A Brief Submitted to the Status of Women Committee

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Madame Chair, Members of the Committee:

Introduction

I began my career as an obstetrical nurse in Toronto. Through this experience, I began to encounter midwives who brought their clients to the hospital when a birth in that setting was the most appropriate choice. I had hoped to join this profession, but at the time, there was no opportunity to do so. I started teaching at the Faculty of Nursing at U of T and eventually found a unique offering of a certificate of midwifery program offered in conjunction with the Masters in Nursing degree at the University of Alberta. I was one of first two graduates from that program. I began practising in Edmonton with a 4 border catchment area (there were few midwives but much interest in care), most of the time before legislation was passed to regulate the profession. I was one of a small group of "long distance" midwives in Canada. In 1999 I received a call to consider returning to Ontario to assume the position of Director/Directrice of le programme de formation des sages-femmes at l'Université Laurentienne. I came for a year and stayed for 22.

I am aware that you have already heard much about the program and the contributions that the program and our graduates have made to healthcare across the country but more specifically in Northern Ontario. I would like to focus on the role that the midwifery/sages-femmes program has played in capacity building.

Capacity Building – Health Human Resources

The majority of current midwifery practices in Northern Ontario did not exist before the Midwifery Program began. As noted in the first session, 60% of the midwives practising in these are graduates of the Laurentian Program. Not only have midwives represented another choice

for northern pregnant people, in some cases they have provided the choice to remain in a community for birth e.g. Elliot Lake, Attawapiskat. Research from the UBC Rural Health Research Centre has suggested that not only are perinatal outcomes improved when maternity care services are close to home; the economics of the. Community are improved when residents believe that the health needs of all age groups can be met close to home (Klein, Johnston, Christilaw, Carty; 2002)

The goal of realizing a birth close to home and with the care of a midwife has a long way to go. Communities that have closed down or are seriously considering closing down maternity care services pose difficult challenges to midwives hoping to set up services in these communities. Will they be able to access hospital or interdisciplinary professional services within a reasonable time span? If hospital-based equipment has already been liquidated, from where might a budget come to cover the costs of the minimal equipment needed?

Birth numbers in a community may not be high enough for a single midwife to make a full time living under the standard midwifery funding model. If that midwife would prefer to work in partnership with a second midwife, financial concerns increase. Some of the recent additions to the provincial funding program make it possible for midwives to apply for funding considerations under a variety of “schedules”. The midwifery association has developed a locum pool to assist midwives with filling in their practice when time off is needed. These additions require planning and flexibility if a locum cannot be identified for the desired time. Emergency absences often mean a temporary “shut down” of the practice. Some midwives are able to expand their scope of practice to include additional services that can expand their sources of revenue. The College of Midwives and other stakeholders have made numerous

requests for extension of the scope of practice with some successes, but the process is slow. The pandemic may help given a recent call for expansion of scope to allow for redeployment of professionals to meet the needs of increased numbers of COVID cases in hospitals. (see appendix Midwifery Scope of Practice, Professional standards for Midwives, Emergency Management and Civil Protection Act 210305_e, 210305_f)

A school of midwifery in a northern university is a useful strategy for informing the population about midwifery and about choices that can be made related to childbirth and childbearing. Having a group of midwifery students in a science, social science or humanities course either as part of required curriculum or as an elective brings awareness of the profession of midwifery to the class, to the faculty and potentially staff of the department. Students bring with them their perspectives on safe care, informed choice, and gaps in the healthcare system. Other students may bring this “hidden curriculum” knowledge to their lives, their families and communities. Do we have a midwife in our community? If not, how do we get one? How might I apply something like informed choice to my other healthcare experiences? How might I become a good healthcare advocate for my parents or my children?

The School of Midwifery developed a “Pelvic Teaching Program” in 2002 to train students in sensitive, respectful and informative pelvic examinations including pap smears. The program was extended to include all students in the Northern Ontario School of Medicine (both sites), Laurentian nurse practitioner students and Sudbury hospital sexual assault nurses. This has resulted in a high proportion of northern Ontario practitioners having this training and conducting this important assessment to individuals who may have avoided this component of health care because they fear pain and embarrassment. While one of the other programs might

pick up this program, the loss of the school of midwifery means that this fall, it is highly possible that none of these students will get this important educational opportunity and it may fall out of the curriculum much to the detriment of northern residents.

Capacity Building – Accessibility to Education

Many of the northern students and graduates of the Laurentian program tell us that they would not have done a degree in midwifery if they could not have remained in the north. They sought an environment that felt familiar and safe. Many considered Sudbury to be a metropolis that stretched their comfort level at the same time as preparing them for realities they would face in practice. Many had family in the Sudbury region. Kirsty will address accessibility for francophone applicants and the need to address accessibility and racism issues for racialized (francophone) applicants/students.

The CNFS (Consortium National de formation en santé) has assisted with some resources for recruitment, scholarships and personnel and operating revenue for le programme des sages-femmes. The CNFS model is one that might be used for other aspects of a northern site for midwifery education. Rather than relying completely on a centralized decision making/policy building structure, each post-secondary institution that offers health programming in French has a local CNFS office. The local coordinator meets with the programs and connects with students to learn about needs and priorities. Funding requests are based on the integration and coordination of local needs. At one point, the Laurentian CNFS worked with us to develop a proposal for universities in other provinces to buy seats for francophone students in the Laurentian program. These would be additional students to our enrolment cap and costs would

be shared among CNFS, the province, and the student. We developed partnerships with provinces across Canada and scored well on the CNFS budget plan. However, there were changes at the federal level and the project was put on hold. The strength of the CNFS model is that it is not perceived to be treading on provincial toes. This model may be a good template for other federal programs that could help to support northern students such as indigenous, francophone and racialized populations. The First Nations and Inuit Branch also has made tremendous contributions to the establishment of indigenous practices and the development of indigenous midwifery education programs. Given that many of the indigenous students in the Laurentian program are just beginning to explore their culture, they may still make their first choice for education at a mainstream institution. It may be important to have ongoing support from FNIB to ensure the success of these students and a means of connection to the newly developed indigenous schools.

Attention to accessibility has also caused us to review who in the north is interested in midwifery and will have the support of their families and community. There is a high proportion of applicants who are first generation university attenders and who apply directly from high school. From discussions with applicants, families and communities we learned that the best chance at retention and ongoing support is when the applicant “looks like” other young adults in the community – applying to and being accepted into a post-secondary program right from high school. This is possible within the admissions standards but there is a bias toward accepting more “mature” students – often with at least one other degree or extensive work-life experience. In 1998 Laurentian admitted two 101 applicants (the Ontario code for direct from high school). These “younger” students not only kept up, grew up and enjoyed the program,

they were often the top students by graduation. Some of these young students have set up and continue to run new practices in northern communities within a few years of graduation. They are a. valuable asset to the north and the midwifery profession. We have admitted 101 applicants each year since 1998 (usually 20-25% of the incoming class)

Capacity Building – Scholarship and Research

Research about midwifery in Canada has had varied interest, particularly among social sciences and humanities disciplines. There are still few midwives with doctoral qualifications in Canada and many have been very occupied with the development of the midwifery program and have not been able to dedicate much time to research. This is further complicated by funding agencies that do not include midwifery/midwives on their drop-down lists for applications or as one of the qualified professions to act as principle researchers or on application review boards or policy development committees. Midwifery becomes an invisible scholarly group in Canadian research circles. There is evidence of changes e.g. the McMaster Midwifery Research Centre (MMRC) and midwife co-investigators on other interdisciplinary research teams. The Canadian Association of Midwives receives funding for many research projects in low income countries. While these are important, this has resulted in northern midwives conducting international research but none in the Canadian northern context. Much of the practice-related research conducted by MMRC or perhaps by other disciplines may be highly relevant to northern midwifery. However, we do not always know if the evidence will apply well to the different context of the north and questions that are important to the north are not part of current research. Are pregnant people in the north well served by the current distribution of research funding? An interdisciplinary group is initiating a group project on the impact of the midwifery

education in the north. However, most are individuals who are terminated from Laurentian and have no institutional support for this research.

The number of midwives who have now completed masters degrees has increased significantly in the past decade and some of these are now in or have completed PhDs. At Laurentian, all terminated midwifery faculty members have completed a PhD or are registered in PhD programs. The Interdisciplinary PhD in Rural and Northern Health was developed with Midwifery as one of the original partners. Two faculty have taught courses and supervised students in this program. The School of Rural and Northern Health is one of the victims of the CCAA cuts and it is possible that the two graduate programs in Rural and Northern Health will be subsumed by the School of Human Kinetics and their graduate programs. It is possible that this important opportunity for health professionals including midwives to learn the intricacies of research in and about this context will cease to exist. The Centre of Rural and Northern Health Research at Laurentian (and Lakehead) continues to exist at this time and may be a good "home" for midwifery researchers with an interest in rural and northern studies.

Capacity Building – Learning from the Land

The opportunity to remain close to the land is identified by many students at Laurentian. They can go swimming in a lake between classes, ice fish, ski, cycle and run on trails; they can pick blueberries while walking between classes and take their small group out to sit on the rocks while they discuss topics in their class. They are surrounded by the scents and sights of nature: a meadow of bee attracting flowers grown with seeds donated by the school of midwifery, a fox family running by, the bears that wander the paths and parking lots. All students learn from the Anishinabek teachings about connection to the land and all its inhabitants. Attention to issues

like climate change become important when students are noticing changes in what is growing, the reproductive patterns of local animals and begin to wonder how these might apply to their clients – what is available for their diets or will their transportation be made difficult because ice roads are not possible in a warm winter and might the human inhabitants also have reproductive changes as a result of climate change?

Recommendations

1. Include Health Services in the responsibilities of **FedNor**. This may provide support for communities that can grow their economic picture when services needed by residents of childbearing age are available locally. This can include: the support of midwifery students in the north to reduce their education costs and reduce post-graduation debt-load, the development of a funding model to accommodate low caseloads at the same time as ensuring a minimum of two midwives in communities, provincial-federal collaboration for indigenous healthcare, clean water, transportation and internet improvements plus a funding model for supporting the re-introduction of maternity care services in hospitals that have closed down these services. (see numerous studies conducted at the UBC rural research centre e.g. by Jude Kornelsen, Stefan Grzybowski)
2. Build on the CNFS model to create federally supported but locally driven programs to address the needs of northern indigenous, francophone, anglophone and racialized students.
3. Support the development of a Northern Midwifery Research Institute (possibly in conjunction with CRaNHR). This can include funding packages within existing midwifery research programs including the Canadian Association of Midwives. It should also make

midwifery an official category for research applications. Funding for graduate students in programs that facilitate northern midwifery/women's sexual health research should have national scholarships made available specifically to them.

4. Support the reintroduction of a school of midwifery in northern Ontario. This continues to need to support the educational and practice needs of northern, indigenous, racialized francophone, and anglophone populations. This may need to be in an entirely new (out of the box) form of consortium. Linkages can be made with the remaining consortium sites but perhaps new linkages could be created that will provide opportunities for urban francophones without forcing a decision between northern or urban for ensuring excellence in francophone midwifery education outside Québec. There could be linkages with the existing and potential indigenous midwifery schools. These are issues that have federal roots and could be an opportunity for new and creative federal-provincial partnerships for the growth of midwifery not only in northern Ontario but also in the rest of Canada.
5. The establishment of an Office of Midwifery within the Federal Government to coordinate and liaise with other departments and professions on questions related to the profession and health issues related to reproductive/sexual health.

References

Klein M, Johnston S, Christilaw J, Carty E. (2002). Mothers, babies, and communities Centralizing maternity care exposes mothers and babies to complications and endangers community sustainability. Canadian Family Physician, 48: 1177-1179.