



*celebrating birth*



***Exploring the Role of Social Support  
in Labour and Delivery for  
First Nations Women and Families***



National Aboriginal Health Organization (NAHO)  
Organisation nationale de la santé autochtone (ONSA)  
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Under the *Canadian Constitution Act, 1982*, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population. NAHO makes every effort to ensure the term is used appropriately.

**Exploring the Role of Social Support in Labour and Delivery  
for First Nations Women and Families**

**First Nations Centre of NAHO**

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## 1.0 INTRODUCTION

*An empowered community is made up by empowered individuals and empowered families, and to me empowerment is feeling at home with who you are, and that begins with the moment of birth. So my own birth story is a great source of strength to me. And so when you ask the question about our children I have to go the long way around and say it all begins with the way they get born.*

Katsi Cook, Aboriginal midwife, Talking Leaves Magazine, Spring 2000.

Pregnancy and childbirth are important moments in the lives of our families and our communities. Honouring and respecting these times is a part of growing healthy individuals, healthy communities, and healthy nations. Supporting women and their families during pregnancy and childbirth has impacts that can carry on for generations. Traditionally, women supporting women during childbirth has been an integral part of this process, and is described as an “ancient and widespread practice”, and that “one of the most profound changes in the childbirth process during the 20th century was to isolate labouring women from her social supportive network” (Maimbolwa, 2004, p.13). For First Nations families, this impact has been amplified, especially in remote regions where women are required to leave their home communities to give birth.

This paper explores a type of support called doula care for First Nations families. Doulas provide emotional and social support for women in labour and postpartum, and work with the non-medical aspects of pregnancy and childbirth. Although the term “doula” and the role of a doula as part of the health care team may not be well known, this specific type of support is not a new concept. Historical artistic representations of birth throughout the world usually include two or more women with the birthing women. One of these women is the midwife, who “is responsible for the safe passage of the mother and baby” and the others are “behind or beside the other, holding and comforting her” (Ashford, 1988, quoted in Doulas of North America, 1998, p. 1).

Although there has been no research about doula care specific to First Nations people, there have been numerous studies demonstrating that continuous social support during labour has

positive impacts on not only labour and delivery, but also on breastfeeding rates and attachment. There is strong consensus from this body of research that “continuous support during labour improves birth outcomes and has no known risks” (Hodnett et al., 2003, p.1).

The disparity in maternal and foetal outcomes between First Nations and non-First Nations populations is great, and clearly shows the need for changes in maternity care for First Nations women. Rates of stillbirth and infant mortality among First Nations have been estimated to be about double the Canadian average (Chalmers and Wen, 2004).

The re-introduction of skilled labour support companionship, or a doula, into the present day maternity care team has shown positive outcomes that have physical, emotional, and economic implications (Trueba et al., 2000, p. 8). Drawing from the scientific literature on continuous emotional and social support for labouring women, the discourses surrounding First Nations women’s experiences of birth, and looking at the gaps in care for First Nations, a clear picture of the role of doula care for First Nations families becomes apparent. It is hoped that through this exploration, the concept of doula care will position itself as a prominent issue in First Nations maternity care today.

The paper is divided into five sections. These are: defining labour support; labour support as an evidence-based practice; an overview of First Nations experiences of maternity care with emphasis on evacuation from rural and remote communities; and how some of the gaps in maternity care can be addressed through doula care. Finally, we will highlight initiatives across Canada relating to doula care and possible models that have the potential to improve First Nations maternity care will be explored.

## **2.0 KEY APPROACHES**

Before we begin the discussion of doula care for First Nations people, a few key ideas must be explained and understood in order to build the foundation for the rest of the discussion. These are: labour support as a right; understanding pregnancy; and First Nations experiences of maternity care

## **2.1 LABOUR SUPPORT AS A RIGHT**

It is important to state that labour support for pregnant women is a right that all women should have, regardless of where they come from or who they are. The Maternity Center Association in the United States stresses that the “consistent presence of a supportive provider during labour and birth should be a guaranteed right for all women” (Hunter, 2002, p. 656). This concept has gained momentum in many countries. For example, in 2001, Uruguay passed legislation mandating the right of every birthing woman to have continuous support. The law states that “every women, during the time her labour lasts, including the moment of birth, has the right to be accompanied by a person she trusts, or if not, at her own will, by somebody specially trained to provide her emotional support” (Legislative General Assembly of the Oriental Republic of Uruguay, 2001). Therefore, while the need of First Nations women to have this support is stressed throughout this paper, labour support is advocated on a global scale and is viewed as a best practice for all labouring women and their families.

## **2.2 UNDERSTANDING PREGNANCY**

It is important to understand that pregnancy is a “complex interaction of biophysical, psychological, social/cultural and spiritual factors” (Kornelson and Grzybowski, 2005, p. 12). The Western medical perspective often treats pregnancy, labour, and childbirth as “potentially pathological conditions for which the mother and/or child require specialized and technological care” (Campero et al., 1998, p. 396). The result of this is that often “the emotional needs and subjective experiences of women during labour and childbirth are not recognized as important and consequently not taken into consideration” (Campero et al., 1998, p. 396). Therefore, a key approach of this paper is to recognize the need to “integrate and further explore the effects and complex interactions of all factors that influence pregnancy, labour and delivery” (Kornelson and Grzybowski, 2005, p. 12). We also stress that “labour is a time of unique sensitivity to environmental factors and that events and interactions during labour may have far-reaching and powerful psychological consequences” (Pascali-Bonaro, 2004, p. 22).

## **2.3 FIRST NATIONS EXPERIENCES OF MATERNITY CARE**

First Nations women’s experiences of pregnancy and labour often differ from non-First Nations. The experiences of First Nations women was clearly articulated in the Royal Commission on Aboriginal Peoples (RCAP) which cited that living conditions and lack of health care choices resulted in disparity in birth outcomes for Aboriginal peoples:



...lack of access to health care and transportation; shortages of food; the lack of appropriate and affordable housing; the absence of culture-based prenatal outreach and support programs for Aboriginal women; and the mandatory evacuation of birthing mothers to distant hospitals, regardless of their medical risk...(as well as) fathers, siblings, grandparents and extended family were excluded from the birthing process, and traditional rituals to name and welcome newborns were delayed or abandoned, (along) with vital contributions of Aboriginal midwives to health promotion and family bonding lost as well. (RCAP, 1996)

Colonialism is also cited as a determinant of health for pregnant First Nations women (Moffitt, 2004, p. 323), including the residential school system; the imposition of Western medicine; government legislation; epidemics; and various other processes that undermined Aboriginal cultures and societies (National Aboriginal Health Organization, 2004, p. 7-8). Because of this, the discourse around birth and pregnancy often becomes a part of the greater dialogue of self-determination and rights for First Nations people and communities.

In a study conducted by Jude Kornelson and Stefan Grzybowski (2005) surrounding rural women's experiences of maternity care, they found, based on the analysis of early data, that "the experiences of Aboriginal and First Nations women warranted a separate investigation" (p. 94). These differences were noted as:

...the increased importance of kinship ties between women and members of their communities, especially around an event like the birth of a child, the socially complex life situation of many Aboriginal and First Nations women that puts them at an increased risk for adverse health- and maternity-outcomes. (p. 94)

It is with this view that this paper approaches the issues of labour support for First Nations women.

### **3.0 WHAT IS A DOULA?**

A woman may receive different types of support during pregnancy and childbirth. The type of support we are focused on is the introduction of a member of the maternity care team that provides "non-clinical aspects of care during childbirth" (Doulas of North America, 1998, p.1). In their position paper, *The Birth Doula's Contribution to Modern Maternity Care*, Doulas of North America (DONA) define doula as:

... a Greek word meaning *a woman who serves*. In labour support terminology, *doula* refers to a specially trained birth companion (not a friend or loved one) who provides labour support. She performs no clinical tasks. *Doula* also refers to laywomen who are trained or experienced in providing postpartum care (mother and newborn care, breastfeeding support and advice, cooking, child care, errands, and light cleaning) for the new family. To distinguish between the two types of doulas, the term *birth doulas* and *postpartum doulas* are used. (Doulas of North America, 1994, p. 1)

In a community-based doula model, this definition expands to include that doulas are: lay women recruited from the communities being served, supporting women from their own neighbourhoods, bridging language and cultural barriers and assisting families in getting health needs met (Broomfield and Abramson, 2006). When speaking of doulas in First Nations communities, this expanded definition is important and should be incorporated into doula training and recruitment strategies.

### 3.1 HISTORY OF DOULAS

First Nations women of North America birthed with a social support network. Observations from early doctors, nurses and anthropologists noted the role of women supporting women in pregnancy and childbirth. Spencer (1950) noted that “help is sought from a female relative or from some older woman who has experience in assisting at a birth.... Even if a woman needs no immediate assistance at delivery, there is generally help at hand should she require it” (p. 1171). Likewise, Abele (1934) observed that in Pueblo communities of the United States “the midwives, friends, and relatives may be summoned (to wait) for the event” (p. 433). In a Cherokee community, it was observed that “a few days before delivery, the husband has to make arrangements for four women to attend to the parturient woman” and that “it is the rule that at least one of the four is a midwife” (Olbrechts, 1931, p. 24). In Navajo communities, the importance of “the extended, closely knit family” in providing “a great deal of mental and

#### Naming Doulas in Indigenous Communities

In indigenous communities, the name *doula* is often replaced with another term. At the American Indian Family Center in St. Paul, Minnesota, the women chose to be called “Turtle Women” because the “turtle symbolizes creation”. The project stresses that Turtle Women receive “DONA training for doulas, but they also have the knowledge that comes from being American Indian” (O’Sullivan, 2004, p. 1). Likewise, in a First Nations community in British Columbia, the women participating in a DONA certified training workshop preferred to be called “aunties” instead of doulas (K. Lindstrom, personal communication, November 3<sup>rd</sup>, 2007). Carol Lynch, a certified doula, was given the name “Toonova’hehe”, meaning “Holding Women” in her Northern Cheyenne language class when she described her profession (1998, p. 155). In Kanestake, Quebec, a well-respected grandmother of the community was trained as a doula and a lactation consultant. Her title was “Ka’nistenhsera Teiakontihsnie” (KT), meaning “she who helps the mother” (BC’s Aboriginal Maternal Health Project, 2006, p. 24).

emotional support as well as physical help” was observed, as well as the role of grandmother of the expectant mother. The grandmother was “close to her (the expectant mother) during this time as are the grandmother’s sisters (also called grandmother)”. The naming of all the “maternal aunts as “mother” is an indication of their deep-seated family cohesiveness”, and as a result, the expectant mother had “so many mothers, all of whom live nearby” that she was well supported during her pregnancy, labour and delivery, and after the birth of her child (Loughlin, 1965, p. 56). Waxman (1990) also noted that historically births in Navajo communities were attended by the “husband and various female friends and relatives” (p. 190). However, this practice of women helping women in labour has been largely disconnected in the experience of First Nations women today, particularly in the case of women who are now obligated to birth away from their home communities. Medical evacuation of pregnant First Nations and Inuit women, usually for at least the last 4 weeks of pregnancy, is a widespread practice in Canada that has taken place since the 1970s (Chamberlain et al., 2001).

The rise of the doula as a paraprofessional member of the maternity care team emerged in North America in the 1980s (Gilliand, 2002, p. 763). It is also been linked to the movement against the rising caesarean section rate during this same period. A militant approach was articulated in the book, *Silent Knife* (1983), in which Nancy Wainer Cohen and Lois Estner encouraged mothers to “refuse procedures and outlined strategies to prevent caesareans” (Cohen and Estner, 1983). It is noted that while this “militancy was a part of the early history and growth of the doula movement, it has not been advocated by any professional doula organization” (Gilliand, 2002, p. 763). Therefore, doulas were often accessed by upper or middle-income women who were seeking alternatives to the medicalization of birth and labour, and embracing the multi-faceted view of pregnancy and labour. In a study done at the University of Michigan interviewing over 1,000 doulas, it was found that 93.8% of doulas were white, and the majority were well educated and married with children (Lantz et al., 2005). Also, because most of the models of doula care are fee for service, many marginalized populations, or populations labelled as ‘high risk’, do not have access to doulas. Despite the “positive health benefits associated with doulas, the women who have the least amount of resources and are most likely to benefit from doula care are the least likely to receive doulas’ services” (Lantz et al., 2005). Doulas working with underserved populations have only recently been gaining support.

In the present context, it is important to join together the understanding that women have traditionally acted as doulas throughout First Nations history, however, the rise of doula care within the medical system has been an event that has been largely separated from First Nations women's maternity care experiences. For example, many Aboriginal women attending the Aboriginal Maternal Health Forum in 2006 in North Vancouver, British Columbia had never heard of doula services before attending the forum (Varley, 2006, p.6). With this understanding, we can then see doula care as a revitalization of a traditional practice and explore ways of incorporating this knowledge into contemporary doula care and training for First Nations women and their families.

#### 4.0 LABOUR SUPPORT AS EVIDENCE-BASED PRACTICE

Labour support is a surprisingly well-studied topic. Numerous qualitative studies, in addition to randomized controlled trials have contributed to the discourse surrounding the value of continuous emotional and social support during labour. In 2002, it was found that there have

##### **Effects of uninterrupted labour support vs. births without continuous support**

**Scott et al. (1999) analyzed 12 clinical studies and found that there was a:**

- **51% reduction in cesarean births;**
- **25% reduction in labour length (average of 98 minutes);**
- **35% reduction in analgesia;**
- **71% reduction in oxytocin augmentation; and**
- **57% reduction in use of forceps/vacuum.**

**(p. 1257- 1264, quoted in Pascali-Bonaro, 2003, p. 5)**

been over “30 published reports, reviews, commentaries, and four meta-analyses... related to the effects of labour support on maternal and fetal outcomes” (Sauls, 2002, p. 733). The findings of these studies are clear: continuous support during labour improves birth outcomes and has no known risks (Hodnett et al., 2003, p.1).

In 2003, the Cochrane Review<sup>1</sup> published a systematic review that included 15 studies involving 12,791 women. Their conclusions were that women who had support were “less likely to have intrapartum analgesia, operative birth, or to report dissatisfaction with their childbirth experiences” (Hodnett et al., 2003, p. 1). In addition to this, numerous qualitative studies have been done to add support to this dialogue (Bowers, 2002, p. 742).

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<sup>1</sup> The Cochrane Collaboration prepares and keeps up-to-date systematic reviews in many areas of health and medicine. Its major quarterly publication, The Cochrane Library, is the best single source of reliable evidence about the effects of health care. Leading medical journals and organizations throughout the world acknowledge the high overall quality of Cochrane Reviews. To learn more about the Cochrane Collaboration, visit its website at: <http://www.cochrane.org/>.

Research surrounding labour support clearly shows that continuous support improves birth outcomes, and is an evidence-based practice. From this body of clinical evidence, the question of whether or not doula care can make a positive contribution to maternal health is answered. However, it is also true that the results of these studies have not had a commensurate impact on maternal health care policies and practices in most countries, including Canada (Hunter, 2002, p. 654).

The next section of this paper goes into detail about the specific functions and actions of labour support that contribute to the improvement of maternal and fetal outcomes. We will look at the role of labour support in two sections. First, through outlining the approach of labour support, care and then discussing some functions of labour support that can specifically address key gaps in First Nations experiences of maternity care.

## **5.0 THE ROLE OF LABOUR SUPPORT**

Doulas are taught seven main functions in their role during labour, birth and the baby's first hour of life. Pascali-Bonaro (2003) defines these functions as:

- Recognize birth as a key life experience;
- Nurture and protect a women's memory of birth;
- Maintain an uninterrupted presence during labour and birth;
- Recognize the effects of emotions on the physiology of labour;
- Provide comfort techniques and encourage positions that promote progress during labour;
- Promote early breastfeeding and bonding. (p. 5)

Looking at these specific points in more detail will allow a deeper understanding of how doulas positively contribute to the experiences of birthing women and their families.

### **5.1 HONOURING BIRTH AND ITS MEMORIES**

As mentioned in the introduction, birth is a fundamental life experience for women, their families, and their communities. Recognizing and honouring this concept is central to the doula's presence at the birth of a child where, as one Turtle Women put it, "the spiritual becomes

tangible” (O’ Sullivan, 2004, p. 2). DONA’s position paper on the role of birth doula explains that “the birth of each baby has a long lasting impact on the physical and mental health of mother, baby, and family” (Doula of North America, 1998, p. 1). Doula learn to recognize that birth is a significant life event that women will remember “in detail for the rest of her life”, and “the words that are spoken to her and the way she is treated overall will shape and mold her memory and feelings” (Pascali-Bonaro, 2003, p.5). Penny Simkin, a founder of DONA and author of many books on this subject, writes about the significance of birth memories. In her studies on this topic, she found that when mothers received “positive support and encouragement during labour” they felt “more positively about their births and themselves as long as 20 years later” (Simkin, 1991,1992). Labour support can not only help a woman during the process of birth, but the effects of this support have far reaching implications for women and their families. A doula can be seen as a protector and nurturer of a woman’s birth memory (Pascali-Bonaro and Kroeger, 2004, p. 19).

## **5.2 CONTINUOUS SUPPORT DURING LABOUR AND BIRTH**

A key defining feature of labour companionship is that the support given by the doula is continuous throughout labour and delivery. In the Cochrane Review (2003), authors Hodnett et al. stressed that continuous support, and not intermittent, is integral to the improvement of birth outcomes with a labour companion (p. 2). Doula are taught to be in constant, close proximity to the labouring mother at all times, from the onset of active labour through delivery. The doula is often near a mother’s head, speaking to her and encouraging her throughout her labour. This, of course, is dependant on the circumstance of the labour, and the wishes of the mother and family, but the constant is that the labour companion is there continuously throughout the birth to respond to the mother’s and family’s emotional and social needs.

## **5.3 RECOGNIZING THE ROLE OF EMOTIONS IN THE PHYSIOLOGY OF LABOUR**

As mentioned above, birth is a key life experience for women and their families, however, stress is a common component of labour and delivery. Stress in relation to First Nations women’s experiences will be discussed further in this paper. Doula are taught to recognize the role of emotions in the physiology of labour. For example, when a birthing mother is feeling anxiety and stress, this can cause a release of catecholamines. This reduces circulation to the uterus and placenta, and the result is that contractions become inefficient and fetal oxygenation is reduced, causing labour to fail to progress (dystocia) (Pascali-Bonaro and Kroeger, 2004, p.

***The Society of Obstetricians and Gynecologists of Canada (SOGC)*** in their clinical practice guidelines state that “the continuous availability of a caregiver to provide psychological support and comfort should be a key component of all intrapartum care programs, which should be designed for the effective prevention and treatment of dystocia (non-progressive labour)” (1995).

20). Penny Simkin describes “emotional dystocia”, in which “distress from deep emotional issues causes excessive production of catecholamines”; however, if a mother is able to “express or releases her feelings” of stress and anxiety, her doula can provide the necessary support to “reconcile strong emotions” that caused the increase in catecholamines (2000, p.70).

Doulas also provide comfort techniques and encourage positions that promote progress during labour, and promote of early breastfeeding and bonding. In addition to these functions, doulas also play important roles as knowledgeable people who have information regarding women’s choices during labour and delivery, communicators between medical staff and the birthing mother and her family, advocates for the birthing mother and her family, and in some cases, cultural brokers during labour and delivery. In the next section, we will explore how doulas could support First Nations women and families in these four areas.

## **6.0 ADDRESSING GAPS IN FIRST NATIONS MATERNITY CARE THROUGH LABOUR SUPPORT**

In 2004, the First Nations Centre and the Ajunginiq Centre of the National Aboriginal Health Organization (NAHO) conducted a preliminary needs assessment entitled *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities*. In the final report, key gaps in maternity care for First Nations women are identified (NAHO, 2006, p. 32). Although this was a preliminary study, the conclusions of the study are very much in line with other dialogues surrounding First Nations birth experiences. Using these key themes as signposts, we can explore ways in which labour support can improve maternity care experiences for First Nations women, in addition to the functions of labour support listed above. While doula services cannot address every issue raised in this section, such as continuity of care, it is clear that the majority of points raised can be, at least in part, ameliorated through the presence of continued support through labour and delivery.

From the preliminary needs assessment, the gaps in First Nations maternity care were identified as: lack of home/ in community birthing; lack of culturally trained staff; lack of continuity in

services; lack of mental and emotional supports; inability to make informed choices; lack of supports for parents and families; and the failure to integrate traditional practices into maternity care (NAHO, 2006, p. 32). Four topics within these gaps will be highlighted to show the potential role of labour support. First, the issue of rural and remote birthing will be addressed. Second, we will look at the issue of cross-cultural communication with care providers. Next, the role of doula as a key part of the integration of traditional practices into maternity care will be discussed.

## **6.1 LACK OF HOME /IN-COMMUNITY BIRTHING**

The topic of evacuation for birth from remote communities into urban centres has been written about at length by various authors (Kornelson et al., 2005; Chamberlain et al., 2001; Kioke, 1999; Jasen, 1997; Paulette, 1987). In Canada today, policies that transfer mothers in late pregnancy to referral communities to give birth are the norm, rather than the exception in most remote communities. Mothers are often transferred in their third trimester and stay for up to six weeks in the referral community. This means that many women are separated from their families, and in some cases, their other children (Chamberlain et al., 2001). This can cause a great deal of stress and anxiety for women birthing away from their community and social support network. As described by First Nations women in the focus groups of the NAHO study, this experience was a “lonely one, often plagued by insecurity, insufficient or inadequate food, the unfamiliarity of strange surroundings, missing family and other children, and an overall stressful experience” (National Aboriginal Health Organization, 2005, p. 32). The role of a doula in this situation needs little explanation considering the functions of labour support described above. As one woman who was preparing to birth in a referral community commented:

We're looking at getting a doula, because depending on when I go into labour and where [my husband] is, you know, it could take him up to eight hours to get down there, which could be too late so we're getting a doula so I won't be by myself. (Kornelson et al., 2005, p. 89)

The Society of Gynecologists and Obstetricians (SOGC) report on best practices for rural and remote birthing also recognizes the importance of this issue. They state that “when policies and practices are formulated, consideration must be given not only to the safety of delivery, but also to family and cultural needs at the time of delivery” (2007, p. 251).



## 6.2 COMMUNICATION AND ADVOCACY

Lack of appropriate communication was also identified in the NAHO needs assessment. Some women described their experiences as not feeling “respected or listened to by their health care providers” (2005, p. 33). Jennifer Watson et al. (2002) describe that, within the context of maternity care experiences of Australian indigenous women, “inappropriate communication techniques” were used and failed to “recognize that indigenous and non-indigenous linguistic conventions may be different” (p. 155). In addition to this difference of communication styles, language itself may become a barrier to effectively communicating with care providers when the mother and family’s first language is not English. The role of a doula is often to act as a communicator or intermediary between primary care providers and the birthing mother and family. This becomes especially important in the context of cross cultural communication. As a Turtle Woman, Betty Day, explains:

...mainstream American culture differs from many American Indian cultures around such issues as when it’s appropriate to touch, speak, make eye contact, or use humour. For some mothers, dealing with issues of cross cultural communication might be a distraction during labour. As someone who is attuned to those differences... (I) am able to help Mothers relax and focus on childbirth. (O’Sullivan, 2004, p. 2)

Having a doula who is of the same cultural and linguistic background can bridge these communication barriers and allow the mother to effectively communicate with her care providers. As facilitators of positive communication, they help to address and consider the woman’s fears. As Pascali-Bonaro (2003) stresses, “with good, support communication, women can participate in decision making, a process that has been shown to contribute to a positive experience and a positive memory of birth” (p. 5).

First Nations women interviewed further expressed this need, as they “often felt pressured to accept treatment without understanding the implications of their decision and without any understanding of other options” (p. 33). Some women felt that their caesarean deliveries or inductions were to “ensure they delivered at a time that was convenient for the doctor”, and because of this, felt it was necessary that there was a need for “someone to provide options for delivery and give them an overview of what is available and what is in their best interest” (p. 38). Communicating with care providers to help First Nations mothers to make informed choices

about their birthing experiences is a key role that a doula can play to enhance First Nations maternity care.

### **6.3 INCORPORATING CULTURAL PRACTICES**

Having a First Nations doula can also assist women to incorporate traditional practices into their birthing experience, and it creates a space where the understanding of these practices is acknowledged and understood. A First Nations woman who was assisted by a Turtle Women described how she did not need to take her focus off her own birthing experience to explain why she would like the hospital room to be smudged (O'Sullivan, 2004, p. 1). Another woman, Tara Rasmussen, who gave birth with a Turtle Women, described how having this traditional practice incorporated into her birth experience made her feel happy and at peace. She had grown up with the scent, and when the birthing room had been cleansed with it she felt "good for my baby to come into the room smelling sage" (O'Sullivan, 2004, p. 1).

Cultural practices surrounding birth differ from community to community, so there is variation in practice. However, sometimes just the presence of a doula from the same cultural background will make a difference in labour support, with or without the incorporation of traditional practices. The key is that the doula "needs to be a member of the community they serve, and they need to be skilled at advocating for themselves and their neighbours" (Disease Management Advisor, 2007, p. 26). As one woman described her doula in a community based program, "she knows where I am coming from and I know where she is coming from, and she helped me in a way nobody else did" (Breedlove, 2005, p. 19). This connection is also important for the women working as labour support. One Turtle Woman's goal is to "make a powerful connection with a pregnant woman... because she sees her own daughters and sisters in the eyes of the mothers she works with" (O'Sullivan, 2004, p. 3). As described by First Nations women in the needs assessment, care has been "largely divorced from their heritage and cultures" (NAHO, 2005, p. 34). First Nation doulas have great potential to bring the recognition of culture and tradition into birthing practices for First Nations women.

The role of, and need for doula care for First Nations women has been made clear in the above sections. Now, we will look at the existing models of labour support care and the possibility of implementing these models into First Nations maternity care.

## 7.0 MODELS OF DOULA CARE AND TRAINING

There is a wide variety of doula care models. The most common model used has been a fee-for-service model (Low et al., 2006, p. 25). More recently, other models of doula care, particularly those targeting specific populations, have emerged. Private practice doulas often charge \$250- \$800 per birth, and because of this, many socio-economically challenged clients do not have access to these services. Some doctors and midwives have also hired doulas to work with their patients (Lynch, 1998, p. 156). Hospital-based doula programs are also gaining popularity in the United States, however, these are slower to come about in Canada. It is important to note that the Cochrane Review reported evidence that maternal and fetal outcomes were better if the labour support came from someone who was not a member of the hospital staff (Hodnett et al., 2003, p. 1). One of the reasons given for this conclusion was that the organization of care in modern maternity units, including “shift changes, diverse staff responsibilities, and staff shortages appear to limit the effectiveness of labour support provided by members of the hospital staff” and that “non-hospital caregivers may be able to give greater attention to the mothers’ needs” (Hodnett quoted in Childbirth Connection, 2003).

### 7.1 EXPLORING THE COMMUNITY-BASED DOULA MODEL

The Community-Based Doula Model (CBDM) was developed to provide labour support services through social service agencies to underserved populations. The CBDM bridges the gap between “health and social services by defining an extended support role that begins in the home community, continues with the birthing woman when she enters the hospital, and follows her back home with her baby in the early postpartum period” (Broomfield and Abramson, 2006). Main differences between fee-for-service labour support and community-based labour support are that the latter targets underserved pregnant women, provides service at no cost to the client, and seeks to employ doulas who are from the communities in which they practice. A

**The Three Main Principles underlying the Community-based Doula Model (CBDM) are that labour support is:**

**Community-based:** Doulas are lay women recruited from their communities being served, supporting women from their own neighbourhoods, bridging language and cultural barriers and assisting families in getting health needs met;

**Relationship-based:** The intervention begins as early as possible in the pregnancy and is based on a long-term, trusting, nurturing relationship between the doula and the pregnant women. The intervention also encourages the involvement of other family members, especially the birth father;

**Collaborative:** A successful program implementation requires the active partnerships of community members, social service providers, health care providers, and funders. (Broomfield and Abramson, 2006)

good example of how doula care has been incorporated into a community-based model of collaborative care is the South Community Birth Program in Vancouver, British Columbia.

## **7.2 SOUTH COMMUNITY BIRTH PROGRAM (SCBP)**

Established in 2004, the SCBP is a primary maternity care program that meets the needs of the low-risk childbearing population in Vancouver, British Columbia in an area that has great cultural diversity. The SCBP offers prenatal care, birth at a hospital (BC Women's Hospital and Health Centre), postpartum care to six weeks, doula support, and family physician referrals. The objectives of the project is to be a model of interdisciplinary care that honours the healthy, natural process of birth, and to provide a safe birth experience and improve health outcomes of women and their babies; and to work in partnership with women to assume an active role in their health care.

The SCBP doula program is provided at no extra cost to the women in the program. The doulas working in the program speak fifteen different languages including Bengali, Cantonese, Mandarin, Japanese, Punjabi, Tagalog, Farsi, Hindu, Urdu, Indonesian, Spanish and French. They try to ensure that the doula that works with the women is communicating in the client's first language. The doulas in the program are provided with DONA training and mentorship with experienced certified doulas. Once they are certified, they are assigned clients, and are paid for the doula care they provide (SCBP, [www.scbp.ca](http://www.scbp.ca), 2008).

## **8.0 CURRENT INITIATIVES**

Doula care and training has begun to gain momentum in some Aboriginal communities across Canada. The following is an overview of some of the initiatives that are currently taking place. Since many of the initiatives happen on a grassroots level, there is minimal information about some of the programs. These initiatives have often grown independently of one another, and there is an identified need for more sharing of these approaches and initiatives within the context of First Nations maternity care.

### **8.1 BRITISH COLUMBIA ABORIGINAL PERINATAL HEALTH COMMITTEE**

The British Columbia Aboriginal Perinatal Health Committee (BCAPHC) grew out of a steering committee that focused on Aboriginal perinatal health and built on the 2006 Maternity Care Enhancement Project that was done for the general population. This committee within the

provincial Perinatal Health Program interacts directly with the Health Authorities. This allows the committee and its staff to be able to affect change in Aboriginal maternity care in a concrete and effective way. The committee has articulated key strategies and directions in regards to Aboriginal perinatal health in British Columbia. One of these strategies is to incorporate doula care. A recommendation that emerged from a recent gathering of the committee is to “increase number of doulas through a variety of educational and interdisciplinary training programs generating a better understanding on each other’s roles” (Barney and Cerani, 2008).

The BCAPHC has formed a sub-committee to work directly on this issue, and at present they are currently developing doula information materials, developing curriculum that is culturally reflective and appropriate, conducting an environmental scan of doula services in First Nations communities in British Columbia, and developing strategies for training and incorporating doula care into existing First Nations health programs.

## **8.2 HAILIKA’AS HEILTSUK HEALTH CENTRE, MATERNAL CHILD HEALTH PROGRAM**

The Heiltsuk Nation is located on the central coast of British Columbia. The mission for the Heiltsuk Health Centre is to develop a community based healing programs that will reduce death rates, injury and disability and partner the promotion of positive parenting, family support and culture/language promotion to strengthen community action and empowerment. The Maternal Child Health Program (MCH) activities include pregnancy and newborn care, nutrition support, child development, parenting classes, accident prevention, and celebrations. The program has incorporated doula services into their program in a unique way. Although there is no birthing facility in the community, and woman are transported to a referral community to deliver their babies, the MCH home visitors are trained as doulas and provide prenatal and postpartum support to their clients. Their approach is described as follows:

The Doulas take a first line role in establishing relationships in the home in a non-threatening way. By bringing useful information for a planned home visit the Doulas are able to establish themselves as resources for information, this enables clients to make informed choices and feel supported. (MCH, 2008)

In their experience with this program, it was also seen that doulas played a role in the development of collaborative relationships between the hospital and the health centre. This is

especially important in times of emergency with pregnancy and childbirth that can arise in remote communities.

### **8.3 THE PUBLIC HEALTH DEPARTMENT OF THE CREE BOARD OF HEALTH AND SOCIAL SERVICES OF THE JAMES BAY CREE, AWASH PROGRAM**

The Public Health Department of the Cree Board of Health and Social Services of the James Bay Cree (CBHSSJB). The Awash team of the CBHSSJB promotes the health and safety of young children, from birth to nine years old, and their families. The services include: interventions for pregnant women, infants and young parents (including prenatal and postnatal services for families in difficulty, midwifery services, and breastfeeding initiatives); prevention of infectious diseases (vaccine preventable diseases, tuberculosis, rabies and zoonoses, and nosocomial infections); and dental health (research and prevention services). The Awash program is also currently developing a ten-day doula training program for their communities. This curriculum fully incorporates traditional teachings and understandings of pregnancy and childbirth with the standard doula training.

### **8.4 HEALTH CANADA, FIRST NATIONS AND INUIT HEALTH, MATERNAL CHILD HEALTH**

The Maternal Child Health (MCH) program of the First Nations and Inuit Health (FNIH) branch of Health Canada has also begun to support doula training for their staff in First Nations communities. The MCH program's long term goal is to support pregnant First Nations women and families with infants and young children, who live on reserve, to reach their fullest developmental and lifetime potential. In identified First Nations communities, the MCH program strives to have contact with all pregnant women and new parents, including home visiting. In FNIH regions (Alberta, Saskatchewan, and the Atlantic region) the MCH program workers have undergone doula training. This training included the standardized doula training, and some of the trainings incorporated traditional birthing knowledge and sharing of cultural experiences. Although it is unclear exactly how the training will be incorporated into the practice of MCH staff, it is seen as a first step towards having First Nations women trained as doulas in their communities.

## **8.5 CANADIAN MOTHERCRAFT BIRTH AND PARENT COMPANION PROGRAM AND WABANO CENTRE FOR ABORIGINAL HEALTH**

The Canadian Mothercraft of Ottawa-Carleton (CMOC) is a non-profit organization established in 1944. It provides programs and services for parents with infants and children. In 1990, they established the Birth and Parent Companion Program (BPCP), which aims to improve prenatal health and birth outcomes for families in the area. The BPCP trains volunteer companions to “provide one on one support, information, companionship and mentoring to mothers who are alone, marginalized, or otherwise “at risk” for parenting” (Canadian Mothercraft, 2007, p. 1). Clients are referred to the program by various health and service organizations. The volunteers are on call 24 hours a day and stay with their clients through the entire birth. The results of this program show that their numbers pertaining to maternal and fetal outcomes are better than average in comparison to the local and provincial averages for all births (Canadian Mothercraft, 2007, p. 8).

The Wabano Centre for Aboriginal Health is an urban health centre that provides quality, holistic, culturally-relevant health services to Inuit, Métis and First Nation communities of Ottawa; engages in clinical, social, economic and cultural initiatives that promote the health of all Aboriginal people; and promotes community-building through education and advocacy.

The CMOC-BPCP and the Wabano Centre for Aboriginal Health have recently engaged in a partnership that will adapt the Birth Companions training program to make it more culturally relevant for Aboriginal volunteers. The two organizations will also support a process through which Birth Companion volunteers will work out of the Wabano Centre for Aboriginal Health.

## **9.0 NEXT STEPS**

The growing awareness of doula care for First Nations women is a promising sign, however, finding the right model of care, and providing funding for doula services remains a challenge. The following next steps identify key themes from this discussion paper, and suggest possible ways forward for First Nations to explore and establish doula services in their communities.

**Awareness:** Raising awareness of doula services and their potential positive impacts is an important first step. By providing information on doula care through a variety of media, community members and other stakeholders will have the tools to support and explore this area

further. Gaining community support for doula care is integral to its success in communities. Also, it is important to gain awareness of other initiatives that are taking place in regards to doula care across Canada. By sharing information and experiences, communities looking at doula care can learn about possible approaches and models of care.

**Training:** Training First Nations doulas is also needed. Incorporating doula training into other existing positions in health care is also important. As well as providing training, the development of curriculum specific to First Nations people needs to be supported.

**Building sustainable models:** Since doula services have only been incorporated into a few First Nations communities in Canada, it is important to explore models of doula care that are sustainable and that fit within the community's needs and desires. Using examples from other communities and building on these experiences is recommended.

**Funding:** Finding sustainable funding for doula services and doula training is an important step in this process. Identifying a variety of possible new funding sources, such as foundations or federal funding, is a first step. Alternatively, collaboration with existing health care systems could be considered. This approach might entail adapting current models and funding structures to include doula services as part of primary health care services.

**Research:** Currently, no research exists on doula care in First Nations communities, or the role of social support in pregnancy and childbirth for First Nations people. This lack of research is a major gap, especially when building projects and identifying possible funding sources. Initiating research in this area is congruent with recent research in the field on indigenous health.

Chantelle et al. (2007), state that:

Researchers have taken a keen interest in the determinants of indigenous health, including poverty, violence, and access to health care... however, (researchers) have so concentrated their efforts on the disparities that few have sought to model thriving health. In particular, there has been a lack of research into how one's societal resources, such as social support, can shape health status. (p. 1)



This shifting of focus from “illness-based research” towards an “approach that understands, explains, and nurtures health” is an important one, and is welcomed into the discussion surrounding First Nations maternal child health (Chantelle et al., 2007, p.1).

## 10.0 CONCLUSION

Throughout this paper, the role of a doula has been defined and advocated as a way of improving birth outcomes for First Nations women. As an evidence-based practice, labour support has shown to improve birth outcomes and have no known risks (Hodnett et al, 2003, p. 1). The positive impacts of labour support are now well-documented, and suggest that doula care should be a significant consideration in policies and practices surrounding First Nations maternity care. In a review of maternity services for indigenous women in Australia, it is stated that “a doula is a short term solution to an existing long term problem” (Hirst, 2005, p. 126). However, throughout this paper, it has been shown that the implications of labour support are far reaching. As one Turtle Women described it, “(it) can have implications that can extend beyond just one birth, and even beyond one generation, because it helps women reclaim a legacy of power that centuries of history have tried to take away. They can pass that legacy along to their children” (O’Sullivan, 2004, p. 2). Carol Lynch (1998) also concludes:

... (doulas) prove to be more than just a nice thought. Not only is it an effective way to lower obstetric expenses and improve the outcome for mothers and babies, it is a concept rife with potential for enhancing mothers’ abilities to confidently and capably parent the next generation of caretakers of our earth (p. 156).

The re-introduction of social and emotional support during pregnancy and childbirth has the potential to improve health outcomes for First Nations women and children. It is hoped that this discussion of doula care for First Nations women will become a part of the greater process for positive change in First Nations maternal health care, and that we will again have the opportunity to mother First Nations mothers through pregnancy and childbirth experiences.

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