Improving Access to Midwifery Care for Aboriginal Women Living in Ontario

A Proposal for Funding Aboriginal Midwives

Submitted to the Ministry of Health and Long-Term Care
Ontario Midwifery Program
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Executive Summary

The Ministry of Health and Long-Term Care, through the Ontario Midwifery Program (OMP), currently funds regulated midwifery in Ontario. The midwifery program provides high-quality, cost-effective care to Ontario women and their families. However, a disparity remains in access to midwives for Aboriginal women; more generally, there is a gap for culturally relevant care that fits into an Aboriginal healing strategy.

This proposal presents how Aboriginal midwives working under the exception to the Midwifery Act (1991) on reserve could be funded by the Ministry of Health and Long-Term Care in a parallel process to the way that registered midwives are currently funded through the OMP.

This proposal provides an overview of Aboriginal maternal and newborn health in Ontario, a summary of the Association of Ontario Midwives involvement in this issue, a brief history of registered and Aboriginal midwifery in the province, and a review of other jurisdictions in Canada. The proposal also includes an outline of the current education and paths to practice for Aboriginal midwives, and addresses issues of public safety. It also presents the current state of readiness of Aboriginal communities to introduce, if funded through the OMP, midwifery care on reserve.

We have provided sample budgets (based on the OMP 2013-2014 New Practice Annual Budget Request), using as examples two communities that are in an ideal state of readiness to introduce midwifery care on reserve (with the exception that they lack funding). Using these sample budgets and including funds for Transfer Payment Agency administration, we would estimate the cost of establishing an Aboriginal midwifery stream within the OMP to be approximately $708,852 for the first fiscal year.

It is our hope that an Aboriginal midwifery stream within the OMP will be realized this year, including a call for proposals that would allow communities to apply for funding on a schedule similar to registered midwives.

Funding Aboriginal midwifery on reserve would greatly increase access to midwifery for Aboriginal women, as well as support the sharing of indigenous knowledge, a very important aspect in returning birth to Aboriginal communities. This investment in midwives is likely to provide a significant return in improved health outcomes for Aboriginal women, newborns and communities, and result in health savings to the health care system through the reduction in evacuations for birth, reduction in low birth weight babies, and reduction in interventions and improved health status. This proposal is very much in line with Ontario’s Action Plan for Health Care. Specifically, this proposal presents an opportunity to fund high-quality, evidence-informed care based on the needs of Aboriginal women and children, Ontario’s most vulnerable population.
Introduction

The Association of Ontario Midwives (AOM) respectfully submits this proposal for funding Aboriginal midwives working under the exception in the Midwifery Act. This proposal outlines how Aboriginal midwives working under the exemption on reserve could be funded by the Ministry of Health and Long-Term Care (MOHLTC) in a parallel process to the way that registered midwives are currently funded through the Ontario Midwifery Program (OMP).

Many Aboriginal communities currently lack appropriate maternal newborn care, especially midwifery care. There is a gross disparity between the health outcomes of Aboriginal women and children vis-à-vis those of Ontario’s general population. The time to act is now to positively impact the health outcomes of Aboriginal women and children by increasing access to midwifery services.

Action Plan for Health Care

Ontario's Action Plan for Health Care focuses on ensuring excellent outcomes and efficient use of health care resources. Midwifery care has excellent outcomes, marked by low intervention rates, as has been demonstrated through the Midwifery Outcomes Report and more recently through BORN. Given midwifery's focus on primary care, prevention and the judicious use of interventions, midwifery care is perfectly aligned with the Action Plan. In addition, extending midwifery care to Aboriginal women and family means that care, especially care during labour and delivery, is kept as close to home as possible. Keeping birth close to home (both in situations like Akwesasne for example, where a woman may be travelling a couple of hours to access care in Cornwall, or in situations like Attawapiskat, where a woman may be evacuated weeks before her due date, waiting in a motel in a community like Kingston, hundreds of miles away, to give birth) improves health outcomes and uses resources efficiently.

Aboriginal midwives are in the ideal position to make clients healthier, given midwifery’s focus on health promotion and prevention. For example, midwives support interventions such as harm reduction and smoking cessation. Aboriginal children are at greater risk of childhood obesity and Aboriginal midwives are well-positioned to implement recommendations from the recent Healthy Kids Strategy to help reduce childhood obesity.

More specifically, Aboriginal midwives educate women of child-bearing age about the impact their health and weight has on their own well-being and on the health and well-being of their children (1.1), enhance primary and obstetrical care to include a standard pre-pregnancy health check and wellness visit for women planning a pregnancy and their partners (1.2), provide
accessible culturally-relevant prenatal education (1.3), and support and encourage breastfeeding for at least the first six months of life (1.4).¹

Aboriginal midwives can provide faster access to health care by screening for conditions (such as gestational diabetes) in the community and making timely and appropriate referrals for care. Aboriginal midwives can also reduce emergency room visits (and considerable time in travel) by providing care in the community and doing house calls, a standard in the midwifery model of care.

Aboriginal midwives are poised to provide high quality, timely, proactive care as close to home as possible. Aboriginal midwives are familiar with the communities they serve, support community goals of traditional teachings and language and can help fill the large gap in services that contributes to disparate health outcomes for Aboriginal families.²

Aboriginal midwives also provide care to mothers and newborns that is responsive to their needs as stated in the vision statement of the Healthy Babies, Healthy Children Program: "Every child (prenatal to age six) in Ontario will be provided with opportunities to achieve his/her optimal potential" and "The goal of the postpartum component is twofold: that every mother and newborn in Ontario will be provided with the support they need in order to make a healthy adjustment in the first few weeks of life; and that all families will have access to parenting information and parenting support that is responsive to their needs."³

According to the report of the 2012 Commission on the Reform of Ontario’s Public Service Report (Drummond Report), some key goals for the future include health-care services that are integrated, that use health promotion as a key component of care, and that keep patients out of hospital. As a model of care for Aboriginal communities, midwifery care is perfectly aligned to these goals.⁴

When Aboriginal midwives become a part of the health-care team of each community, communities will be supported to become healthier and health-care costs will be reduced. Ensuring that Aboriginal women and their families can access midwifery care on reserve is an action that is aligned with both the principles of the Drummond Report as well as Ontario’s Action Plan for Health Care.


Present and Future Funding

Ontario currently has Aboriginal midwives ready to make an impact in their communities, but there exists no systemic funding for them to do so. The Aboriginal Health and Wellness Strategy has funded Aboriginal midwives at the Tsi Non:we Ionnakeratsta’ Ona:grahsta’ on Six Nations since 1996, but there is no funding increase projected. A small investment by the Ministry of Health and Long-Term Care into funding for Aboriginal midwifery could lead to significant health improvements for Aboriginal women and families. Funding Aboriginal midwifery specifically through the OMP would also allow a streamlining of processes and increase in coordination of services and efficiency of administration. For example, the OMP has already developed many systems, such the funding formula for clinical equipment, which could be applied to Aboriginal midwives as well.

This proposal focuses on funding Aboriginal midwifery services based on reserve. We propose to address midwifery services on reserve first while acknowledging that the majority of Aboriginal families currently live off reserve in urban areas. We believe that this is a logical first step toward increasing access to midwifery care for Aboriginal women.

This proposal provides an overview of Aboriginal maternal and newborn health in Ontario, a summary of the AOM’s involvement in this issue, a brief history of registered and Aboriginal midwifery in the province, and a review of other jurisdictions in Canada. The proposal also includes an outline of education for Aboriginal midwives, for ensuring public safety, funding, the establishment of new practices, and evaluation. It also presents the readiness of a few Aboriginal midwives who are ready to practice and what type of investment they would need to start providing much needed care in their communities in the next year.

In the future, midwifery practices could adopt a blended model with both registered and Aboriginal midwives practicing together. This may prove to be a robust approach to meet the needs in some communities: Aboriginal midwives could provide culturally relevant care while educating the registered midwives about that care. At the same time, the registered midwives could provide clients with some aspects of care not available to Aboriginal midwives, such as hospital privileges. There may also ultimately be a place for agreements between the provinces, particularly with regards to reserves that straddle two different provinces, such as Treaty 3 land between Manitoba and Ontario.

We are confident that this proposal outlines a solid foundation for a provincially funded program of Aboriginal midwifery. Future developments and outcomes are dependent on the establishment of this foundation.

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5 The Environics Institute. The Urban Aboriginal People’s Study: Main Report. 2010.
Overview of Aboriginal Maternal Newborn Health in Ontario

Canada’s Aboriginal people face alarming disparities vis-à-vis the rest of Canada’s population. More importantly, it is the most vulnerable women and children who face the greatest disparity. We begin by providing the context that delineates the need for this proposal for funding for Aboriginal midwives with an overview of maternal and newborn health in Aboriginal communities. This includes some examples of the health disparities that exist for Aboriginal women and children and how Aboriginal midwifery has positively affected health outcomes for Aboriginal families. The negative impact of women leaving their communities to access care, of evacuating women out of their communities to give birth, and the general lack of cultural sensitivity and safety for Aboriginal women are especially important to note.

The literature suggests that the context contributing to these health disparities includes the experience and process of colonialism, residential schools, the loss of midwifery in Aboriginal communities, the routine evacuation of Aboriginal women for birth from their communities, and the lack of culturally competent/responsive care.

*Health disparities are, first and foremost, those indicators of a relative disproportionate burden of disease on a particular population. Health inequities point to the underlying causes of the disparities, many if not most of which sit largely outside of the typically constituted domain of “health”…time and again health disparities are directly and indirectly associated with social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering upon the Aboriginal populations of Canada. In analyses of health disparities, it is as important to navigate the interstices between the person and the wider social and historical contexts as it is to pay attention to the individual effects of inequity. Research and policy must address the contemporary realities of Aboriginal health and well-being, including the individual and community-based effects of health disparities and the direct and indirect sources of those disparities.*

Evidence also demonstrates a disproportionate burden of ill health and adverse outcomes in maternal and newborn health for Aboriginal women and newborns.

- Infant mortality among First Nations is at least twice the rate of the Canadian population – 1.7 to 4 times higher.

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8 ibid.
• Aboriginal children are more likely to die in the first year of life.\textsuperscript{11}

• Sudden Infant Death Syndrome (SIDS) is 12 times higher.\textsuperscript{12}

• There are higher rates of low and high birth weight babies, preterm birth, gestational diabetes, and C-sections.\textsuperscript{13}

• There are disproportionately high rate of sexually transmitted infections, complications in pregnancy and delivery, and sexual violence.\textsuperscript{14}

• Canada ranks sixth on the World Health Organization Human Development Index, however, First Nations in Canada would rank 68\textsuperscript{th}.\textsuperscript{15}

• Aboriginal people have significantly worse general health and more challenging living conditions than the Canadian population.\textsuperscript{16}

In addition, Aboriginal populations have a younger demographic and higher birth rate compared to the Canadian population. Between 1996 and 2006, the overall Aboriginal population grew by 45\%, compared with 8\% for the non-Aboriginal population in Canada,\textsuperscript{17} placing additional emphasis on the need to ensure quality and accessible maternal and newborn health services in Aboriginal communities.

The Health Council of Canada has noted how a gap in funding of Aboriginal health-care providers can have an influence on the degree of client/consumer compliance (and therefore health outcomes):

“Despite Canada’s commitment to cultural diversity, our health care workforce does not adequately reflect minority groups in our population, a gap that has implications for patient outcomes. Multicultural representation is lacking in some health professions, and there are concerns that rising tuition fees (particularly in medicine) restrict representation by socioeconomic class. The HHR summit focused particularly on the shortage of Aboriginal health professionals – from First Nations, Inuit and Métis communities. The Health Council of Canada has recommended that provinces increase the numbers of First Nations, Inuit and Métis professionals in the health workforce.”\textsuperscript{18}

\textsuperscript{11} Adelson N. op. cit., S. 54
\textsuperscript{12} Smylie J, Adomako P. , op. cit.
\textsuperscript{14} ibid.
\textsuperscript{15} ibid.
\textsuperscript{17} ibid., p. 43.
Evidence also demonstrates that the health inequities and adverse health outcomes experienced by Aboriginal populations are a direct result of colonialism and residential schools. Both colonialism and residential schools are significant historical events that have undermined the long-standing traditions of First Nations and have contributed to the decline and loss of midwifery in Aboriginal communities.19,20

**Cultural Safety for Aboriginal Women**

Evidence has demonstrated that conflicts within the health-care system can arise due to differing views regarding health between Aboriginal peoples and Western medical systems.21 These conflicts can create barriers to care and result in women experiencing paternalistic attitudes and racism.22 In one study, the fear of experiencing racism meant women were less likely to seek out care in the first place.23 The notion of women experiencing health services in an environment that, at times, seems to increase barriers rather than facilitate access is supported in the Society of Obstetricians and Gynaecologists of Canada guideline on working with Aboriginal communities and its implicit intent of attempting to educate providers to disarm paternalism and racism.24

On the other hand, research has shown that optimal health care can be delivered when it is rooted in respect that flows from those who hold power and privilege, along with an awareness of the dominant social position they are in. But it also requires giving space to the affected community to make decisions based on their needs. One study on the “discredited medical subject” notes several examples of what this can look like on the ground: “Clinic practices and policies that convey respect for Aboriginal women’s primary roles as gate-keepers to the health care system and community leaders. They take into account poverty and the social and historical forces behind poverty. And, just as importantly, practices and policies that ensure the meaningful participation of Aboriginal women in decision making at the local health level.”25

What is critical here is a dialectic between an awareness of power and privilege alongside a meaningful engagement and collaboration with Aboriginal communities. This approach enhances the effectiveness of achieving challenging health objectives. It takes into account the

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20 Health Council of Canada., op. cit.


22 Health Council of Canada., op. cit., p. 7

23 ibid.

24 Society of Obstetricians and Gynaecologists of Canada. op. cit. (S42)

historical and ongoing colonial policies that create health disparities, and will assist in achieving better health outcomes by being open to and informed by community-driven processes.

In a personal communication with Aboriginal midwife Katsi Cook in March 2014, it was noted that Aboriginal community health governance in turn must ensure the meaningful participation and collaboration of Aboriginal women, who are leaders and gatekeepers to the health-care system, in health discourses and decision-making at the local level.

Aboriginal midwives taking care of Aboriginal women and their families is an optimal solution to the issue of cultural safety. Moreover, Aboriginal midwives from the community in which women live recognize and understand the individual needs of the community from a number of perspectives that are based on the current and changing needs of the community. Some examples are the need for trauma-informed care and health education and care that is delivered in groups (so as to build community among participants/patients, as the group-based prenatal program Centering Pregnancy has been shown to do). Katsi Cook states: “These practices are part of creating a future in which the minds, bodies, and spirits of Indigenous peoples who have been devastated by disease, historic trauma, sexualized trauma, shame and addictions, find recovery, healing and wellbeing through the sustainable source of power in the sharing circle. Centering Pregnancy provides mothers the opportunity to participate in their prenatal care in an open, welcoming environment, enriched with the sharing of women’s knowledge, experiences and indigenous intelligence.”

Community-based cultural practices such as medicines and traditional ceremonies surrounding the life cycle reinforce the identity of the families and therefore the health of the community. In a video produced by the AOM, an Aboriginal woman named Sara Luey describes her birth with Aboriginal midwives: “It wasn’t just the midwives. I felt like I had all of my ancestors there. It was very powerful; it gave me the strength I needed.” Sara credits the culturally relevant care she received from her midwives for empowering her to turn her life around and regain custody of her child.26

Many Aboriginal families are keen to return to their original teachings and create healthier communities to live in, whether on or off reserve. Returning midwifery to Aboriginal communities can support this restorative process. Midwifery clinics align with other practices and supports such as local community health clinics, local health councils, and nearby hospitals when transfers are needed. Moreover, Aboriginal midwifery mirrors the community health governance model that is integral to many Aboriginal communities. Community health governance is a team-led approach, involving elders and youth in the community who are renewing Aboriginal communities through learning that their voices are important, taking responsibility for birth, and creating a new generation of Aboriginal midwives and support that will deepen the synergy of the community.

Routine Evacuation of Women from Their Home Communities for Birth

Since the 1960s and 1970s, modern obstetrical practices replaced traditional practices in rural and remote Aboriginal communities, and since most communities did not have obstetrical facilities or staff, women had to leave their communities to give birth. The history of evacuating women from rural and remote communities to give birth, its negative consequences for communities and the continuation of culture and tradition, and the relationship between stress and negative birth outcomes has been well documented. Some point to the practice of regular evacuation from a woman’s home community for birth as the “colonization of birth” and the “residential schools of medicine” because of its potential to disrupt and undermine not only the individual health of the woman and newborn, but that of the entire community. The residential school system, and the process of removing children from their families and communities, has been widely acknowledged as a “profound failure,” including in an official apology issued by the prime minister of Canada in June 2008.

Having to leave a home community to access birth care has been shown to negatively impact women and communities. It causes childbirth to become a stressful and costly event and one that increases the vulnerability of women, especially pregnant teenagers. A health forum with young Aboriginal mothers found that they echoed the negative impacts of routine evacuation and recommended bringing birth closer to home and back into the hands of Aboriginal women. Yet in many northern Aboriginal communities, health policies dictate routine evacuation of all pregnant women 36 to 37 weeks’ gestation to deliver in a Level 2 hospital, regardless of the woman’s obstetric risk profile. Carol Couchie, a midwife who has devoted her career to the resurgence of midwifery in Aboriginal communities, notes that this has created a system whereby Aboriginal women must choose between their culture and their safety. Thus she argues for care that does not make women face this unbearable choice.

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28 Society of Obstetricians and Gynaecologists of Canada, op. cit. (S33).
Routine evacuation is also extremely costly to the health-care system; for example, $12 000 is the estimated cost savings every time midwives assist with a birth in northern Quebec.\(^{34}\) In British Columbia, data from 2004-2005 shows that there is an average additional cost of $3600 incurred from a woman giving birth in a referral community.\(^{35}\)

But there are also social costs to women and their families. Women report negative experiences giving birth outside of their communities; these experiences are often accompanied by a sense of isolation, from leaving behind children and family members, loneliness, anxiety, depression, loss of appetite and increased smoking. The idea of having one of the most life-affirming and positive events in a community being taken out to a faraway, unfamiliar place leads to increased community based depression and loss of ceremony and positive cultural norms.\(^{36}\)

Having to leave a home community to access birth care from a skilled birth attendant does not only occur in far north communities. Women from Treaty 3, for example, have described the negative impact of having to travel 1.5 to 2 hours to Kenora to receive care, because it still disrupts their ability to give birth on their territory, with their families and in their traditions.\(^{37}\) Many groups, including the Native Women’s Association of Canada,\(^ {38}\) have expressed concern regarding the continued medical evacuation of Aboriginal women from their families and territories. The AOM position statement ”Midwives Support Keeping Birth Close to Home” outlines the significant positive outcomes that occur when birth remains in the community.\(^ {39}\)

\(^{34}\) Health Council of Canada., op. cit., p. 46  
\(^{35}\) Kornelsen J. et al., op.cit.  
\(^{36}\) Kornelsen J. et al., op.cit.  
Recent AOM Efforts to Improve Access to Midwifery Care for Aboriginal Women and Families

In 2011, the AOM identified gaps in access to care for Aboriginal communities in Ontario, including gaps in funding for Aboriginal midwives working under the exception clause in the *Midwifery Act 1991*. The AOM Board of Directors decided to engage in efforts to improve access to midwifery care for Aboriginal women. At the same time, in 2011, members of the Canadian Association of Midwives (CAM) passed a resolution at their AGM to work toward strengthening Aboriginal midwifery in Canada. Both in Ontario and across Canada, a particular concern is the lack of access to midwifery care for women living on reserve, as well as the routine evacuation for birth in rural and remote communities. Both CAM and the AOM have been clear that Aboriginal midwives should determine and lead the efforts.

To determine next steps, the AOM conducted an environmental scan of Aboriginal midwifery in Ontario. The birth centre at Six Nations provided an excellent example of Aboriginal midwives providing community driven care within a strong clinical-care program that is culturally responsive, incorporates traditional Aboriginal knowledge, produces excellent outcomes and is highly regarded in the literature as a model for best practice.\(^{40}\)

Yet barriers remain. Midwives at Six Nations Maternal and Child Centre run a four-year midwifery education program for Aboriginal women, taking in about one student per year. Midwives graduating from the education program at Six Nations find they are unable to establish midwifery practices in their home communities as there is currently no funding stream that can be accessed by Aboriginal midwives working under the exemption.

In Quebec, where traditional midwifery education is recognized, the College (Ordre des Sage-Femmes de Québec, OSFQ) assesses each graduate from Nunavik individually, triggering the ability for that midwife to be recognized by the College. Funding to practice midwifery can then follow. There is no parallel mechanism in Ontario for graduates from Six Nations.

The AOM began consultations with the National Aboriginal Council of Midwives (NACM) and midwives at Six Nations to discuss potential ways to support better access to care. Initial consultations revealed an interest among Aboriginal midwives working under the exemption to be able to participate in the AOM as members. The significant need to educate the public and increase the profile and understanding of Aboriginal midwives working under the exemption was also highlighted in consultations.

Since then, the AOM has provided support for the development of a proposal for Neepeeshowan Midwives, a new registered midwifery practice in Attawapiskat and the

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\(^{40}\) Native Women’s Association of Canada. Aboriginal Women And Reproductive Health, Midwifery, and Birthing Centres: An Issue Paper. 2007 June. 9p.
surrounding coastal communities. This practice was funded in May 2012 by the Ontario Midwifery Program. The AOM has also provided support to two Aboriginal midwives in Tyendinaga and Akwesasne looking for funding to provide midwifery services in their communities.

In 2012, after conducting consultations with Aboriginal midwives, the AOM created the role of Policy Analyst, Aboriginal Midwifery, to work as staff lead on advancing this work. In November 2012, the AOM Board designated improving access to midwifery care for Aboriginal communities as an area of priority for the AOM. The AOM convened a coalition of stakeholders from across the province concerned with Aboriginal maternal and newborn health. The Coalition to Improve Access to Aboriginal Midwifery has been meeting since January 2013 and members of the coalition have reviewed this proposal and provided letters of support. In 2013, at the AOM’s annual conference, the membership passed a resolution to include Aboriginal midwives as members of the AOM. The AOM has continued to build relationships with Aboriginal midwives and Aboriginal stakeholders and, after thorough consultations, this proposal is the result of those efforts.
A Historical and Legislative Overview of Aboriginal Midwife and Registered Midwife Designations

Aboriginal Midwife (AM)

In 1989, the Interim Regulatory Council of Midwives realized that consultations with Aboriginal communities needed to take place. They struck an equity committee and travelled to seven Aboriginal communities across Ontario. At the end of the consultations, it became clear that the direction from the communities was that the practice of Aboriginal midwifery remain intact at the community level. From this, the exemption clause for Aboriginal midwives became part of the *Regulated Health Professions Act 1991* and the exception clause was written in to the *Midwifery Act 1991* (see below). The exemption effectively ensured that Aboriginal midwives could freely continue to provide care to their communities.

Registered Midwife (RM)

In Ontario, the *Midwifery Act 1991* was proclaimed in 1994. This legislation allowed midwives to register with the College of Midwives of Ontario to participate in the current OMP. According to NACM membership information, there are currently 11 RMs who are Aboriginal working in Ontario.

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### Regulated Health Professions Act 1991

Exemption, aboriginal healers and midwives

35. (1) This Act does not apply to,

(a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or

(b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

### Jurisdictions of Colleges

(2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College.

### Midwifery Act 1991 Exception for Aboriginal Midwives

(3) An aboriginal person who provides traditional midwifery services may,

(a) use the title “aboriginal midwife”, a variation or abbreviation or an equivalent in another language; and

(b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife. 1991, c. 31, s. 8 (3).

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Improving Aboriginal Maternal Newborn Health Through Midwifery

Paths to Practice: Aboriginal Midwifery Education Programs

Currently there are three ways in which Aboriginal persons can acquire the education and skills to become a midwife. One is through Tsi Non:we lonnakeratstha Ona:grahsta’ Midwifery Training Program housed within the birth centre at Six Nations. The second option is through the baccalaureate Midwifery Education Program (MEP) offered at Ryerson, McMaster and Laurentian universities. A third option for those who have graduated from the education program at Six Nations is to go through the International Midwifery Preregistration Program (IMPP) at Ryerson University. Graduates from the MEP and IMPP can work in Ontario and become a registered midwife (RM) funded through the MOHLTC via the OMP and work in a provincially funded practice group.

Tsi Non:we lonnakeratstha Ona:grahsta’ Midwifery Training Program

The Tsi Non:we lonnakeratstha Ona:grahsta’ Midwifery Training Program is housed within the Six Nations Maternal and Child Centre. Graduates from this program work under the Aboriginal exemption clause in the Midwifery Act 1991. They are not registered with the College of Midwives of Ontario. They carry the knowledge and ceremonies passed down through the generations and have practiced safely and in culturally appropriate ways for close to 20 years.

The Six Nations Maternal and Child Centre is accredited by Accreditation Canada and has been identified as a Health Council of Canada Promising Practice with regards to traditional knowledge and cultural approaches and care in the community.42

The education program at Six Nations was modeled on the university-level curriculum taught in the MEP. The Six Nations program also offers programming developed from a culturally based perspective which includes well-woman health days, fathering programs, self-care programs and in-home, 24/7, on-call breastfeeding support by an Aboriginal midwife who is trained in breastfeeding and lactation support. The well-woman health-care days serve women who may have never had a Pap test or breast examination, but will access care because they feel safe with the care that the midwives provide, according to Julie Wilson of Tsi Non:we lonnakeratstha Ona:grahsta’ in a personal communication on February 6, 2014.

There are now a number of graduates of the Six Nations training program who are ready to practice at Akwesasne, Tyendinaga and Parry Sound. Until now, Aboriginal midwifery graduates found employment at the birth centre at Six Nations.

42 Health Council of Canada., op. cit.,
The Baccalaureate Midwifery Education Program (MEP) offered at Ryerson, McMaster and Laurentian Universities.

The MEP is a university level program that trains midwives at three sites in Ontario. Graduates of this program generally become registered midwives and begin to practice in an established midwifery practice in Ontario.

One of these provincially funded midwifery practices is Seventh Generation Midwives of Toronto (SGMT). Its mandate is to serve the Aboriginal population of Toronto as part of its client base through culturally safe care. There are currently eight Aboriginal women who are registered midwives practicing at SGMT. The practice has been identified as a Health Council of Canada Promising Practice with regards to traditional knowledge and cultural approaches and care in the community.

Another is K’Tigaaning Midwives in Powassan, Ontario. There are other practices scattered across Ontario that have registered midwives who are Aboriginal working in or close to Aboriginal communities, and also registered midwives who are non-Aboriginal who work with Aboriginal communities.

The International Midwifery Preregistration Program

The IMPP at Ryerson University is a nine-month bridging program for midwives trained in another jurisdiction. Midwives who graduate from the IMPP are also eligible to register with the College of Midwives of Ontario. It’s important to note that while the IMPP was intended to enable midwives trained in jurisdictions outside of Canada to practice in Ontario, one midwife currently practicing in Sudbury, Naomi Wolfe, graduated from Six Nations and then went on to also complete the IMPP in order to become registered in Ontario.

Public Safety

Six Nations Maternal and Child Centre has been provincially funded by the Aboriginal Healing and Wellness Strategy since 1996. The Six Nations Aboriginal midwifery practice is community directed and governed under the auspices of the Six Nations Council. It is through the Six Nations Council, Six Nations Health Services, the Tsi Non:we lonnakeratstha Ona:grahsta’ Maternal and Child Centre Advisory Committee and Grandparents Group “Ionkhisothokon> / Ethsot so>” (our grandparents) that the authority to practice and provide services to the people is given.

43 Seventh Generation Midwives Toronto. www.sgmt.ca
44 Health Council of Canada., op. cit.,
Aboriginal midwifery involves communities being at the centre; setting the standard and overseeing the midwifery practitioner, who is accountable to that community in a formal manner that allows the community to be sure that all practitioners are safe, fully qualified, authorized and continue to update their skills and knowledge. This high standard of service is necessary to ensure that Aboriginal people receive a high-quality of health care and that there is accountability. Aboriginal midwives are thus governed by their community and its councils, as opposed to a college like registered midwives.

Registered midwives in Ontario are all insured by the Healthcare Insurance Reciprocal of Canada (HIROC), Canada’s leading provider of health care liability insurance. The AOM has engaged HIROC to look at the possibility of providing a similar insurance service to Aboriginal midwives funded through the OMP. In the fall of 2013, HIROC executives toured the birth centre at Six Nations and met with the director, the midwives, the staff, as well as staff from the AOM. HIROC expressed how impressed they were with the model of safe practice provided by the Aboriginal midwives at the Six Nations Maternal and Child Centre. They communicated an openness and willingness to provide a liability insurance policy to the Aboriginal midwives at Six Nations (and potentially to other birth centres in Aboriginal communities) should they require one in the future. The AOM would be happy to continue to work on establishing a liability insurance program for OMP-funded Aboriginal midwives with HIROC.

With the new Aboriginal midwife membership category, the AOM now can provide the same supports for safe practice to Aboriginal midwives as it does for registered midwives. These services include access to professional development funds and education events, the LifeWorks program, access to policy and insurance and risk management staff and resource material for support as well as access to the 24-hour PLEASE (Professional Liability Emergency Assistance ServicE) line for confidential risk management support.

**Funding Mechanisms**

The proposed funding mechanism for Aboriginal midwives is based on developing a process that is parallel to the current funding for registered midwives through the OMP.

**Establishing New Practices**

The initial step for flowing funding would be the requirement for Aboriginal midwives to write and submit new practice proposals, following the same deadlines as those outlined for registered midwifery new practice proposals. Aboriginal midwives would apply to a parallel but dedicated funding stream that would be earmarked for both new practice groups as well for growing practices in the future.
Similar to registered midwives, Aboriginal midwives would include in their proposals for new practices:

1. An introduction to the new practice, the names and background of the midwives.
2. A proposed catchment area.
3. A rationale for the practice, including the need for midwifery care, numbers of women who need to travel outside of the community to give birth, results of community consultations, including demographic and statistical information.
4. The documented support of community stakeholders.
5. The proposed human resources and a rationale for the funding model and courses of care requested.
6. The proposed start-up date.
7. A conclusion summarizing the main points of the proposal.
8. A bibliography citing the content.
9. Supporting documentation for the proposal.
10. An annual budget request spreadsheet, including provisions for office equipment, leasehold improvements, remote practice grants, professional liability insurance and funding for second attendants.
11. A caseload variable request template.

Aboriginal midwives receiving funding from the OMP for the first time would be able to access a personal equipment grant similar to the New Registrant Equipment Grant. The new registrant provision within regulated midwifery would not apply to Aboriginal midwifery, since Aboriginal midwives are not registered in the same manner and the numbers of Aboriginal midwives are too small to permit different classes of providers. Allowances would need to be made to ensure Aboriginal midwives entering practice for the first time could access funding for equipment.

The Role of the TPA

Aboriginal midwives who want to establish a new practice would submit new practice proposals directly to the OMP or through their designated Transfer Payment Agency (TPA) and receive ongoing funding for providing midwifery services.

Appropriate TPAs for Aboriginal midwifery practice groups could potentially be one of the Aboriginal Health Access Centres (AHACs). AHACs already have a provincial mandate to be responsive to the needs of the Aboriginal communities both on and off reserve, in urban, rural and northern locations. The goals of AHACs are clearly in line with the goals of this proposal for Aboriginal midwifery funding. As with existing TPAs for registered midwives, the local AHAC would be familiar with the needs of the community and the gaps in service and would

thus be well poised to act as a TPA between the Aboriginal midwifery practice group and the OMP. Involving the AHACs would also help establish strong linkages between the Aboriginal midwives and other health-care providers in the community. It would also facilitate interprofessional care and increase access to timely proactive care as close to home as possible for Aboriginal families. Administratively, AHACs are also appropriate as transfer payment agencies since they already receive and manage provincial funds.

**Ongoing Funding**

Once an Aboriginal midwifery practice group has been established, the funding for providing midwifery services could take two different models: a course of care fee model, like most midwifery practice groups in the province, or a fixed annual fee (FAF) model recognizing that Aboriginal midwives may practice under exceptional circumstances. A fixed annual fee model is currently being proposed for one midwifery practice in the province. Please refer to the proposal for an FAF submitted by Christine Roy for details on this model.

**Course of Care Fee Model**

Registered midwives in the province are currently funded on a course of care basis. This funding model could be applied to Aboriginal midwives as well. Similarly, Aboriginal midwives would also be eligible for caseload variables, travel supplements, and second attendant fees as applicable. Aboriginal midwives would start at the fee level that corresponds with their units of active work as a midwife in Ontario.

**Fixed Annual Fee Model**

A fixed annual fee (FAF) could replace the course of care payment for midwives who meet the criteria. The criteria would include those practices providing care in remote settings, in highly interprofessional settings and in settings that provide care to marginalized women and newborns. Instead of course of care payments, midwives in eligible practice groups would be compensated through a FAF.

The realities of caring for mothers and newborns in both remote settings and in settings that provide care to highly marginalized clients poses a challenge to recruitment and retention. A FAF would alleviate some of the conflict and stress that stems from the course of care mechanism and positively contribute to the sustainability of midwifery practices providing care to Ontario’s most vulnerable mothers and newborns. In addition, the FAF would further enable interprofessional collaboration between midwives and physicians, enabling clients to seamlessly move between providers as dictated by medical need.

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Evaluation

In our discussions with Aboriginal midwives and communities, there is support for evaluation that is driven and led by the community, following indigenous principles that look at both short and long term impacts. The research principles of ownership, control, access and possession—or, in short, of self-determination—are paramount in any evaluative process involving research based on the gathering of information from First Nations, Inuit or Métis people.

The AOM and Aboriginal stakeholder groups, including the Indigenous Knowledge Network for Infant, Child and Family Health of the Centre for Research on Inner City Health at St. Michael’s Hospital are working with the Better Outcomes Registry Network (BORN Ontario) to integrate the Six Nations Maternal and Child Centre data into BORN, as well as data from Aboriginal midwives. BORN is currently collecting data from all registered midwives and obstetrical and newborn care providers in Ontario and is well positioned to examine outcomes. More importantly, BORN has access to comparator data that is very important when looking at outcomes. An infrastructure and training component would be required to ensure that Aboriginal midwives could fully participate in, and access, BORN. The Aboriginal midwifery practice groups could also use the invoicing system through BORN.

Readiness

This section highlights two communities with midwives who are ready to submit a proposal for funding in the 2014-2015 fiscal year. In addition, there are three communities that would be ready in the next few years to integrate Aboriginal midwives should funding be available.

The Mohawk Nation at Akwesasne

Jasmine Benedict and Joyce Leaf are both Aboriginal midwives ready to practice at Akwesasne but are unable to at present due to lack of funding. In the first year of funding, they estimate that they could provide courses of care to 26 to 30 women total.

Jasmine Kahentineshen Benedict graduated from Birthwise Midwifery School in Bridgton

Maine in 2006. She also completed an additional preceptorship program among the indigenous Maori of New Zealand. Catherine Joyce Wathahiiostha Leaf graduated from the Tsi Non:we lonnakeratstha Ona:grahsta’ the midwife training program at Six Nations in 2008.

Benedict and Leaf are fully supported by their band to start a midwifery practice in their community, the Mohawk Council of Akwesasne. Currently, Benedict and Leaf contribute to the community by providing pro bono work and counselling, as well as workshops and presentations pertaining to pregnancy and birth education. Both have worked with youth in schools educating on the traditional role of midwives and their duties to increase interest and participation from youth. Aboriginal midwifery is important in Akwesasne in order for the relationships and bonds within the community to grow stronger.

There are two second birth assistants in Akwesasne: Neddie Thompson and Tricia Herne are both certified doulas and trained in the necessary emergency skills (NRP and CPR). These two women are known throughout Akwesasne for their passion for the natural birth process and the integration of culture and spirituality of birth.

The Health Council Chief at Akwesasne has recently communicated deep concern to the AOM that the C-section rate for women from Akwesasne, who have to travel to give birth in nearby Cornwall, has greatly increased. This chief is keen to have midwives practicing in the community in an effort to lower the C-section rate for community, resulting in better health outcomes for the women as well as lower health-care costs for the province.
Midwifery - Born at Akwesasne – Story of an Elder

Elder Ernest Kaientaronkwen Benedict is well known to many within Akwesasne, and across the entire Nation for the work he did in protecting our Indigenous rights. Ernest was born at Akwesasne. He travelled far and away from Akwesasne over the years, in pursuit of the rights of Indigenous peoples. He always came home. He loved Akwesasne and he was proud to be from Akwesasne.

Ernest was 92 years old when he went over to the Mohawk Nation Council of Chiefs office in Tekaswenkarorens and he stood in the bookstore-office that is at the front of the building and looked around for a little while getting his bearings. He then announced with a smile on his face and pointing to an area near the front of the building, that this is the place he was born. The exact place in Akwesasne which belonged to him.

A midwife assisted his mother Kiohawihton in his birth. He was the middle child of eight and that is the way it was done back then in 1918.

Within the Haudenosaunee (Iroquois) communities, many of our parents and grandparents were born at home with the help of community midwives skilled in the cultural practices associated with home birthing. Midwifery within our community was a common practice until at least the 1950s. After that, more modern birthing practices were introduced and midwifery became replaced by clinical and hospital care outside of our communities. Fortunately, our memories of these practices has not been totally forgotten.

In the 1970s, there came a rebirth of the practice at Akwesasne, as one young woman chose to bring the legacy of her grandmother’s midwifery practice back to the community.

Others became interested in the fine work that a handful of woman were able to inspire and to encourage them to work on revitalizing our ancient cultural practice within a modern context.

It was very successful. Children were born. Our relationships and bonds within our communities grew stronger.

Unfortunately, our ability to bring new midwives into practice was not judicious and for a time there appeared a short gap in filling that honorable position within our community.

Today, with a resurgence toward revitalizing our culture and integrating our own cultural practices into our contemporary lifestyles, community midwifery will have an important role.
Kenhte:ke Midwives (Tyendinaga) Kontinenhanónhnha Tsi Tkaha: Nayen “They are protecting the seeds at the Bay of Quinte”

Dorothy Green is an Onkwehónwe Aboriginal midwife who graduated from the Aboriginal Midwifery Program at Six Nations. Dorothy is Kanienkehaka, Wolf Clan from Tyendinaga Mohawk Territory. Dorothy’s primary catchment area is Tyendinaga Mohawk Territory, serving local women and families, but her birth care team plans to liaise with Maternal and Child Health Services in surrounding Aboriginal communities within a one-and-a-half-hour radius that includes Hiawatha First Nation, Alderville First Nation, Curve Lake, Islands in the Trent Waters in Peterborough County (includes Islands in Pigeon, Buckhorn and Stony Lakes).

Historically, the Mohawks of the Bay of Quinte community, like all Aboriginal communities, were cared for by midwives. Both of Dorothy’s maternal and paternal great-grandmothers were midwives in their communities. The re-establishment of midwifery services will fit with the healing work and post-colonial vision that the community strives to attain today and for the future generations.

Dorothy started her community practice in May of 2011 by running her clinic from her home. She is ready to practice and has recently moved her clinic to a larger, central location in the community. She has done extensive research for many years as to the needs of her community. She has support from the Mohawks of the Bay of Quinte, the Tyendinaga Mohawk Council and community health programs. Her community-based model of care is designed, developed and delivered to Aboriginal families in Tyendinaga and surrounding rural and urban communities. Her practice will emphasize the importance of cultural continuity, defining Aboriginal midwifery as a fundamental community resource blending cultural ways, preventative care and appropriate use of technology. This, in turn, will motivate women to reclaim their power to make their own birth choices and take control of their health, which will strengthen clans, communities and nations.

Dorothy has worked tirelessly on the creation of her practice for the past six years; most notably, she has developed a full-fledged birthing centre proposal for Tyendinaga based on exhaustive consultations, interviews, surveys and petitions in her community. Dorothy has received recognition as an Aboriginal Midwife by a Tyendinaga Mohawk Council Resolution. She has taken the Ontario Women’s Health Network Leadership Training, has been a student representative for NACM and has been a community doula. Dorothy is a teacher of sexual and reproductive health, coming of age, parenting and indigenous approaches to the cycle of life in her community and will continue fulfilling that important role. Thus, she anticipates being able to provide approximately 15 courses of care in her first year of funding through the OMP while doing outreach in the community. A budget worksheet for her practice is included in the appendices.
Midwives of Georgian Bay

Midwives of Georgian Bay was approved by the OMP in 2013 as a new midwifery practice located in Parry Sound, Ontario near Wasauksing First Nation. Judy Rogers, RM is working with Faith Pegamagahbow, an Aboriginal midwife who graduated from Six Nations Maternal and Child Centre and lives in Parry Sound. Currently, Faith is acting as Judy’s second birth attendant. However, Judy and Faith are planning to practice in a collaborative care model in the future, with Faith eventually moving into the role of the primary midwife. At this time, there is no funding for Faith to work as an Aboriginal midwife with Judy. Midwives of Georgian Bay forecast that they will be able to serve five First Nation communities in their area.

Treaty # 3 and Grassy Narrows

Grassy Narrows First Nation has had a long history with Aboriginal midwifery. Grassy Narrows falls within the area of Treaty # 3 land, which is in a rural and extends to a remote area of Northern Ontario, 88 kilometers north of Kenora, Ontario. The community of Grassy Narrows has expressed a strong interest in having Aboriginal midwives practicing on their reserve and has developed a community plan including a vision for a birth centre. Currently there are registered midwives nearby who can service this community with limited capacity, but acknowledge that the community needs Aboriginal midwives in addition to their services. Grassy Narrows is actively seeking to find midwives to train to become Aboriginal midwives.

Neepeeshowan Midwives in Attawapiskat

Christine Roy has been practicing as a registered midwife in Attawapiskat since 2013 in an OMP-funded practice. Living and practicing in Attawapiskat is extremely challenging; thus far, it has been very difficult for Christine to recruit another registered midwife to join her practice. However, she has had Aboriginal midwives express an interest in providing care with her in Attawapiskat. Funding for Aboriginal midwives through the OMP could further increase access to midwifery care for women in Attawapiskat.
Investment

Ensuring that Aboriginal women and their families are able to access midwifery care on reserve is an investment that can lead to both short and long term savings for the health care system. There is great potential for cost savings to the health care system when midwifery care is established in the community. Cost savings result from demonstrated lower rates of intervention and caesarean sections in midwifery care, health promotion and harm reduction in pregnancy (regarding healthy weights and smoking cessation especially) leading to fewer low birth weight babies and other pregnancy complications. Higher rates of breastfeeding also affect long term population health and the model of midwifery practice including home visits and 24hr access results in fewer costly emergency room visits.

We have provided sample budgets (based on the OMP 2013-2014 New Practice Annual Budget Request) for two practices that are ready to submit a proposal in the 2014-2015 fiscal year as appendices to this document. The start-up fees include leasehold improvements and equipment grants. It should be noted that leasehold improvement fees may be higher on reserve, as adequate building structures may not exist. The base fees cover the clinical courses of care, the base disbursements include professional liability insurance for midwives, benefits, travel and second attendant fees. Taking these into consideration and including funds for transfer payment agency administration and program evaluation (amount for evaluation not included), we would estimate the cost of establishing an Aboriginal midwifery stream within the OMP to be $708,852 for the next fiscal year.

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<table>
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<tr>
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<tr>
<td>Startup fees at Tyendinaga:</td>
<td>$107,702</td>
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<td>Base fees at Tyendinaga:</td>
<td>$ 40,920</td>
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<td>Base disbursements at Tyendinaga:</td>
<td>$ 62,443</td>
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<td>Caseload variables at Tyendinaga:</td>
<td>$ 92,752</td>
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<tr>
<td>Startup fees at Akwesasne:</td>
<td>$100,127</td>
</tr>
<tr>
<td>Base fees at Akwesasne:</td>
<td>$ 76,384</td>
</tr>
<tr>
<td>Base disbursements at Akwesasne:</td>
<td>$105,772</td>
</tr>
<tr>
<td>Caseload variables at Akwesasne:</td>
<td>$ 92,752</td>
</tr>
<tr>
<td>Transfer payment agency: 2 @ $15,000 =</td>
<td>$ 30,000</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$708,852</strong></td>
</tr>
</tbody>
</table>
Conclusion

The Ministry of Health and Long-Term Care currently funds a program of regulated midwifery that provides high-quality, cost-effective care. However, a disparity remains in access to midwives for Aboriginal women and more generally, there is still a gap for culturally relevant care that fits into an Aboriginal healing strategy. Funding Aboriginal midwifery on reserve would greatly increase access to midwifery for Aboriginal women, as well as support the sharing of indigenous knowledge, a very important aspect in returning birth to aboriginal communities.

We believe that this proposal provides a concrete plan for increasing access to midwifery for Aboriginal women. More importantly, it has been demonstrated that high-quality Aboriginal midwifery that is responsive to the needs of the community can effectively have a positive impact on health outcomes for women and their families. This proposal is very much in line with Ontario’s Action Plan for Health Care. Specifically, this proposal presents an opportunity to fund high-quality, evidence-informed care based on the needs of Aboriginal women and children, Ontario’s most vulnerable population. Also, this proposal presents the right care, at the right time, in the right place. Funding Aboriginal midwives represents a small investment that has the potential to greatly positively impact health outcomes and save future health-care costs.
Selected Annotated Bibliography

Toolkit

This toolkit provides an overview of Aboriginal midwifery in Canada and in the global context. It provides an environmental scan of aboriginal midwifery models of care, education programs, and regulation across Canada.

Policy Statements, position papers, and practice guidelines

This position paper affirms the role of midwives in supporting interprofessional maternity care in Ontario. The AOM advocates for funding mechanisms that support IPC and for the particular needs of communities to be the key determinants in the nature of IPC initiatives.

This paper expresses support for strategies that maintain birth as close to home as possible based on evidence that demonstrates that requiring women to travel away from their community to one centralized hospital for maternity care leads to several undesirable results, namely: poorer outcomes for women and newborns; the atrophy of other aspects of women’s health care; withdrawal of family physicians from the community; loss of skill sets in remaining health care providers; and exodus of businesses and residents from the community.

This paper, endorsed by the five groups, explores best practices for rural maternity care and makes 14 recommendations to that effect including a focus on collaborative interprofessional care.

In this special supplement, the SOGC provides comprehensive guidelines to the provision of sexual, reproductive and gynecological health services to Aboriginal women. It include information on the social determinants of health and how the history of colonization has
improved these. The document provides 24 recommendations in the consensus guideline. One of the recommendations reads: "All health professionals should acknowledge and respect the role that Aboriginal midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year." Another: "Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated."

This statement recommends the return of birth to rural and remote communities for low-risk women and enabling women in those communities to make informed decisions about where to give birth.

Reports

This document, created by the Health Council of Canada, provides perspective on Aboriginal health disparities and disseminates information about best practices and existing innovations to deliver health care to Aboriginal people. Included in the “promising practices” are Seventh Generation MidwivesToronto and Tsi Non:we Ionnakeratshta Ona:grahsta’ Maternal and Child Centre, providing a continuum of traditional and contemporary services and programs, including an Aboriginal Midwifery training program.

This report provides a comprehensive overview of Aboriginal midwifery in Canada including existing programme and key initiatives. This report highlights the success of the Tsi Non:we Ionnakeratshta Ona:grahsta’ Six Nations Maternal and Child Centre and Aboriginal Midwifery Training Program.

National Aboriginal Health Organization (NAHO), Birthing Through First Nations Midwifery Care. 2009.
This paper provides information on the state of First Nations midwifery, with an overview of damage done by colonialism and the current shortage of health care providers for Aboriginal people, including midwives. The paper affirms the importance of a woman-centered model of maternity care in which informed choice, choice of birth place, and continuity of care are essential. Two possible models of First Nations care are presented, the results of a March 2009 National Aboriginal Midwifery Forum.
This paper provides a critical analysis of contemporary First Nations research and some options for First Nations Communities with regards to research, monitoring, evaluation, cultural knowledge, etc. The model is rooted in the ownership of a First Nations community to its cultural knowledge/data/information. It also includes control at all stages of research, access to information and data about themselves and their communities, and ownership or stewardship of the data itself. It is a process where the First Nations community is involved at all stages and drives the research agenda.

This paper reviews some of the factors that intersect with gender to impact health and well-being of Aboriginal women, as well as recent evidence regarding their health status. It also provides some examples of promising initiatives but recognizes that addressing these challenges is complex within a multi-jurisdictional framework of health care provision and within the diverse contexts of Aboriginal women's lives.

The Ontario Women's Health Council appointed the Ontario Maternity Care Expert Panel to examine and make recommendations to improve maternity care in Ontario. The panel considered maternity care broadly, but included a review of midwifery, both Aboriginal and Registered. OMCEP recognized that Ontario faced challenges in meeting the needs of Aboriginal women, both in urban and rural settings. In their consultations, they heard that Aboriginal women wanted to be able to incorporate Aboriginal midwives into their care and received maternity care in their own communities.

Research and academic papers

This paper explores the disproportionate burden of ill health and social suffering experienced by Aboriginal people, and recommends that they be addressed through culturally-sensitive health programming and further research.

The objective of the paper was to review current policies that recommend evacuation of all pregnant women from primarily Aboriginal remote communities. The paper makes six recommendations, including that midwifery care and that midwives should be an integral part of improving care in these communities, that protocols for client care be developed in
conjunction with midwifery programs, and, that midwives working in remote regions should be seen as primary caregivers for all pregnant women in the community.

This qualitative investigation documents the experiences of First Nations women from Bella Bella/Waglisla, B.C. who gave birth away from their communities. Themes from the interviews included the influence of care providers in decision-making, the isolating experience of birth in a referral community, the stress of travelling to access care, the value of emotional and practical support from family and community, and community confusion regarding the decision to close local maternity services.

Following interviews with 12 elders with knowledge of historical birthing practices in their home community, this paper concludes that the provision of maternity care to Aboriginal people should include an acknowledgement of traditional birthing practices. Facilities for providing care should consult with their communities to understand their needs and create appropriate programming.

This study focuses on one remote First Nations community in Canada following the implementation of midwifery services. It highlights how evacuation of women for birth does not effectively address the Millenium Development Goal of having a skilled birth attendant at every birth. When considering future midwifery implementation in similar communities, the authors urge midwives to engage in both political and clinical negotiations to ensure they are able to practice effectively. The authors further warn that national policy and issues of jurisdiction among levels of government can be a barrier to midwifery implementation.

This research analyzed birth outcomes and infant mortality for births classified by maternal mother tongue (Inuit, First Nations or non-Aboriginal) and by community type (predominantly First Nations, Inuit or non-Aboriginal). The study concluded that there was a disconcerting rise of some mortality outcomes for births to First Nations or Inuit mother tongue women and to women in predominantly First Nations and Inuit communities, in contrast to some improvements for births to non-Aboriginal mother tongue women and to women in predominantly non-Aboriginal communities in rural or northern Québec, indicating a need for improving perinatal and neonatal health for Aboriginal populations.
Media

In the wake of the announcement that a midwifery clinic would be coming to Attawapiskat, this article explores how it could make a difference to the Aboriginal women in the community. The community has been advocating for midwifery as a means to keep birth in the community and to prevent the evacuation of some of the women. In this article, Midwife Christine Roy also expresses the desire to have Cree women from the community train to become midwives to be able to provide culturally appropriate care to their people.

Kielburger C, Kielburger M. Cultural respect is a health issue for Canadian Aboriginals. Ottawa Citizen, Aug 18, 2013.
This article presents some of the stereotypes that interfere with the provision of good care to Aboriginal women. Midwife Sara Wolfe, discusses the updates to the Society of Obstetricians and Gynecologists guideline for providing culturally-sensitive care to Aboriginal women and families.

This long-form feature explores how a lack of political will and a lack of financial support is sustaining the practice of evacuating pregnant women from communities in the North, even though it is not optimal for Aboriginal women. It draws the parallels between the trauma associated with birth evacuation to that of residential schools in terms of people being removed from their communities.
## Appendix A:

### Canadian Jurisdictional Review

**Regulated Midwifery Across Canada** - Updated November 2013

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>First Year of Regulation</th>
<th>First Year of Public Funding</th>
<th>Number of Midwives</th>
<th>Employment Status</th>
<th>MEP</th>
<th>Number of Birth Centres</th>
<th>Births Attended by Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>1998</td>
<td>1998</td>
<td>222 practicing, 34 non-practicing</td>
<td>Independent practitioners</td>
<td>UBC</td>
<td>0</td>
<td>14% of total births in BC (44,113 total births 2012/13)</td>
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<tr>
<td>AB</td>
<td>1994</td>
<td>2009</td>
<td>78 RMs</td>
<td>Independent practitioners</td>
<td>Mount Royal University</td>
<td>2 (not funded - private service)</td>
<td>4% of total births in AB (53,585 total births 2012/13)</td>
</tr>
<tr>
<td>SK</td>
<td>2008</td>
<td>2008</td>
<td>14 RMs</td>
<td>Employees of 3 (out of 13) regional health authorities and 1 First Nations hospital</td>
<td>None</td>
<td>0</td>
<td>367 births (represents 2.5% of 14,918 total births 2012/13)</td>
</tr>
<tr>
<td>MB</td>
<td>2000</td>
<td>2000</td>
<td>38 practicing, 22 non-practicing</td>
<td>Employees of 4 (out of 5) regional health authorities</td>
<td>UCN (north/south program)</td>
<td>1</td>
<td>904 births, or 5% of births in MB (16026 total births 2012/13); 50% priority populations, 25% out of hospital</td>
</tr>
<tr>
<td>ON</td>
<td>1994</td>
<td>1994</td>
<td>680 RMs (100 RM clinics)</td>
<td>Independent practitioners</td>
<td>McMaster, Laurentian, Ryerson</td>
<td>2 pilot projects</td>
<td>15% of births in ON (142,462 total 2012/13); 150,000 RM-attended births since 1994</td>
</tr>
<tr>
<td>Province</td>
<td>Start Year</td>
<td>End Year</td>
<td>Number of RMs</td>
<td>Employment Status</td>
<td>Institution</td>
<td>Number of Births</td>
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<tr>
<td>QC</td>
<td>1999</td>
<td>1994</td>
<td>150</td>
<td>Salaried, independent professionals</td>
<td>UQTR</td>
<td>13</td>
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<td>NS</td>
<td>2009</td>
<td>2009</td>
<td>9</td>
<td>Employees of 3 regional health authorities</td>
<td>None</td>
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<td>NU</td>
<td>2011</td>
<td>2011</td>
<td>2</td>
<td>Employees of regional health authorities</td>
<td>Arctic College</td>
<td>Number of births by midwives unknown. Total births 2012/13 846.</td>
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<td>NWT</td>
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<td>None</td>
<td>Number of births by midwives unknown. Total births 2012/13 677.</td>
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<td>NB</td>
<td>2010</td>
<td>N/A</td>
<td>0</td>
<td>None</td>
<td>7021 total births 2012/13</td>
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<td>NL</td>
<td>N/A</td>
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<td></td>
<td></td>
<td>4420 total births 2012/13</td>
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<td>PEI</td>
<td>N/A</td>
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<td>1440 total births 2012/13</td>
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<tr>
<td>YK</td>
<td>N/A</td>
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<td></td>
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<td>440 total births 2012/13</td>
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</table>

Total births 2012/13 - Statistics Canada: [http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo04a-eng.htm](http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo04a-eng.htm)
# Aboriginal Midwifery Across Canada


Note: *# of AMs (Aboriginal midwives) represents NACM members only, thus it includes both registered midwives and those working under exemptions

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Regulation</th>
<th>Education</th>
<th>Funding</th>
<th># of AMs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>Exemption clause for Aboriginal midwives who practiced midwifery prior to legislation (1998); no provision for “new” Aboriginal midwives. There are College of Midwives of British Columbia bylaw provisions for developing an Aboriginal category of registration, however, no such category is currently in place.</td>
<td>The University of British Columbia has a 4-year baccalaureate program. The program reserves seats for self-identified Aboriginal students.</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>AB</td>
<td>No provisions for Aboriginal midwives.</td>
<td>Mount Royal University has a four-year baccalaureate program and reserves 10% of seats for self-identified Aboriginal students.</td>
<td></td>
<td>1</td>
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<tr>
<td>SK</td>
<td>Saskatchewan legislation does not mention Aboriginal midwifery.</td>
<td></td>
<td></td>
<td>0</td>
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<tr>
<td>MB</td>
<td>No provision for Aboriginal midwives in the Midwifery Act, however, by mandate, there is a standing committee on issues related to midwifery care to Aboriginal women that advises the</td>
<td>Since 2006, the University College of the North (UCN) has offered kanacotinowawosowin Bachelor of Midwifery program (KO B.MW.). Now offered at the University of Winnipeg.</td>
<td>The Kinosao Sipi Midwifery Clinic in Norway House provides prenatal and postpartum midwifery care,</td>
<td>3</td>
</tr>
<tr>
<td>Province</td>
<td>Remarks</td>
<td>Program Details</td>
<td>Funding Details</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>-----------------</td>
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<td></td>
</tr>
<tr>
<td>ON</td>
<td>Exception clause in Midwifery Act (1994), Exemption clause in Regulated Health Professions Act (1991).</td>
<td>The Tsi Non:we lonnakeratstha Ona:grahsta’ Aboriginal Midwifery Training Program is three years in length, and consists of tutorials that address Aboriginal women’s unique health issues. The program combines western obstetrical practices and standards with traditional Aboriginal practices and standards. All training components are completed at the Maternal and Child Centre with Aboriginal midwife instructors.</td>
<td>The Tsi Non:we lonnakeratstha Ona:grahsta’ is funded through the Aboriginal Health and Wellness Strategy, others systemically unfunded, some receive funding through their band council.</td>
<td></td>
</tr>
<tr>
<td>QC</td>
<td>Clause in the Midwives Act for Aboriginal communities to negotiate an agreement with the government for Aboriginal midwives to practice in their communities without being registered with the Ordre des Sage-Femmes du Québec (this has yet to be used). Also, a separate Act for the Cree Nation.</td>
<td>Nunavik Community Midwifery Education Program is an academic and clinical education program for Inuit women working in their own communities on the Hudson and Ungava Coasts of Nunavik (Northern Quebec). The program uses a modular, competency-based curriculum. The program emphasizes learning in ways appropriate to Inuit culture, including learning in the Inuktitut language, and focuses on the role of the midwife in community health, especially in the areas of sexual health and well-woman care. This program is offered through maternity programs in health centres on the Hudson and Ungava coasts in Quebec. Graduates can register with the OSFQ.</td>
<td>Inuulitsivik and Tulattavik health centres</td>
<td></td>
</tr>
<tr>
<td>NS</td>
<td>No separate clause for Aboriginal midwifery in the Midwifery Act, however, there is a project in development to consult with the Mi’kmaq communities of Cape Breton on culturally appropriate midwifery models.</td>
<td></td>
<td></td>
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<tr>
<td>NU</td>
<td>Exemption clause for Aboriginal midwives who practiced midwifery prior to legislation (2011). No provision for “new” Aboriginal midwives.</td>
<td>Midwifery Education Program at Nunavut Arctic College is offered in partnership with the Department of Health and Social Services and prepares graduates to enter into midwifery practice in Nunavut. Prior to the Midwifery Diploma Program, students complete the Maternity Care Certificate Program. The program introduces students to the cultural, spiritual and traditional practices of Inuit midwives and is also designed to reflect the goals, values and ethical codes established as territorial and national standards and regulations. It is expected that graduates from the program will be able to meet standards set by the Canadian Midwifery Regulatory Committee (CMRC) and provide care that is culturally appropriate for and acceptable to the residents of Nunavut.</td>
<td>Rankin Inlet and Cambridge Bay birth centres</td>
<td>5</td>
</tr>
<tr>
<td>NWT</td>
<td>Aboriginal midwifery is not recognized in NWT regulation. However, the Standards of Practice for registered midwives in the NWT mentions honouring “traditional and cultural birth practice,” and striving to “understand the wisdom of Elder’s teachings and the contributions of traditional midwifery.”</td>
<td>Fort Smith Health and Social Services Midwifery Program</td>
<td>0</td>
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<tr>
<td>NB</td>
<td></td>
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Appendix B:

Sample Budgets:

Akwesasne Mohawk Nation

Tyendinaga Mohawk Nation
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<th>CCS</th>
<th>Base Fees</th>
<th>Operation Fee</th>
<th>Fee Incentive</th>
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<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
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<td>$2,403</td>
<td>$2,297</td>
<td>$2,085</td>
<td>$1,984</td>
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2013-14 PROPOSED BASE FEES

Base Fees
New Practice Group
Form of Annual Budget
Schedule "E"
## New Practice Group Annual Budget Request

### Summary

**Name of Proposed MPG:** The Mohawk Nation at Akwesasne

**Version:** 2013-14 New Practice Group Annual Budget Request

**Date:** 31-MAR-14

**The Mohawk Nation at Akwesasne**

### Table: Annual Budget Request

<table>
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<tr>
<th>Base Fees</th>
<th>New Registrant Fees</th>
<th>Miscellaneous Funding</th>
<th>Total Annual Budget Request</th>
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**APPROVED ANNUALIZED BASE BUDGET**

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<th>Caseload Variables</th>
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**TOTAL ANNUALIZED BUDGET REQUEST**

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<th>CCS</th>
<th>2013-14 Proposed Total</th>
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**Proponent Signatures**

**Position:**

**Signature:**

---

**Legend**

- Base Fees
- New Registrant Fees
- Miscellaneous Funding
## Schedule E

New Practice Group

January 2012

### Form of Annual Budget

#### Base Disbursements

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</tbody>
</table>

**Notes:**

- **Total** column sums the values for each year.
- **Base Disbursements** include all proposed amounts.
- **Travel** and **CCs** represent specific budget items.
- **Liability** and **Other** sections may require additional clarification or data.

---

Schedule „E“
<table>
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<tr>
<th>Name of Practice Group:</th>
<th></th>
<th>Quantity</th>
<th>2010-11 MOH</th>
<th>Total Dollar Requested</th>
<th>Rationale</th>
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<tr>
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<td>Stethoscope – adult</td>
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<td>Stethoscope – infant</td>
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<td>-1 needle driver/holder</td>
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</tr>
<tr>
<td>Glucometer</td>
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<tr>
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<td>Infant pan scale</td>
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<td>Paper shredder</td>
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<td>Coffee table</td>
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<tr>
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<td>645</td>
<td>645</td>
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<tr>
<td>Item</td>
<td>Quantity</td>
<td>Unit Cost</td>
<td>Total Cost</td>
<td></td>
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<tr>
<td>----------------------------------</td>
<td>----------</td>
<td>-----------</td>
<td>------------</td>
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<tr>
<td>Book shelves</td>
<td>3</td>
<td>160</td>
<td>480</td>
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<tr>
<td>Locking cabinet</td>
<td>2</td>
<td>282</td>
<td>564</td>
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<tr>
<td>File cabinet – up to 4 drawer</td>
<td>1</td>
<td>440</td>
<td>440</td>
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</tr>
<tr>
<td>Sterilizer- Autoclave</td>
<td>1</td>
<td>5,505</td>
<td>5,505</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed</td>
<td>1</td>
<td>920</td>
<td>920</td>
<td></td>
<td></td>
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<tr>
<td>Client chairs - @ $120</td>
<td>3</td>
<td>25</td>
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<tr>
<td>Speculums – set of 3</td>
<td>3</td>
<td>300</td>
<td>300</td>
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<tr>
<td>File cabinet – 2-drawer</td>
<td>1</td>
<td>1,500</td>
<td>3,000</td>
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<tr>
<td>Birthing Pool</td>
<td>2</td>
<td>1,500</td>
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<td>Microscope</td>
<td>1</td>
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<td>T.E.N.S.</td>
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<td>150</td>
<td>300</td>
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<td></td>
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<tr>
<td>Electronic File Storage</td>
<td></td>
<td>Provide Quotes</td>
<td>Provide Quotes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electric Fetal Monitor (with print-out)</td>
<td></td>
<td>Provide Quotes</td>
<td>Provide Quotes</td>
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<td></td>
</tr>
<tr>
<td>Bilimeter with sensor</td>
<td>2</td>
<td>2,800</td>
<td>Currently under review</td>
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<td></td>
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<tr>
<td>Hands free communication device (bluetooth)</td>
<td>2</td>
<td>80</td>
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<td></td>
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<tr>
<td>Laryngeal Mask Airways with CO2 Detectors (10)</td>
<td>2</td>
<td>350</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bag for storing and hanging IV equipment</td>
<td>2</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedpan (slipper pan) - autoclavable</td>
<td>4</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating source/heating pad</td>
<td>2</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$ 40,127</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) why is the Practice Group requesting this item?

(b) Are these items required to establish or maintain the operation of the Practice Group?

(c.) Is this a new purchase or a replacement item? If replacement why?

(d) How will this equipment improve access to midwifery services?

(e) How will this equipment improve the quality of midwifery services?
<table>
<thead>
<tr>
<th>Caseload Variables</th>
<th>CV1</th>
<th>CV3</th>
<th>CV4</th>
<th>CV5</th>
<th>CV6a</th>
<th>CV6b</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CV4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>34</td>
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<td>34</td>
<td>20</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>TOTAL</td>
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</table>

2013-14 Proposed Caseload Variables
## New Registrant Disbursements and Grants

### New Practice Group

Form of Annual Budget

**Schedule “E”**

<table>
<thead>
<tr>
<th>New Registrant Disbursements and Grants</th>
<th>Proposed</th>
<th>NR Disbursements</th>
<th>Equipment</th>
<th>NR Grants</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Proposed</th>
<th>NR Disbursements</th>
<th>Equipment</th>
<th>NR Grants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$160</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</table>

2013-14 Proposed New Registrant Disbursements and Grants
<table>
<thead>
<tr>
<th># of Midwives</th>
<th>Operation Fee</th>
<th>Fee Incentive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$728</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$744</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>$0</td>
</tr>
</tbody>
</table>

**New Registrant Fees**

**2012-13 Approved NR**

**Total 2013-14 Proposed NR**

**TOTAL** $1,964
### Grants

#### New Practice Group

**Schedule E**

**Form of Annual Budget**

<table>
<thead>
<tr>
<th>Grants</th>
<th>Remote Practice</th>
<th>Leasehold Improvements</th>
<th>Equipment</th>
<th>Office</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14 Proposed</td>
<td>$100,127</td>
<td>$60,000</td>
<td>40,127</td>
<td>$</td>
<td>$160,000</td>
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</table>

Note
## Schedule "E"

### Form of Annual Budget

**New Practice Group**

**Name of Proposed MPG:** Nayen Tyendinaga Mohawk Territory

**Version:** 2013-14 New Practice Group Annual Budget Request

| Base Fees | $40,920 |
| Base Disbursements | N/A |
| Grants | $107,702 |
| New Registrant Fees | 0 |
| New Registrant Disbursements | N/A |
| New Registrant Grants | 0 |

**TOTAL ANNUAL BUDGET REQUEST:** $211,065

**Caseload Variables:**

| CCS | 34 |

**APPROVED ANNUALIZED BASE BUDGET:** N/A $103,363

**Proponent Signatures:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Legend</th>
<th>Position</th>
<th>Base</th>
<th>New Registrant</th>
<th>Miscellaneous Funding</th>
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</thead>
<tbody>
<tr>
<td></td>
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**Date:** 31-Mar-14

**Name of Proposed MPG:** Nayen Tyendinaga Mohawk Territory

**Summary**

**New Practice Group** Form of Annual Budget Schedule "E"
<table>
<thead>
<tr>
<th>MW</th>
<th>CCS</th>
<th>$40,920</th>
<th>N/A</th>
<th>N/A</th>
<th>$</th>
<th>Operation Fee</th>
<th>Per CC</th>
<th>Fee Incentive</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>MW1</td>
<td>15</td>
<td>$40,920</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
<td>$40,920</td>
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<tr>
<td>MW2</td>
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<td></td>
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<td>$0</td>
<td>$2,085</td>
<td>$744</td>
<td>$2,085</td>
<td>MW2</td>
</tr>
<tr>
<td>MW3</td>
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<td></td>
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<td>$0</td>
<td>$2,191</td>
<td>$744</td>
<td>$2,191</td>
<td>MW3</td>
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<tr>
<td>MW4</td>
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<td>$0</td>
<td>$2,297</td>
<td>$744</td>
<td>$2,297</td>
<td>MW4</td>
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<td>$0</td>
<td>$2,364</td>
<td>$744</td>
<td>$2,364</td>
<td>MW5</td>
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<tr>
<td>MW6</td>
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<td>$0</td>
<td>$2,403</td>
<td>$744</td>
<td>$2,403</td>
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<td></td>
<td>CV1</td>
<td>CV3</td>
<td>CV4</td>
<td>CV5</td>
<td>CV6a</td>
<td>CV6b</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>------</td>
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<td></td>
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<tr>
<td>Total</td>
<td>34</td>
<td>20</td>
<td>10</td>
<td>1</td>
<td>3</td>
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<td></td>
</tr>
<tr>
<td>Caseload Variables</td>
<td>CV1</td>
<td>CV3</td>
<td>CV4</td>
<td>CV5</td>
<td>CV6a</td>
<td>CV6b</td>
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2013-14 Proposed Caseload Variables
<table>
<thead>
<tr>
<th></th>
<th>Proposed NR Grants</th>
<th>Proposed Travel/CC</th>
<th>Other Liability</th>
<th>NR Disbursements</th>
<th>Proposed CCS</th>
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<tr>
<td>Equipment</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>NR Grants</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Total</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</table>

**TOTAL**

2013-14 Proposed New Registrant Disbursements and Grants
<table>
<thead>
<tr>
<th></th>
<th>2013-14 Proposed NR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Registrant Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCS # of Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee Incentive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NR Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per CC # of Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Midwives</td>
<td></td>
<td></td>
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<tr>
<td>NR Fees</td>
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<td></td>
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<tr>
<td>Total</td>
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New Registrant Fees
New Practice Group
From the Annual Budget
Schedule "E"
<table>
<thead>
<tr>
<th>Number</th>
<th>Remote Practice</th>
<th>Grants</th>
<th>Leasehold Improvements</th>
<th>Equipment</th>
<th>Office</th>
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<tbody>
<tr>
<td>107,702</td>
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<td>$75,000</td>
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<tr>
<td>32,702</td>
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<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$107,702</td>
<td></td>
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</table>

**2013-14 Proposed Grants**
<table>
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<tr>
<th>ITEM</th>
<th>Quantity</th>
<th>Requested</th>
<th>2010-11 MOH</th>
<th>Total Dollar Requested</th>
<th>Rationale</th>
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</tr>
<tr>
<td>Birth Bag</td>
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<td>90</td>
<td>90</td>
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<td></td>
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<tr>
<td>Birth Stool</td>
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<td>285</td>
<td>285</td>
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<td></td>
</tr>
<tr>
<td>Blood Pressure Kit</td>
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<td>163</td>
<td>163</td>
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<tr>
<td>Doppler</td>
<td>2</td>
<td>900</td>
<td>1,800</td>
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<tr>
<td>Fetaloscope</td>
<td>2</td>
<td>110</td>
<td>220</td>
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<tr>
<td>Ophthalmoscope</td>
<td>1</td>
<td>300</td>
<td>300</td>
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<td></td>
</tr>
<tr>
<td>Stethoscope – adult</td>
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<td>94</td>
<td>188</td>
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<td></td>
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<tr>
<td>Stethoscope – infant</td>
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<td>146</td>
<td>292</td>
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<td>Infant Resuscitation Kit</td>
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<td>350</td>
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<tr>
<td>Oxygen Kit (includes 2 tanks w/2 adjustable regulators &amp; 1 back up tank)</td>
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<td>1,100</td>
<td>1,100</td>
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<tr>
<td>Portable suction</td>
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<td>Hanging Scale (2 slings)</td>
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<td>150</td>
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<td>Small breast pump</td>
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<td>Headlamp/flashlight</td>
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<tr>
<td>Tweezers</td>
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<tr>
<td>Thermometer (1)</td>
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<td>14</td>
<td>14</td>
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<td></td>
</tr>
<tr>
<td>Speculum</td>
<td>1</td>
<td>30</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 sets of birth instruments each having:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-3 forceps/clamps</td>
<td>2</td>
<td>52</td>
<td>104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 episiotomy scissors</td>
<td>2</td>
<td>137</td>
<td>274</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 cord scissors</td>
<td>2</td>
<td>115</td>
<td>230</td>
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<td></td>
</tr>
<tr>
<td>-1 ring forceps</td>
<td>2</td>
<td>71</td>
<td>142</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 sets of sutureting instruments each having:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 needle driver/holder</td>
<td>2</td>
<td>78</td>
<td>156</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 suture scissors</td>
<td>2</td>
<td>43</td>
<td>86</td>
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<td></td>
</tr>
<tr>
<td>-1 tissue forceps</td>
<td>2</td>
<td>25</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 mosquito forceps</td>
<td>2</td>
<td>36</td>
<td>72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 set of suture removal instruments having:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 suture removal scissors</td>
<td>1</td>
<td>57</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 mosquito forceps</td>
<td>1</td>
<td>36</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1 large needle driver (if suturing instruments have small one)</td>
<td>1</td>
<td>78</td>
<td>78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflex Hammer</td>
<td>1</td>
<td>25</td>
<td>25</td>
<td></td>
<td></td>
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<tr>
<td>Reception chairs for clients</td>
<td>3</td>
<td>120</td>
<td>360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk &amp; Chair</td>
<td>1</td>
<td>645</td>
<td>645</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer station and stand</td>
<td>1</td>
<td>225</td>
<td>225</td>
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</tr>
<tr>
<td>Computer</td>
<td>1</td>
<td>1,580</td>
<td>1,580</td>
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<td></td>
</tr>
<tr>
<td>Printer</td>
<td>1</td>
<td>600</td>
<td>600</td>
<td></td>
<td></td>
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<tr>
<td>Software</td>
<td>1</td>
<td>1,000</td>
<td>1,000</td>
<td></td>
<td></td>
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<tr>
<td>Facsimile machine</td>
<td>1</td>
<td>425</td>
<td>425</td>
<td></td>
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</tr>
<tr>
<td>Photocopier</td>
<td>1</td>
<td>750</td>
<td>750</td>
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<tr>
<td>Telephone system</td>
<td>1</td>
<td>2,900</td>
<td>2,900</td>
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</tr>
<tr>
<td>Examination table</td>
<td>1</td>
<td>1,500</td>
<td>1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucometer</td>
<td>2</td>
<td>66</td>
<td>132</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult scale</td>
<td>1</td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant pan scale</td>
<td>1</td>
<td>425</td>
<td>425</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination lamp</td>
<td>1</td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refrigerator</td>
<td>1</td>
<td>315</td>
<td>315</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper shredder</td>
<td>1</td>
<td>105</td>
<td>105</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee table</td>
<td>1</td>
<td>275</td>
<td>275</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception desk and chair</td>
<td>1</td>
<td>645</td>
<td>645</td>
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### Office Equipment - Leasehold Improvement - Remote Practice Grant - Grant Approvals

<table>
<thead>
<tr>
<th>Name of Practice Group</th>
<th>Description</th>
<th>Quantity</th>
<th>Unit Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book shelves</td>
<td></td>
<td>2</td>
<td>160</td>
<td>320</td>
</tr>
<tr>
<td>Locking cabinet</td>
<td></td>
<td>1</td>
<td>282</td>
<td>282</td>
</tr>
<tr>
<td>File cabinet – up to 4 drawer</td>
<td></td>
<td>1</td>
<td>440</td>
<td>440</td>
</tr>
<tr>
<td>Sterilizer- Autoclave</td>
<td></td>
<td>1</td>
<td>5,505</td>
<td>5,505</td>
</tr>
<tr>
<td>Bed</td>
<td></td>
<td>1</td>
<td>920</td>
<td>920</td>
</tr>
<tr>
<td>Client chairs - @$120</td>
<td></td>
<td>2</td>
<td>120</td>
<td>240</td>
</tr>
<tr>
<td>Speculums – set of 3</td>
<td></td>
<td>2</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>File cabinet – 2-drawer</td>
<td></td>
<td>1</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>Birthing Pool</td>
<td></td>
<td>2</td>
<td>1,500</td>
<td>3,000</td>
</tr>
<tr>
<td>Microscope</td>
<td></td>
<td>1</td>
<td>500</td>
<td>500</td>
</tr>
<tr>
<td>T.E.N.S.</td>
<td></td>
<td>1</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Electronic File Storage</td>
<td></td>
<td></td>
<td></td>
<td>Provide Quotes</td>
</tr>
<tr>
<td>Electric Fetal Monitor (with print-out)</td>
<td></td>
<td>1</td>
<td>Provide Quotes</td>
<td>Provide Quotes</td>
</tr>
<tr>
<td>Bilimeter with sensor</td>
<td></td>
<td>1</td>
<td>2,800</td>
<td></td>
</tr>
<tr>
<td>Hands free communication device (bluetooth)</td>
<td></td>
<td>1</td>
<td>80</td>
<td></td>
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<tr>
<td>Laryngeal Mask Airways with CO2 Detectors (10)</td>
<td></td>
<td>1</td>
<td>350</td>
<td></td>
</tr>
<tr>
<td>Bag for storing and hanging IV equipment</td>
<td></td>
<td>1</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Bedpan (slipper pan) - autoclavable</td>
<td></td>
<td>2</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Heating source/heating pad</td>
<td></td>
<td>1</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>32,702</strong></td>
</tr>
</tbody>
</table>

(a) why is the Practice Group requesting this item?

(b) Are these items required to establish or maintain the operation of the Practice Group?

(c.) Is this a new purchase or a replacement item? If replacement why?

(d) How will this equipment improve access to midwifery services?

(e) How will this equipment improve the quality of midwifery services?
<table>
<thead>
<tr>
<th>Base Disbursements</th>
<th>Liability</th>
<th>Number of Midwives</th>
<th>Other</th>
<th>Special 2nd Attendant</th>
<th>Total Attendant</th>
<th>Travel</th>
<th>Travel/CC</th>
<th>Proposed Base Disbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed</td>
<td>39,404,993</td>
<td>1</td>
<td>$6,652</td>
<td>$18,000</td>
<td>$5,952</td>
<td>$36,091</td>
<td>$62,443</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C:

Letters of Support

Kelly Dobbin, CEO & Registrar, College of Midwives of Ontario
Kerry Bebee, Co-chair, National Aboriginal Council of Midwives
Joanna Nemrava, President, Canadian Association of Midwives
Patrick Madahbee, Grand Council Chief, Chair, Ontario Chiefs Committee on Health, Chiefs of Ontario
Doris Grinspun, Chief Executive Officer, Registered Nurses’ Association of Ontario
Hiltrud Dawson, Health Promotion Consultant - Breastfeeding Project Lead, Health Nexus
Julie Wilson, Supervisor of the Six Nations Birthing Center, Tsi Non:we Ionnakeratstha Onagrahsta’
Jessica Danforth, Executive Director, Native Youth Sexual Health Network
Joe Hester, Executive Director, Anishnawbe Health Toronto
Michael K. Mitchell, Grand Chief, Mohawk Council of Akwesasne
Sue Herner, Akwesasne Museum Program Coordinator, Akwesasne Cultural Centre
Donald Maracle, Chief, Mohawks of the Bay of Quinte
Allison Brant, Family Health and Child Development Program Manager, Mohawks of the Bay of Quinte
Julie Wilson, Supervisor of Maternal and Child Centre, Tsi Non:we Ionnakeratstha Onagrahsta’
Mary McBride, RM, IBCLC, Tyendinaga Mohawk Territory
Mary McCauley, Community Health Nurse, Community Wellbeing Centere, Deseronto
Dr. Jason M. Young, Maracle Chiropractic. Tyendinaga Mohawk Territory
May Maracle, client of Dorothy Green’s, Tyendinaga Mohawk Territory
Jillian Downer, client of Dorothy Green’s, Tyendinaga Mohawk Territory
Chief Warren Tabobondung and Councillor Deborah Pegahmagabow - Health Portfolio, Wasauksing First Nation, Parry Sound
Warren White, Ogichidaa, Grand Council Treaty #3
Sara Wolfe, Aboriginal Registered Midwife, Partner, Seventh Generation Midwives Toronto
March 14, 2014

Juana Berinstein
Director, Policy and Communications
Association of Ontario Midwives
365 Bloor Street East, Suite 800
Toronto, ON, M4W 3L4

Dear Ms. Berinstein,

I am writing in my capacity as Registrar of the College of Midwives of Ontario ("CMO") to acknowledge the Association of Ontario Midwives’ proposal to have a parallel funding stream made available to aboriginal midwives.

As you are aware, over two decades ago, the Ministry made a policy decision to exempt aboriginal midwives and aboriginal healers from the Regulated Health Professions Act ("RHPA") and the Midwifery Act. An aboriginal person who provides traditional midwifery services may, use the title “aboriginal midwife” and hold himself or herself out as a person who is qualified to practice in Ontario as an aboriginal midwife.

Aboriginal midwives who provides traditional midwifery services to aboriginal persons or members of an aboriginal community are not subject to CMO midwifery standards of practice, the requirements prescribed in the Midwifery Act (1991), the Regulated Health Professions Act (1991), nor the regulations under either of those acts.

Despite having no jurisdiction over midwives using the title “aboriginal midwife” in Ontario, the College of Midwives would support programs made available to aboriginal midwives that are designed to positively impact the health outcomes for women and babies using their services.
Information concerning the exemption is available on e-laws:

RHPA - http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm#BK35we

Please do not hesitate to contact me should you have any questions.

Regards,

[Signature]

Kelly Dobbin, RM
Registrar-CEO
March 24th, 2014

Ellen Blais
Policy Analyst, Aboriginal Midwifery
Association of Ontario Midwives
365 Bloor St. E.,
Suite 800
Toronto, Ontario
M4W 3L4

Dear Ellen Blais,
Policy Analyst, Aboriginal Midwifery,

The National Aboriginal Council of Midwives would like to join the AOM in asking the Ministry of Health and Long Term Care, Ontario Midwifery Program to support funding for Aboriginal midwives working under the exemption in the Midwifery Act. This funding would enable midwives to work in their home communities.

NACM's vision is of “Aboriginal midwives working in every Aboriginal community” and we feel that secure funding would make great strides towards this vision. As Aboriginal midwives, we see the critical need for culturally secure care within our communities and the difference midwifery care makes within Indigenous and underserved communities alike. The health and well-being of First Nations, Métis and Inuit families is of central importance for Aboriginal peoples.

At the moment in Ontario there are unacceptable disparities between Aboriginal and non-Aboriginal communities. Most Ontario families live in communities where they have access to midwives, who can offer them continuity of care and the option of giving birth at home. On the other hand, although many Aboriginal communities are growing, most do not have access to midwifery services. Lack of funding prevents qualified Aboriginal midwives from being able to provide care to families from their communities. We are very concerned that the infant mortality rate is 1.7-4 times higher among Aboriginal communities. We are also aware that the loss of birth in many communities has had a devastating impact. Many Aboriginal families are split apart at what should be a joyful time, as women from rural and remote communities have to leave their families behind for several weeks at the end of their pregnancy.

We feel that funding of Aboriginal midwifery would offer a culturally appropriate and financially sound option. Research from other rural and remote locations in Canada has shown that keeping birth close to home would both help to strengthen communities, while providing safe care to families. The midwifery model of care encourages home births for healthy women.

National Aboriginal Council of Midwives Tel. 514 807-3668; Fax 514 738-0370: nacm@canadianmidwives.org
In the future, if communities identify the need for birth centres, this option could also be pursued. It should be noted that these two options have been shown to be very cost-effective. In addition, as midwives we know that birth grounds and anchors the community. Having the possibility of being present at births will increase capacity for the youth to become midwives. We truly believe that this will also increase the strength of communities culturally, which will result in less child welfare involvement and improved breastfeeding rates. It is time that Aboriginal women in Ontario have access to the same options of care in pregnancy as other Ontario residents.

The National Aboriginal Council of Midwives is a diverse group of midwives from all regions of Canada, representing First Nations, Inuit and Métis communities. We recognize that the good health and well-being of Aboriginal mothers and their babies is crucial to the empowerment of Aboriginal families and communities. We advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities consistent with the U.N. Declaration on the Rights of Indigenous Peoples. As active members of the Canadian Association of Midwives, we represent the professional development and practice needs of Aboriginal midwives to the responsible health authorities in Canada and the global community.

If the AOM requires any additional support that NACM can provide, please do not hesitate to contact Valérie Perrault, administrator, at nacm@canadianmidwives.org or 514 807-3668.

Sincerely,

[Signature]

Kerry Bebee (co-chair)
on behalf of the National Aboriginal Council of Midwives
March 24, 2014

Association of Ontario Midwives
365 Bloor St. E.,
Suite 800
Toronto, Ontario M4W 3L4

To whom it may concern,

The Canadian Association of Midwives (CAM) is the national organization representing midwives and the profession of midwifery in Canada. The mission of CAM is to provide leadership and advocacy for midwifery as a regulated, publicly funded and vital part of the primary maternity care system in all provinces and territories.

CAM fully supports the Association of Ontario Midwives’ request to the Ministry of Health and Long Term Care, Ontario Midwifery Program, to support funding for Aboriginal midwives working under the exemption clause in the Midwifery Act, therefore enabling these midwives to work within their communities.

A UNICEF report published in April 2013, found that Canada ranked 22nd out of 29 developed countries for infant mortality rates. This alarming statistic is attributed primarily to higher rates among Aboriginal people. Midwives are well positioned to address the specific challenges still faced by women in rural, remote and Aboriginal communities across Canada.

CAM believes that midwifery is fundamental to maternal and newborn health services, and that every woman in Canada should have access to a midwife’s care for herself and her baby, as close to home as possible. In provinces where midwifery is established, midwives have a proven record for providing safe, excellent, cost-effective care, with low intervention rates and high satisfaction rates. Women who have access to midwifery care are less likely to experience antenatal hospitalization, regional analgesia, episiotomy, and instrumental delivery. Midwives play an important role in reducing chronic disease by having the highest breastfeeding rates of any maternity care provider, and by focusing on nutrition and smoking cessation during pregnancy, which can lead to fewer low-birth weight babies. Keeping birth close to home is proven to increase better outcomes, strengthen communities, foster healthy nutrition, pregnancy planning, and encourage breastfeeding.

Do not hesitate to contact us should you have any questions or concerns:
director@canadianmidwives.org

Sincerely,

[Signature]

Joanna Nemerava, President/Présidente
Canadian Association of Midwives/Association canadienne des sages-femmes

59 Riverview, Montréal, Québec, H8R 3R9
Tel: 514-867-3669 Fax: 514-736-0370 Email: admin@canadianmidwives.org
www.canadianmidwives.org
CHIEFS OF ONTARIO

March 19, 2014

The Honourable Deborah Matthews, M.P.P.
Minister of Health
Ministry of Health and Long-Term Care
Hepburn Block, 11th Floor,
80 Grosvenor Street,
Toronto, ON M7A 2C4

Dear Minister Matthews:

This letter is in support of the proposal Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives, to the Ministry of Health and Long Term Care, Ontario Midwifery Program from the Ontario Association of Ontario Midwives.

As you may be aware, in many First Nation communities in Ontario, birth has been removed from the community through decreased access, and in many cases, no access, to traditional Aboriginal midwifery services. As the ceremony of birth is a joyful event in a family and community, we feel that bringing birth back to our communities will strengthen our homes and families in many ways. Aboriginal Midwives would be working under the Exception Clause in the Midwifery Act 1991 and the exemption in the Regulated Health Professions Act.

In many Aboriginal communities, there are increased rates of infant mortality, prenatal and postpartum depression, SIDS, high and low birthweight babies, and higher rates of family violence. With community based midwifery care through increased access to Aboriginal Midwives, women will have close access to culturally safe prenatal, intrapartum and postnatal care. Rates of breastfeeding (which we know is a much healthier choice for infants) will increase. Re-hospitalization rates of women or their infants will decrease as midwifery care encompasses the postpartum time period for up to six weeks.

Midwives are well poised to support families in their home communities. Women will not have to abandon their other children for weeks at a time to give birth in a far away hospital, travelling home, often alone with an infant on a bus, or plane. Women would have greater access to breastfeeding support and postpartum care in their home community. Funding for Aboriginal Midwives would be in line with your Ministry’s newly announced funding to promote breastfeeding, and would support your stated goal of “doing what we want them to do — breastfeeding — if we provide the right supports for them.”
The Chiefs in Ontario would welcome the funding for Aboriginal Midwives to provide the much needed services in their communities, as there is no federal funding for these services.

Respectfully,

[Signature]

Grand Council Chief Patrick Madahbee, Chair
Ontario Chiefs Committee on Health
Chiefs of Ontario

cc: Ontario Chiefs Committee on Health
    Health Coordination Unit
    Ellen Blais, Association of Ontario Midwives
    Tracy Antone, COO Health Unit Coordinator
March 28, 2014

Kelly Stadelbauer, RN, BScN, MBA
Executive Director
Association of Ontario Midwives
365 Bloor Street East, Suite 800
Toronto, ON M4W 3L4

Dear Kelly,

This letter is to affirm the support of the Registered Nurses’ Association of Ontario (RNAO) for the Association of Ontario Midwives’ (AOM) submission to the Ministry of Health and Long-Term Care on Improving Access to Midwifery Care for Aboriginal Women Living in Ontario—A Proposal for Funding Aboriginal Midwives.

In the context of massive federal cuts to Aboriginal health groups in Canada, there is no more urgent public health issue than the ongoing inequities in health outcomes of First Nations, Inuit, and Métis. It is unconscionable that infant mortality among First Nations with status is nearly twice that of the general Canadian population and infant mortality among Inuit is four times higher that of the general Canadian population. A systematic review of pregnancy and neonatal outcomes of Aboriginal women showed an increased risk for preterm birth, high birth weight, stillbirth, neonatal, and perinatal mortality in Canada. Babies and Aboriginal people of all ages living in Ontario must have same chances to live and be healthy as other Ontarians who are non-Aboriginal.

RNAO recognizes that ongoing health inequities in Aboriginal populations are being caused by social determinants of health that are proximal (such as income, employment, housing, education, food security), intermediate (such as access to health care, education, community infrastructure, cultural continuity), and distal (such as colonialism, racism and social exclusion, and self-determination). AOM’s proposal to improve access to midwifery care for Aboriginal women in Ontario will improve access to essential health care services in their home communities in a way that will help build cultural safety. Preventing routine evacuation of pregnant women from their communities due to the availability of safe, person-centred midwifery care by Aboriginal midwives has the potential to prevent disruption and forgo parallels with residential schools trauma.

RNAO supports AOM’s concrete plan for increasing access to “high quality Aboriginal midwifery that is responsive to the needs of the community” as a means to improve health outcomes for women, their families, and their communities. This approach is consistent with the literature and Ontario’s Action Plan for Health Care’s objective of providing “the right care, at the right time, in the right place.” As you know, RNAO’s
Best Practices Guidelines Program includes a number of resources that we are delighted to share with our midwifery colleagues, which are available online at http://RNAO.ca/bpg:

- Breastfeeding
- Client Centred Care
- Developing and Sustaining Interprofessional Healthcare
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Establishing Therapeutic Relationships
- Integrating Smoking Cessation into Daily Nursing Practice
- Interventions for Postpartum Depression
- Primary Prevention of Childhood Obesity
- Supporting and Strengthening Families Through Expected & Unexpected Life Events
- Woman Abuse: Screening, Identification and Initial Response
- Working with Families to Promote Safe Sleep for Infants 0-12 Months of Age

Thank you for the opportunity to review this exciting and compelling proposal that will, if implemented, improve access to midwifery services for Aboriginal women in Ontario.

Warm regards,

[Signature]

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.Ont.
Chief Executive Officer
Registered Nurses’ Association of Ontario

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5 Shah et al, 37.
March 27, 2014

To whom it may concern.

Health Nexus/ Nexus Santé is Ontario’s leading health promotion organization. Our mission is to develop health promotion capacity to enhance community well-being, and advocate for policies and resources that promote health. We have two major programs (the Best Start Resource Centre and the Health Promotion Hub) and undertake projects. We are the only health promotion organization designated as a French Language Service provider by the Ontario government. We assist service providers in their health promotion work by providing consultations, knowledge exchange and transfer, training, networking opportunities, and resources.

The Best Start Resource Centre provides services to service providers working with prenatal and postpartum families and families with young children. We often work with service providers working with disadvantaged populations. In our work, we have witnessed first-hand the needs of service providers working with Aboriginal families and the need for more equitable services. We know the need of Aboriginal families for more equitable services.

The beneficial effects of midwifery care have been well established. We can only imagine the benefits Aboriginal midwifery care would have on the lives of mothers, children and families in Aboriginal communities. The Government of Ontario currently supports community initiatives to improve the health of children from an early start according to the Healthy Kids Report. We believe Aboriginal midwifery would complement the Government priorities and have a huge positive impact.

We fully support AOMs proposal and hope that Ontario will be a leader in providing support and training for Aboriginal midwives and Aboriginal midwifery.

Sincerely

Hiltrud Dawson
Health Promotion Consultant – Breastfeeding Project Lead
March 24, 2014

Ellen Blais
Policy Analyst, Aboriginal Midwifery
Association of Ontario Midwives
365 Bloor Street, East
Suite 800
Toronto, ON
M4W 3L4

Dear Ellen Blais:

I would like to extend a formal letter of support for the invaluable work that you are doing with regard to Aboriginal Midwifery in Ontario. Your work within Aboriginal communities is very timely since as you are aware, Aboriginal women in Canada face the highest maternity related poor health outcomes along with many social issues which contribute to overall poor health and wellness. Aboriginal Midwifery has shown itself to be a gold standard of care within Aboriginal communities.

I support your Aboriginal midwifery proposal to the Ministry of Health and Long Term Care. Certainly this proposal has the potential to have a far reaching impact within Aboriginal communities. I would like to extend not only my support but my assistance with any potential future developments that may follow the positive outcome of this proposal.

If I can be of further assistance please feel free to call me at (519) 445 4922.

In Health,

Julie Wilson, BHSc in Midwifery
Supervisor of the Six Nations Birthing Centre
The Native Youth Sexual Health Network  
2345 Yonge St.  
PO Box 26069  
Toronto, ON  
M4P 0A8

Association of Ontario Midwives  
365 Bloor St. E.,  
Suite 800  
Toronto, Ontario  
M4W 3L4

March 24th, 2014

Dear Ellen,

This letter is in support of the proposal Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives, Ministry of Health and Long Term Care, Ontario Midwifery Program. As a national Indigenous organization that works across issues of sexual and reproductive health, rights, and justice we know firsthand the importance of Indigenous midwifery, doula, and birth worker support.

As you may be aware, in many Aboriginal communities in Ontario, birth has been removed from the community through decreased access, and in many cases, no access, to traditional Aboriginal midwifery services. As the ceremony of birth is a joyful event in a family and community, we feel that bringing birth back to our communities will strengthen our homes and families in many ways.

In many Aboriginal communities, there are increased rates of infant mortality, prenatal and postpartum depression, SIDS, high and low-birth weight babies, and higher rates of family violence. With community based midwifery care through increased access to Aboriginal midwives, women will have close access to culturally safe prenatal, intrapartum and postnatal care. Rates of breastfeeding (which we know is a much healthier choice for infants) will increase. Re-hospitalization rates of women or their infants will decrease as midwifery care encompasses the postpartum time period for up to six weeks.
Midwives are well poised to support families in their home communities. Women will not have to abandon their other children to attend birth in a far away hospital, whereas currently women are away from their families for weeks at a time.

Women have little access to breastfeeding support and postpartum care as they are travelling home for days alone with an infant on a bus, or plane. The cost savings alone in transportation funding will be substantial.

In particular we write this letter in support of Dorothy Green’s midwifery work in Tyendinaga and Jasmine Benedict’s midwifery work in Akwesasne. We have had the honor of knowing and working with these two phenomenal Indigenous midwives who bring much needed birth and reproductive health, rights, and justice knowledge to their communities on a daily basis. Support for the incredible work that they continue to do no matter what obstacle is critical.

Please do not hesitate to contact me should you have any questions or concerns.

Sincerely,

Signature

Jessica Danforth
Executive Director, Native Youth Sexual Health Network (NYSHN)
jdanforth@nativyouthsexualhealth.com
920-883-2821
March 27, 2014

Association of Ontario Midwives
365 Bloor St. E., Suite 800
Toronto, ON  M4W 3L4

Dear Ellen:

This letter is in support of the proposal Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives, Ministry of Health and Long Term Care, Ontario Midwifery Program.

As you may be aware, in many Aboriginal communities in Ontario, birth has been removed from the community through decreased access, and in many cases, no access, to traditional Aboriginal midwifery services. As the ceremony of birth is a joyful event in a family and community, we feel that bringing birth back to our communities will strengthen our homes and families in many ways.

In many Aboriginal communities, there are increased rates of infant mortality, prenatal and postpartum depression, SIDS, high and low birthweight babies, and higher rates of family violence. With community based midwifery care through increased access to Aboriginal midwives, women will have close access to culturally safe prenatal, intrapartum and postnatal care. Rates of breastfeeding (which we know is a much healthier choice for infants) will increase. Re-hospitalization rates of women or their infants will decrease as midwifery care encompasses the postpartum time period for up to six weeks.
Midwives are well poised to support families in their home communities. Women will not have to abandon their other children to attend birth in a far away hospital, whereas currently women are away from their families for weeks at a time.

Women have little access to breastfeeding support and postpartum care as they are travelling home for days alone with an infant on a bus, or plane. The cost savings alone in transportation funding will be substantial.

Anishnawbe Health Toronto is willing to extend any support that may be required.

Sincerely,

[Signature]

Joe Hester
Executive Director
Association of Ontario Midwives
365 Bloor St. E.
Suite 800
Toronto, Ontario
M4W 3L4

Wa’tkwanonhwera:ton/Greetings:

This letter is in support of the proposal *Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives* to the Ministry of Health and Long Term Care, Ontario Midwifery Program.

As you may be aware, in many Aboriginal communities in Ontario, birth has been removed from the community through decreased access and in many cases no access to traditional Aboriginal midwifery services. As the ceremony of birth is a joyful event in a family and community we feel that bringing birth back to our communities will strengthen our homes and families in many ways.

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Midwives are well poised to support families in their home communities. Women will not have to abandon their other children to birth in far away hospitals—currently women are away from their families for weeks at a time. Re-hospitalization rates of women or their infants will decrease as midwifery care encompasses the postpartum time period for up to six weeks.

Thank you for your time and any consideration of the proposal for funding for Aboriginal Midwives, as there is no Federal funding for these services. If you have any questions, feel free to contact me at (613) 575-2348 extension 2250.

Sincerely,

Michael K. Mitchell
Grand Chief
Association of Ontario Midwives  
365 Bloor St. E.,  
Suite 800  
Toronto, Ontario  
M4W 3L4

She:kon/Greeting,

This letter is in support of the proposal Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives, Ministry of Health and Long Term Care, Ontario Midwifery Program.

As you may be aware, in many Aboriginal communities in Ontario, birth has been removed from the community through decreased access, and in many cases, no access, to traditional Aboriginal midwifery services. As the ceremony of birth is a joyful event in a family and community, we feel that bringing birth back to our communities will strengthen our homes and families in many ways.

In many Aboriginal communities, there are increased rates of infant mortality, prenatal and postpartum depression, SIDS, high and low birthweight babies, and higher rates of family violence. With community based midwifery care through increased access to Aboriginal midwives, women will have close access to culturally safe prenatal, intrapartum and postnatal care. Rates of breastfeeding (which we know is a much healthier choice for infants) will increase. Re-hospitalization rates of women or their infants will decrease as midwifery care encompasses the postpartum time period for up to six weeks.

Midwives are well poised to support families in their home communities. Women will not have to abandon their other children to attend birth in a far away hospital, whereas currently women are away from their families for weeks at a time. Women have little access to breastfeeding support and postpartum care as they are travelling home for days alone with an infant on a bus, or plane. The cost savings alone in transportation funding will be substantial.

I would have welcomed the support of a mid-wife and am in support of this care being available to other aboriginal women more widely in the near future.

Yours truly,

Sue Herne

Akwesasne Museum program coordinator  
321 State Rte 37  
Hogansburg, NY 13655  
518-358-2461  
www.akwesasneculturalcenter.org
March 27, 2014

Kenhte:ke Birth Advisory Working Group
c/o Community Wellbeing Centre
50 Meadow Drive
Tyendinaga Mohawk Territory, Ontario
K0K 1X0

To Whom It May Concern:

Tyendinaga Mohawk Territory, located on the north shore of the Bay of Quinte is approximately 8,500 people, who are represented by the Tyendinaga Mohawk Council as the governance body. In considering our Strategic Health Plan and the expressed interest and participation of the community membership, we are excited to be a part of the efforts that is committed to returning the sovereign right of birth to our community.

We have been provided with supportive documentation that details Aboriginal Midwifery, and to have in place, a Mohawk Council Resolution that recognizes one of our members as a graduate and with legal title, Aboriginal Midwife. This individual, along with credentialed, qualified attendants, are passionate to provide this valued service to women and their families.

The Birth Search February 2012 provided community involvement opportunity and input that highly recommends ensuring a birth centre on our Territory, and demonstrates clearly that the services in surrounding communities, are not sufficient to meet our need. In conclusion, we, the Tyendinaga Mohawk Council fully support and have intentions to assist in accessing funding, that would secure Birthing Service for the Mohawks of the Bay of Quinte membership. Concerns or questions can be directed to the Council through the Chief Administrative Officer, Administration, Mohawks of the Bay of Quinte at 613-396-3424.

Nyawen tsi atakwayenawase
(Thank-you for your assistance)

[Signature]

R. Donald Maracle
Chief, Mohawks of the Bay of Quinte
March 17, 2014

To whom it may concern;

This is a letter of support for the Mohawks of the Bay of Quinte proposal submission to the Ministry of Health and Long Term Care. We fully support the development of an Aboriginal Midwifery practice in our community. Although Obstetrical and registered Midwifery services are available, these models of care do not address the specific cultural and social needs of our people.

Aboriginal Midwifery has the potential to bring back midwifery to our community and traditional birthing practices. Our community wants to reclaim the right to birth our children in our community using traditional birthing practices and a holistic model of care.

Thank you

Allison Brant
Family Health & Child Development Program Manager
Mohawks of the Bay of Quinte
March 21, 2014

To Whom It May Concern:

May this serve as a letter of support for Tyendinaga’s proposal submission. I fully support the development of an Aboriginal Midwifery practice on Tyendinaga. At the present time, Aboriginal Midwifery services are not available to community members who reside within the Tyendinaga territory. Although Obstetrical and Registered midwifery services are available, these models of care do not address the specific cultural and social needs of their people.

I believe that the Aboriginal Midwifery model of care as per the “exemption code for Aboriginal Midwives” under the Midwifery Act, 1991, is best suited to meet the birthing needs within their community. Aboriginal Midwifery has the potential to bring Traditional midwifery back to their community thereby strengthening community ties and Traditional birthing practices. The Tyendinaga community wants to reclaim their inherent right to birth their children on their own territory using a Traditional and more holistic model of care.

If you require more information, please do not hesitate to contact Julie Wilson at the phone number listed below.

In Health,

Julie Wilson, BHSc in Midwifery
Supervisor of Maternal and Child Centre
Letter of support for Kenhte:ke Midwives

My name is Mary McBride and I have worked with Dorothy Green, Aboriginal Midwife for the last 2 years. I am a certified birth attendant and have experience as a registered nurse for over 40 years working mostly in pediatrics and maternity. I am now registered in the non practising class. I am also a certified Lactation Consultant and have worked with moms and their babies/toddlers on Tyendanaga Mohawk Territory since August 2012.

I support Dorothy and her bid to have a healthy babies born here on the territory.

Mary McBride, RN (non practicing) IBCLC

March 21, 2014
March 19, 2014

Re: The Association of Ontario Midwives (AOM) submission proposal to the Ministry of Health and Long Term Care to Fund Aboriginal Midwives Practicing under the Exemption

To Whom It May Concern:

It is with great pleasure that I submit this letter in support of Dorothy Green who is an Aboriginal Midwife and has been operating an Aboriginal Midwifery Practice from her home since May 2011 without funding or access to resources.

She is an experienced midwife whose passion is to support the women with the understanding of holistic traditional practices such as the medicines, ceremonies and the sacredness that surrounds the giving of new life (birth).

I am a Community Health Nurse who was born at home on the Mohawk Territory with the assistance of an aboriginal elder (midwife). I received my education and vocation and since returned to my home community to finish off my Nursing career.

I work with women prenatally and over time several have chosen to experience a home birth. Upon hearing their stories of the positive support they received during their nine month journey and the support they received after is similar to what my mother shared with us as a family.

The choice of giving birth outside a hospital setting is not a new phenomenon and a birthing centre would help alleviate the waiting list that the Quinte Midwives have been experiencing.

What is needed in our community is funding for the practice and for the development of the Kenhnte:ke Birthing Centre here in Tyendinaga Mohawk Territory.

In Peace and Friendship,

Mary McCauley

Community Health Nurse
Community Wellbeing Centre
50 Meadow Drive
Deseronto, ON
KCK 1X0
Tel: 613-967-3603/Fax: 613-962-4210
marym@mbq-tmt.org
March 19, 2014

To Whom it May Concern

It is with great enthusiasm I support Dorothy Green and Aboriginal Midwifery on the Tyendinaga Mohawk Territory. Midwifery allows families to choose and plan one of the most important experiences of their lives. There is nothing greater than being able to have your children in the comfort of your own home with people who truly believe birth is a safe, beautiful and natural ability for a woman. We had both our children at home with the support of a midwife. They were moments we will cherish forever.

I truly believe that Aboriginal Midwifery should be a supported and funded program for all native reserves. The community deserves the right to choose between midwifery or a medical approach to pregnancy and the birth of their children. Many countries around the World still primarily use a form of midwifery for pregnancy support and birth of children. In North America midwifery utilization is continually on the rise.

I look forward to having Midwifery as a mainstay on the Tyendinaga Mohawk Territory and fully support Dorothy Green taking charge of the program.

If you have any questions please feel free to contact me at 613-876-5855 or maraclechiropractic@gmail.com.

Sincerely Yours in Health,

Dr. Jason M. Young DC, CSCS
March 19, 2014

Association of Ontario Midwives
365 Bloor St. E.,
Suite 800
Toronto, Ontario
M4W 3L4

Dear Ellen,

I am a longtime resident of Tyendinaga Mohawk Territory and I am writing to express my support of the proposal Improving Access to Midwifery Care for Aboriginal Women Living in Ontario – A Proposal for the Funding for Aboriginal Midwives, Ministry of Health and Long Term Care, Ontario Midwifery Program.

In May 2012, I decided to contact Dorothy Green an Aboriginal Midwife in our community. It has always been my lifelong dream of having a midwife during a pregnancy. At 40 years old, my dream became a reality, I was having my first time pregnancy and first time baby!

I loved having Dorothy throughout my pregnancy to answer questions or any concerns I may have had, and believe me I had a lot. She was very helpful with providing me with either a pamphlet, book or by voicing her knowledge through her traditional teachings and experiences.

Although I could not experience a home birth, due to my age and health reasons, Dorothy was by my side supporting me every step of the way, in hospital. If I ever have the opportunity again to be blessed with a ‘second gift’, I’m going to seek out Dorothy for guidance and support once again, through another wonderful journey of life.

Sincerely yours,

May Maracle
To whom it may concern:

My name is Jillian Downer, my husband Mike and I had the absolute pleasure of working with Dorothy Green, Aboriginal Midwife over the course of my pregnancy with my daughter Hailey, born August 7, 2013. Because of health issues, I also was followed by an Obstetrician, but Dorothy provided the most excellent supportive care before, during, and after delivery, above and beyond what I could ever imagine.

While pregnant, Dorothy was very knowledgeable and was always willing to attend appointments with me, particularly when I was meeting with specialists or attending high risk pregnancy appointments to support me and often ask excellent questions that I hadn’t thought of. This was so amazing for me because I am from Newfoundland and all of my family still lives there, so to have someone so dedicated and caring to take care of me was a true blessing.

I had appointments with Dorothy regularly. Miranda Brant attended many of our appointments as well. She was wonderful as well, very thoughtful and kind. At appointments they measured my stomach, we listened to the baby’s heart and she talked with me about pregnancy, my expectations for delivery, my overall wellness and any issues that arose. She was very patient with me and calming; she took a very traditional and spiritual approach which was exactly what I wanted. It was also an amazing experience to learn from Dorothy as well.

During the days leading up to delivery, Dorothy was checking in on me to see how I was doing and came with Miranda to see me right away when my waters were leaking. She walked with me and stayed with me through the day until she advised me to me to get checked at the hospital. Both woman came with me to the hospital and stayed with me into the night but my contractions stopped. Dorothy was there with me first thing in the morning when I was induced. Again, Dorothy was at my side when I needed her most. She encouraged me and stayed with me guiding me through the labour. She took such amazing care of me. Once Hailey was delivered, Dorothy was an excellent advocate for me and Mike as there were some issues that arose after her delivery. Dorothy then followed Hailey and I for the next six weeks. She answered many questions for me and gave me great advice.

Dorothy has great community contacts and woman working with her. Mary McBride provided breastfeeding support to me the day after birth. She was very patient and was really encouraging. She also provided me with great advice which has helped me continue breastfeeding up to this point.

I wish everyone could experience the privilege of working with someone like Dorothy during their pregnancy and delivery. There would have a lot more positive birth stories. Her passion for her work is clear and I believe that it would be an asset to community for her to continue her work. Woman will benefit from the dedication of Dorothy, Miranda and Mary. I also believe a birthing centre would be a great help to support the woman in the community. I would have loved to have worked with Dorothy and given birth in a birthing center. In the intrim, any additional help they would receive to help provide services would be an asset to the community and future generations.

Thank you for your time,

Jillian Downer
March 24, 2014

Ontario Midwifery Program
Primary Health Care and Family Health Teams
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
1075 Bay Street
9th Floor
Toronto, Ontario
M5S 2B1

Dear Sirs and/or Madams

Re: Support of the Association of Ontario Midwives for the funding of Aboriginal midwives under exemption under the Midwifery Act

At a most recent meeting of the Wasauksing First Nation's Health and Social Service Committee held on March 18, 2014 the committee provided a consensus vote supporting the movement to seek funding approval by the province of Aboriginal Midwives under the exemption within the Midwifery Act.

Additional discussions were had on the history of midwifery within our community and the importance of bringing back a practice that was present until the 1960s. With an average birth rate of eleven (11) births per year. The committee would like to have the option for our women to engage in maternal/family care that will be healthier and provide more in-depth care at the right time and in the most appropriate place. The community of Wasauksing believes that this service would greatly benefit our families and the overall community.

Wasauksing is fortunate to currently have a member who is a fully trained Aboriginal Midwife in the community. A major factor that will be a great determinant in the utilization of midwifery services and in the ability to encourage our women to take Midwifery up as a career option not only within our community but all along the Highway 69/400 corridor. As well, it was deemed that the care provided for by the midwife team would enhance the experience of the whole family during the pre-natal; labour and delivery, as well as post natal period by providing culturally-relevant/competent and safe care, within our First Nation and Aboriginal communities.

Our committee was also informed about the role that the Aboriginal Midwife and Registered Midwives play in; supporting healthy lifestyles; smoking cessation; harm reduction in pregnancy; support in implementation of the Healthy Kids Strategy where the goal is to reduce childhood obesity; supporting breast feeding practices of young moms and lastly, all of the work done in enhancing primary and obstetrical care by the provision of
pre-pregnancy health check, wellness visits, and the provision of culturally-relevant prenatal education.

Our committee is well aware of the disparities in health that our people suffer, our population generally speaking is vulnerable to a myriad of health; economic and social ills. Our infant mortality and morbidity is much, much greater than the national average, our children are more likely to die within the first year of life and overall our general population have significantly worse general health and very challenging living conditions. We would very much like to close these gaps and see this support of a fully functioning Aboriginal Midwife(s) as integral to this work.

These gaps were further evidenced by the Association of Ontario Midwives in 2011 which included the gap in funding for Aboriginal Midwives who work under the Exemption Clause in the Midwifery Act 1991. A resolution made by the Association of Ontario Midwives was to work towards improving access to midwifery services by Aboriginal Women.

We as the committee agree with the direction of “strengthening Aboriginal Midwifery” as a key movement at this time and endorse this completely; we are prepared to lobby our own territorial leadership to meet this end.

It with great pleasure that we, the Chief and Council and our Health and Social Service Committee endorses the movement of the Association of Ontario Midwives proposal with this support letter and look forward to future movements towards this end.

Yours in community spirit

Chief Warren Tabobondung  
Councillor Deborah Pegahmagabow-Health Portfolio
March 28, 2014

Mr. Richard Yampolsky
Ontario Midwifery Program
Ministry of Health and Long Term Care

Toronto, ON

Dear Mr. Yampolsky,

On behalf of Seventh Generation Midwives Toronto (SGMT), it is my pleasure to write this letter in support of the Association of Ontario Midwives application to the Ontario Midwifery Program, MOHLTC, to support funding for Aboriginal midwives working under the exception clause of the Midwifery Act.

Seventh Generation Midwives Toronto (SGMT) is a well-established midwifery practice group of 14 registered midwives, eight of whom identify as Aboriginal. We were the first midwifery practice group to be funded by the Ontario Midwifery Program at the Ministry of Health and Long Term Care that has a focus on outreaching and providing culturally skilled care to Aboriginal families. We are eager to support innovation for the growth of Aboriginal midwifery in Ontario, particularly when it allows excellent community based services close to home.

Many of the families who seek care from our practice come in part because they want to include traditional teachings and an Indigenous worldview in their experience of having a baby. We have seen first hand the positive impact of bringing cultural knowledge into practice, often while supporting women with complex medical and/or social needs such as poverty, crisis due to domestic violence, using and/or recovering from drug and alcohol abuse, and/or those facing child protection involvement. Funding Aboriginal midwives to work in their own communities is an ideal opportunity for Ontario to contribute to positive solutions to address the unacceptable disparities in health outcomes for Aboriginal women and children.

SGMT is proud to see the continued development of excellence in culturally secure care for Ontario’s Aboriginal communities. The funding proposal by the AOM is an excellent step towards improving the lives of our future generations, and we strongly encourage you to give it serious consideration.

Sincerely,

Sara Wolfe
Aboriginal Registered Midwife
Partner, SGMT

CC Ellen Blais, Policy Analyst, Association of Ontario Midwives
Association of Ontario Midwives
365 Bloor Street East, Suite 800
Toronto, Ontario M4W 3L4

Dear Kelly Stadelbauer, Executive Director

Re: Aboriginal Midwifery Advocacy

Boozhoo! I would like to acknowledge the partnership between the Association of Ontario Midwives and Treaty #3 Midwifery Working Group. The participation of AOM in working group meetings with Treaty #3 representatives has been an asset in connecting Treaty #3 to resources and updates on provincial activity on promoting midwifery care.

We are aware that AOM is submitting a proposal to request the Ministry of Health and Long Term Care to open funding for Aboriginal Midwives. In my last communication with Minister Matthews, I brought forward a number of challenges regarding health care services, including the need to support Aboriginal Midwives in Treaty #3. We hope to continue to work with your organization and the Ministry of Health and Long Term Care to explore ways to increase the number of Aboriginal midwives practicing in Treaty #3, including recruitment and education efforts, and improve access to maternal health services.

We hope to have AOM staff participate in the upcoming gathering and launch of Treaty #3 Midwifery resources to help increase awareness of midwives and promote the return of traditional birthing.

Miigwech,

[Signature]

Warren White,
Ogichidaa

c.c. Treaty #3 Midwifery Working group