The province determines how many graduates we will have and students we will take in each year. It is managed by the province, which ensures that the right number of midwives are active in the system. That number has not changed for several years.

In the future, we will continue to offer 90 spots throughout the province. The challenge will continue to be to offer the program in French, as Ryerson's and McMaster's long-term programs are offered in English. At Laurentian University, five or six people were studying in French each year, which meant about twenty people were enrolled in the program over the four years of training. This is a large number, but it reflects the challenge of offering a fairly expensive program to a very small number of students.

Ms. Andréanne Larouche: As you say, the clinical placements will happen, as you will ensure travel in Northern Ontario and locations where training is offered in French. However, challenges will remain in terms of guiding people who want to take the training in French. I imagine that the same will be true for Indigenous people and that the challenges will continue.

Ms. Berger, I'd like to ask you a question about this.

You talked about student redistribution and the choices you had to make. Perhaps you can confirm that the issue with the programs that had to be terminated is essentially financial. That's what I heard you say. Can you confirm that?

What are your thoughts on the financial argument that was used to justify shutting down the midwifery program?

Ms. Marie Josée Berger: Thank you for the question.

I'd like to add something to what Mr. Haché said. Students who are currently completing their fourth year of the program are staying at Laurentian University. We will ensure that they complete their placements until the end of December, and they will graduate from Laurentian University.

Those in their third year will have letters of permission, but their placements will continue in Sudbury and Northern Ontario. This transition is confirmed.

Those in first and second year will transfer to McMaster University and Ryerson University to complete their studies. As Mr. Haché mentioned, the consortium receives funds from the Ministry of Health and the Ministry of Colleges and Universities. All of this is being coordinated by the consortium.

When you look at the number of students enrolled, the programs that need to be offered, and the quality that needs to be provided—which is really important for a midwifery program like the one the consortium is implementing—one thing becomes clear: even though we're working together to implement the program and the educational curriculum, the fact remains that the revenue doesn't really match the costs.

● (1130)

[*English*]

Mr. Charlie Angus (Timmins—James Bay, NDP): I have a point of order, Madam Chair.

The Chair: Go ahead, Mr. Angus.

Mr. Charlie Angus: Madam Chair, I've been told that ParlVU has no sound. There are many people in northern Ontario who are trying to pay close attention to this issue. I think we need to find out why they're not able to hear the testimony of the witnesses.

The Chair: I definitely agree.

Clerk, can we pause for a moment until we get that working? Thank you.

Madame Larouche, you have less than 30 seconds left.

[*Translation*]

Ms. Andréanne Larouche: Ms. Berger, as I understand it, the clarification you provided was about solutions being considered for the next step, which were discussed with Mr. Haché.

When you were talking about costs and revenue, I misunderstood the end of your remarks because Mr. Angus spoke.

So I will come back to my question. As I understand it, when the decision was made to cut programs at Laurentian University, it was because of revenue.

How do you feel about that argument when a health program like midwifery is involved?

Ms. Marie Josée Berger: This program is extremely important. However, Laurentian University did not have the revenue to offer a quality program and cover all the expenses associated with it.

[*English*]

The Chair: Excellent.

Now we'll go to the NDP for six minutes.

Go ahead, Mr. Angus.

Mr. Charlie Angus: Thank you, Madam Chair.

Thank you, Madam Blais, for being here. I would love to speak with you about midwifery, particularly in the north in communities like Fort Albany, Attawapiskat and Moose Factory, and I hope we can speak at another time. Today I'm going to have to focus on the situation at Laurentian.

Mr. Haché, the bankruptcy protection act has been around since 1933 and, according to the experts I've spoken with, it has never been used on a public institution, and certainly not a university. One of the tools it's used for is to give breathing room to be able to restructure.

I'm interested in the decision that was made to fire 100 professors, cancel 58 undergrad courses and kill 11 postgraduate courses in the midst of the final week of classes. Why did you sign off on that date? Why did you not give the students a chance to finish their year?

Mr. Robert Haché: Thank you very much for the question.

In effect, all students had a chance to finish their year. Let me start by saying that.

Under the CCAA process, we had an initial stay of proceedings from February 1 to April 30. That was the length the court gave us to initiate the negotiations and conversations that needed to be had for the changes that needed to be implemented before the 30th of April so that the court could consider providing an extension of that stay—

Mr. Charlie Angus: Okay, but I have to stop you there. Students did not get the opportunity to finish their year, because you were firing professors before courses had been marked. You were telling professors there was no severance, that they were out the door. You were cancelling and taking down the online course information before students finished their year.

I have spoken with students who have told me that their degree has been irreparably damaged. This was a decision you made. To tell me that these students got to finish their year is false. You had the breathing space with CCAA. Why did you use the most tense week in a student's year to cancel the year and fire the teachers?

Mr. Robert Haché: I'm sorry, but that is not correct. No teacher left the university before April 30. Most teachers—

Mr. Charlie Angus: No, they were told they were going out the door, and that caused chaos.

Mr. Robert Haché: They were told—

Mr. Charlie Angus: You were pulling down the course information. Why did you not give them the breathing space?

● (1135)

Mr. Robert Haché: All students got to complete their year. The course information you're referring to is course information for next year. As I attempted to explain, we were required to do so because of the timeline of the court-imposed stay of proceedings. I will point out that all of the changes that occurred were negotiated, changes either with the academic senate of the university on the programming side or with the labour unions on the staff and faculty side.

Mr. Charlie Angus: I find that interesting, because on January 25 the labour union at Laurentian said they were filing a complaint that you were bargaining in bad faith. They also stated that you had saved $10 million since 2018 with cuts to the staff. I think it's really unfair for you to claim that labour unions signed off on this decision to start firing the teachers before the year ended.

I want to just step back from here, because I read your filings. They're extensive. It would have taken months of planning to make the decision to kill the midwife program or the physics program or mining engineering, so when did you start the process of evaluating which courses would be terminated? Was it n December or January? When did that process start?

Mr. Robert Haché: The process for evaluating the courses that would be terminated started after February 1. It was a process that included representatives of the academic senate of the university, which met many, many times. The university provided data—financial data, enrolment data—on the programs, and then a series of negotiations were held to land on the programs that were sustainable and could continue for the university and the programs that unfortunately needed to be closed in order for the university to have the chance to continue.

Mr. Charlie Angus: I guess the frustration that we have.... I mean, for us in northern Ontario, Laurentian is a symbol. My father became a graduate in his forties because he could go to a school in northern Ontario. He became a professor of economics. I've spoken with students who have come from across Canada to go to Laurentian because it's a symbol, yet what we see is this image of chaos and disregard for people I've spoken with who have been irreparably harmed. The idea that you used the CCAA to initiate this doesn't make sense, because, Mr. Haché, you told the students that last spring you were almost at a balanced budget. You said you were almost at a balanced budget. Then in October you said you had a debt of about $7 million. Then you told them in the last week of their school year that they had a choice: You were either going to shut the school down or do these massive cuts.

Who made the decision that those were your only two options?

[*Translation*]

The Chair: Mr. Haché, are you there?

Ms. Larouche, do you have a comment?

Ms. Andréanne Larouche: Madam Chair, the interpreters are saying that for Ms. Blais and Mr. Haché, the signal is bad and they are having trouble understanding their words and interpreting them. I also see that their image is frozen.

The Chair: All right.

[*English*]

Mr. Charlie Angus: Madam Chair, I've lost about a minute there, so can you add that time?

The Chair: Actually, it's 30 seconds. The 30-second sign was up.

Mr. Charlie Angus: Well, with the intervention....

The Chair: I stopped the clock at the intervention, Mr. Angus.

I:ll give 30 seconds for Mr. Haché to respond to your question.

Mr. Robert Haché: I'm not sure exactly what the question was, because I had some audio issues as well.

Mr. Charlie Angus: The question was this. You told the students last spring that you were just a couple of hundred thousand dollars away from having a balanced budget. Then in October you said your debt was about $7 million, with an impact of $5 million to $10 million from the pandemic. Then on April 2 you dropped this bombshell that you had only two choices: You were either going to shut the university, which had had 60 years of public investment, and walk away on it, or you had to do these massive cuts.

You're not telling us something here. Were you not aware that the debt was there, or were you using this process for other reasons—to cut your staff with your collective bargaining agreements? Why did you go from telling people that you were almost at a balanced budget to telling us that you had to shut the doors, and that took place in less than a year?

Mr. Robert Haché: Simply, it was required that we have a balanced budget. At that point, Laurentian had no additional capacity to take on additional debt.

We did work very hard prior to the pandemic to meet the projected budget of the year, but then with the overall.... We just simply had no more room at the end of that.

On February 1, we had to take the decision, as Laurentian was insolvent. We had no alternative but to close the doors or to initiate this process. We initiated this process to provide a future for the students.

● (1140)

The Chair: I'm sorry. That's the end of your time, and I would point out that I certainly was more than generous with the time.

Now we're going to Ms. Wong for five minutes.

Hon. Alice Wong (Richmond Centre, CPC): Thank you, Madame Chair; and thank you to all the witnesses.

I'm really sorry to hear of the closure of this very important program. As a former faculty member as well, and then later on becoming the administrator, I know the challenges on both sides of the table whenever you talk about funding.

However, I have several questions.

First of all, regarding the impact of COVID-19, I understand that because of COVID-19, many programs are not fully attended by students. Therefore, fees as revenue and other programs that are generating revenues might have been impacted.

As Laurentian administrator, can you comment on that to explain your decision?

Mr. Robert Haché: Indeed, the campus has been functioning virtually since the middle of March of last year, when COVID fully arrived. At that point, Laurentian was actually the first university to transition from face-to-face to virtual programming. We did it virtually overnight. All students completed their term. We ran a spring term.

Enrolments have not been significantly impacted by COVID per se, but students are not on campus. We are actually looking forward to a return to campus this September, but for the past year, students have been working virtually. They have been advancing in their studies and the programming continues to be offered.

A significant portion of revenue at the university happens through activities that occur on campus. The loss of so-called ancillary revenue and residences that are not being used and so on do provide financial challenges to the university. Also, a number of additional expenses were incurred because some activity needs to continue on campus, such as research, so there were increased safety protocols and cleaning and all the rest of it.

COVID has had an impact, but it was not the only impact on Laurentian. There were a number of issues that Laurentian has faced over the past decade that ultimately led us to where we were at the end of January.

Hon. Alice Wong: Do you have a special program for international students at your campus?

Mr. Robert Haché: We do have international students at Laurentian, studying in a variety of areas. I would say the greatest concentration is in the faculty of management.

Hon. Alice Wong: Have they been affected by COVID, therefore affecting the revenue? Everybody knows that international education brings a lot of revenue to universities and colleges.

Mr. Robert Haché: Yes, there's no question that students have been impacted, but I really want to applaud the efforts of the Government of Canada to provide the additional flexibility that they provided last year to allow international students to continue to study virtually. That has been really important. By and large, international students at Laurentian have continued in their programming.

It is particularly challenging when classes are at three o'clock in the afternoon at Laurentian and that means it's three o'clock in the morning where the international student is actually studying from. However, we've done our best to provide opportunities to view lectures at convenient times, rather than specific times, and do whatever we can to accommodate international student learning. That has continued.

The international student enrolment at Laurentian has actually not dropped as significantly as at many other institutions, but has been maintained. It is something, of course, that will be important as we look towards the fall, and hopefully the penetration of the vaccine and the reopening of travel and so forth, to be able to welcome international students back on campus. They are important to the university. They are important to the whole community. Having that international flavour on campus is important to all students.

● (1145)

Hon. Alice Wong: Yes. Thank you very much, President.

My next question is directed to our first nations—

The Chair: I'm sorry, Ms. Wong. You're out of time.

Ms. Sidhu, you have five minutes.

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

Thank you to all the witnesses for joining us today.

Ms. Blais, you spoke of how you would like to see more resources put towards indigenous midwifery training. What are some of the ways you've been able to incorporate indigenous medical practices with western ones?

Ms. Ellen Blais: That's a really, really important question.

I think one of the things to point out is that a lot of the time, that kind of programming within the midwifery programs that exist in the three university programs has not necessarily integrated indigenous knowledge, whether it be cultural from elders or from within communities. This is why we feel that directing some funding and some strategies towards including culturally based education coming from within communities would be relevant and appropriate for indigenous people in their communities to identify that they wanted to be midwifery students and to learn more. Then it would be well tailored so that communities could begin to self-define what that means.

I hope that helps answer your question.

Ms. Sonia Sidhu: Thank you, Ms. Blais.

Madam Chair, I want to give my time to my colleague Marc Serré.

The Chair: Very good. Go ahead, Monsieur Serré.

Mr. Marc Serré: Thank you, Madam Chair, and thank you, Ms. Sidhu.

Mr. Haché, you understand that for the students, the faculty, the staff and the community there's a big issue with the process that's been followed—the transparency and also the image—to rebuild Laurentian University. The concern moving forward now is will Laurentian, through the CCAA process, be selling assets? This is one of the most beautiful campuses in Canada. I've lived it. I've been on it and I am continuing to do that. We do not want to have any of these assets sold off.

As you know from budget 2021, Paul Lefebvre and I and many of the Liberal francophones met directly with several ministers, including Minister Joly, Minister Freeland and Minister Champagne, and we were successful in having $120 million in the federal budget in 2021. We have to find solutions. What have you done to work with the Province of Ontario to make sure that we look at support immediately? What can the federal government do to support the province? Right now we haven't seen any proposals from the province. Moving forward, what can we do to support the province? What are you doing to get the province to work on a plan to move forward?

Mr. Robert Haché: First, let me agree with you that Laurentian truly does have a picturesque campus. That is a really important feature of the university.

We have been in conversation with the province continuously for many, many months about the situation that Laurentian is in, how we're progressing now through the CCAA process, and what will be needed, as we come out of the process, to have a university that will be sustainable into the future. Those conversations are happening with great regularity with the province, more than once a week at the present time. We are working with them to develop the package of supports that will help the university be sustainable going forward as it transitions out of the CCAA process.

At the same time, we are doing an audit of space at the university. It is important that we be able to ensure that we have the infrastructure we need to support the students going forward and to support the university going forward. That's the other aspect of it. We must ensure on the one hand that we have the campus and we have the buildings and facilities that will support the educational mandate of the university going forward. At the same time, should we identify some infrastructure that is truly surplus to the university, that is costing money to have at the university and that is not needed, there is a duty to look at how we can realize something from those assets that otherwise would be a cost to the university.

Note that I'm not talking about the lands of the university, necessarily; I'm really focused on physical infrastructure in terms of buildings and structures that might have other purposes that could benefit the university going forward.

● (1150)

[*Translation*]

The Chair: Thank you.

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 witnesses for participating in this committee meeting. In the first round of questions, I had the opportunity to address Mr. Haché. This time, I would like to speak to Ms. Blais as well.

Ms. Blais, you kind of answered my question, but could you tell us more about the impact of the closure of Laurentian University on women's health and the availability of culturally appropriate services for Indigenous families?

[*English*]

Ms. Ellen Blais: Thank you for the opportunity to address your question.

I think it's very important right now.... To think that indigenous people will feel okay, with what I've heard, it's not okay to have them necessarily go down south for the remainder of their education.

The accessibility of a northern program is absolutely important for all indigenous communities in the north. The north of Ontario is the size of France. We have 160 first nations in Ontario, many in the north, and we've heard that many communities are very interested in developing midwifery programming in their communities. For indigenous people to have to go down south is not acceptable. They need programming in the north, and this is something that's very important to them. We need indigenous content in our programming, which northern Ontario can certainly deliver, instead of adding in any indigenous content as an afterthought. Relocating to communities like Toronto or Hamilton for university-level midwifery programming is out of the reach of many indigenous students. Gaining tuition funding is not always easy, and some of the timelines that are required, according to some of the loan institutions, to finish our degrees do not work for our communities.

There are many things to think about in terms of the closure in the north. I've heard from many indigenous students that the north is where they want to remain.

The Chair: Very good.

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

Ms. Lindsay Mathyssen (London—Fanshawe, NDP): Madam Chair, I think it's Mr. Angus still.

The Chair: We have Mr. Angus again for two and a half minutes.

Mr. Charlie Angus: Thank you, Madam Chair, and thank you, Madam Mathyssen, for giving up time.

Mr. Haché, thank you for coming today. Again, when I talk to people in northern Ontario, there are still many deep questions.

I go back to these statements that you made to the students. You were looking at a balanced budget last spring, and then you had $10 million of additional expenses as a result of COVID. That makes sense. Every university and every community college I'm aware of has been hit hard. Everybody's been hit hard by COVID.

Who made the decision that the only option to get out of this was to go into bankruptcy protection? Who made that call? Who told you that it was your only option?

Mr. Robert Haché: Thank you very much for the questions.

First to provide some context, Laurentian has had the poorest financial health of any university in the province.

With respect to the decision, the decision was made by the board of governors of the university at the very end of January.

Mr. Charlie Angus: Okay.

Prior to that, though, when you knew you were getting into deeper and deeper trouble, did you go to Minister Romano or to the federal government to try to get some breathing room? This is about finding breathing room to work with your creditors. Did Minister Romano or the federal government tell you that you were on your own? Why were you not able to get that breathing room?

We're talking about an institution that is unique for francophones, for indigenous, for working-class northern Ontario. People come from all over the world to this university. I can't imagine they all just said, “Hey, well, whatever, we'll just see it all torn down.”

To get that breathing space, were you turned down by the province, and did you talk to the feds?

● (1155)

Mr. Robert Haché: Thank you again for the question.

In the months leading up to the decision to file, we indeed had extensive conversations with the Ministry of Colleges and Universities and with the minister's office—i.e., with the province. We also had conversations at the federal level about what could potentially be done.

I can't comment on the decision-making process on the government side. All I can say is that at the end we were left with no alternative—

Mr. Charlie Angus: Was that the reason you had to go into CCAA? Was it because at the provincial and federal level, they were not willing to help out an institution as important as Laurentian?

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

We'll now go with the remaining time. We have two minutes each for the Conservatives and Liberals. We'll start with Ms. Shin for two minutes.

Ms. Nelly Shin (Port Moody—Coquitlam, CPC): I'd like to thank the witnesses for being present today and helping us have this discussion on this very important topic.

I'd like to ask Ms. Ellen Blais how the COVID pandemic has impacted the services of midwives in indigenous communities.

Ms. Ellen Blais: That's a really good question. Thank you.

When I think about midwives being in community, certainly in the urban and some of the more rural areas, I believe there has been quite a bit of continuity of care. Midwifery services have continued programming. There were some initial issues around obtaining PPE for communities, but services have continued. There has been the same level of home births and hospital births that there were.

Going into a home for a birth, of course, requires that the families themselves don their own gear. However, it has been relatively stable. The issues have been with the ones who have to fly out for the births, which I mentioned earlier.

With some of the issues that have happened, I have heard that there has been difficulty finding housing or hotels when you have to fly south and to find places to stay when you're discharged from the hospital. Family members have not been allowed to come with you. There have been issues with blood products and things like that, which have not been able to stay stabilized when you have to travel thousands of kilometres away.

Some communities, I've heard as well, have not had any health care services in the first nations because of COVID and lack of human resources during that time.

The Chair: That's very good.

Now we'll go to Monsieur Serré for the final question.

[*Translation*]

Mr. Marc Serré: Thank you, Madam Chair.

I thank the witnesses for being with us today.

Mr. Haché, I want to go back to local solutions. We have post-secondary institutions like Collège Boréal, Cambrian College and the Northern Ontario School of Medicine.

Do you have any suggestions to help us work together and find solutions to support Laurentian University?

There is no Ministry of Colleges and Universities at the federal level, as they are under provincial jurisdiction.

How will you work with the province and local communities to come up with a solution for the federal government, which is here at the table to help you?

Mr. Robert Haché: Thank you for the question.

As we've seen today, it's a resource issue. If it had sufficient resources, Laurentian University could continue to offer its midwifery program. It's just a matter of starting conversations with the federal government and provincial governments to generate the necessary resources. We may also need to work with our partners—

[*English*]

The Chair: Excuse me. I think Ms. Hutchings said she couldn't hear.

Ms. Gudie Hutchings (Long Range Mountains, Lib.): There's no translation, Madam Chair.

The Chair: Could I have the clerk check on that, please?

Mr. Robert Haché: I could repeat it in English, if that would help.

The Chair: I think—

The Clerk of the Committee (Ms. Stephanie Bond): Please proceed.

● (1200)

The Chair: I think it's working again, so go ahead.

[*Translation*]

Mr. Robert Haché: I was almost done.

I was saying it's about resources and if you work with the provincial governments and with the federal government to generate resources, we could continue to offer a midwifery program, even at Laurentian University. It's about having the resources to make the program sustainable over the long term. We can also work with our partners at Collège Boréal, specifically with respect to French-language training, to find other solutions.

The Chair: Thank you.

That's all the time we have. I'd like to thank our witnesses for their testimony, which will help us in our study.

[*English*]

We're going to suspend momentarily so we can do the sound checks for the next panel.

● (1200)

_____(Pause)_____

● (1205)

The Chair: I call the meeting back to order.

Welcome to our study on midwifery services in Canada.

I'm very pleased to welcome our witnesses today. Each will have five minutes for their opening remarks.

From the Canadian Midwifery Regulators Council, we have Tracy Murphy, the executive director, and Louise Aerts, the chair.

From the National Aboriginal Council of Midwives, we have Claire Dion Fletcher, an indigenous registered midwife and the co-chair, and Brenda Epoo, also an aboriginal registered midwife and another co-chair.

From Regroupement Les sages-femmes du Québec, we have Josyane Giroux, president and midwife.

We will have all, eventually. We'll start with our guests from the Canadian Midwifery Regulators Council.

Louise, you can begin. You have five minutes.

Ms. Louise Aerts (Chair, Canadian Midwifery Regulators Council): Thank you, Madam Chair and members of the committee. My name is Louise Aerts and I am the board chair of the Canadian Midwifery Regulators Council.

I am speaking to you today from the unceded Coast Salish territory, represented by the Musqueam, Squamish and Tsleil-Waututh Nations.

I am pleased to have this opportunity to appear before the committee regarding your study on midwifery services in Canada.

The Canadian Midwifery Regulators Council is a network of provincial and territorial midwifery regulatory authorities. Collectively, we regulate the profession of midwifery in Canada. As is the case with many other health professionals, each jurisdiction has its own midwifery regulatory authority or college, which works to ensure public safety by setting registration requirements, setting and enforcing standards for safe and ethical care, and responding to complaints from the public about midwifery services. Midwives must register with the college in their province or territory in order to practise.

Midwifery is currently regulated in all jurisdictions in Canada except Prince Edward Island. Ontario was the first jurisdiction to regulate in 1993, followed by B.C. in 1998. Yukon is our newest jurisdiction to be regulated. This took effect in April of this year. The CMRC is now supporting P.E.I. as it works to regulate midwifery.

There are fewer than 1,700 practising midwives in Canada. Ontario has the most, with around 800 practising midwives. The next-largest jurisdiction is B.C., with 325. At the other end of the spectrum, there are 10 midwives in the Northwest Territories, six in New Brunswick and six in Newfoundland and Labrador.

I'd like to speak about indigenous midwifery from a regulatory point of view.

Indigenous students may take any of the recognized midwifery education programs in Canada and are eligible for registration in their jurisdiction through the regular channels. Further, Ontario and Quebec have laws that provide exemptions from registration for indigenous midwives working in their communities. In Ontario, the exemption clause has been enacted, but it has not yet been enacted in Quebec.

In B.C., the Midwives Regulation includes the ability to regulate a class of indigenous midwife. This also has not been enacted.

The CMRC's mission is to encourage excellence among Canadian midwifery regulatory authorities through collaboration, harmonization and best practice. Some of these recent efforts have included revised entry-to-practice midwifery competencies, common registration requirements, and a shared letter of standing and professional conduct. We are also working to harmonize self-assessment by midwives, indigenous midwife self-identification, labour mobility and emergency skills training certification.

The CMRC owns and administers the Canadian midwifery registration exam, the CMRE. All midwifery regulatory authorities except Quebec require applicants to successfully complete this exam prior to registration. Each year, 110 to 150 midwifery candidates write the CMRE. These individuals are from our Canadian baccalaureate midwifery education programs or bridging programs for internationally educated midwives.

As evidenced by these numbers, midwifery is a small professional group and is limited in terms of growth by the numbers of graduates entering the profession each year—i.e., under 150 across the country.

The CMRC was disappointed to learn of the closing of Laurentian University's midwifery program. This leaves only six baccalaureate midwifery education programs in the country, and only in the provinces of B.C., Alberta, Manitoba, Ontario and Quebec. The CMRC hopes that the Laurentian University midwifery program will be relocated to a new university that, like Laurentian, can provide instruction in English and French and serve the needs of indigenous students and communities.

Midwifery regulators in Canada are ready to assist in the creation of indigenous-led pathways for regulation or exemption. We ask that the committee consider ways to expand investment in indigenous midwifery, which includes creating diverse pathways to education.

Midwives play a vital role in the provision of equitable, accessible, culturally safe and high-quality health care. In some jurisdictions, temporary emergency registration has allowed eligible midwives to register quickly, on a short-term basis, to assist with the COVID-19 pandemic efforts. Further, some jurisdictions have issued public health orders that have expanded midwives' scope of practice to fill needs brought about by the pandemic.

Thank you for your time and consideration. I hope these remarks have helped you to understand the regulation of midwifery in Canada. I am happy to take any questions you may have.

● (1210)

The Chair: Excellent.

We're going to continue, then, with Ms. Dion Fletcher for five minutes.

Ms. Claire Dion Fletcher (Indigenous Registered Midwife, Co-Chair, National Aboriginal Council of Midwives): Thank you, Madam Chair and members of the committee.

Greetings from the many communities of indigenous midwives that make up and contribute to the National Aboriginal Council of Midwives.

I would like to start by acknowledging the land we gather upon today. It is the land that brings us health, wisdom and opportunity for renewal.

My name is Claire Dion Fletcher, and I am a Lenape-Potawatomi and mixed settler midwife.

Indigenous midwives have been the backbone of our communities from time immemorial. Colonization, including the medicalization of birth, sought to erase our pivotal role in our communities, our indigenous knowledges and our governance systems, drastically contributing to the poor health outcomes we see today.

Anti-indigenous racism is a problem in this country. It exists in all of our systems: judicial, health, education and beyond. Indigenous midwives provide a protective force against racism—not only in our role as indigenous health care providers, not only in our role as advocates for our clients and not only in being a witness to how our people are treated, but also by providing care in a way that promotes the sovereignty of indigenous people, so that our babies, from the moment of birth, are surrounded by indigenous knowledge and teachings and grow up with us as a part of their community to help them understand their bodies and their rights.

Indigenous midwives are culturally safe care for our communities. We are not the same as mainstream midwives. Yes, there are many similarities, but there is no replacement for indigenous midwives in our communities. Growing and sustaining indigenous midwifery is a direct commitment to addressing anti-indigenous racism and gender inequality that all levels of government can make today.

The following are our three recommendations.

Recommendation one is a reinvestment in indigenous midwifery by the federal government. We must acknowledge that substantive equity starts at birth. The Government of Canada made a historic first five-year investment in indigenous midwifery in 2017. We urge the federal government to renew and substantially increase this funding in 2022 and beyond.

We have numerous reports that highlight the inequities in health outcomes for indigenous people. How many more reports do we need before we take real action? The health of indigenous women, girls and gender-diverse people is an indicator of the health and wellness of the entire nation, and we are failing. The recently released report on the state of the world's midwifery indicates that investing in midwives directly improves health outcomes. A substantial and long-term commitment to indigenous-led midwifery increases equitable access to sexual and reproductive health, works toward addressing gender-based violence and promotes the empowerment of all members of our communities, particularly women, girls and gender-diverse people.

Recommendation two is the addition of midwifery to the job classification system of the Treasury Board of Canada. At present, there is no federal recognition for the profession of midwifery, which creates barriers for communities wanting to hire midwives. Midwives are essential primary health care providers. The lack of recognition by Treasury Board is a key barrier to establishing and sustaining midwifery services for indigenous communities. The cost of non-indigenous-led primary health care to the health system and to indigenous communities is unjustifiable.

Recommendation three is an investment in indigenous-led midwifery education. As indigenous midwives, we know that education programs need to be close to home. We need to train and retain more students within our communities. The closure of the Laurentian midwifery education program is devastating for rural, northern, francophone and indigenous midwifery.

However, we need to also be clear about the limitations of the current university-based education program for indigenous midwifery students. These programs have rigid structures that do not acknowledge the family and community roles of indigenous students and are based in colonial systems that fail to recognize the importance of indigenous knowledge and ways of being. The recognition of indigenous knowledge is a skill in midwifery, and it is crucial for meeting the health needs of our communities.

Our current system is failing prospective indigenous midwives and urgently needs to be reimagined. Indigenous midwives in communities across the country are working to diversify pathways to education for indigenous midwifery students. It's time for the government and the university system to catch up and invest seriously in indigenous-led midwifery education. This is a commitment the government can make as part of its work in addressing anti-indigenous racism.

Anti-indigenous racism is the root of inequity in Canada. Our colonial legacy has been uniquely borne out by indigenous women, girls and gender-diverse peoples, which affects all of our families. Indigenous midwives return to indigenous communities the respect, autonomy and reverence for all of our life-givers.

● (1215)

Anushiik. Thank you.

The Chair: Thank you very much.

We're going to briefly pause while we do sound checks for our two other witnesses who are here now.

[*Translation*]

Ms. Giroux, you have the floor for five minutes.

● (1220)

Ms. Josyane Giroux (President, Midwife, Regroupement Les Sages-femmes du Québec): Good afternoon.

I hear music. I don't know if I'm the only one, but it's going to be hard to do my presentation.

[*English*]

The Chair: Clerk, could you check why she's still hearing music?

[*Translation*]

The Clerk: I don't know why you are hearing music. It's not coming from us.

Ms. Josyane Giroux: Okay, it stopped.

The Chair: You may begin your presentation, Ms. Giroux. You have the floor for five minutes.

Ms. Josyane Giroux: Good afternoon, everyone.

Madam Chair, I thank you for having me here today.

My name is Josyane Giroux. I am a midwife and president of the Regroupement Les Sages-femmes du Québec. In Quebec—

I'm sorry, but there's an audio lag. I can still hear myself speaking.

[*English*]

The Clerk: Madam Chair, please suspend.

The Chair: We'll suspend while we address the technical issue.

● (1220)

_____(Pause)_____

● (1220)

[*Translation*]

The Chair: Ms. Giroux, you have the floor again for five minutes.

Ms. Josyane Giroux: Thank you, Madam Chair.

Good afternoon, everyone.

I thank the committee for having me here today.

I am Josyane Giroux, a midwife and president of the Regroupement les Sages-femmes du Québec, or RSFQ.

The RSFQ is the professional association that represents more than 240 midwives working in the profession throughout the province. It works to develop the profession and its specificity within Quebec's health care system. In collaboration with the authorities and citizen groups, the RSFQ is committed to supporting access to midwifery services that meet the needs of the population.

The RSFQ also defends the free choice birthplace for women or people who give birth, in accordance with the standards of practice of the profession, as well as its philosophy of practice. The RSFQ is recognized by Quebec's department of health and social services as a spokesperson for midwives, and it negotiates their working conditions.

In Quebec, midwifery has been legally recognized since 1999. At the time, there were already six birth centres where 50 midwives worked. In 2008, the Quebec government published its perinatal policy, in which it pledged that, by 2018, midwifery services would be available in all regions of Quebec, that 10% of women and birth attendants could access services and that there would be a total of 20 birthing centres across the province.

According to 2019-20 data, only 4% of maternity follow-ups are carried out by midwives. Many regions still don't have access to services, and all the birthing centres have very long waiting lists, sometimes representing 30% of the number of annual follow-ups that can be offered by the teams.

We think there are three main reasons for this slow-motion development. First, the lack of recognition of the profession in general and its crucial role in reproductive and sexual health is a major issue. The midwifery model of practice, based on relational continuity, confidence in autonomy and respect for the physiological process of pregnancy and childbirth, is not recognized and valued.

In Quebec, the lack of knowledge of the profession heightens tensions and still leads to refusals of collaboration by medical teams. Ultimately, this remains an obstacle in the development of interdisciplinary services or projects that meet the needs of communities. The government has failed in its crucial role of demystifying and valuing the midwifery profession and its importance to the health system. On a day-to-day basis, it is midwives and families who are experiencing this pressure and are still fighting against misperceptions about their practice by clinical teams and the public.

The second major deficiency is the lack of workforce planning and workforce monitoring consistent with the objectives presented. Despite numerous representations in this regard by the RSFQ and other organizations, the warnings were not heard by the Quebec department of health social services. Midwives and families are the main victims of this lack of political leadership, as labour shortages are now affecting all midwives and forcing them to reduce services to the population. At this very moment, more than 20 contracts are unfilled in the province, and the opening of at least two birthing homes has been delayed.

In Quebec, the Université du Québec à Trois-Rivières is the only educational institution for the midwifery profession. It has a capacity of 24 students per year since the program opened in 1999, but is struggling to fill these places due to the lack of midwives to accompany trainees. It is essential that national consultation work involving the groups and community-based organizations directly involved, including citizen groups, be undertaken in order to find solutions and establish a clear plan.

The third very important element to consider in the analysis of the development of midwifery services and its slowness is the gender discrimination that midwives experience. The midwifery model, developed to meet the needs of women and pregnant persons and whose services are mainly aimed at women, is the source of indecent working conditions. Quebec midwives, at the end of their careers, earn 20% less than their comparable pay equity jobs. In Quebec, in 2019-20, the government paid only a total of $23,561,343 for midwifery services, including all operating costs. These working conditions, in addition to the context described above, lead to many early departures from the profession, exacerbating the shortage of human resources.

At the same time, the RSFQ operates solely based on membership dues, as the government does not recognize the importance of a strong professional association for supporting the development of the profession. Our association therefore struggles to meet all the needs, both those of its members in a global way and the support in the strategic work more than necessary.

Finally, it is with humility that I would like to add that the elements I've described are an exacerbated reality for women, pregnant people, and midwives from indigenous communities.

● (1225)

To date, there is no clear plan to provide families in these communities with access to midwifery services. Collaboration is at its starting point between governmental and legal organizations, communities, universities, and associations.

Our NACM colleagues and indigenous midwives will certainly be able to explain the issues in detail, but we believe it is crucial that the committee look at these matters.

In short, the RSFQ asks the provincial, territorial and federal governments to set up a campaign to demystify, promote and recognize the midwifery profession; invest in the establishment of a working committee for workforce and development planning in line with community needs; provide funding to professional midwifery associations, essential in supporting practice at all levels; recognize gender discrimination faced by midwives and adjust working conditions to end it; and prioritize work for the training, accessibility and development of midwifery services in indigenous communities.

Thank you, committee members, for your attention.

I will be happy to answer any questions you may have.

The Chair: Thank you very much.

[*English*]

We're going to pause for a moment now to do a sound check for Brenda Epoo.

Now we will go to Ms. Claire Dion Fletcher, who will read Brenda's remarks. Thanks so much.

● (1230)

Ms. Claire Dion Fletcher: Thank you, Madam Chair and members of the committee, for allowing me to speak on behalf of Brenda. It's unfortunate that she's not able to connect, as she brings a very unique perspective to this committee.

I'm now going to read her statement for you, as follows.

My name is Brenda Epoo and I'm an Inuk midwife from Inukjuak, a small village in the remote Arctic region of Nunavik, Quebec. I am part of a team of indigenous midwives that serves seven villages on the Hudson coast, using modern and traditional Inuit midwifery skills.

The month of May celebrates midwives and nurses globally. To acknowledge this, the World Health Organization and partners launched “The State of the World's Midwifery 2021” report, which tells the story of the COVID-19 pandemic and how midwives serve their communities in a time of crisis.

A key finding of the report is that during the crisis there has been an increase in violence and reduced access to essential reproductive and sexual health services, and that, critically, midwives play a crucial role in providing support and guidance and access to these important health services.

Across the world, including here in Canada, women and gender-diverse pregnant people are struggling, which has led to increases in maternal mortality, unintended pregnancies, unsafe abortions and infant mortality. While Canada has an established public health care system, it is highly inequitable.

At home in the Arctic, midwives are the leaders of the maternity. We protect our communities and help lessen the impacts of COVID-19 on families. Our Inuit-led model of midwifery is culturally appropriate, with excellent clinical outcomes, including 86% of births taking place in Nunavik between 2000 and 2015. Our model leads the world in linking traditional and medical ways of knowing, and yet we remain largely unrecognized and unseen.

The significant contributions we make day in and day out are not known to most Canadians and policy-makers. Systemic racism is rampant in the health care system, especially against indigenous people. We need a more compassionate and thoughtful system that recognizes the important role that indigenous medical professionals play as clinicians, educators and mentors.

The National Aboriginal Council of Midwives believes that investments in indigenous-led community-based education strategies are critically needed. This investment will create meaningful opportunities for indigenous training, apprenticeships and, ultimately, increased culturally relevant service capacity.

NACM has already developed a sophisticated indigenous midwifery core competency framework that allows communities to customize opportunities to maximize local benefit. We are ready to partner on expanding this initiative to create a more inclusive, responsive and equitable health care system, especially for indigenous people living in rural and remote communities.

Here in the north, we do more than catch babies and do postpartum care. We provide an opportunity for children to be born on our land, in our communities, with a sense of place and pride. It's all about our families, communities and creating future generations of healthy people.

Thank you.

The Chair: Thank you very much.

I apologize for all of the technical difficulties. It looks like we will get in one round of questions.

We will begin with Ms. Wong for six minutes.

Hon. Alice Wong: Thank you, Madam Chair.

Thank you to all the witnesses from different parts of our nation. I have had the privilege of visiting many of your communities. I was especially impressed that we have somebody from B.C., because my riding is in Richmond Centre. Welcome, Louise, as one of our witnesses.

I understand that the professional recognition of midwives is so important, because then it leads to status, pay equity and a lot of those related issues. Can either Tracy or Louise comment further on how important it is for the regulators to make sure the quality's out there and that the midwives get the training and recognition, especially in pay equity and all the other areas?

● (1235)

Ms. Louise Aerts: Thank you for the question.

I think it's really important that midwives are regulated health professionals, that we are able to provide the safety that comes with being part of a regulated college. It speaks to the registration requirements, those education requirements. It speaks to the quality assurance programs that we put in place, and in particular the ability to respond to any complaints and address any conduct or competence issues that might exist. That has definitely impacted the professionalism of midwifery.

However, a lot of the issues that the other witnesses have spoken to remain. There are areas that still block midwives and there are lots of turf wars between different providers and such. Definitely in terms of where we've gone in professionalizing this and through regulation, I think we've gone a long way. Wherever midwifery can be recognized as a primary care service benefits midwives across the country.

Hon. Alice Wong: Thank you.

My other question is about foreign credential recognition. I think this is also a very important element to meeting the growing demand for midwives across the nation. This is a federal committee, so I want you to comment further on that, please.

Ms. Louise Aerts: At the moment, there are two bridging programs for internationally educated midwives in Canada, one in Ontario and one in B.C. The method for getting registered in Canada as an internationally educated midwife is to take one of the bridging programs in order to bridge to the Canadian model of midwifery. As I say, at present, there are just the two programs that are bringing in internationally educated midwives.

Hon. Alice Wong: Thank you.

My next question is directed to Madame Fletcher.

You did mention a lot about inequity and also the recognition that we just mentioned for the professional status of indigenous people. You also mentioned in some of your reports that access to health care services is challenging in many indigenous communities, which may force indigenous people to seek care outside their communities, and then they report experiences of racism and violence. I'm really alarmed by what the council has reported. Madame Fletcher, can you comment further on that, please?

Ms. Claire Dion Fletcher: Yes. Thank you for this question.

As I mentioned in my remarks, we have a number of reports that have been put out at both the national and provincial levels. There's the “In Plain Sight” report from B.C., the “First Peoples, Second Class Treatment” report, and the recommendations from the Truth and Reconciliation Commission, the study on missing and murdered indigenous women and girls. We have numerous reports that speak to the racism that indigenous people face in the health care system, and this is happening to us on a daily basis and really affects access to care.

One of the ways to combat it is by having indigenous health care providers. The closer to the community and the closer to our ways of knowing and being that those providers are, the better it will be for our health outcomes.

Hon. Alice Wong: Thank you.

In my past experience visiting indigenous families and seniors especially, I have heard them mention that language has always been a challenge when they go outside their communities for health care services. Can you comment further on that point, please?

● (1240)

Ms. Claire Dion Fletcher: Yes, that is a crucial aspect, and thank you for bringing it up.

Not being able to access health care in your own language makes it extremely difficult. We can see this in many areas of health care, but as one of the earlier witnesses said, imagine being in labour and trying to deliver your baby and not being able to speak in the language of the health care providers who are providing your care. Imagine the difficulty that presents at such an important time in being able to understand what is happening to your body, what health care providers are doing and what is going on in the room.

It's an extremely isolating experience, and then to be in the situation that a number of indigenous women are when giving birth far from home.... You don't have family members around. You don't have the support of your extended family or your community. It's very isolating and it does not improve health outcomes.

The Chair: That's very good. Now we'll go to Ms. Hutchings for six minutes.

Ms. Gudie Hutchings: Thank you, Madam Chair; and to all the witnesses, thank you for your passion. This has certainly been an education process for us on the committee and a topic that has been so interesting.

I live in a very rural riding, and there are many similarities with indigenous people for people in rural ridings.

Louise, I have a question for you. How has the COVID-19 pandemic impacted the practices of midwives all across the country, but especially in rural areas? Do you have a comment or two on that?

Ms. Louise Aerts: Sure. I'll start with the positive. I think the COVID-19 pandemic has forced us, across the board, to think outside the box, and in some ways jurisdictions have looked to midwives to solve some of the issues that have come forward. In some cases, they have expanded the scope of midwives. Midwifery is quite unique in that it is defined in terms of the restricted activities as services provided to a pregnant person or someone in the postpartum period. Midwives have lots of skills, knowledge, education and judgment that fall outside that period as well.

One example is being able to test for COVID. Midwives within the regulation could do that for their pregnant clients but not for the general public, so health orders were expanding those services. Similarly, for administering the vaccines, midwives could do so for their clients but not necessarily for the full public. Therefore, midwives were looked to and scope was expanded through temporary orders to allow midwives to fill those gaps. Because they are in rural and remote areas and they have that knowledge, skill and judgment already, it was a natural extension, which has been positive.

On the negative side, and very much in terms of the burnout piece, some of the existing structures that were in place for others around personal protective equipment didn't fall into place for midwives right away, especially in the home birth setting. Everyone knows there was very limited PPE available across the country, but what there was, was in the hospital setting. Midwives weren't able to immediately access PPE for home birth, and they really had to again think outside the box to be able to provide care in a safe way.

I think there is a general burnout. We have seen increases in home births through the pandemic, as people looked to avoid being in the hospital setting. There was a lot on midwives to manage. Often there are very few midwives available in small communities, so to have someone need to isolate or come into contact with COVID-19 was very impactful on those communities.

Ms. Gudie Hutchings: Thank you for your answer.

Claire, the NACM produced a community readiness guide. It was to support indigenous communities as they re-establish and grow their community-based midwifery services.

Can you tell us a few things about the guide? How was it developed and how has it been received throughout your communities?

Ms. Claire Dion Fletcher: Yes. Thank you.

It was developed from the work that NACM has been doing over a number of years in reaching out to communities, talking about bringing birth back and discussing what midwifery could look like in our communities.

One of the things about indigenous midwifery is that when you look across the country at all the different ways indigenous midwifery looks, you see a lot of variety. From the midwives who practise in Nunavik to the midwives who practise at Six Nations to indigenous midwives out in B.C., how we practise looks different.

● (1245)

The Chair: I think she's frozen. We'll just pause here.

Ms. Gudie Hutchings: I hear her just fine, Madam Chair.

Ms. Claire Dion Fletcher: I'll keep going, Madam Chair.

It looks different because indigenous midwifery comes from within the needs of our communities. We always start with our community, the birthing person and the birthing family. Then we think about what those people need. What is it that our communities need to have better access to health care, to have culturally based and safe care? What is it they want from their birth, and from their sexual and reproductive care? That's how we start.

That's what the community readiness guide helps to do. It talks to the community about going through those processes of thinking about what midwifery would look like in your community.

Ms. Gudie Hutchings: Wonderful. Thank you for that.

Ms. Giroux, why do you think Quebec falls behind the national average in births that have been delivered by midwives?

I think it was May 5 when you called on the Government of Quebec to recognize the place and effectiveness of midwifery services and to look for solutions. Do you think that's the crux of the issue of why midwifery is not used as much in Quebec?

[*Translation*]

Ms. Josyane Giroux: Thank you for the question.

As I said earlier, the reasons are quite varied. The main reason there hasn't been a clear plan is that there is no recognition of the profession. Midwives aren't recognized for their work or their importance in the health care system as front-line professionals.

There is a significant lack of awareness of our work among the public and government bodies. There is still a lot of work to be done in this respect. There has never been a campaign or project to address this issue. Every time new services are introduced in the regions, everything has to be redone. This simple awareness work, which must be done on a daily basis, requires a great deal of time and energy from professional midwives.

All of this obviously has consequences and slows down, among other things, the development of the profession. There are a number of things that come into play, but I think essentially, as I mentioned, this is the one thing that needs to be improved.

The Chair: Thank you.

Ms. Larouche, you have six minutes.

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

I'd like to thank the witnesses, Ms. Dion Fletcher, Ms. Aerts, Ms. Murphy and Ms. Giroux, for being with us today. It's always interesting to hear the reality of midwives on the ground.

I'd like to start by going back to what Ms. Aerts said, which is that the pandemic revealed that this profession had experienced a certain lack of resources, including a lack of personal protective equipment, or PPE.

It's important to work on the recognition of the profession, but it's also important to give it more resources, whether by facilitating access to PPE or by giving it more financial resources. Better funding could help put in place more projects that focus, for instance, on training midwives and even on recognizing midwives.

So I'd like to know more about this lack of resources. Ms. Aerts, one of the things you talked about was PPE.

Ms. Giroux, I'd also like to hear your comments about this lack of resources.

[*English*]

Ms. Louise Aerts: One of them, of course, is the PPE. Another is about the different supports that can be in place. There are different structures across Canada for how midwives are compensated. In some jurisdictions it is an employment model and in other jurisdictions it's a fee-for-service model. British Columbia and Ontario, as our two largest providers, are fee-for-service models.

There wasn't a lot in terms of supports, so that meant there were no sick days. The pandemic relief funding that came out for physicians, for example, didn't immediately follow for midwives. It was something that had to be thought out by the associations in the different jurisdictions to support those kinds of needs. In fact, all the jurisdictions are sort of catching up on that front, but I think that was a major one.

Again, if you needed to isolate, if you didn't work, you didn't get paid, so that was very impactful for midwives in the fee-for-service areas.

● (1250)

[*Translation*]

Ms. Andréanne Larouche: Ms. Giroux, do you have anything to add about the lack of resources and this recognition that could also improve the development of the midwifery profession?

Ms. Josyane Giroux: Thank you for the question.

In fact, the pandemic has exacerbated the problems we have, including the lack of midwives, which I mentioned. In the short term, these are things we couldn't necessarily address. However, the lack of resources for our professional association, among others, was particularly noticeable. During the pandemic, considerable effort has been made to support members with all the new developments, from all the new clinical guidelines to implementing the measures and obtaining protective equipment. Having worked with all the professional associations across the country, I can confirm that we were all in the same situation, and it would have helped us tremendously at that time to have additional resources.

Obviously, I'm talking about financial resources that would allow us to have people working with us.

The challenges facing midwifery fall to few people. As we move forward, that's one of the important things to look at in terms of the development of the profession.

Ms. Andréanne Larouche: Beyond recognition, the federal government is increasing health transfers. Quebec and the other provinces should be given more financial resources to help the profession develop. That's what I understand from your remarks.

A witness on a previous panel made the connection between childbirth and the importance of midwifery for women in indigenous communities. This person even made the connection to residential schools and argued that, in the spirit of reconciliation, recognizing that midwifery and the assistance of midwives in caring for babies from birth in indigenous communities could really help the reconciliation process.

Ms. Aerts or Ms. Dion Fletcher, I invite you to share your opinion on the matter, or even Ms. Giroux, who raised the issue of the importance of recognizing midwives in indigenous communities, even in Quebec.

[*English*]

Ms. Louise Aerts: Claire, why don't you take that one?

Ms. Claire Dion Fletcher: Thank you.

Yes, this is something that is important in all of the provinces and in Quebec as well. Again, I'm going to reference the numerous supports we have that speak to this and that speak to the importance of indigenous midwifery in improving health outcomes but also as a step toward reconciliation and ensuring that our knowledge and our ways of being are protected and that we provide a protective force for our families. We take care of our families. We work to keep our families together, and midwives play a crucial role in that.

As the previous witness, Ellen Blais, said—and I'm sure as Brenda would speak to, and any indigenous midwife I know—the role we play not just in promoting the well-being of our communities but also in showing the strength of our families and how we can parent our children is crucial to our families' staying together. To the numerous systems in this country that try to take our families apart, it's just showing that we can parent and that we can parent well.

The Chair: Very good.

For the last round of questioning, we have Ms. Mathyssen for six minutes.

Ms. Lindsay Mathyssen: Thank you so much, Madam Chair.

Thank you to the witnesses.

In previous days on this study, we heard specifically a recommendation from.... Forgive me; I forget. I think it was a couple of the witnesses. Anyway, they said that they would like to see a national chief midwifery officer and the creation of that national branch.

Ms. Aerts, could you speak to how the federal government could support that and if that would be beneficial?

● (1255)

Ms. Louise Aerts: I absolutely think it would be beneficial. I use an analogy borrowed from someone else: We need a conductor. That type of role and that type of person could help to serve as the conductor to be able to think about all the different pieces and how to allocate the monies and look at midwifery from that big-picture perspective. I absolutely think that there would be a need for and a benefit to such a position.

Ms. Lindsay Mathyssen: Ms. Dion Fletcher, how could this office better support, without subsuming, and be an ally and be there with a new movement towards indigenous midwives? Do you see it as a separate office, or have you thought about that? Has there been a recommendation going forward?

You talked about all the different types of indigenous midwifery, so could it go hand in hand?

Ms. Claire Dion Fletcher: I think that needs a little bit more thought and a little more planning, but I do think that there are ways we can work together.

Even from this panel today, and also on other days, all of the midwives who've been speaking have talked about indigenous midwifery. I think that's something to highlight. Whether the midwives are indigenous or not, there is a strong recognition of the importance of indigenous midwifery from our non-indigenous midwifery colleagues.

We only need to look at the very strong partnership between the Canadian Association of Midwives and the National Aboriginal Council of Midwives to see ways that we have figured out to work together and to support each other. We often think about non-indigenous organizations as being the support for indigenous organizations, and that is a notion that we really try to disrupt at NACM and CAM. We actually see the ways that the National Aboriginal Council of Midwives has contributed to the development of the Canadian Association of Midwives and how we work together at a partnership level. That is something that could extend to this midwifery chief officer, and we would be able to think about it and work that through.

Ms. Lindsay Mathyssen: I find it fascinating, at least in Ontario, where I'm a member of Parliament, that midwifery services have been delivered for 30 years, yet there is this constant push-back and there isn't recognition within hospitals that there is this underpayment. Again, in Ontario, they've been fighting for pay equity. They've actually been working through the Human Rights Commission for pay equity.

Ms. Giroux, you spoke about that specifically. Is there a similar movement in Quebec? Are Quebec midwives looking at that? You specifically addressed pay equity as a huge deterrent to attracting some midwives as well.

[*Translation*]

Ms. Josyane Giroux: Thank you for the question.

Legally, the situation in Quebec is very different from that in Ontario. The Pay Equity Act applies to the midwifery profession. However, the way the act was written, and the things I mentioned today, only the top level is considered in job evaluation. There are all kinds of ways to look at it and see that in fact the 20% pay differential I was talking about earlier is seen at the career level. So how were the pay scales designed? How are midwives' time commitments to all the families they serve recognized or not? There isn't much financial recognition for this.

The challenges remain very significant. We address them in different ways depending on the context. I think the pandemic has highlighted issues around gender discrimination, and we're talking about a number of health care professions that are primarily occupied by women.

We want to continue to work towards that, because that's the reality. I can say that the situation is the same for midwives across the country. They all face these challenges.

● (1300)

[*English*]

The Chair: Very good. That is the end of our time for today.

I thank our witnesses for your service to women in Canada, and also for your testimony today and helping us with our report.

For committee members, you will have received the second draft of the unpaid work study. Is it okay to request that all of your supplemental or dissenting reports be submitted by June 1, which is next Tuesday, in order that we stay on schedule to be able to table that report? Is that okay? Yes? That's good. All right.

I would remind you that our meeting on Thursday is from 6:30 to 8:30 in the evening, Eastern Standard Time, and we will be finishing up the women's unpaid work study and then moving on to the report on sexual misconduct in the military.

Is it the pleasure of the committee to adjourn? Seeing that it is, we shall see you on Thursday night.

Thanks again. Have a great day.

The meeting is adjourned.