

# Maternal Health in Canadian Aboriginal Communities: Challenges and Opportunities

André B. Lalonde, MD, FRCSC, Christine Butt, BA, Astrid Bucio, MA

Society of Obstetricians and Gynaecologists of Canada, Ottawa ON

## Abstract

In response to the direct and indirect consequences of removing birthing practices from communities, Canada is exploring new initiatives to return childbirth to Aboriginal communities. Lessons learned and insights into this major problem can be used internationally to plan efforts to reduce maternal mortality in low-resource countries around the world.

## Résumé

En réaction aux conséquences directes et indirectes des efforts ayant cherché à faire en sorte que l'accouchement ne soit plus pratiqué dans les diverses communautés autochtones, le Canada explore maintenant de nouvelles initiatives visant à rétablir cette pratique. Les leçons tirées de ce processus et les révélations issues de l'étude de ce problème important peuvent être utilisées à l'échelle internationale pour planifier les efforts visant la diminution des taux de mortalité maternelle au sein des pays ne disposant que de faibles ressources.

J Obstet Gynaecol Can 2009;31(10):956–962

## INTRODUCTION

Canada's Aboriginal communities<sup>a</sup> have, for centuries, fought to protect their cultures, their languages, and their right to health. Colonization brought assimilationist views and strategies which forced Aboriginals to suppress many of their traditional beliefs, customs, and practices. As their traditional ways of life eroded, so too did their health. Throughout post-contact history, generally as a result of early European contact, Aboriginal communities have been plagued by epidemic diseases, such as tuberculosis, influenza, dysentery, and smallpox. Compounding the problem of poor health even further is the historical trend of non-Aboriginal authorities taking control of Aboriginal health and continually transferring this control to other

non-Aboriginal agencies when their efforts prove unsuccessful. Still today, Aboriginal people suffer from health and social conditions far worse than Canadian averages, as seen in the Table. Years of assimilation efforts have resulted in the loss of traditional Aboriginal knowledge and the disappearance of traditional healers.

Modern thought has questioned history and categorically condemned assimilation policies, as the negative effects of their implementation have become so obvious. Today, we realize that in order to be successful in our efforts to treat illness and disease, we must take into account the importance of cultural traditions, knowledge, and beliefs, as well as the importance of community participation in the decision-making and implementation processes.

Childbirth is an important life event in all cultures and provides an excellent example of the need to integrate culturally sensitive approaches within the delivery of health care services. Birthing practices vary from culture to culture, each with distinct traditions and beliefs about how a baby is to be brought into the world.

In Canada, providing adequate maternal health services to Aboriginal communities has proven challenging. Limited resources, large geographic distances, varying language groups, and differing cultural beliefs and traditions have all contributed to increasing the complexity of providing every woman with a safe childbirth. Drawing from the lessons that Canada has learned while working to improve maternal care for Aboriginal women, this article aims to support current efforts in returning childbirth to communities, as well as to share insights into how these lessons could be useful in strengthening international efforts to reduce maternal mortality in low-resource countries around the world.

**Key Words:** Maternal health, Aboriginal midwifery, traditional midwives, childbirth, cultural sensitivity, community participation, task shifting, international women's health

Competing Interests: None declared.

Received on April 30, 2009

Accepted on May 12, 2009

<sup>a</sup>The term "Aboriginal" is used throughout this article, and refers, in a collective sense, to Inuit, First Nations, and Métis people. We acknowledge the fact that this term overgeneralizes, as Aboriginal people in Canada are very diverse culturally, linguistically, and in their geographic settings.

## **BACKGROUND**

Since early contact and colonization, non-Aboriginal agencies have assumed responsibility for health care delivery to Aboriginal communities. Attempts aimed at improving Aboriginal people's health were met with great challenges, which led to innumerable shifts of responsibility. With the formation of Canada in 1867, the responsibility for Aboriginal peoples was transferred to the federal government. Since then, however, the responsibility for Aboriginal affairs has been shifted countless times between different departments and branches, often with no clear definition of the role that each should play regarding service delivery.<sup>1</sup> Ultimately, the responsibility for health care delivery to the non-reserve Aboriginal population has been shifted to the provincial and territorial governments. The federal government maintains a role as funder, while the First Nations and Inuit Health Branch is in charge of transfer payments and health service delivery to on-reserve First Nations and Inuit communities. Because the First Nations and Inuit Health Branch is not fully recognized as a health system within the Canadian health care system, it is subject to the same rules and procedures that govern federal departments. This is a concern, because it results in increased paperwork and excessive procedures that are not appropriate for a health system.<sup>2</sup>

Colonization, epidemic diseases, missionization, and residential school systems have all contributed to the loss of cultural identity suffered by Aboriginal communities. Because health and healing are closely intertwined with spirituality and culture, attempts to control Aboriginal ways of living, along with the emergence of Western medicine, resulted in a loss of traditional healing knowledge and of healers themselves. Among the many losses that Aboriginal peoples have experienced since the time of early contact, their loss of control over issues related to health and health care services has been one of the most detrimental.

In the past 30 years, however, Aboriginal groups have entered a new era of self-determination regarding health care.<sup>1</sup> With the growing acceptance of alternatives to Western medicine, we have seen the resurgence of certain healing ceremonies, such as the sweat lodge and the shaking tent. "Traditional healing" does not rely simply on knowledge recovered from the past; it is in a constant state of evolution, meaning that contemporary Aboriginal healing incorporates certain aspects of Western medicine and has adapted to changing social and cultural conditions.

The last few decades have also brought a reversal in government strategies with respect to the delivery of health services to Aboriginal communities, and many efforts have been made to integrate Aboriginal culture and tradition into

treatment programs and hospital settings, creating a more culturally-sensitive approach to health care delivery.

Although there are evident challenges, including those of legislation, regulation, and recognition, in trying to work simultaneously with both Western medicine and Aboriginal healing systems, the consequences of not doing so are too great to ignore. It has been over 30 years since the Alma-Ata Declaration of 1978, in which Canada, along with 134 other countries, endorsed a new definition of health provided by the World Health Organization. This definition states that "health is . . . a state of complete physical, mental, and social wellbeing and not merely the absence of disease."<sup>3</sup> In order to attain the highest possible state of health within Aboriginal populations, we must recognize cultural continuity as an important health determinant and favour an optimal blending of the two medical traditions.

Attempts to restore health among Aboriginal populations must also take into consideration decades of negligence and failures to address the important social and economic factors that contribute to the decline in their quality of life. Aboriginal populations have exceptionally high rates of suicide, drug and alcohol use, domestic violence, poor housing conditions, and low income compared to the rest of the Canadian population. Poor social and economic conditions have led to the deterioration of Aboriginal health, disrupting any efforts made for improving health outcomes. Such issues are not unique to rural areas, and in fact, are even more complex in large cities, where many Aboriginal people find themselves in situations of poverty and homelessness. Even though there may be more programs and treatment centres available nearby, Aboriginal people living in urban areas are often subject to even harsher health and social problems. Without addressing the cultural, and possibly linguistic, barriers that impede Aboriginal people in seeking the services they need, the proximity of these services is irrelevant. In order to improve health among Aboriginal populations, progress must be made in addressing the social and economic conditions that affect their quality of life and, as in the case of health care delivery, these issues also need to be dealt with using culturally sensitive approaches.<sup>4</sup>

Childbirth is, a sacred event in Aboriginal cultures, as it is in most cultures. It is a life event, that has a great impact not only on the woman giving birth but also on her family and the community as a whole. The birth involves sacred traditions and much celebration. In the past, the role of assisting a woman through childbirth was given to a midwife, who not only assisted in the physical aspects of childbirth, but was an important figure during the traditional ceremonies as well. The art of midwifery was passed on through generations and taught from grandmothers to mothers.<sup>5</sup>

**Table 1. Comparison of health and social indicators of Aboriginal women and non-Aboriginal women in Canada**

	Aboriginal women	Non-Aboriginal women
Aged 15-54 (% national population) <sup>25</sup>	357 725 (1.1%)	8 717 265 (27.8%)
Fertility Rate <sup>26</sup>	3.4 (Inuit) 2.5 (Registered Indian)	1.61
Mothers under the age of 18 <sup>26</sup>	9%	1%
Life expectancy <sup>27</sup>	76.6	82.1
Neonatal death rate <sup>4</sup>	5.12 per 1000 live births	4.2 per 1000 live births
Post neonatal death rate <sup>4</sup>	6.85 per 1000 live births	2.1 per 1000 live births
Infant mortality rate (1994) <sup>4</sup>	12.0 per 1000 live births	6.0 per 1000 live births
Average annual income (CAD) <sup>28</sup>	13 300 (43% aged >15 had incomes below low income cutoff <sup>29</sup> )	19 350 (20% aged >15 had incomes below low income cutoff)
HIV <sup>30</sup>	Account for approximately 50% of all HIV-positive test reports among Aboriginal people (IV drug use)	Account for 16% of all HIV-positive test reports among non-Aboriginal people
Substance abuse <sup>26</sup>	Alcohol-related hospital admissions are three times higher among Aboriginal women than among the general population	
Incarceration <sup>31</sup>	Aboriginal women account for less than 2% of women in Canada yet make up 29% of women in federal prisons (July, 2003)	
Spousal homicide rates <sup>31</sup>	4.72 per 100 000 couples	0.58 per 100 000 couples

Midwifery was one area of Aboriginal medicine that Europeans seemed to accept from the beginning of contact. In fact, many non-Aboriginal women frequently called upon Aboriginal midwives to assist them during childbirth, at least in the early years before medical services were available.<sup>1</sup> Aboriginal midwives have, throughout history, developed a wide range of methods and techniques to assist childbirth. For example, one common practice among the Arikara is the use of plant products, such as chokecherry juice, to alleviate postpartum hemorrhage.<sup>5</sup>

Midwifery, not only among Aboriginal populations, but also among Canadians nationally, experienced a drastic decline in the mid 1800s, as the profession of obstetrics developed and the use of forceps and anaesthetics was introduced. As explained in The National Aboriginal Health Organization's report on Aboriginal Midwifery in Canada, "the knowledge explosion in pharmacology, hygiene, physiology, etc., was not provided to midwives, whose practice generally remained informal and based on generations-old remedies and procedures."<sup>5</sup> As modern obstetrics in hospitals became the preferred choice of most mothers in Canada, the public eventually grew to believe that midwife-attended births were unsafe. This attitude concerning childbirth practices spread to Aboriginal health programs, resulting in increased emphasis on modern

medical intervention and the need to legitimize and regulate traditional midwifery use among Aboriginal women.<sup>5</sup>

Limited resources, isolation, and lack of personnel make it difficult to serve Aboriginal communities with the same level of care as in urban areas. This has become clear in recent years, as governments struggle to develop effective solutions to provide quality medical care to even the most remote areas. For example, in order to ensure a safe birth for mothers and newborns, it has become routine to evacuate Aboriginal women from their remote communities at 36 weeks' gestation and transfer them to urban areas which have the necessary facilities to deal with maternal complications.<sup>6</sup> Whereas births used to take place in communities and involve midwives, family members, and the community as a whole, today these roles have been overtaken by medical staff working in far away centres.<sup>7</sup> Although evacuation is meant to provide a safe delivery, it separates the mother from her family and her social network support, forcing her to experience one of her most important life events surrounded by unfamiliar languages, culture, people, and food.<sup>6</sup> Such stress and isolation negatively impacts the health of the mother and entails a lack of continuity of care, which adds challenges to her emotional recovery and adaptation to motherhood.<sup>8</sup>

Evacuation also has negative impacts on the health of families, on the cultural integrity of communities, and on the portion of public funding devoted to Aboriginal health care. The evacuation policy fails to provide women with a right to health services that include respect for their culture. As the costs for evacuation are high, fewer funds are left for health promotion and preventative care in Aboriginal communities. Furthermore, the traditional Aboriginal knowledge needed to manage the birth of future generations is lost in the process.

Because the evacuation policy has provoked considerable criticism, new initiatives are emerging to transfer the responsibility of maternal care services yet again, but this time back to Aboriginal communities. This change of direction presents an interesting opportunity to bridge culture and medicine, but one that comes with many challenges.

### **RETURNING MIDWIFERY CARE TO ABORIGINAL COMMUNITIES: CHANGING PERSPECTIVES IN CANADIAN PRACTICE**

In reviewing the history of Aboriginal health in Canada, we are reminded of many failing attempts to address Aboriginal health care within a culturally sensitive framework. As Canada enters an era that is facing an extreme shortage of maternity care providers, and as the global economic recession increasingly affects existing resources and funding, it is necessary to re-examine current practice and find a balance that will blend sustainability, safety, and cultural sensitivity in future interventions that aim to reduce maternal mortality and morbidity.

Canada has already taken steps towards achieving this goal. There is growing acceptance of the role that Aboriginal midwifery can play, in part because of the urgency regarding the shortage of maternity care providers, but also because of an increased awareness of the poor maternal health outcomes among Aboriginal populations and a greater understanding of the importance of cultural continuity as a health determinant.

Nevertheless, it is important to acknowledge that the term “Aboriginal Midwifery” groups together midwives with different backgrounds in terms of experience and education. Although there is not a unique definition of midwifery, for the purpose of clarity, we propose three general types of midwives presented by the Midwives Alliance of North America,<sup>9</sup> each of which relates to the type of training received.

1. The direct entry midwife, who is an “independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing”;

2. The traditional/lay midwife, who is “an uncertified or unlicensed midwife . . . educated through informal routes such as self-study or apprenticeship rather than through a formal program”; and
3. The nurse-midwife, who has achieved education in nursing and midwifery.

Such distinctions are important to consider when planning maternal health programs, and the roles of each type of midwife should be determined based on her competencies and skills. For example, traditional midwives could be key to surmounting the cultural and linguistic barriers to providing quality care to mothers. Their role may be best defined as one of “health promoter,” as their close connection to the community and their understanding of Aboriginal culture and traditions would make them good candidates for connecting with and educating Aboriginal women. Formally trained midwives could assist at normal births and collaborate with physicians in identifying high-risk pregnancies. Aboriginal midwife training programs have been established in some provinces, such as Ontario, British Columbia, and Manitoba, in an effort to attract Aboriginal midwives from communities and train them in a way that combines traditional practice with technical knowledge, leading to maternal care providers with cultural competency.<sup>10,11</sup>

Many Aboriginal women have expressed their concerns and their desire to give birth close to their community, and their voices are now being heard. Today, we can see the emergence of several initiatives aimed at returning birthing practices to Aboriginal communities.

Birthing centres have been established in some communities as an attempt to allow Aboriginal women to remain in their communities when giving birth and to carry on the tradition of sharing this important life event with the community. The Rankin Inlet Birthing Centre provides a good example of how midwives can contribute to the return of birthing to communities, while their weekly meetings with physicians allow for a collaborative decision-making process in identifying high-risk pregnancies.<sup>12</sup>

Services to facilitate collaboration and sharing are also emerging as modern telecommunications become increasingly available to isolated areas. The Irnisuksiiniq—Inuit Midwifery Network, for example, uses fax, telephone, and Internet to promote knowledge transfer in the field of Inuit Midwifery.<sup>13</sup> Conferences, such as the Invitational Gathering on North American Indigenous Birthing and Midwifery, also provide an opportunity for government health officials to meet with representatives from Aboriginal communities and discuss possible strategies to promote the awareness and strengthen the practice of Aboriginal midwifery.<sup>5</sup>

Several Aboriginal organizations and government services are increasing funding and taking initial steps to implement midwifery education and services for many communities. Further research on these topics is also contributing to the development and implementation of policies and programs that support midwifery and returning birth to Aboriginal communities. Such initiatives carefully integrate traditional Aboriginal knowledge into the delivery of maternal care services.

Aboriginal midwives are also receiving support from professional associations, such as the Society of Obstetricians and Gynaecologists of Canada and the Canadian Association of Midwives, who are addressing issues related to the appropriate recognition, legislation, regulation, funding, and education of Aboriginal midwives in Canada.

The SOGC recognizes that issues of maternal health care for Aboriginal women have been overlooked for too long and that the recent initiatives proposed are long overdue. As a professional medical association devoted to ensuring that every woman in Canada has access to maternity care services, the SOGC is committed to supporting the revival of midwifery in Aboriginal communities. In an effort to support midwives and Aboriginal organizations, as well as to respond to the needs of Aboriginal women themselves, the SOGC is using its influence to facilitate discussion among governments, communities, and health care professionals.

Over the past few years, the SOGC has been working to convince Canadian governments of the growing crisis in obstetrical care and is urging officials to adopt an Aboriginal Birthing Initiative that will prepare communities for the challenges that lie ahead.<sup>14</sup> The SOGC further recommends that federal, provincial, and territorial governments adopt the Multidisciplinary Collaborative Primary Maternity Care model, which fosters respect for the contributions of all disciplines, including nurses, nurse-practitioners, midwives, family doctors, and obstetricians.<sup>15</sup> With many allies in Parliament already, the SOGC is well-positioned to work on advocacy campaigns that address the need for improved maternal health services in Aboriginal communities. By using pre-established contacts and networks, the SOGC can help Aboriginal representatives acquire a secure place at policy-making round tables and support their recommendations for action.

In 2000, the SOGC laid out a set of culturally competent and culturally appropriate guidelines for health care providers working in Aboriginal communities.<sup>4</sup> The society is also currently working on developing memoranda of understanding to assist Aboriginal leadership organizations with the planning of future programs and interventions. The focus of the SOGC has been on collaborating with

Aboriginal leadership organizations and communities, provinces, territories, agencies, and Aboriginal health professionals, in an attempt to build bridges and create partnerships. Through learning and sharing, the goal of such partnerships is to develop protocols and models of care that will enable Aboriginal mothers to stay in their communities for birthing, with the delivery of prenatal care in the mother's language of choice, and with respect for traditional prenatal and maternity methods.<sup>16</sup>

### **FROM NATIONAL TO INTERNATIONAL: EXPANDING CANADA'S CHANGING PERSPECTIVES TO ADDRESS MATERNAL CARE IN RESOURCE-CONSTRAINED COUNTRIES**

The lessons learned throughout our history could be useful in the planning of current global health strategies. Similarly, there is much to learn from other initiatives emerging in countries around the world. Chile, for example, has recently put forth a pilot project to improve health services to indigenous populations using a culturally sensitive approach, which includes consultations at the local level, as well as community participation. Bolivia has sanctioned a series of laws regarding indigenous populations and health, including laws that give recognition to traditional medical systems. Argentina has established a network of intercultural facilitators and health promoters to address linguistic and cultural barriers to providing health services to indigenous populations. Peru has created the Instituto Nacional de Medicina Tradicional, which aims to integrate indigenous medicine with Western medicine.<sup>17</sup> Bilateral learning between countries could provide useful insights into the advantages and disadvantages of certain policies or programs already in place elsewhere. Similarly, Canada's and the SOGC's recent efforts to support the return of midwifery care to Aboriginal communities could provide insights for the creation of culturally appropriate and cost-effective solutions to reduce maternal mortality rates in resource-constrained countries around the world.

Through working at the international level, Canadian health practitioners have been encouraged to open their eyes to new ways. In so doing, they have become increasingly aware that marginalized and resource-constrained populations exist here in Canada and that the need to address their issues is just as great as the need to address the issues of populations in developing countries.

Assembly of First Nations National Chief Phil Fontaine, noting that Canada's Governor General, the Right Honourable Michaëlle Jean recognized "a developing world right here in Canada," quoted her statement that "[t]here is urgent work that needs to be done in our own backyard, and this work could be an example for the entire world."<sup>18</sup> As is

often the case in developing countries, efforts to improve health care services to Aboriginal populations in Canada are hindered by long distances to remote and isolated communities, linguistic and cultural barriers, lack of health personnel, and poor social and economic conditions. If current initiatives of returning birth to Aboriginal communities do in fact succeed in overcoming these obstacles, Canada will be on the right path towards both improving Aboriginal women's health and offering a positive example for addressing maternal health issues around the world.

In the 2008 UNFPA State of World Population Report, it is emphasized that "culturally sensitive approaches are essential for reaching the Millennium Development Goals, including MDG 5."<sup>19</sup> It is clear that in order to improve maternal health at the international level, program implementation strategies must work closely with communities to provide culturally appropriate solutions, which not only respond to health issues but also integrate the need to address social, political, and economic factors that influence health outcomes. In order to fully understand the health needs of any population, it is essential to listen to the voices of those who are to receive the proposed services.

As in Aboriginal communities, traditional midwives have been present in communities around the world for many centuries. Women have always given birth, and traditions, knowledge, and beliefs have been shaped differently in all culture groups. When integrating Western medical technology and practices into the health systems of low-resource countries, we must be careful not to promise more than can be delivered. Trained medical experts are scarce and funding even more scarce. Proposed initiatives to address maternal health should take into consideration the full chain of health professionals and look for areas where task shifting may be possible. Traditional or lay midwives, for example, could provide emotional support and postnatal education to birthing mothers. Midwifery training programs could provide a solution to the lack of obstetric medical experts, especially in isolated and rural areas. However, the fact that 15% of all births everywhere have a risk of complications cannot be disregarded.<sup>20,21</sup> It is therefore important that such task shifting be accompanied by collaborative relationships between health professionals, as well as strong systems of referral and counter-referral for dealing with complicated births.

Canada is not the only country proposing to return midwifery care to communities. Several midwifery training programs are beginning to appear in countries around the world.

In Guatemala, the SOGC has been supporting the integration of traditional Mayan midwives, or *comadronas*, into the District Hospital of Solola.<sup>22</sup> These traditional midwives

have received specialized training and are playing important roles in applying culturally sensitive approaches to reduce maternal mortality and to provide a more comfortable setting for indigenous women giving birth. An important achievement for these *comadronas* has been in overcoming discrimination and their fear of accompanying their patients to the hospital. Through the strengthening of collaborative relationships, they have now gained recognition and acceptance by the medical and nursing personnel of the hospital.<sup>23</sup> A midwife training program has also emerged in Afghanistan in an effort to reduce maternal mortality rates.<sup>24</sup> A problem for women in Afghanistan is the cultural bias against their being treated by male doctors coupled with the severe shortage of trained female birth attendants that has resulted from restrictions on the education of girls. Furthermore, as traditional customs forbid women to travel without a male companion, few women in rural villages manage to deliver outside their home. In an effort to fill the overwhelming need for female birth attendants in Afghanistan, UNICEF established an extensive midwifery training program throughout the country that has already shown optimistic results.<sup>24</sup>

## **CONCLUSION**

Canada is not alone in having a shortage of maternal health personnel, and it is time to consider where and how task-shifting can take place. The training of both traditional and direct-entry midwives is a strategic approach to improving maternal health, which integrates community involvement and cultural sensitivity. It is also key to providing services in rural and remote areas that lack proper health facilities. The return of midwifery care to Aboriginal communities could reduce the number of obstacles inhibiting the success of maternal health care delivery while allowing for a more holistic and patient-centred approach to providing health services in general.

The SOGC supports the return of birthing to Aboriginal communities and is working to build collaborative relationships that could strengthen and accelerate policy and program implementation, allowing low-risk births to take place within communities and within a culturally sensitive framework. For such an initiative to be successful, the SOGC recommends that the return of midwifery care to Aboriginal communities be accompanied by

- Active participation of Aboriginal community members
- Sufficient funding from federal, provincial, and territorial governments
- Adequate training of both traditional and direct-entry midwives, including continuing education
- An integrated system of monitoring and evaluation

- Pre-established mechanisms for referral of high-risk pregnancies
- Continuous support from the health care system
- Collaboration between health care professionals
- A culturally sensitive approach to the planning and implementation of maternal health services.

The SOGC is committed to listening to the voices of Aboriginal communities and to working in collaboration with them throughout the process of returning midwifery care to Aboriginal communities.

Health is not merely an absence of disease; it is intricately linked to culture, religion, social status, and economic welfare. In order to advance Millennium Development Goal 5 of reducing maternal mortality worldwide, the SOGC believes it is important for health professionals and policy makers alike to step back and see the whole picture: one that is not focused merely on health and illness, but that also integrates cultural continuity and community participation.

## REFERENCES

1. Waldram JB, Herring DA, Young TK. *Aboriginal health in Canada: historical, cultural, and epidemiological perspectives*. 2nd ed. Toronto: University of Toronto Press; 2007.
2. Wadden M. Where the pavement ends: Canada's Aboriginal recovery movement and the urgent need for reconciliation. Vancouver: Douglas and McIntyre; 2008:175.
3. World Health Organization. Declaration of Alma-Ata. International Conference on Primary Health Care; September 6–12, 1978; Alma-Ata, USSR, Available at: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf). Accessed March 20, 2009.
4. Smylie J, Lessard P, Bailey K, Couchie C, Drieger M, Eason EL, et al. A guide for health professionals working with Aboriginal peoples. SOGC Policy Statement, CPG No. 100, December 2000. *J Obstet Gynaecol Can* 2000;22:1056–61.
5. National Aboriginal Health Organization. *Celebrating birth—Aboriginal midwifery in Canada*. Ottawa: National Aboriginal Health Organization; 2008:12.
6. Couchie C, Sanderson S. A report on best practices for returning birth to rural and remote Aboriginal communities. SOGC Report, CPG No. 188, March 2007. *J Obstet Gynaecol Can* 2007;29:250–60.
7. Birth. The Aboriginal Nurse. January 2002. Available at: [http://findarticles.com/p/articles/mi\\_qa3911/is\\_200201/ai\\_n9056272](http://findarticles.com/p/articles/mi_qa3911/is_200201/ai_n9056272). Accessed March 30, 2009.
8. Smith D. *Comprehensive maternal child health care in First Nations and Inuit communities*. Ottawa: Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada; 2002.
9. Midwives Alliance of North America (MANA). Definitions. Available at: <http://mana.org/definitions.html#DEM>. Accessed April 2, 2009.
10. College of Midwives of Manitoba. Exploring midwifery as a career. Available at: <http://www.midwives.mb.ca/becoming.html>. Accessed: April 9, 2009.
11. Native Women's Association of Canada. *Aboriginal women and reproductive health, midwifery, and birthing centres: an issue paper*. Paper presented at: National Aboriginal Women's Summit; June 20–22, 2007; Corner Brook NL.
12. University of Manitoba; Faculty of Medicine. *Nunavut–Rankin Inlet Birthing Centre*. Available at: [http://www.umanitoba.ca/faculties/medicine/units/northern\\_medical\\_unit/popups/physician\\_info/birthing\\_centre.shtml](http://www.umanitoba.ca/faculties/medicine/units/northern_medical_unit/popups/physician_info/birthing_centre.shtml). Accessed April 9, 2009.
13. The Innuksuiniq–Inuit Midwifery Network. What's new. Available at: <http://www.naho.ca/inuit/midwifery/english/index.php>. Accessed: April 7, 2009.
14. Society of Obstetricians and Gynaecologists of Canada. *A national birthing initiative for Canada. An inclusive, integrated and comprehensive pan-Canadian framework for sustainable family-centered maternity and newborn care*. Ottawa: SOGC; January 2008. Available at: <http://www.sogc.org/projects/pdf/BirthingStrategyVersionJan2008.pdf>. Accessed: August 5, 2009.
15. Campbell K, Anderson M, McNamee M. MCP2: Multidisciplinary collaborative primary maternity care. Paper presented at: Maternal Child Youth Conference; June 3, 2006; Vancouver BC.
16. Nowgesic MA. An introduction to the integration of Aboriginal health for the SOGC. Paper presented at: Invitational Gathering on North American Indigenous Birthing and Midwifery; Washington, DC; May 5–8; 2008.
17. Ministry of Health Chile. *Encuentro Internacional Salud y Pueblos Indígenas: Logros y Desafíos en la Región de las Américas [International health and indigenous peoples series: Achievements and challenges in the region of the Americas]*. Washington, DC: Pan American Health Organization; 2003.
18. Assembly of First Nations. *Speaking Notes for Assembly of First Nations National Chief Phil Fontaine*. Available at: <http://www.afn.ca/article.asp?id=3324>. Accessed April 7, 2009.
19. United Nations Population Fund. *State of world population 2008. Reaching common ground: culture, gender and human rights*. UNFPA; 2008:4. Available at: <http://www.unfpa.org/swp>. Accessed August 5, 2009.
20. United Nations Population Fund. *Safe motherhood: skilled attendance at birth*. Accessed at: [http://www.unfpa.org/mothers/skilled\\_att.htm](http://www.unfpa.org/mothers/skilled_att.htm). Accessed: March 25, 2009.
21. World Health Organization. *Reproductive health and research: making pregnancy safer*. Available at: [http://www.searo.who.int/EN/Section13/Section36/Section129/Section396\\_1446.htm](http://www.searo.who.int/EN/Section13/Section36/Section129/Section396_1446.htm). Accessed March 25, 2009.
22. Society of Obstetricians and Gynaecologists of Canada. Available at: <http://sogcic:10100/sites/SOGCInfoBank/External%20PartnersStakeholders/Shared%20Documents/AffiliateSocietiesOrganization/FECASOG/preIntegracionSololaE.ppt>.
23. Replogle J. Training traditional birth attendants in Guatemala. *Lancet* 2007;369(9557):177–8.
24. United Nation's Children Fund. *State of the world's children 2009: maternal and newborn health*. New York: UNICEF; 2008:60.
25. Statistics Canada. 2006 Census. Available at: <http://www.stats.can.ca>. Accessed: April 17, 2009.
26. Stout MD, Kipling GD, Stout R. *Aboriginal Women's Health Research Synthesis Project final report*. Ottawa: Centres of Excellence for Women's Health Program, Women's Health Bureau, Health Canada; 2001.
27. Health Canada. *First Nations, Inuit, and Aboriginal health: First Nations comparable health indicators*. Available at: [http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/2005-01\\_health-sante\\_indicat-eng.php](http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/2005-01_health-sante_indicat-eng.php). Accessed April 27, 2009.
28. UN Plan for Action Committee. *Women and the economy: a project of UNPAC*. Available at: <http://www.unpac.ca/economy/awe.html>. Accessed April 27, 2009.
29. The Centre for Equality Rights in Accommodation. *Aboriginal women and housing*. Available at: <http://www.equalityrights.org/cera/docs/barrchp3.htm>. Accessed April 27, 2009.
30. Canadian Aboriginal AIDS Network. *HIV/AIDS and Aboriginal women, children and families: a position statement*. Ottawa: 2004.
31. Canadian Association of Elizabeth Fry Societies. *Aboriginal women: criminalization, over-representation, and the justice system*. Available at: <http://www.elizabethfry.ca/eweek06/pdf/aborig.pdf>. Accessed April 27, 2009.