

maternity MATTERS

Why should we be concerned about the state of maternity care?

Because maternity care is different from other health services.

First, babies cannot wait — *there can be no waiting lists for maternity care*. Second, *women's experiences during pregnancy and birth, good or bad, can deeply affect how women feel about their babies, about themselves as mothers, and their other relationships*. Providing pregnant and birthing women with good care therefore improves the lives of women and their children both immediately and in the long term.

MATERNITY MATTERS IN CANADA

Childbirth is a major event in the lives of women who become mothers, and for their families and communities. Each year in Canada, over 300,000 women give birth. Most of the time pregnancy and childbirth are healthy experiences for both women and their babies. Pregnancy and birth are, in fact, so *ordinary* or commonplace that they may be invisible – in society as well as on political and health agendas. Because it is such an ordinary part of life, we have just assumed that good maternity care is readily available for women and families as they move from pregnancy through birth, to breastfeeding and parenting.

Maternity Care refers to care for a woman and baby throughout pregnancy (prenatal), birth and in the early weeks after the birth (postnatal or postpartum).

Despite its everyday occurrence however, pregnancy and childbirth are approached as serious, potentially life-threatening *medical* conditions, requiring both medical specialists and a great deal of technology, rather than as normal, healthy physiological events. Given this approach to pregnancy and childbirth, access to medical care affects where and how women experience these life events.

Today, in Canada, there are reforms to maternity care provision that raise questions about whether it is really available for women and their families. Fewer family physicians are providing maternity care, especially during labour and birth. Even routine prenatal care is difficult to get in some communities. And fewer small hospitals provide maternity care, forcing many women to leave their families and travel long distances to give birth.

Governments, health authorities, physicians and nurses tend to think of recent changes in maternity care as a human resource problem because there are fewer experts to provide care. But maternity matters in Canada for many more reasons. Not only do women have difficulty finding supportive, attentive, respectful care providers close to home. Women also need care providers who use what we already know from research and experience about what helps and what harms women and their babies.

In the following pages you will find a discussion of issues and trends, and an examination of what evidence there is about the best possible ways to care for pregnant and birthing women.

PREGNANCY AND CHILDBIRTH IN CANADA

Most Canadian women have healthy pregnancies and give birth to healthy babies. Whether measured by maternal mortality (the number of women who die as a result of pregnancy and childbirth) or maternal morbidity (the number of women who develop complications as the result of childbirth), Canadian women today fare better than those in previous generations. They also fare better than women in most other countries in the world. Canadian newborns are usually healthy because most women do get some prenatal care, our standard of living is high and births are attended by skilled, competent physicians and midwives. It is important to note however, that Canadian averages can mask significant differences among women, reflecting differences in access to care as well as other conditions for good health that underlie healthy pregnancies. For example, women and their babies living in some regions of Canada, as well as many Aboriginal women and their babies, are at higher risk of complications than are others in Canada.

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WHO NEEDS MATERNITY CARE?

The short answer is that **we all** need good maternity care, because the health of mothers and babies is crucial to all of Canada.

Of course *all* women who become pregnant need maternity care. In Canada, “all women” is also “many different women”. Women whose families have lived here for centuries and women who are newcomers. Women pregnant as teens, and in their 40s. Women pregnant for the first time and for the sixth time. They have small children at home, grown children, or have lost children. The pregnancies are planned and unplanned, wanted and not wanted. Many women have a female or male partner, many do not. Not all pregnant women want to be mothers and some do not become mothers when there is a complication in the pregnancy or when the baby will be raised by someone else. Women need maternity care whether they live in the large cities, the high arctic, isolated coastal communities, small towns or in the country. Every woman has particular needs based on her language, culture, social status and a myriad of other factors in her life. Women require care that is sensitive to their beliefs and traditions, provided by physicians, midwives and nurses who welcome them, their partners and families.

In general, pregnancy and birth in Canada are safe but we cannot be complacent. Consider the following:

There is a very real shortage of maternity care providers, especially those attending women during birth. In some rural communities, a combination of closed maternity wards and fewer family physicians providing maternity care means that even routine prenatal care is difficult to obtain. In larger towns and cities obstetricians now attend most women giving birth. As a group, obstetricians are getting older and many cannot or do not want to work the very long hours attending women in labour that they worked

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when they were younger. Maternity nurses in hospitals meanwhile find themselves caring for more women in labour at the same time because of staff shortages. Midwives are not funded to care for women in all provinces, and they are not yet widely available in the provinces in which they are regulated.

The widespread view of birth as a potential medical emergency to be managed, rather than as a healthy life event, has led to increased dependence on technology and interventions. When used appropriately, medical and surgical interventions such as Caesarean sections and inductions of labour

(medication or breaking the waters) can be life-saving. But they are not risk-free for birthing women or for their babies. In fact some interventions lead to further complications.

Finally, in some provinces and regions health reform has increased maternity care costs. Medical and nursing care are still provided for free but other important elements of pre- and postnatal care such as childbirth classes, midwives, and breastfeeding counselling and other support services are only available to those who can afford them, depending on where they live in Canada.

MATERNITY CARE PROVIDERS IN CANADA

Many different professionals provide some or all maternity care. The landscape can be a bit confusing.

Childbirth educators and **breastfeeding counsellors** provide specialized instruction and help before and after birth, respectively. Childbirth educators may be employed by hospitals or in public health; others work independently in community agencies. Breastfeeding counsellors or lactation consultants may be employed as part of the medical system, but usually only in cities, so women may not know where else to find breastfeeding support.

Doulas are trained labour companions, skilled in providing women with support and comfort during labour as well as in the postnatal weeks. Their training includes non-medical pain relief for labour. Their services are not covered by medicare but women choose their help where midwives are not available, because they do not know who will be with them during birth, or because they want the support of an experienced companion during their labour.

Family physicians may provide maternity care. Some will provide care during pregnancy and then again to the family after a birth, but not all provide care during labour and birth. In fact fewer family physicians give care during labour than even 10 years ago. Family physicians are trained to do surgeries, like Cesarean sections, but they may not be able to keep up their skills or the local hospital may no longer admit women for maternity care. ►

WOW! There are so many choices to make when you're having a baby.

Well you don't have to think twice about a midwife because they're not available here.



Midwives provide maternity care to women throughout the childbearing year. They are primary caregivers, that is, women can go to midwives for care directly, without referral. Midwives care for women and babies from early in pregnancy, ordering and receiving tests as needed. They attend women at home or in birth centres, and they can admit women for hospital births. Midwives are trained to deal with many complications during pregnancy and birth. After birth, midwives care for women and babies for up to six weeks, assisting with breastfeeding, early days of parenting, and watching over the postpartum healing. Midwives provide care in rural and remote communities but are not yet regulated and available in all provinces.

Nurses are the largest group of maternity care providers. Labour and obstetric nurses very often care for women during labour, but most are not allowed to deliver babies. Public health nurses may provide prenatal education and may do postnatal visits to check on the health of women and babies after birth.

Obstetricians are doctors with additional intensive training in female sexual and reproductive health care, including surgical training. Most women in Canada give birth with an obstetrician in attendance, as fewer family doctors attend labour and birth and midwives are not yet widely available.

WHAT THE EVIDENCE TELLS US ABOUT GOOD QUALITY MATERNITY CARE

Many of us have been led to believe that more technology is always better, that care by obstetricians is always better than care by family physicians and midwives, that urban care is always better than rural care, and that big hospitals are always better than small. However, despite what we may have come to believe, and despite the images we now see so often on TV, pregnancy and birth do not have to be managed emergencies. Here's what we already know about what good maternity care looks like.

Good prenatal care should be available relatively close to home.

Regular prenatal visits, in an office or at home, allow a rapport to develop between a woman and her provider; the provider can learn more about the woman's personal situation and often head off potential problems. Many midwives and family doctors care for women starting early in the pregnancy, monitoring the health of mother and fetus over the weeks and months and giving advice about nutrition and what changes to expect, among other things. Good prenatal care should include time to discuss labour and birth, a woman's questions and concerns, her hopes and her fears. Good prenatal care also includes a chance for the provider to learn about possible physical, emotional and social circumstances and challenges as the woman prepares for a birth. Much of this early prenatal care can be provided by a variety of skilled and competent providers such as nurse practitioners, who are in regular contact with midwives or physicians. Women report that ideally, they want to see only one person throughout their care, the same person who is with them in labour and during the delivery. The providers a woman does see should be knowledgeable about her and the community in which she lives. This can include striving to understand or be prepared to hear about cultural expectations for pregnancy, labour and birth as well as practical matters such as whether the woman has a telephone at her home, relies on public transportation, or whether she is safe in her home.

Prenatal tests should be used cautiously.

To detect some complications in pregnancy, maternity care includes standard tests to measure pregnant women's blood sugar levels and blood and urine composition. There are other tests for an array of conditions – from diabetes to genetic concerns – which are also becoming standard, although their safety for the woman and her baby are not yet confirmed. Even ultrasound tests have not been proven safe for routine use. Years ago women were routinely x-rayed to judge the relative size of the baby and to predict how difficult labour and birth might be. Now we realize that routine x-rays are not safe at all and the practice has been dropped. Similarly, prenatal assessments and tests that are considered routine today may be proven unsafe in years to come. Women and society at large have been led to believe that

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“getting your ultrasound” should be an ordinary part of prenatal checkups. However, there is a wealth of literature and evidence to say that routine use of ultrasounds is not indicated for women whose pregnancies are progressing normally.

There may be good reasons to conduct some prenatal tests. Women need to be given full information about what a test entails, why it is needed, what it can detect, and what a positive or negative result will mean for them and their babies. Often women find that if their pregnancies or their babies’ growth are found to be complicated or compromised, they are forced to make decisions for which they have not been prepared, because a test was performed in the course of ordinary prenatal care and suddenly they have to cope with a result that they didn’t ask for.

Women in labour and giving birth need a supportive respectful setting with appropriate use of interventions.

Supportive care for childbirth begins before labour starts, with good information provided about what to expect physically, and what to expect from the midwife or doctor. What will happen in the hospital or birth centre? What is routine and how well will the woman’s own wishes be met? Who can be with her? A partner? Mother? Aunts? Other children? Labour companion?

A supportive, respectful setting for birth is much more than furnishings, beds and cushions. More labour floors in hospitals are renovated to meet the requests for showers and baths during labour, as well as for privacy and accommodation for family to stay after the birth. But there is more than enough evidence that

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WHAT THE EVIDENCE TELLS US Cont'd

these changes are insufficient if they are not accompanied by a fundamental shift in attitude to birth and birthing women, away from a view of perpetual crisis management. This attitude begins with a basic trust in the physiological process of labour and birth. Research has shown that women who give birth in an atmosphere that is quiet, patient, and respectful of women's abilities to deliver babies, usually fare better. They and their babies require fewer interventions and the infants are less likely to lose weight or show other symptoms of trauma in the first days after the births.

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A 2006 study of Canadian birth practices found that only 25% of births in this country proceeded without intervention. In other words *in 75% of all births*, some sort of medical or surgical intervention was used. This contravenes and contradicts standards set by the World Health Organization and Health Canada.

There is good evidence that when women are not able to participate fully in making the decisions about how the labour and birth should and will proceed – with enough time to consider the information they are given – they will have to cope

with emotional trauma for weeks and months after the birth. This trauma is often dismissed, since everyone involved is supposed to be happy that all turned out well in the end, but women report that they relive the experience again and again if they were not able to take part in the decisions for their births.

Women have always welcomed relief from the overwhelming sensations and pain of labour. But medical pain control does not need to be providers' first choice. All drugs flow to the unborn baby and the longer they are given to the mother, the greater the effect on the infant. ►

A TRAIL OF INTERVENTIONS

Without a doubt, interventions, ranging from induction (starting) or augmentation (speeding up) of labour, to the use of epidural anesthetics, to the use of forceps, vacuum extractors or Caesarian sections to help with delivery, have eased women's pain and saved lives. Their *routine use*, in straightforward labours and births however, is consistently proven to carry risks for women and babies and they frequently lead to other interventions without better outcomes for women and babies overall.

For instance, many providers and hospitals will routinely induce labour in women whose pregnancies go on too long (about 41 weeks). Induced labours frequently develop with contractions that are very strong and painful, very quickly. To ease a woman's discomfort and pain, an epidural or some other pain reduction will be given. Both the original induction and the pain medication confine the woman to her bed, reducing her ability to move about as the labour continues. Meanwhile, because of these drugs, the baby's ability to cope will be electronically

Research conducted over the past 30 years or more has shown that if women are provided with one-to-one, personal, attentive and competent support throughout labour (and are free to move about for comfort), their need for medical pain relief is substantially reduced. In some studies it was found that *not* offering or suggesting medication, but making suggestions for changes in position, moving about, massage, and other support instead, reduced women's pain and increased their feelings of being able to cope. That is, women took some cues from their care providers, feeling more confident about their ability to manage labour if care providers were not immediately resorting to medical pain relief. Respectful, attentive care is not about watching for impending disaster – it means watching for any change that might need attention, while helping women cope through labour and birth. Surgical interventions should be offered only when required, rather than routinely.

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BRINGING BIRTH BACK TO COMMUNITIES¹

As part of the response to the need to bring birth back to Aboriginal communities, four birth centres were started in different parts of Canada.

Inuulitsivik Health Centre in Purvinituq, Quebec was started in the 1980s. A registered midwife or physician and community midwife assist local women in birth as an alternative to traveling to Moose Factory or Montreal. Women receive prenatal and postnatal care as well.

Rankin Inlet in Nunavut has had a birth centre for the central arctic since 1993. When midwives are available, women can deliver their babies at the centre, but there is chronic turnover of staff. The community would ideally like to have Inuit primary care providers on staff at all times.

The Ikewirokwas Midwifery Program is a Mohawk nation program which trains midwives in Quebec, Ontario and the U.S.

Tsi Non:we Ionakeratstha Ona:grahsta is on the Six Nations of the Grand River Reserve in Ontario. Full time Aboriginal midwives provide prenatal, labour, birth and postnatal care to any woman who chooses their services. They also provide training to new Aboriginal midwives.

¹ National Aboriginal Health Organization. 2004. Midwifery and Aboriginal Midwifery in Canada. Ottawa: NAHO.

monitored. Obstetric nurses, in short supply, come and go from the labour room as their time allows. It is common that the baby's heart rate will show distress from the drugs used and it is now urgent to have the baby delivered. The woman's ability to work with her body is diminished because of the pain medications and her reduced ability to feel the contractions. Forceps or vacuum extraction may be used, preceded by a surgical cut to the vaginal walls (episiotomy). It is not unusual for induction of labour to lead to a Caesarian delivery as the

surgery is more straightforward to perform than extraction (i.e. for the physician).

The evidence available simply does not support the necessity of these interventions as routine. Women who continue past 40 or 41 weeks in their pregnancy can be assessed for their and their babies' continued good health. There are good medical reasons to continue to watch both mother and baby, but a longer pregnancy, in and of itself, does not necessarily mean that an induction is needed.

WHAT THE EVIDENCE TELLS US Cont'd

Women need to give birth closer to home.

Just as women should be able to get regular prenatal care close to home, there is ample evidence that giving birth close to home is also important.

For the last 20 to 30 years women in northern Canada have been flown out of their home communities to give birth in southern hospitals. Inuit and other Aboriginal midwives who attended northern women were silenced, prevented from practising or risked arrest. Canada used to recruit nurse midwives to nursing stations because of their obstetric and other medical skills, but stopped doing so in the mid- to late 1970s. As the perception of birth as a disaster-waiting-to-happen developed, more and more women were expected to leave their home, families, and often other young children, to wait for labour and birth in a city far away. Women of the north, Inuit, First Nations and other Aboriginal women, describe how this practice has removed the celebration of birth from their communities, disconnecting mothers and their new babies from fathers and other family. Important traditional knowledge and skills are being lost as the last of the original midwives become ever older.

One reason fewer doctors provide birthing care at all is that there have been changes to medical guidelines about how many births physicians must attend every year, and under what circumstances. Doctors in some small communities may not provide enough maternity care to meet those guidelines. Other, cost-cutting reforms in health services mean that fewer regional hospitals can or will provide maternity care. Yet recent research demonstrates that forcing women to travel to give birth increases their risks and leads to poorer health for them and their babies.



Midwives can attend birthing women out-of-hospital, including in women’s homes or in birth centres. They follow standards and guidelines that protect women, but still allow for greater flexibility in where many women can give birth.

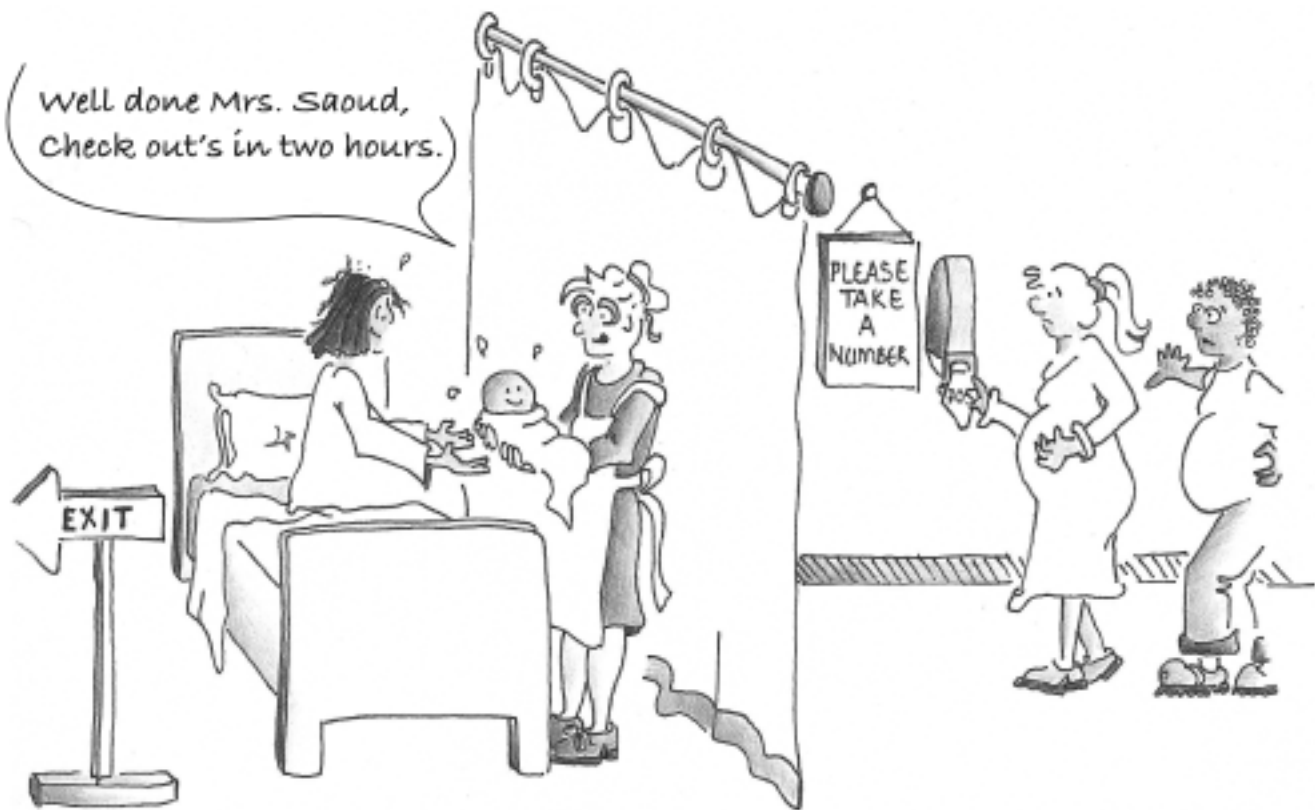
Midwives can attend birthing women out-of-hospital, including in women’s homes or in birth centres. They follow standards and guidelines that protect women, but still allow for greater flexibility in where many women can give birth. If complications arise, midwives have protocols for getting other medical assistance and for transporting women and babies to hospital if necessary. Except in Alberta, physicians in all provinces are not currently allowed to deliver babies out of hospital, thus restricting women’s choice of birth place where midwives are not available. Most provinces and territories though have been slow to fund midwifery care or midwifery education to make midwives more available to women and their families. At the time of writing, midwifery care is available in BC, Alberta (though not publicly funded), Manitoba, Ontario and Quebec, as well as Nunavut and Northwest Territories.

Women need accurate information about who is available to attend them.

Women and maternity care providers know that ideally, a woman should know the person who attends her in birth. The rise of regulated midwifery in Canada transpired in part because of women’s dissatisfaction with the fragmented care they received. For most women in Canada, maternity care may be provided by a whole succession of “carers”. Many women find it is remarkably difficult to find out who will be caring for them. Prenatal classes and sessions on birth plans probably will not prepare them for what will really happen.

For example, a woman sees her family physician as well as the nursing and clerical staff in the doctor’s office during the early weeks of the pregnancy. If she is lucky enough (or can afford it, as few are paid for under medicare) she may also meet a prenatal or childbirth educator. If she already knows that her doctor will not be catching the baby and an obstetrician will do the delivery, she may meet the named obstetrician, and all the staff in that doctor’s office, once by mid-pregnancy. Many doctors are training students in the course of their work. To all these people a woman may have to recite her reproductive and health history. For a hospital birth, there are new clerks and admitting staff to meet when the labour is underway, who also must record the woman’s medical history. On the labour and delivery ward are obstetric nurses to meet and if labour is long, nursing shifts may change once or twice. An obstetrician arrives for the delivery but, depending on whose turn it is to be on call, this doctor may not be the obstetrician the woman met during her pregnancy. There are new nurses to meet after the baby is born, and finally when a woman is discharged from hospital she may be visited by a public health nurse. Fragmented indeed.

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WHAT THE EVIDENCE TELLS US Cont'd

In contrast, a midwife's practice and model of care allow her to spend considerable time with each woman at each prenatal visit. The pregnant woman meets a second midwife and in most cases one of the two midwives will attend the woman throughout labour and birth, sometimes with the assistance of obstetric floor nurses. After the birth, mother and baby are seen by the midwife at home regularly for the first six weeks after the birth. With so few midwives yet in practice in Canada though, this ideal cannot always be achieved. Midwives must be able to take some time off and there are few others to share the workload.

Midwives, physicians and nurses discuss whether *continuity of care* is the same as *continuity of carer*. Is it enough that a woman is attended by midwives, physicians and perhaps nurses who share a similar philosophy and attitudes about birth (continuity of care)? Or is it possible to uphold a commitment to ensuring women can depend on the same person to be with them through all the stages of the childbearing year (continuity of carer)?

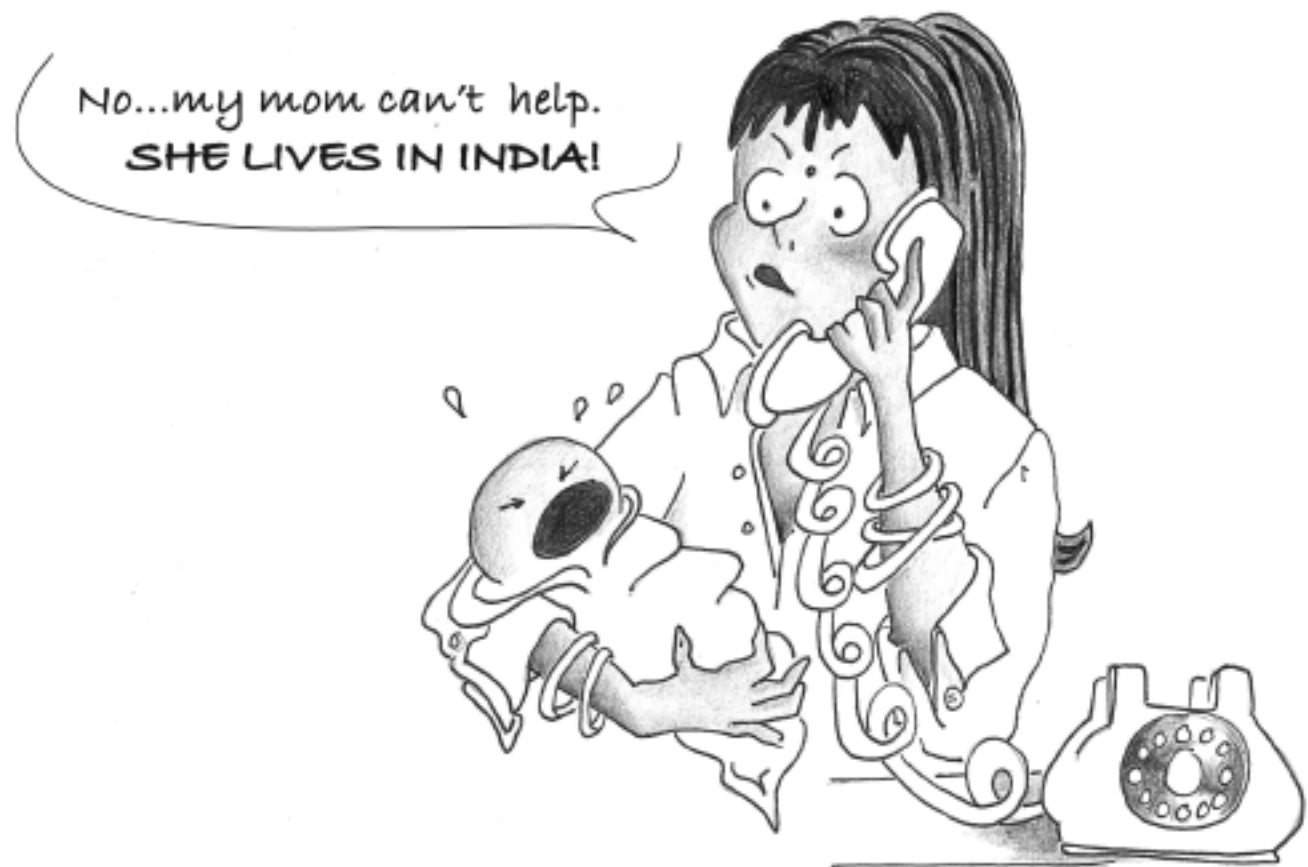
The evidence shows that women can benefit from either type of continuity. As long as pregnancy, labour and birth are treated respectfully and with confidence, as long as good attentive care is given, most women will proceed through all the stages without difficulty. In such cases women and their babies fare better.

Women need good postnatal care.

After birth, women and infants need good follow-up care. Postnatal care is often perceived as an extra, as if the safe arrival of the baby means that mother and baby require no further attention. But it's tough to find good support and advice for breastfeeding and looking after babies is hard work. As with other aspects of maternity care we have explored here, there is solid evidence about what women and babies need after birth: good support and attention through the early weeks.

The trend to early discharges (within 48 hours after birth) has been partly a response to women pointing out they were not sick, but it has not been good for everyone. Early discharge works for women with good support and diminishes the perception of birth as an illness requiring long hospitalization. When women are well, the birth has gone as they wished, and there are good supports at home, mothers and babies do fine, as seen among those who give birth at home or in birth centres. However, readmission rates in Canada for women and babies are high. Whether they live far from care and hospital or they live quite close by, if there are not enough supportive providers locally, postnatal maternity care can be inadequate.

Some difficulties start earlier. The International Baby-Friendly™ Initiative, adopted by the World Health Organization and endorsed by over 14,000 hospitals worldwide, has a ten-point plan, with specific criteria for Baby-Friendly™ hospitals. Only five hospitals and birth centres in Canada have received Baby-Friendly™ accreditation. This means the recommended steps to support mothers and babies are not necessarily routinely followed in most of Canada. Women report that they feel unready; they don't get the time and attention they need to start breastfeeding successfully. If they do ask for help they find lactation consultants (breastfeeding counsellors) are only available during regular business hours – but babies need to be fed every 2 or 3 hours around the clock! In the meantime, many obstetric, postpartum and public health nurses do not have adequate training in breastfeeding support. For new mothers there is an added strain that comes with the perception that this should somehow come naturally, that they are failing in the business of motherhood if they don't get it right, right away. Instead it is maternity care that is failing women.



ALL THIS WE KNOW ALREADY

We know a great deal about what is needed. With so much evidence about what works, why is it still not in place?

Health reforms and cutbacks have coincided with a number of other factors – more stringent guidelines for doctors about the number of births they should attend each year and how close-by surgical backup must be. Fewer medical students see uncomplicated births and fewer are choosing to do obstetrics and maternity care in their practice. There is most certainly a media focus on the drama of alarming birth stories: the baby who was saved, the extraordinary delivery, the life-saving medical interventions, and not nearly enough about uncomplicated, straightforward supported births – to be equally celebrated.

Not all health reforms have involved cutbacks in services. Funded regulated midwifery was introduced in some parts of Canada beginning in the 1990s to improve access, particularly for women living in rural and remote locations. There is a greater acceptance by administrators, doctors and nurses of home birth and a greater understanding across Canada that midwives provide care in hospitals, not just in homes. (This means women are not forced to choose between a hospital birth *or* a midwife-attended birth.) But it is also true that legislation, regulation and funding for midwifery have been implemented unevenly across the country – with the result that some women can get midwifery care and others cannot. Other health reforms, as mentioned, have included closing local maternity wards at smaller hospitals, and expecting women to pay for basic necessities such as diapers during hospital stays. These seemingly small changes mean that maternity care is more costly for women.

Moreover, some health reforms are still in the works – which means we can't be certain whether or not they will be beneficial for women and babies. Practitioners and policy makers are discussing collaborative care, meaning shared and integrated responsibilities for maternity care. The discussions are still conceptual and it is not clear yet what exactly collaborative care is and for whom it is most beneficial – provider, woman or both. Does it mean that maternity care is further divided, which women have repeatedly said they don't want? It will be important to return to the evidence we have about what women need and want before implementing new policies.

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SO, WHAT IS TO BE DONE?

Good maternity care starts with an understanding that pregnancy and birth are ordinarily healthy events, with a belief that most of the time the mother and baby will continue to develop together as they have for millennia. We have the evidence and we have learned how to make sure that pregnancy, birth and beyond are healthy and safe for both women and babies. We know that when basic needs are met, with safe stable housing, good nutritious food, sterile practice, as well as personal attentive care throughout, most women will have a healthy pregnancy. When women can give birth close to home or in their own home, when birth is allowed to unfold without interference and women feel safe, confident, well cared for by providers they know, when babies and mothers are attended in the early weeks, encouraged through the physical and emotional changes, assisted in breastfeeding and watched for strong development, then mothers and babies thrive.

Excellent maternity care should not be about a specific provider, location or procedure, but rather about a philosophy and model of care that is woman- and family-centred. Many providers could, in fact, offer woman- and family-centred care if supported by appropriate changes in the definition, funding and delivery of maternity care services. It should be grounded in the recognition that birth is a normal healthy process, based on the available evidence. It should be sustainable, close to home, publicly funded, one-to-one care. Maternity care must be available as needed during pregnancy, through labour or in the critical early weeks after the birth.

For these factors to be in place, we need political will and interest to see maternity care as a vital part of primary care. We need policy makers to invest in education of midwives. We need nursing and medical training to include many opportunities to be part of straightforward births. The current approaches to maternity care tend to put budgets and efficiencies ahead of the needs of women and families. We need to reform our thinking as well as our approach to maternity care if we hope to provide the best possible care and support for women and their families as they make their way from pregnancy to parenting.

WHERE TO FIND MORE INFORMATION

Publications: Centres of Excellence for Women's Health (CEWH)

More CEWH resources are available at www.cewh-cesf.ca

- **“Maternity care for rural women: A thing of the past”** in *CWHN Network*, Vol. 8, No. 3/4, Spring 2006. Discusses the limited maternity care services available in rural communities, and looks at the social and psychological effects on women. Available at: www.cwhn.ca/network-reseau/8-34/8-34pg11.html
- ***Midwifery Care: Women's Experiences, Hopes And Reflections***, by Meaghan Moon and Lorna Breitzkreuz, Prairie Women's Health Centre of Excellence, 1999. Documents women's experiences of midwifery care to determine if the kind of care women received from their midwives was satisfactory, and to see if this care corresponded with midwives' perspectives on what women want. Available at: www.pwhce.ca
- ***Solving the Maternity Care Crisis: Making Way for Midwifery's Contribution***, by Jude Kornelsen, British Columbia Centre of Excellence for Women's Health, 2003. Discusses how midwives are ideally positioned to meet demands for maternity care. Provides policy recommendations to improve midwifery's contribution. Available at: www.bccewh.bc.ca
- ***Want to Know More About Midwives?*** Atlantic Centre of Excellence for Women's Health, 2006. A booklet that describes the meaning of midwifery and the contribution of midwives to primary health care renewal. Available at: www.acewh.dal.ca

Other Publications

- ***Baby's Best Chance: Parent's Handbook of Pregnancy and Baby Care***, 6th Edition, British Columbia Ministry of Health, 2005. An up-to-date, Canadian handbook on pregnancy, birth and taking care of your baby for the first six months. Easy to read and recommended by a wide range of health care professionals. Available for purchase through www.publications.gov.bc.ca
- **“Childbirth practices, medical intervention & women's autonomy: Safer childbirth or bigger profits?”** by Maureen Baker, in *Women's Health and Urban Life*, Vol. 4, No. 2, 2005. Examines the factors that influence childbirth and breastfeeding practices such as new technologies, changing labour markets, medical and corporate profits and the politics of choice. Available at: www.utoronto.ca/~socsci/sever/journal/contents4.2.html
- ***Family-Centred Maternity and Newborn Care: National Guidelines***, 4th Edition, Health Canada, 2000. Intended to assist hospitals and other health care agencies in planning, implementing, and evaluating maternal and newborn programs and services. Available at: www.phac-aspc.gc.ca/dca-dea/prenatal/fcm1_e.html

- ***Guide pour la revendication d'une maison de naissance***, by Marie-France Beauregard for the Regroupement Naissance-Renaissance with the Comité femmes-sages-femmes, Regroupement Naissance-Renaissance, 2006. A how-to guide for mobilizing communities to organize a birthing centre with midwifery services. Available at: www.naissance-renaissance.qc.ca
- ***Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences*** by E. R. Declercq, C. Sakala, M. P. Corry and S. Applebaum. Childbirth Connection. 2006. Mothers' views and experiences of planning for pregnancy, labor and birth, being home with a new baby, physical and emotional health after birth, and opinions about choice, control, knowledge and decision-making in childbirth. Available at: www.childbirthconnection.org/
- ***Midwifery and Aboriginal Midwifery in Canada***, National Aboriginal Health Organization, 2004. Discusses midwifery in Aboriginal and non-Aboriginal communities, and presents emerging models of community-based care based on Aboriginal midwifery. Available at: www.naho.ca
- ***The Birth Book***, by William Sears, M.D and Martha Sears, R.N., Little Brown, 1994. This resource guide focuses on the birthing experience, covering the gamut of possibilities with the goal of helping readers take control of their own birthings.
- ***The Ten Steps and Practice Outcome Indicators for Baby-Friendly™ Hospitals. Guidelines for WHO/UNICEF Baby-Friendly™ Initiative (BFI) in Canada.*** Breastfeeding Committee for Canada. 2004. The Baby-Friendly™ Hospital Initiative is a global effort by the World Health Organization and UNICEF to foster the health of babies through promoting and supporting breastfeeding. A Baby-Friendly™ hospital ensures that a mother can make a truly informed decision and then supports her decision in an inclusive way. Available at: www.breastfeedingcanada.ca/html/bfi.html

Organizations

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| • <i>Canadian Association of Midwives</i> | www.canadianmidwives.org/ |
| • <i>Canadian Doula Association</i> | www.canadiandoulas.com |
| • <i>Childbirth Connection</i> | www.childbirthconnection.org |
| • <i>DONA International</i> | www.dona.org |
| • <i>Irrisuksiiniq-Inuit Midwifery Network</i> | www.naho.ca/inuit/midwifery/whats_new-e.php |
| • <i>Ressources-Naissances</i> | www.ressources-naissances.com/ |
| • <i>Society of Obstetricians and Gynaecologists of Canada</i> | www.sogc.org/ |

WHO WE ARE AND WHAT WE DO

Women and Health Care Reform consists of Pat Armstrong (Chair), Madeline Boscoe, Barbara Clow, Karen Grant, Margaret Haworth-Brockman, Beth Jackson, Ann Pederson and Morgan Seeley. We came together in 1998 as a collaborative group of the Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Bureau of Women's Health and Gender Analysis, funded through the Women's Health Contribution Program. Our mandate is to coordinate research on health care reform and to translate this research into policies and practices. For more information on our work, visit our website at:
www.cewh-cesf.ca/healthreform/

The Centres of Excellence for Women's Health of the Women's Health Contribution Program were initiated by the Bureau of Women's Health and Gender Analysis of Health Canada in 1996. The Centres are multi-disciplinary and operate as partnerships among academics, community-based organizations and policymakers. Their major aim is to inform the policy process and narrow the knowledge gap on gender and health determinants. Information and links to the WHCP members are available at:
www.cewh-cesf.ca

ordering information

Copies of this booklet can be downloaded from www.cewh-cesf.ca/healthreform/index.html
or ordered free from:

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*“Pregnancy and birth are unique for each woman. Women have diverse experiences and needs. Women and families hold different philosophies of birth, based on their specific knowledge, experience, culture, social and family background, and belief systems. ...The approach to caring for women and families should involve **adapting care** to meet their needs, rather than expecting women and families to adapt to institution or provider needs.”*

Family-Centred Maternity and Newborn Care:
National Guidelines. Health Canada. 2000