NURSING HANDBOOK – PRECONCEPTION THROUGH EARLY CHILDHOOD

A PRACTICE RESOURCE FOR COMMUNITY HEALTH NURSES

First Nations Health Authority
Health through wellness

Nursing Handbook

Preconception through Early Childhood

A Practice Resource for Community Health Nurses

2nd Edition

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Acknowledgements

The First Nations Health Authority's (FNHA) vision is Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities.[(1)]

The FNHA supports BC First Nations individuals, families and communities to achieve and enjoy the highest level of health and wellness by: walking with them on their health and wellness journeys; honouring traditions and cultures; and championing First Nations health and wellness within the FNHA organization and with all of our partners. [(1)]

We respectfully acknowledge the Coast Salish peoples, including those of the shíshálh (Sechelt), Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) territories on which this resource was created. We acknowledge them as the First Peoples of these lands and we acknowledge the traditional and ancestral territories throughout BC in which all of the contributors and collaborators to this resource reside.

ʔul nu msh chalap | Huy chexw a | hay č xʷ q̓ ə | Huy ch q'u | Thank you

Contributors & Collaborators

This handbook was developed by the FNHA Maternal Child Nursing Team, within Collaborative Practice, in consultation with Elders, nurses, First Nations birthers, and specialists with expertise in their respective fields.

We are grateful to everyone who contributed to and with whom we collaborated on this handbook including but not limited to:

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Purpose of the Handbook

The purpose of this handbook is to provide guidance for Community Health Nurses (CHNs) working and living in First Nations community-based settings. It provides CHNs with information and knowledge to assist them with providing care and support for people who are pregnant and parenting. This handbook also connects CHNs to appropriate resources as well as guides them to reflect on their nursing practice in relation to preconception through early childhood health. Other health care workers may also find the information in this handbook useful in supporting the people they serve.

How to Use the Handbook

1. The handbook is divided into five sections:

    - Cultural Safety and Humility and the Perinatal Period
    - Before Baby Comes
    - Birthing
    - The Time After Birth
    - Loss in Pregnancy

    The easiest way to find where you need to go is to locate the topic or a keyword pertaining to the topic in the table of contents. Clicking on the word will take you directly to the page.

2. Each section begins with a set of reflective questions. These questions are for you to ask yourself. They are intended to guide you through a process of self-reflection that will help to inform and support your integration of the material.

3. Create a journal for yourself. Use this journal when answering the reflective questions. In this way you will support your own cultural humility journey.

4. Each section ends with extended learning on a selected topic. The extended learning sections often integrate further self-reflective questions.

5. You will notice 'Red Flag' boxes throughout the book. These are designed to support you in learning the cardinal 'red flag' symptoms and signs of specific topics.

6. There are 'Nurse's Stories' throughout this book that are intended to exemplify subject material. These Nurse's Stories are true stories shared with permission from nurses in community.

7. There are 'Spotlight' stories throughout the book that highlight personal experiences and stories of Indigenous individuals. These stories are shared with their explicit permission.

8. Please ensure you have access to Gathering Space (GS), FNHA's intranet, as there are hyperlinks and references to documents that can only be accessed through GS. If you do not have a username and password, please reach out to your FNHA Community Health Practice Consultant. Once you have GS access, you can access it here: https://partners.fnha.ca/pages/default.aspx. You can also follow the instructions here https://www.fnha.ca/Documents/FNHA-Nursing-Services-Request-for-Access-to-Gathering-Space.pdf to request access to GS.

9. Hyperlinks are provided to support you in accessing important documents and resources. If the hyperlink does not work, try searching the key words listed in the hyperlink as frequently the site is still working but under a different url. Please let us know at mchnursing@fnha.ca if a link isn't working.

10. The handbook is designed to be a live document on Gathering Space (GS) and will be updated as needed. We encourage you to always refer to the most recent version online.

11. This handbook provides an introduction to perinatal and early childhood topics. It does not replace clinical judgement, critical thinking or the necessity to research a topic in greater depth as needed.

12. In this handbook, the terms "primary care provider (PCP)" and "health care provider, health care people or health care professional" are **not** used interchangeably. In this handbook, PCP refers to a physician, registered midwife, or nurse practitioner. "Health care provider/people/professional" refers to anyone, including allied health, who provides health services.

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Introduction

Etuaptmumk | Two-Eyed Seeing

In 2004, Mi'kmaq Elder Albert Marshall introduced the term *Etuaptmumk* or Two-Eyed Seeing. It means, "To see from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together." (3, p3)

This Handbook endeavours to present itself and its content through an *Etuaptmumk* lens, bringing both Indigenous ways of knowing and Western ways of knowing in parallel and together in order to support Community Health Nurses in providing the safest and most humble perinatal care possible for community members. This is in alignment with the following teaching:

> "If we pray in a circle, and face the eagle feather placed on the drum in the centre of the circle, we see the feather differently even though we are looking at the same thing. Together, our perspectives contribute to the full perspective of that drum and feather in a way a single view does not capture."
>
> - Skwxwú7mesh Úxwumixw Elder Syexwáliya

"This teaching recognizes the strengths of BC First Nations knowledge, medicines, and healing practices alongside mainstream health knowledge and medicine." (44)

- Joe Gallagher, former CEO of the First Nations Health Authority

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Language Matters

The FNHA Maternal Child Health team consulted with First Nations Elders, nurses, leaders and colleagues to discuss, collaborate and decide on how best to move forward in a good way with language within this handbook. Michelle Prince, the FNHA Practice Consultant in Elder Care, captured this collaboration with the following quote:

"The language within this handbook strives to honour the language bridging journey we are all on. Collectively we are moving away from gender-laden language to gender neutral and non-binary language while still honouring and upholding traditional matriarchal roles and language within First Nations context and culture. In this handbook we will be focusing more on terms such as parent, birther or lifegiver. This is a learning journey and we are not experts. We strive to use gender neutral language and to be as inclusive as possible within this handbook. In the case of direct quotes, we have not altered the wording and therefore terms such as 'woman or mother' and other gendered terms may be present."

Using positive, people-first and inclusive language is vital to providing services that are safe and accessible for all people experiencing pregnancy, childbirth and parenthood. This ensures that people of all genders and life experience are included in the information that impacts their health, ability to make informed choices and their access to perinatal information and support. Being a parent is not defined by biology. [(51)]

Using positive, people-first and inclusive language emphasizes the strength, innate ability and resiliency of all people. This acknowledges the identity of people who may or may not have a diagnosis or trait, without identifying them as that particular trait. [(5)] For example, instead of referring to someone as a "pregnant woman," try, "individual who is pregnant," or instead of "diabetic," try "person with diabetes." [(64, p2)]

Using inclusive language signals that diversity is welcome. [(63)] This means avoiding, "gender-markers" and assumptions until you know the words people use to describe themselves and their families. [(63)] For example, instead of "husband/wife," try "partner/spouse," or instead of, "mother/father," try, "parent." Once you have built relationship and know the words people use to describe themselves, use them in a respectful and professional manner. [(63)]

Please see the following resource for gender inclusive language:

Queer Terminology from A to Q by Qmunity:
https://qmunity.ca/wp-content/uploads/2019/06/Queer-Glossary_2019_02.pdf

While we strive for inclusivity of all people and genders, it is important to acknowledge, uphold and honour traditional matriarchal roles in First Nations communities. Please refer to the next section – Honouring and Upholding Matriarchal Roles for more information.

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Honouring and Upholding Matriarchal Roles

All of the following is from Sacred and Strong: Upholding Our Matriarchal Roles (p.6). This is an incredible resource that we encourage you to read.

"Our culture has always celebrated life. Our children got their first traditional name at birth: it was their child name. At 10, they got another name. As an adult, another name. As they become older, another name. So there was tradition. We've always celebrated life. And uplifted our children."

- First Nations mother living in Bella Bella

"In First Nations communities, **the birth of a baby is a sacred event to be joyously celebrated**. Each Nation has distinctive teachings, knowledge and ceremonies that surround each phase of the journey – from preconception through pregnancy and childbirth. **Women are honoured and accorded special respect for their role as life givers, which is seen as a tremendous gift**."

"Traditionally, matriarchs taught girls and young women about respecting and caring for their bodies as well as about their Nation's customs with respect to pregnancy, childbirth and mothering. This transmission of wisdom by First Nations mothers, grandmothers and aunties, who also provided vital webs of support as extended family, has a protective influence on healthy child development and has ensured the strength and continuity of generations of First Nations."

"Colonialism introduced patriarchal, devastating and intrusive laws, policies, practices and systems that undermined and suppressed the active and respected roles of First Nations women and broke up families. These included forced surgical sterilization, the residential school system, the Sixties' Scoop, and the child welfare system. The sharing of valuable teachings surrounding pregnancy, childbirth, and mothering between generations was disrupted, but the teachings were not lost."

"Today, although First Nations mothering occurs within the context of historical and ongoing colonial policies and practices, many Nations and matriarchs are actively sharing their traditional teachings and restoring their customs, and many First Nations parents and their infants continue to benefit from them."

"The inherent resiliency of First Nations is exemplified in the vital role that women and mothers continue to play in their communities, and in the resurgence and reclamation of traditional roles, teachings and practices around pregnancy, childbirth and mothering. The vision of healthy and self-determining individuals, families and communities is inextricably linked to First Nations women as the bearers of strong future generations."

Role of the Community Health Nurse in Perinatal and Child Health

The role of the Community Health Nurse in the care of individuals who are pregnant or parenting and in the care of children to age six, is to support those individuals in shaping their pregnancy journey, in receiving safe and timely perinatal care and to support the health of children to age six. Building relationship and trust will support the good work you do in providing culturally safe, humble, and trauma-informed perinatal care.

The expectations and specific duties of your role as CHN will vary from community to community. It is therefore important to always keep in mind the Controls on Practice put forth by the BC College of Nurses and Midwives (BCCNM).

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The Controls on Practice is a shared responsibility between the government, the BCCNM, employers and CHNs. [55] Everyone must work together to ensure the public receives safe, competent and ethical care. [55] Beginning at the bottom of the pyramid, and moving upward, each control narrows the CHN's practice. [55,56]

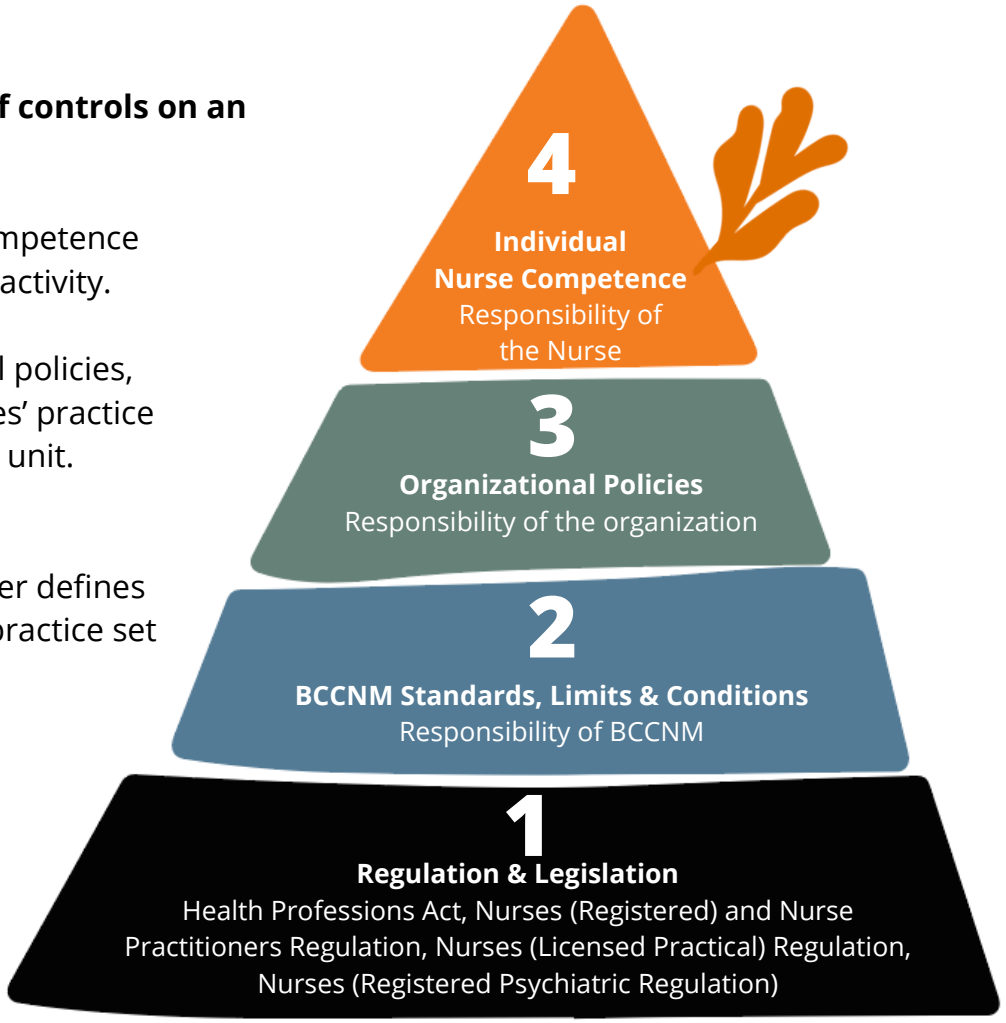
There are four levels of controls on an RN/NP/LPN's practice:

4 An individual nurses' competence to carry out a particular activity.

3 Employer/organizational policies, which may restrict nurses' practice in a particular agency or unit.

2 Complements and further defines and limits the scope of practice set out in the Regulation.

1 Sets out the scope of practice in fairly broad strokes.



Everyone Has a Role in Reconciliation

An opening message from Connie Paul,
RN, Tsartlip/Okanagan First Nation

I lift my hands up to the nurses who are working in First Nation communities. I have been nursing for 33 years and I have heard many Elders and people speak about truth and reconciliation. The most important teaching I received is that there is an assumption that truth and reconciliation is about forgiving the government. When you are looking at intergenerational trauma, the child that grows up under the care of parents who attended Indian Residential School needs to be taught their parents' true history. Nurses need to know and understand the impacts of Indian Residential School. That child needs support to understand their intergenerational trauma and to help them with any unresolved trauma and resultant issues in their family. The child/adult needs to know why their family members haven't healed yet.

Open your journal and take a few minutes to reflect on what reconciliation means to you. Write down, draw, say out loud or acknowledge in a way that is meaningful to you, your thoughts and reflections on reconciliation.

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It is important to address, understand, and participate in reconciliation and acknowledge the devastating impact across generations that colonization and policies of assimilation such as the Indian Act had and continue to have on Indigenous People in Canada.

Some of the content in this handbook may bring about unpleasant feelings or thoughts. Everyone has a unique background and lived experience. "This information is intended to acknowledge the culturally unsafe care that exists in the health system and to begin to address it." (2, p0)

What is reconciliation?

> For me, reconciliation isn't about forgiving the government. It's about forgiving my parents.
>
> – Connie Paul RN, Coast Tsartlip/Okanagan Nation

The Truth and Reconciliation Commission's definition of reconciliation is "an ongoing process of establishing and maintaining respectful relationships." (29)

Perinatal Service British Columbia's (PSBC) cultural safety resource, Honouring Indigenous Women's and Families' Pregnancy Journeys highlights, "A willingness to learn, engage with, and reflect on Indigenous history and culture" as being critical in understanding our role in enacting cultural safety and in exemplifying reconciliation. "Colonial interference and defining historical events, such as experiences with residential schools and the Sixties Scoop, have resulted in **intergenerational trauma** among Indigenous families," (3, pix) It is therefore important to build trust, safety and to learn about the community you serve and the people within.

> Accept invitations to community events to learn more about and to build relationship with community members as an important act of reconciliation.
>
> – Lucy Barney, T'it'q'et Nation

We can understand where we are going by understanding where we have been. "It is important for healthcare providers to support Indigenous women to reclaim the traditions and beliefs that supported healthy pregnancies in the past." (3)

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Reflect on how important reconciliation is for the Indigenous people who are receiving care.

– Shanice Ryder, Community Health Nurse, Penelakut Tribe

We encourage you to read the following:

1. Perinatal Services BC (PSBC)'s Practice and Cultural Safety Resource for improved perinatal care, created by aunties, mothers, grandmothers, sisters, and daughters (2021): Honouring Indigenous Women's and Families' Pregnancy Journeys

2. FNHA's Sacred and Strong – Upholding Our Matriarchal Roles: The Health and Wellness Journeys of First Nations Women and Girls Living in BC (2021)

To all First Nations
women and girls.
All of you. You are beautiful.
You are loved. You are resilient.
May you be free from pain and suffering.
May you be safe. May you love yourself.
May you be healthy. May you feel strong.
May you find your roots and feel
grounded, connected, supported.

– Melanie Rivers
Tiyaltelwet, Squamish First Nation [51]

3. Truth and Reconciliation Commission of Canada: Calls to Action (2015) and the Government of Canada's Delivering on Truth and Reconcilation Commission Calls to Action

4. Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care Summary Report (November 2020): *In Plain Sight*

Cultural Safety & Humility and the Perinatal Period

Self-Reflection

What does cultural safety mean to you?

What does cultural humility mean to you?

Open your journal and write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts on cultural safety and cultural humility:

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Was there a Residential School or Day School in the Community you are serving? Whose land are you on? See this web-based app to learn more: whose land am I on

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Cultural Safety & Humility

"As Health Care Providers, we don't know it all." [2, p1]

Cultural safety and humility pieces are woven throughout this handbook. The messaging below scratches the surface of this important topic and is intended to serve as an introduction and to build upon your knowledge of cultural safety and humility. The FNHA website has a wealth of information in both written and visual format on cultural safety and humility and is a great place to explore further.

See the Cultural Safety and Humility section of FNHA's website:
www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/cultural-safety-and-humility

And see the "Client and Family Information Sheet on the British Columbia Cultural Safety and Humility Standard:
healthstandards.org/files/HSO_CSHClientandFamilyInformationSheet_EN.pdf

Cultural Safety

"We have achieved cultural safety when First Nations tell us we have." [2, p2]

Cultural safety is an outcome that comes from respectful engagement that recognizes and addresses the power imbalances in the healthcare system. [77] It creates an environment free of racism and discrimination, one in which people feel safe. [77]

Cultural safety means health care professionals adopt a *humble, self-reflective clinical practice* that positions them as *respectful and curious partners* when providing care, rather than as a figure of higher knowledge and authority. [2]

"Cultural humility and cultural safety in the health system requires health professionals to acknowledge they are always on a journey of learning, and being open to listening to what better care means for First Nations and Indigenous peoples. We all need to acknowledge, **'it starts with me'."** [2, p1]

Cultural Humility

"Cultural humility is a process of *self-reflection* to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on *mutual trust*. Cultural humility involves humbly acknowledging *oneself as a learner* with respect to understanding another's experience." (2, p11)

"When health care professionals engage with First Nations peoples from a place of cultural humility, they are helping to create a safer health care environment where individuals and families experience *respect*." (2, p9)

Please ensure you are familiar with the BCCNM's Indigenous Cultural Safety, Cultural Humility, and Anti Racism Practice Standard (15) as well as the Companion Guide to this practice standard.

Reflection question:

Name the 4 R's of cross-cultural dialogue: *hint – see PSBC's Cultural Safety Resource Honouring Indigenous Women's and Families' Pregnancy Journeys

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Informed Consent

In the context of colonial violence, intergenerational trauma, and Indigenous-specific racism and discrimination, consent and what it means and represents, is a powerful tool of reconciliation as well as a requirement of nursing practice. We encourage you to go beyond the BCCNM's Consent Practice Standard and to reflect on the many themes to which consent is connected such as cultural safety and humility, trauma-informed practice, truth and reconciliation, building relationship and trust, practicing in an anti-racist way and supporting individuals through a Two-Eyed seeing lens.

Here is a tool you could provide to community members who are pregnant. It is a helpful and concise way to support them in navigating important decisions.

The BRAIN acronym – an Informed Decision-Making tool:

(58)

Another important document to be familiar with is the FNHA's Informed Consent for Contraception Decision-Making Guide:

(57)

The following messaging is direct from the FNHA website, see: https://www.fnha.ca/what-we-do/chief-medical-office/informed-consent-for-contraception

Informed Consent for Contraception is a patient-led *shared decision-making guide* that can be used in conversations with an individual about methods of birth control. Its purpose is to help prevent decisions about contraception being made in an acute setting (that is, just before, during or after giving birth) and to ensure the individual's voice is heard and understood.

The guide includes a form that can be used as a checklist for ensuring that consent to a contraception method is informed and has been given freely and prior to the acute setting. Note: This form cannot be used in place of surgical or procedural consent. Surgeries and procedures require a separate consent form as well.

Individual Choice - When it comes to birth control, it is the individual's choice, and the individual's choice alone, which method of birth control they want or whether to use birth control at all.

Where the individual is a part of a group that has been discriminated against, such as First Nations, Métis and Inuit people, the requirements of consent are even greater.

Replacement decision-making (healthcare providers or others making decisions for people), is illegal with respect to methods of birth control. Seeking consent for any form of birth control (including tubal ligation) while an individual is in the peripartum period (just before, during and after giving birth) is medically negligent and unethical.

Background - The coerced sterilization of Indigenous women, both permanent and by long-acting birth-control interventions, is an issue of ongoing concern.

In response to this concern, the Office of the FNHA Chief Medical Officer, in consultation with Senator Yvonne Boyer and Perinatal Services BC created this shared decision-making guide to informed consent for contraception.

The FNHA would like to thank Senator Boyer, Perinatal Services BC, the project team and community members and reviewers for their contributions to the development of this guide.

Shared Decision-Making - The healthcare provider must explain the risks and benefits of the birth control method chosen to the individual before the individual goes into labour and delivery. The person must be given time to consider their options and genuine desires before this period. This is called shared decision-making over time.

Consent cannot be obtained when a person is under pressure, is under the influence of pain medications or sedation, or has suffered a traumatic delivery. A person may withdraw consent at any time.

Practicing in a Trauma-Informed Way

"Trauma involves the experience of an event or series of events or circumstances that are overwhelming, and that has lasting negative effects on one's ability to cope in daily life." (6, p7)

"Supporting First Nations Peoples, families and communities takes more than your nursing degree. Just having the nursing knowledge is not sufficient. Knowing and understanding the root cause of peoples' lived experiences is of the utmost importance. Recognizing that the devastating impacts of colonization are still occurring today is crucial. There is still work to be done."

- Michelle Prince,
FNHA Practice Consultant, Elder Care

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Trauma informed care is a way of being and working. [(5)]

What does this mean?

"Working in a trauma-informed way is not about implementing a rigid set of skills or tasks, but instead ***is a way of being and working daily with all participants*.**

Working in a trauma-informed way ***means to universally provide safety, choice and collaboration with all participants*,** and avoiding approaches that may retraumatize.

It's not necessary for individuals to disclose a history or current experiences of trauma for pregnancy outreach programs workers to support them in a trauma-informed way.

Working in a trauma-informed way *means creating a sense of safety and trust* ***between staff and participants*."** [(5, p7)]

"This way of being requires ongoing education, self-reflection and practice from practitioners." [(5, p7)]

CHNs can provide a safe and welcoming physical environment, obtain informed consent for all decision-making, services and referrals, as well as provide clear expectations and follow through on commitments. By doing this, CHNs will create a sense of safety and trust. [(5)]

Remember it is important to provide choices and to collaborate with individuals who are pregnant in order to identify *their* needs as well as to build upon the pregnant person's skills and strengths. [(5)]

Here is a video (6 min) for health care professionals on the topic of compassion-informed care. It was created by Indigenous Health, Northern Health and the National Collaborating Centre for Indigenous Health (NCCIH) to aid health care practitioners in their ongoing journeys to build respectful relationships with the people whom they serve, particularly Indigenous peoples and Indigenous communities.

Video:

https://www.indigenoushealthnh.ca/resources/videos#compassion-informed-care

For more information and to learn more about trauma-informed practice principles, go to the BCAPOP's Handbook (p.8) at:

https://www.bcapop.ca/resources/Documents/BCAPOP%20Handbook%20Supplement%20Perinatal%20Substance%20Use%20Sep%202019.pdf

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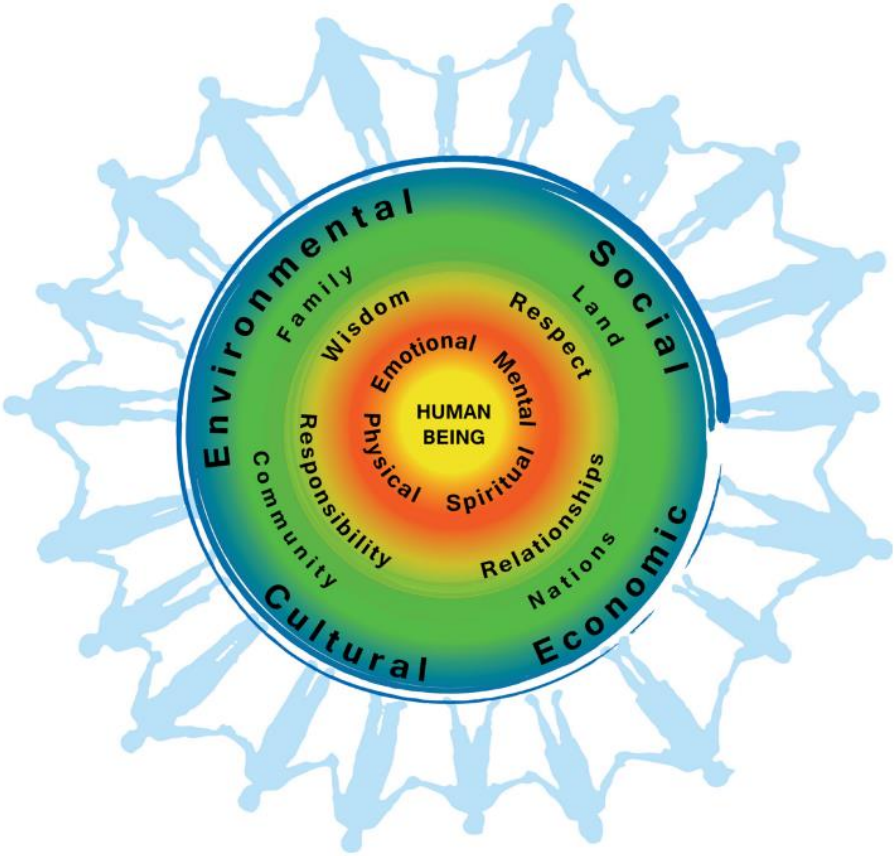
First Nations Perspective on Health and Wellness



"The First Nations Perspective on Health and Wellness articulates a **holistic** vision of wellness. First Nations recognize that good health and wellness starts with every human being and extends outward to include broader social, economic, cultural and environmental determinants of health and wellness. **Colonization interrupts this worldview** and a Western European perspective of health became the dominant lens on which our current health care system is based. It is not possible to build a culturally safe system without this understanding, therefore, **the First Nations Perspective on Health and Wellness is a critical lens for FNHA, First Nations and our health partners**." (2, p8)

The following information is from https://www.fnha.ca/wellness/wellness-for-first-nations/first-nations-perspective-on-health-and-wellness

Centre Circle

The Centre Circle represents individual **Human Beings**. Wellness starts with individuals taking responsibility for our own health and wellness (whether we are First Nations or not). In the context of perinatal health, one could look at the family who is pregnant or parenting as being at the centre of the circle – the individual who is pregnant takes care of their own health which in turn takes care of the fetus' health.

Second Circle

The Second Circle illustrates the importance of **Mental, Emotional, Spiritual** and **Physical** facets of a healthy, well and balanced life. For example, pregnancy may be a catalyst for a person to enhance their mental, emotional, spiritual and physical health – as a CHN, what are some ways in which you can support this?

Third Circle

The Third Circle represents the overarching values that support and uphold wellness: **Respect, Wisdom, Responsibility** and **Relationships**. All other values are in some way essential to the four below:

1. **Respect** is about honouring where we come from: our cultures, traditions, and ourselves.
2. **Wisdom** includes knowledge of language, traditions, culture and medicine.
3. **Responsibility** is something we all have: to ourselves, our families, our communities and the land.
4. **Relationships** sustain us.
   For example, the CHN is **responsible** for being **respectful** and for building **relationships** with community members. In parallel, the CHN also acknowledges the inherent **wisdom** of the people they are supporting while also supporting them in developing their own responsibility of taking on the role of parent, teacher, and/or leader.

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Fourth Circle

The Fourth Circle depicts the people that surround us and the places from which we come. **Land, Community, Family** and **Nations** are all critical components of our healthy experience as human beings. For example, CHNs recognize the importance of family for a person who is pregnant and how they may want family to be present during their labour and birth and throughout their pregnancy journey. There may be birthing ceremonies that involve the land such as placenta burial. There may also be birthing ceremonies that involve the community such as a Baby Welcoming ceremony.

The Fifth Circle

The fifth circle depicts the **Social, Environmental, Cultural** and **Economic** determinants of our health and well-being. These determinants of health have a profound impact on a person's pregnancy and parenting as well as the health of the child. For example, does the family have access to clean water, consistent and safe living arrangements, and healthy houses (eg no mold)? Do they have the ability to buy items such as nutritious food, a crib and a car seat? Ministry of Children and Family Development (MCFD) involvement in a person's life or the fear of their involvement is another example of a situation that can lead to stress. All of these examples and other determinants of health can greatly affect the stress on a family and the health and wellness of and the risk of mortality and morbidity for birther and baby.

Outer Circle

The **people** who make up the Outer Circle represent the FNHA Vision of strong children, families, elders and people in communities. The people are holding hands to demonstrate togetherness, respect and relationships, which in the words of a respected BC elder can be stated as "one heart, one mind." Children are included in the drawing because they are the heart of communities and they connect us to who we are and to our health.

Extended Learning

Think of a few culturally safe and humble questions you could ask the person who is pregnant with whom you are working.

Open your journal and write down, draw, say out loud, or acknowledge them in a way that is meaningful to you.

Example - Are there any traditional beliefs and practices you would like to include in your pregnancy journey?[3] Hint – for more culturally safe and humble question examples, go to Part 1 of the FNHA Prenatal Assessment/Education Form

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Name the 6 practice principles that support culturally safe, humble and trauma-informed perinatal care: *hint – see PSBC's Honouring Indigenous Women's and Families' Pregnancy Journeys

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Before Baby Comes
(The Prenatal Period - 0 Weeks to Birth)

PREGNANCY LASTS ABOUT 40 WEEKS OR 9 MONTHS

0-14 WEEKS
1st Trimester

15-27 WEEKS
2nd Trimester

28 WEEKS TO BIRTH
3rd Trimester

BIRTH TO 8 WEEKS
Post Partum

Self-Reflection

When you first arrive in community, one of the most important things to do is to meet with the community and find out who's who and what services are already offered. Is there a HeadStart program? Is there a formal Maternal Child Health program? Is there a Community Health Representative (CHR)? Is there a Family Worker or Health Support Worker? Are there counsellors in community? Knowledge Keepers? Community Matriarchs? Doulas? Are there any Prenatal Classes? If you're not sure, a great way to start is by meeting with the CHR. The CHR is a trusted local in and from community. This is one of the most important relationships you will have in Community.

_____

_____

How would you describe pregnancy support? Write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts and reflections on what pregnancy support means to you:

_____

_____

When does prenatal care begin? When the urine pregnancy test is positive? When a person misses their period? When a person begins to know that they would like to have children? Write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts and reflections on prenatal care:

_____

_____

Preconception care: "Preconception care is a broad term that refers to the process of identifying social, behavioral, environmental and biomedical risks to a woman's fertility and pregnancy outcome with the goal of reducing these risks through education, counseling and appropriate intervention." (30)

Prenatal care: "Employs risk assessment, health promotion and education, and therapeutic intervention to help ensure the birth of a healthy newborn while minimizing maternal risk." (31)

Preconception care occurs before a person is pregnant and prenatal care occurs once a person is pregnant.

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What can you, the CHN in community, do to support individuals in the time before they are pregnant? What are some ways in which you can provide culturally safe and humble preconception care?

Write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts and reflections on what excellent preconception care means to you:

_____

_____

Perinatal Support (Doulas)

Traditionally, perinatal support has been provided by:

Grandmothers
Matriarchs
Knowledge Keepers
Elders
Mothers
Aunties
Sisters
Daughters and
Doulas

Perinatal support may also be provided by:

Anyone whom the individual seeks out for support and guidance
Partners/Fathers
Community Health Representatives
Prenatal Classes
HeadStart
Health Care Providers
Other pregnancy and birthing support programs in the Community

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Doulas:

(32)

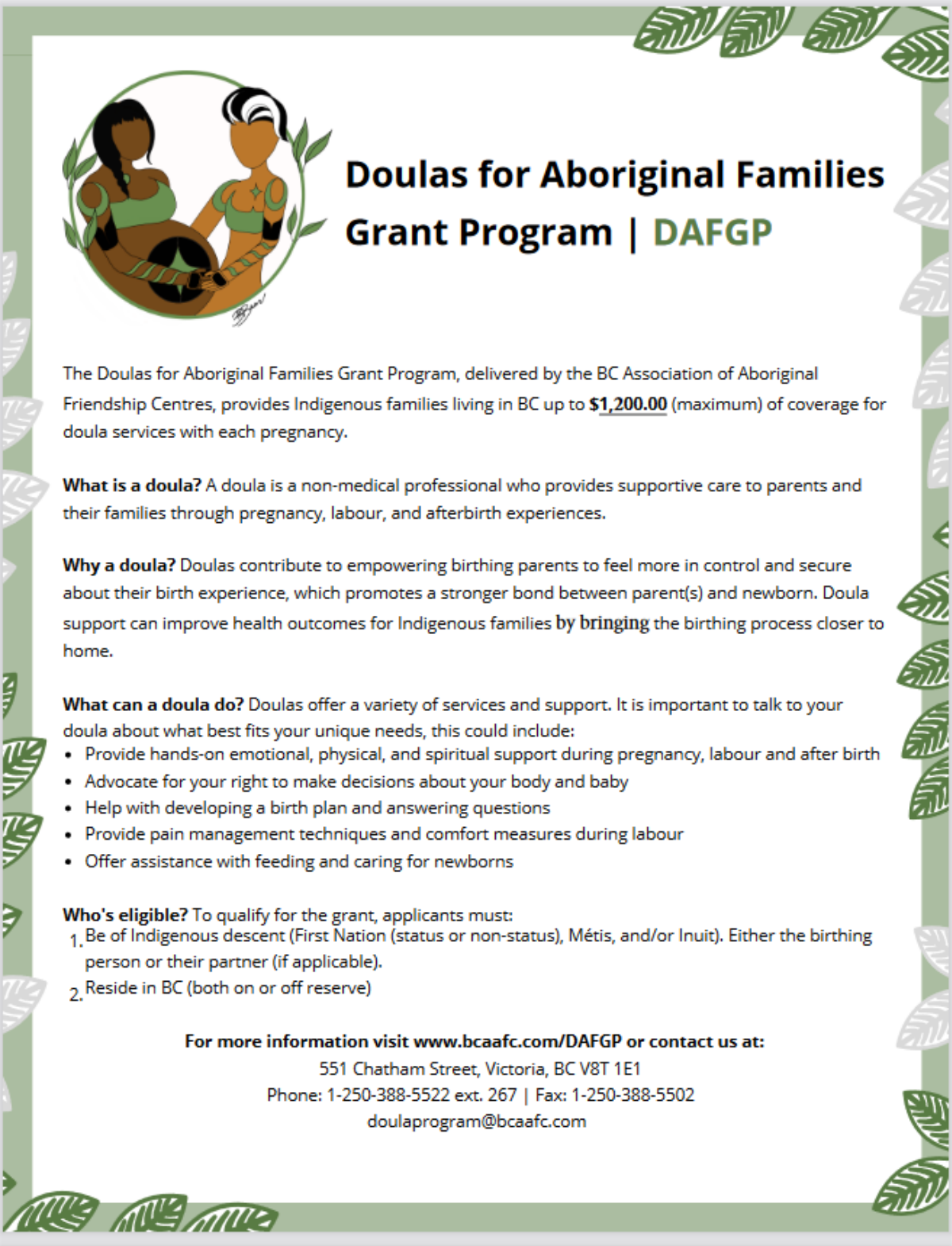
"A doula provides emotional, physical and spiritual support for expectant mothers and their families during pregnancy, labour and the postpartum period. Building on the role of the traditional Aunty, Indigenous doulas / birth keepers can assist in honouring traditional and spiritual practices and beliefs associated with maternity care and support the language and cultural needs of the woman and her family." (32)

There are many doula collectives and services being established around the province. We encourage you to speak with community members as well as your FNHA community health practice consultant and FNHA maternal child health team to learn about who may be providing these services in the community you are supporting. You can also refer to the DAFGP – Doulas for Aboriginal Families Grant Program - website for a list of doulas.

Here is a great video (1 hour) by Miranda Kelly and Lucy Barney, "Looking Back at Our Traditional Roles in Midwifery."

See the Doulas section on the FNHA website for more information as well.

How to access a doula and the funding for a doula:



Doulas for Aboriginal Families Grant Program | DAFGP

The Doulas for Aboriginal Families Grant Program, delivered by the BC Association of Aboriginal Friendship Centres, provides Indigenous families living in BC up to **$1,200.00** (maximum) of coverage for doula services with each pregnancy.

What is a doula? A doula is a non-medical professional who provides supportive care to parents and their families through pregnancy, labour, and afterbirth experiences.

Why a doula? Doulas contribute to empowering birthing parents to feel more in control and secure about their birth experience, which promotes a stronger bond between parent(s) and newborn. Doula support can improve health outcomes for Indigenous families by bringing the birthing process closer to home.

What can a doula do? Doulas offer a variety of services and support. It is important to talk to your doula about what best fits your unique needs, this could include:

- Provide hands-on emotional, physical, and spiritual support during pregnancy, labour and after birth
- Advocate for your right to make decisions about your body and baby
- Help with developing a birth plan and answering questions
- Provide pain management techniques and comfort measures during labour
- Offer assistance with feeding and caring for newborns

Who's eligible? To qualify for the grant, applicants must:

1. Be of Indigenous descent (First Nation (status or non-status), Métis, and/or Inuit). Either the birthing person or their partner (if applicable).
2. Reside in BC (both on or off reserve)

For more information visit www.bcaafc.com/DAFGP or contact us at:

551 Chatham Street, Victoria, BC V8T 1E1

Phone: 1-250-388-5522 ext. 267 | Fax: 1-250-388-5502

doulaprogram@bcaafc.com

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Choosing a Primary Care Provider

The perinatal period can be "particularly challenging for Indigenous Peoples, for whom discrimination, racism, dehumanizing interactions and a loss of autonomy in the healthcare system are everyday experiences" [(3, pvii)]

To practice in a culturally safe way when we support individuals who are pregnant, we must ensure that we are *respectful* of Indigenous Peoples for who they are, that we provide them with information that is *relevant* to and *respectful* of their worldviews, that we encourage *reciprocity* in the patient-nurse relationship and that we empower and enable Indigenous Peoples to be responsible and have agency over their decision-making and health. [(3)]

Choosing a Primary Care Provider (PCP):

- In British Columbia, individuals who are pregnant may choose a Family Physician (General Practitioner) or a Registered Midwife (RMW) to provide perinatal care. [(78)] A Nurse Practitioner (NP) can provide perinatal care for healthy pregnancies for the earlier part of the pregnancy and will transfer care to a Physician or RMW prior to delivery. If the pregnancy is deemed high risk or there is a concern, the Primary Care Provider will refer the individual who is pregnant to an Obstetrician or Perinatologist (physicians who specialize in maternal-fetal medicine).

The importance of developing relationship and partnership with the local health care providers:

- It is important for the CHN to, as best as possible, work closely with the local maternity care providers. For example, for communities near Prince Rupert, all prenatal care is provided by a group of family doctors at the North Coast Maternity Clinic (NCMC) located in Prince Rupert. All individuals who are pregnant go to the NCMC to receive prenatal care. Therefore, it is important to include the NCMC in all communication pathways regarding individuals who are pregnant in the community you are supporting, if you are working in a community near Prince Rupert.

- In rural and remote settings where there isn't a PCP present at all times, CHNs can consult, collaborate and liaise with the Maternity and Babies Advice Line (MaBAL) and other local care providers in order to support individuals who are pregnant to receive prenatal care while remaining in community.

Remember that you must always obtain informed consent first from the person you are supporting prior to consulting with another health care provider.

Indigenous Midwifery

> We are not just about catching babies. We are nutrition. We are breastfeeding. We are safety in remote areas. We are insurance for our young families. (59)
>
> – Carol Couchie

At present in Canada, there are two Community-Based Indigenous Midwifery Education programs and they are in Ontario and Quebec. Although there is not yet a similar program in BC, there are certainly RMWs who are Indigenous and practice the principles of Indigenous Midwifery in BC. See this FNHA news article and the National Aboriginal Council of Midwives for more information.

"An Indigenous midwife is a committed primary health care provider who has the skills to care for pregnant people, babies, and their families throughout pregnancy and postpartum."

Indigenous Midwives: (59)

- Are knowledgeable about all aspects of women's sexual and reproductive health
- Provide education that helps keep the family and the community healthy
- Promote breastfeeding, nutrition, and parenting skills

An Indigenous midwife is the keeper of ceremonies, a leader and mentor, and someone who passes on important values about health to the next generation.

Why Indigenous Midwifery Matters

- Indigenous midwives have specific core competencies.
- We respond to needs that are unique to Indigenous peoples.
- We bring birth back to communities.
- We enable a reduction in the number of costly medical evacuations for birth in remote areas.
- We maintain and restore our traditional ways.
- We advocate that all Canadians have universal and equitable access to healthcare, specifically sexual and reproductive health.

Resurgence of Indigenous Midwifery

Indigenous communities across Canada have always had midwives. Indigenous midwives were once a cornerstone of every Indigenous community.

"It has only been in the last hundred years that this practice has been taken away from our communities. This occurs as a result of colonization and ongoing systemic racism in the Canadian health care system. As a result of losing midwifery, important leadership in the health care delivered to Indigenous communities and families was lost. Access to primary care around maternity and maternal-child care was compromised. This has had a devastating impact both on the preservation of culture and on maternal and newborn health outcomes in Indigenous communities across Canada.

Despite this, there are Indigenous midwives practicing in communities across Canada. Increasing the number and capacity of Indigenous midwives fulfills the Truth and Reconciliation Commission's Calls to Action to recognize the value of Indigenous healing practices, and to increase the number of Indigenous professionals working in the health care field." [(59)]

See National Aboriginal Council of Midwives for more info:
https://indigenousmidwifery.ca/indigenous-midwifery-in-canada/

And see Midwives Association of British Columbia for more info including how to find an RMW: https://www.bcmidwives.com/indigenous_families.html

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Options (Parenthood, Adoption, Kinship Care, Abortion)

It is important to always first explore how the individual is feeling about taking a pregnancy test, finding out they're pregnant, or their pregnancy in general. Pregnancies may be happy news, overwhelming news, unintended or unplanned news. Some individuals may feel unsure or ambivalent toward finding out they're pregnant while others may feel certain they want to, or don't want to, continue with the pregnancy. The following information is intended to give a brief overview of the options a person has when they are pregnant. Your role as the CHN is to ensure that the individual you are supporting is aware there are options and that you will support them and their decision.

There are options:

1. **Parenting** – Continuing with the pregnancy, giving birth and raising the child.

2. Abortion – Taking a medication or having a medical procedure to end the pregnancy.

   See abortion under 'Loss in Pregnancy' in this Handbook

3. **Adoption** – Continuing the pregnancy, giving birth and placing the child with another family/individual permanently.

4. **Kinship care** – Continuing the pregnancy, giving birth and placing the child with a family member (grandparent, aunt, uncle, older sibling) or someone else who has an established relationship or cultural connection to the child and family. Kinship care can be temporary or permanent. For more information see: https://www2.gov.bc.ca/gov/content/family-social-supports/fostering/temporary-permanent-care-options

The Pregnancy Options Line 1-888-875-3163 throughout B.C., offers a confidential phone line to support people in BC who are experiencing an unintended or unplanned pregnancy. Short-term telephone counselling is provided as an option as well as current information regarding services available in community.

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Providing Prenatal Care

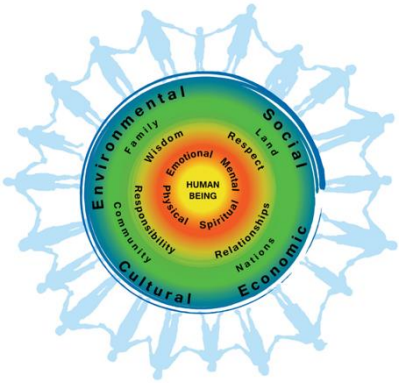
Culturally safe and humble care, harm reduction, reconciliation and decolonization all start with relationship building. Relationships are underpinned by trust, honesty, understanding, teamwork, humour and laughter. [(1)]

Providing prenatal care is the perfect ongoing opportunity to build relationship. In healthy pregnancies, individuals who are pregnant should be seen once every 4 weeks in the first and second trimesters and then every 2 weeks in the third trimester until closer to the due date whereupon they should be seen once per week. The document "Prenatal Education and Assessment form ('the checklist') is discussed shortly and provides further guidelines on how often a person who is pregnant should be seen during the prenatal period.

The following is a list of areas of care that are a part of providing prenatal care:

The Whole Person – Mental, Emotional, Spiritual and Physical Wellness

Thinking back to the First Nations Perspective on Health and Wellness, let's look more closely at the centre and second circles.



Centre Circle

The Centre Circle represents individual **Human Beings**. Wellness starts with individuals taking responsibility for their own health and wellness.

Try to use as many open-ended questions as possible when supporting an individual:

Initial visit – Introduce yourself: "You can call me (name) and my pronouns are (they/their; she/her; him/his), it is important to me that this is a safe and welcoming environment. Is there anything important I should know about your name or gender identity? For example, how you prefer to be addressed, your pronouns or how to refer to body parts?"

Name and pronouns are important, but only one part of gender and sexual identity. By starting with these questions, the goal is to create a safe space for the individual to lead the conversation and disclose to the extent they are comfortable doing so. Please ensure the individual's name, pronouns and preferences are in an easy-to-read place within the chart so that other health care providers don't repeat the same questions or even worse, misgender or cause harm.

In the case of making a mistake, see Appendix H – Two-Spirit, gender-affirming, gender-diverse, and non-binary resources for an excellent poster from Trans Care BC on how to remedy mistakes because we all make mistakes time to time.

Any visit – "Tell me about your health and wellness."

This may seem like too broad of a question, however the open-ended nature provides an opportunity for the individual to direct the conversation toward their health and wellness goals and priorities.

- E.g. – "Tell me about some of the ways in which you look after your mental/emotional/spiritual/physical health."
- E.g. – "What is important for you today in your pregnancy journey?"
  This helps you to understand the person's priorities and focus.
- E.g. – "Is there anything that is concerning you today or do you have any questions?"
  This helps to set priorities for the appointment.

Second Circle

The Second Circle illustrates the importance of the **Mental, Emotional, Spiritual** and **Physical** facets of a healthy and balanced life.

Here are a few examples of questions you could ask:

- Tell me about your mental/emotional spiritual/physical health.
- Tell me about what is on your mind today.
- Tell me about your circle of support.
  These will be the people who can assist the individual. They will also be the people whom you could offer to support with information on pregnancy, birth etc. - if the individual is interested and consents.
- Do you have people you trust and with whom you can talk?
  This assists you in knowing how to support the person. Are they alone? Well supported?

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The FNHA has created a **video series** that aims to support life-givers and their families before and after the sacred ceremony of birth.

In the following videos, Elders and Knowledge Keepers share traditional teachings along with messages and words of encouragement for expectant parents.

The series is introduced by Toni Winterhoff (Ey Claney). A member of Xa'Xsta (Douglas) First Nation, living and working on Sto:lo Territory, Toni is also a healthy children specialist at the FNHA.

The series features videos from:

- **Gwen Therrien** (Malihatkwa), Xa'Xsta (Douglas) First Nation. A traditional healer, Gwen is also a published author and an Elder-in-Residence at Health Canada's Iskotew Lodge (Gwen's video, 5.03 mins)
- **JC Lucas**, Nuu-Chah-Nulth First Nation (JC's video, 9.29 mins)
- **Lucy Barney**, T'it'q'et First Nation. Lucy is a retired Registered Nurse with a Master of Science in Nursing. She has worked in many roles including cultural advisor in Patient Experience at the FNHA and Indigenous Lead at PSBC. (Lucy's video, 6.20 mins)
- **Marguerit James**, Penelakut Tribe (Marguerit's video, 3.57 mins)
- **Wendy Ritchie** (Thetsimya), Skowkale First Nation. A matriarch in her nation, Wendy is also a Traditional Wellness Specialist in the FNHA Fraser Salish Team (Wendy's video, 2.44 mins)
- **Toni Winterhoff** (Ey Claney) is a Xa'xsta member living and working on Sto:lo territory. Toni works at the FNHA as a Healthy Children Specialist (Toni's video, 7.29 mins)

FNHA Prenatal Assessment/Education Forms ('Prenatal Checklist')

The prenatal assessment and education forms are a set of documents to guide you through supporting people who are pregnant. There are two versions - one for nursing stations and one for health centres. The forms can be used as a reference and documentation tool.

There are 2 Parts to the Prenatal Assessment/Education forms and they complement each other:

1. **Part 1 -** Provides a comprehensive assessment of an individual's emotional, mental, spiritual and physical health. It also provides a detailed list of educational topics to discuss with an individual in the form of open ended questions.

2. **Part 2 -** Is a quick reference checklist for health care providers as to when certain activities or procedures are recommended throughout the pregnancy.

The following two graphics are examples of the first page for Part 1 followed by the first page for Part 2 for health centres. You can find both the health centre and nursing station forms on Gathering Space (GS) at under 'General Assessment': https://partners.fnha.ca/sites/HomeandCommunityCare/Prenatal_Clinical_Resources/Forms/Document%20Type1.aspx

(For assistance with gaining or re-gaining access to GS, see How to Use the Handbook)

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First Nations Health Authority
Health through wellness

Prenatal Assessment/Education Forms - Part 1 & 2: Health Centres

Final: March 12, 2020.

Client name or identifier #_____ **Updated (partial) April 27th, 2021**

Small page numbers at the end of some sentences – they link to information in the reference page section of this document-pg 9-20.

Topic: *Questions / statements to help guide assessing the specific topic and to learn the person's goals, priorities, concerns, knowledge.*	**Date discussed**	**Client and/or nurse's comments:** *if you need to write detailed comments, and/or if there needs to be follow-up with the client, your usual charting systems should also be used.*	**Signature**
General: (could be asked >1 time)			
What is important for you today, in your pregnancy journey? *(helps you understand her priorities and focus)*			
How did you feel when you realized you were pregnant? *(assists you in knowing how to support her)*			
Is there anything that is concerning you today or do you have any questions? *(again to set priorities for the visit)*			
Do you have traditional/cultural customs that are important to you that would be helpful for me to be aware of? *(purpose of asking is to assist you in supporting her during her pregnancy journey)*			
Who is in your circle of support? *(people that can assist her, that you can also offer to educate about pregnancy, birth etc. - if client is interested/agrees)*			
Do you have people you can talk with and trust? *(don't need names, purpose is to assist you in knowing how to support her: is she alone, well supported)*			
What pregnancy stories have you heard about? *(support the positive and explain any concerning stories – remember to acknowledge/factor in cultural beliefs)*			
What support services are you aware of that can help support you during the pregnancy? *(is she aware of services in community, nearby, apps for phone)*			
Choices in pregnancy and birth: place of birth, type of health care professionals			

The forms can be found here under 'General Assessment': https://partners.fnha.ca/sites/HomeandCommunityCare/Prenatal_Clinical_Resources/Forms/Document%20Type1.aspx

First Nations Health Authority
Health through wellness

Prenatal Assessment/Education Forms - Part 1 & 2: Health Centres

Final: March 12, 2020.
Updated (partial) April 27th, 2021

Client name or identifier #_____

Part 2 Prenatal Checklist

See the reference pages 9-20 for the details on the use of the updated checklist.

Name:	Gravida: Term: Preterm: Abortion: Living:
DOB:	LMP: Confirmed EDD[1]:
Age at delivery:	Risk Factors:
☐ Low Risk ☐ High Risk (HR)	**Planned transfer date to Birthing Community[2]:** (town where client will give birth) _____(date & location) (Low risk: 36-38wks, high risk: as per MD/NP)

Prenatal Visit (date)	Prenatal Checklist Part 2: Recommended Prenatal Care (Health Centres) Health Centres: generally clients will be seen by their MD/NP/midwife for the activities listed below. Some health centres may provide some of these tests. This list can be used by CHN's to guide discussions with clients and inform them of timing of activities.	Signature and date Signature reflects a discussion
Initial CHN Visit: _____ **1st Trimester MD/NP Visit:** _____ **12 wks:** _____	☐ Discuss dating ultrasound (at 8-13 weeks) with clients. It would be ordered by their MD/NP/midwife (HCP). Assist with booking appointment as needed. ☐ Point of care blood glucose test early[3] prn (1st visit) _____ (check for undiagnosed diabetes) ☐ Genetic screening[4]: has client received information from their HCP? _____ is further counselling needed? _____ follow up discussion and/or connect with appropriate person____ ☐ Discuss timing of prenatal Genetic Screening[4] to clients who choose to have the tests: SIPS #1 at 9-13+6 weeks (between 10-11+6 best time), SIPS#2 later –see next page. ☐ Review and/or discuss health history (any information that may influence overall health in pregnancy). Physical examination may be provided (or parts of one) by some CHN's in some communities (note: pelvic exam during pregnancy only by MD/NP/midwife[5]) ☐ Lab work: recommended lab work at beginning of pregnancy (ordered by HCP): CBC, TSH, HBsAg, HIV, STS[6], Rubella titre, blood ABO group, Rh status, antibody screen[6] urine C&S Some other tests may also be ordered as needed: FPG, Hep A, B & C if at risk, Ferritin if risk for anemia. varicella antibody if history uncertain Tests that MD/NP/midwife will/maybe completing: swabs for Chlamydia/Gonorrhea [5] vaginal exam[5], pap test[5] (only if due/needed) ☐ Recommend and provide prenatal vitamins/folic acid 0.4-1mg per day[7 & 17] ☐ Discussion/assessment/support related to substance use[8] (e.g. TWEAK screening tool) ☐ Review immunization history ☐ Recommend and offer inactivated influenza vaccine prior to and during flu season ☐ Ensure client aware of programs in community related to pregnancy ☐ Discuss/review educational topics for early pregnancy – see prenatal education section ☐ Introduce discussions related to mental health and well being. As appropriate, screening for anxiety, depression, stress[9, 12]	

p.1

https://partners.fnha.ca/sites/HomeandCommunityCare/Prenatal_Clinical_Resources/Forms/Document%20Type1.aspx

First Nations Health Authority
Health through wellness

Prenatal Assessment/Education Forms - Part 1 & 2: Health Centres

Final: March 12, 2020.

Client name or identifier #_____ **Updated (partial) April 27th, 2021**

Prenatal Visit (date)	Prenatal Checklist Part 2: Recommended Prenatal Care (Health Centres) Health Centres: generally clients will be seen by their MD/NP/midwife for the activities listed below. Some health centres may provide some of these tests. This list can be used by CHN's to guide discussions with clients and inform them of timing of activities.	Signature and date Signature reflects a discussion
2nd Trimester MD/NP Visit: _____ **16 wks:** _____ **20 wks:** _____	☐ Prenatal Genetic Screening[4] – SIPS #2 at 14-20+6 weeks (ideally 15 weeks for remote) ☐ Discuss HCP recommending a detailed ultrasound at 18-20 weeks. Do they need assistance with transportation? ☐ Discuss/review educational topics for mid pregnancy – see prenatal education section ☐ Point of care blood glucose prn[3] (e.g. not done 1st trimester, if signs/symptoms, concerns) ☐ Each visit 2nd trimester assess and/or discuss that HCP will be assessing at each visit: BP, weight, urine, fetal heart rate, fetal movement[10] ☐ Discuss/review educational topics for mid pregnancy – see prenatal education section	
24 wks: _____	☐ Discuss the recommendation for Gestational Diabetes Screening[11] at 24-28 weeks ☐ Discuss the recommendation for bloodwork: ABO group, Rh D status, ABO screen[6] 26-28 weeks prn (HCP would provide requisition) ☐ Discuss fetal movement[10] at 26-32 weeks ☐ Assist as needed receiving MD/NP orders for date of transfer to birthing community ☐ Assist as needed with letter to patient travel confirming date of transfer to birthing community ☐ Potential assessment of: BP, weight, urine, fetal heart rate, fetal movement[10] ☐ Discuss/review educational topics for mid pregnancy – see prenatal education section	
3rd Trimester MD/NP Visit: **28 wks:** _____ **30 wks:** _____ **32 wks:** _____ **34 wks:** _____ **36 wks:** _____ **37 wks:** _____ **38 wks:** _____ **39 wks:** _____	☐ Edinburgh Postnatal Depression Scale screening[12] Screening recommended for all women at 28-32 weeks. + Anxiety to be assessed with this tool- see pg 14 & 16 # 9, 12. ☐ Ensure client who is Rh negative (and un-sensitized), is aware that RhoGAM[13] is recommended at 28 weeks. Client may need information and/or assistance with travel. RhoGAM would be given by HCP or at local hospital. ☐ Discuss that their HCP may recommend a repeat CBC (it should be coordinated with repeat Rh antibody screen if required) ☐ Discuss the Tdap vaccine[14]. The vaccine is now publicly funded for everyone. ☐ Confirm plans for transfer of care and traveling out for birth ☐ Discuss/review educational topics for mid-end pregnancy – see prenatal education section ☐ Each visit 3nd trimester assess and/or discuss that HCP will be assessing at each visit: BP, weight, urine, fetal heart rate, fetal movement[10] ☐ Discuss the recommendation for a vaginal-anal swab for Group B Strep screening[15] at 35-37 weeks (would be completed by HCP) ☐ Discus the recommendation for suppression therapy for women with history of recurrent HSV[16] (would be prescribed by HCP). ☐ Discuss timing of transfer to birthing community[2] - low risk: 36-38 wks; high risk: as per MD/NP	

Please refer to pages 9-20 for information on the topics identified with a reference number.

p.2

https://partners.fnha.ca/sites/HomeandCommunityCare/Prenatal_Clinical_Resources/Forms/Document%20Type1.aspx

Here are some suggestions for relationship building:

> **"I find it best to follow-up with individuals about a week after their appointment with their Primary Care Provider (Family Physician, Midwife, Nurse Practitioner). I usually make a phone call and ask how their appointment went. I ask if they felt that all of their questions were answered and if their concerns were addressed. I then ask if any additional questions or concerns have come up for them since their appointment."**
>
> – Shanice Ryder, Community Health Nurse, Penelakut Tribe, Hulitun Health Society

Immunizations and Pregnancy

Vaccines are an important part of a healthy pregnancy. They help protect both birther and baby against serious diseases.

Some diseases are particularly harmful to people who are pregnant and their babies and can cause birth defects, premature birth, miscarriage, and death. Many of these diseases can be prevented through vaccination.

For example, regarding the Tdap (tetanus, diphtheria, acellular pertussis) vaccine:
"Pertussis is an endemic and cyclical disease in BC that disproportionally affects infants less than 1 year of age. Lack of maternal immunity increases an infant's susceptibility to infection, both by increasing the risk of disease in the mother (and subsequent transmission to the infant) and by not providing sufficient passive protection through antibody transfer (via the placenta or via breast milk). Infants who have not initiated vaccination or completed the primary series of pertussis immunization are at highest risk for pertussis complications, including hospitalization and death. **Tdap vaccination in pregnancy provides passive protection to infants until they are able to receive the 1st dose of pertussis-containing vaccine at two months of age**." (62, p2)

See Appendix G Immunizations and Pregnancy for key messages, supports, resources and specific information on immunizations and pregnancy.

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Physical Assessment

Performing a physical assessment will depend on your scope, your competence, expectations of your role in the health care setting in which you are working and resources/equipment available. Please review Role of the CHN in Perinatal and Child Health.

Physical assessment for individuals who are pregnant typically includes:

- An initial head-to-toe physical assessment in order to give you a baseline and to catch any red flags.
- Detailed health history as per the PSBC antenatal record parts 1 + 2.
- Focused gastrointestinal assessment every visit.
- Vitals with particular attention to blood pressure (see below).
- Urine dip, weight, fundal height, fetal heart rate as per the PSBC antenatal record parts 1 and 2.

Blood pressure (BP) [8]

- Any elevation in BP compared to the individual's "normal" BP, should be closely monitored and reported to their Primary Care Provider (PCP).
- Assess for other signs and symptoms of pre-eclampsia. https://www.healthlinkbc.ca/pregnancy-parenting/pregnancy/risks-and-complications-during-pregnancy/pre-eclampsia

Urine dip [8]

- Urine is tested for protein – elevated levels can be a sign of pre-eclampsia or it may indicate kidney disease. Assess for other signs and symptoms of pre-eclampsia. Discuss any abnormal results with Primary Care Provider as soon as possible.
- Urine is tested for ketones. Elevated levels could indicate Diabetic Ketoacidosis (DKA) or lack of adequate nutrition or caloric intake. Check blood sugar to gain more information and discuss abnormal levels with the PCP as soon as possible. If the individual has diabetes you could also discuss any abnormal levels with the other people providing diabetes care such as a diabetes educator etc.

Weight [8]

- It is important to approach, assess and discuss this topic with sensitivity as the purpose is not to cause shame or guilt but rather to support a healthy pregnancy.
- By assessing weight over the pregnancy, we can see if there is a gain or loss in weight or no change. A rapid weight gain might mean there is more than one fetus (multiple gestation) or maybe there is fluid retention secondary to pre-eclampsia or diabetes. If there is no or little weight gain, there may be issues with nausea and vomiting, inadequate nutrition secondary to food insecurity or a growth restriction.

- See HealthLink BC's file on Pregnancy: Healthy Weight Gain
- See PSBC's Healthy Weight During Pregnancy

The following physical assessment pieces won't be applicable to all CHNs. For example, a CHN in a health centre likely will not be palpating the fundus, performing Leopold's Maneuvers or listening to baby's heartrate with a Doppler because the PCP will be responsible for this. These types of assessments are more common for nurses working in a nursing station. However, like any assessments completed by a nurse, you would only perform them if you have the knowledge, skills, competency to do so and it is within the scope of your role as determined by your job description. Please review Role of the CHN in Perinatal and Child Health

Fundus

Symphysis-fundal height (SFH) measurements are important to have throughout the pregnancy in order to help determine if the pregnancy is progressing in a healthy way.

Performing Leopold's Maneuvers will help in measuring fundal height as well as assisting in determining the best spot to place the Doppler to listen to the baby. Discuss with the individual first what the procedure will consist of and always keep in mind the individual's level of comfort. For example, do they prefer to keep their clothing on and to move it out of the way when the CHN places the Doppler or would they like a sheet or blanket/towel with which to cover themselves? Ask them where they feel the baby kick the most. Allow them to feel what you are feeling. If their partner is with them, involve them too (so long as the individual who is pregnant has consented to that).

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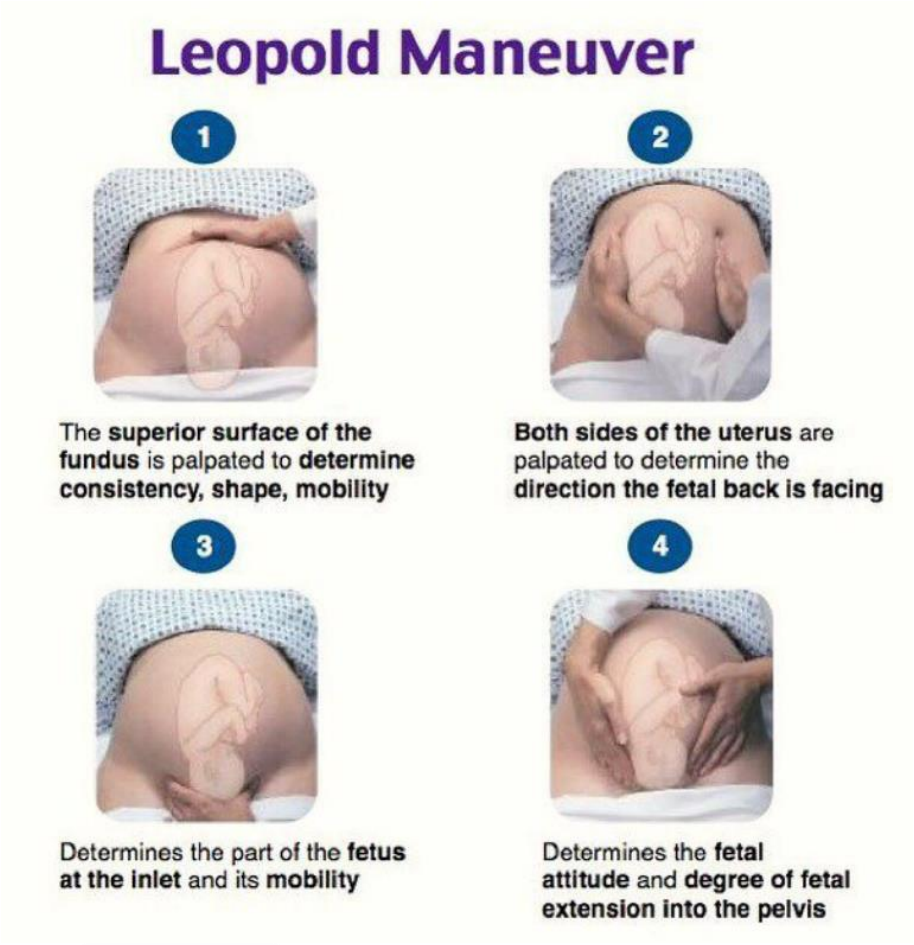
Leopold's Maneuvers

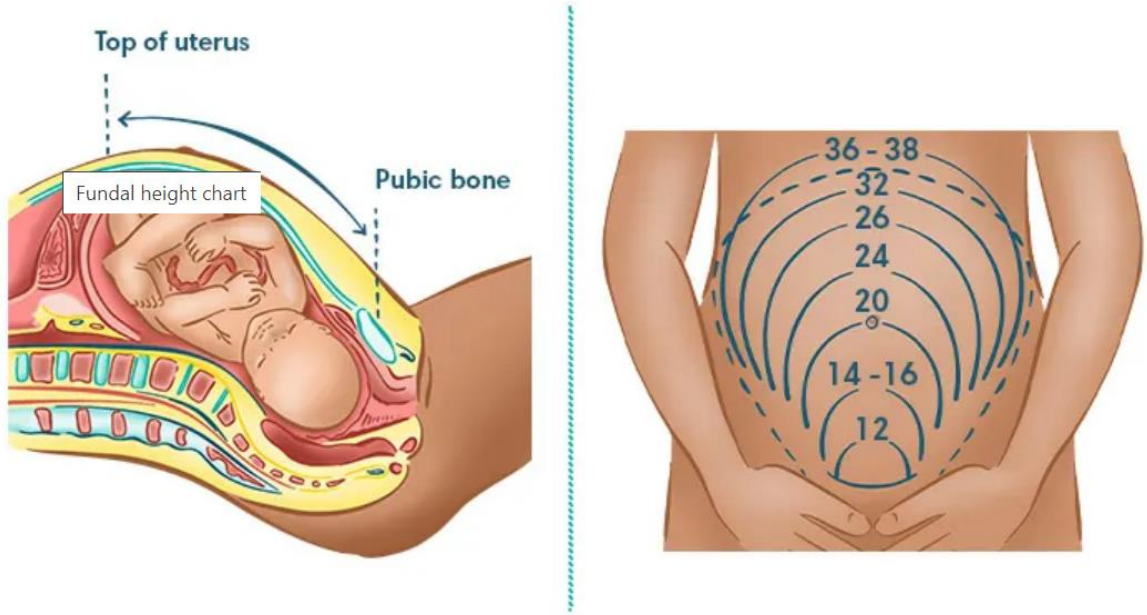
- *Explain the procedure and obtain verbal consent*
- *Ask patient to empty her bladder*
- *Position patient as shown in the picture*
- *Ensure patient is comfortable and well relaxed before starting the maneuvers*

How to position the patient for performing Leopold maneuvers



The 4th maneuver is advanced and typically not performed by CHNs when providing routine prenatal care in community.

Measuring symphysis-fundal-height (Leopold's Maneuver #1 will have helped you determine where the fundus is):



Now that you know how to perform Leopold's Maneuvers and have found the baby's back, this is the spot to place the Doppler to listen to baby (ensure a few drops of Doppler gel are placed first).

Fetal Heart Rate and Fetal Movement [(8)]

Fetal Heart Rate (FHR):

- Normal: 110-160 beats per minute (bpm), regular rate, accelerations may be heard. If no accelerations are heard, baby could be sleeping.
- Abnormal: rate less than 110bpm or greater than 160bpm, changing FHR baseline, decelerations and/or an arrhythmia heard
- If there are any concerns with what you are hearing – contact the PCP. If unable to contact the PCP, consult with MaBAL
- Fetal movement is expected, normal and healthy.
- Around 18-20 weeks, baby's movements can be felt (kicks, rolls, flutters). Some people, especially if second or greater pregnancy may feel movement earlier (13-16 weeks).
- Fetal movement should not decrease or stop when the pregnancy is close to term, but because the baby is much bigger the type of movement or the way it is felt might change. Every baby is different and the client knows their baby and what is normal for that baby.

Fetal Movement Count (FMC) [9]:

Counting fetal movements is also a great way to connect with baby while in the womb. FMC encourages the person who is pregnant to be aware of their baby and it helps to foster connection. They may notice that baby becomes active after a glass of apple juice or perhaps they notice that their baby tends to take a nap around the same time each day.

Here is a patient handout from VCH regarding fetal movement counts:

What does fetal movement count mean?

A fetal movement count is the number of times the baby moves during a given period. Babies do not move constantly. Babies normally sleep for 20–40 minutes and usually not more than 90 minutes, then wake up and move around. One way to check on your baby's health before birth is to count the number of times he or she moves for a certain period each day. You may start this as early as 26 weeks or 6½ months pregnant.

You can feel movement as the baby pushes against the wall of your uterus (womb). You can also feel the baby move by placing your hands on your abdomen. Sometimes you can see a ripple or little bump on your abdomen when the baby changes position. Some women describe the movements as "rolling,: "stretching," or "pushing."

Why are we counting baby's movements?

An active baby is usually a healthy baby. These movements can be a reassuring sign of your baby's health before birth and give valuable information to you and your caregiver about your baby's continued well being. The movements will change in pattern and sensation as the baby grows, but they should not stop all together.

Follow these directions for this simple, important test of your baby's health.

- It is recommended that you count your baby's movements in the early evening as studies show an increase in baby movements at that time.
- Position yourself in a side lying or semi-reclined position with your hand on your belly.
- Note the time the counting started on the chart.
- Count distinctive baby movements until a count of 6 is reached (can take 1 to 2 hours).
- Note the time taken to reach a count of 6 movements.
- Use the record chart on the back of this handout to record the movements.

Baby's movements are usually in clusters or episodes. Each cluster or episode must be followed by a pause of half a minute or more with no movement, before a second cluster or episode of movement can be recorded.

What if your baby does not move or moves only a little?

- **If there are still less than 6 movements in 2 hours, call your doctor or midwife or the hospital where you are giving birth, as soon as possible and ask for the birthing unit.**

There are other ways to check the health and well being of your baby. For example the nurse can monitor the heart rate pattern over time. This is called a non stress test (NST), or fetal surveillance.

VCH Parenting Website

This is Vancouver Coastal Health's one-stop website for information on pregnancy and caring for children from birth to age five. Visit the "Kick Counting" section for more information on Fetal Movement Count.
http://parenting.vch.ca/

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Oral Health

Oral hygiene and dental check-ups are an important part of care during pregnancy. Preventing and treating tooth decay and mouth infections can help the development and oral health of the baby. Research shows there may be a link between dental diseases and having a pre-term or low-birth weight baby. Changing hormones may cause gums to swell, bleed more easily and feel irritated. It is recommended to have regular dental check-ups during and after pregnancy. (12, p5)

Be sure to discuss with the individuals you are supporting ways to enhance oral health such as eating a balanced diet, limiting sweet drinks and sticky snacks, ensuring their calcium intake is adequate and that they are taking prenatal vitamins. All of these things help both the person who is pregnant as well as the health of their baby including the health of baby's teeth as they begin to form at 5-6 weeks gestation.

The FNHA Children's Oral Health Initiative (COHI) webpage has excellent information and resources: https://www.fnha.ca/what-we-do/maternal-child-and-family-health/childrens-oral-health-initiative **such as:**

- **Oral Health 101 – a Guide** https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Healthy-Eating-101.pdf
- **Pregnancy and Oral Health poster** https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-COHI-Pregnancy-Oral-Health.pdf

Estimating Date of Delivery

Estimated date of delivery (EDD) [7] – The EDD is 280 days from the first day of the last menstrual period (LMP) and 266 days from the date of conception. Only 4 percent of women deliver on their EDD partly because of current limitations of methods used, but also because of normal variation of intrauterine growth and timing of spontaneous delivery.

Naegele's rule [7] — Naegele's rule is the most common method of pregnancy dating. The EDD is calculated by counting back three months from the LMP and adding seven days. As an example, if the LMP is February 20, then the EDD will be November 27.

- LMP = February 20
- Count back 3 months = Feb 20 > Jan 20 (1 month) > Dec 20 (2 months) > Nov 20 (3 months)
- Add 7 days = Nov 20 + 7 days = November 27

If the LMP is May 28, then the EDD will be March 4. Naegele's rule assumes a 28-day menstrual cycle with conception happening on day 14.

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Prenatal Care and Adolescents/Youth

Prenatal care for adolescents and youth include additional considerations in order to ensure their wellbeing. For example, there may be additional advocacy, assessment and referrals needed in order to support youth in pregnancy such as supporting increased nutritional needs and food security, supporting youth in their education journey and understanding the legal position of youth.

Nutrition, Puberty and Growing a Baby

Adolescents are growing, starting puberty and experiencing body and mood changes. Add to this the increased nutritional needs of an individual who is pregnant and it becomes additionally important to ensure the individual is nutritionally supported and food secure. For example, "anemia and iron deficiency are more common among adolescent girls due to menstrual bleeding and for others, due to insufficient iron intake." [(33)] The youth you support may require additional advocacy, support and follow-up to receive ongoing assessment of serum iron levels as well as access to and consistent use of iron supplements and iron rich foods. As a CHN, you may be able to support a youth to recognize the importance of consistently taking their iron supplements. You could provide information on nutrition and iron rich foods (see Baby's Best Chance p.17). By building rapport and relationship, you may also be able to support them in ensuring they receive the required assessments and bloodwork, such as serum iron levels, throughout their pregnancy.

See the Nutrition and Food Safety section in this handbook for more information on the Prenatal Nutrition Program and supporting food security.

See the Prenatal Assessment and Education Forms section of this handbook for more information on when to advocate for or help to support an individual to receive further bloodwork testing for iron levels and potential iron therapy.

Community Supports

Youth who are pregnant may require or benefit from additional community supports. Is the youth aware of the supports that are available in community? These may include educational support such as school counselling, virtual learning or take-home-homework-packages, nutritional support such as the Prenatal Nutrition Program, or financial support such as social assistance through the Band Administration office. Find out if there is a HeadStart or a Youth Centre in community as these may provide additional supports.

We recommend connecting with the local Community Health Representative and Health Director to learn about what community supports are available for youth in pregnancy within the community you are working.

Well-Being

We know that during adolescence, the prevalence of depression can be twice as great in those who identify as girls than those who identify as boys. [33] We also know that many body and mood changes come with pregnancy as well as strong emotions and feelings. There could be changes in social, recreational and sports activities and even possible isolation from friends and family. Therefore you as the CHN should be ready to provide additional support to youth in pregnancy in terms of mental health and wellness and overall well-being. This could include booking weekly appointments to check-in, and supporting the youth in making a social support plan including phone numbers and virtual contacts for mental health and wellness supports.

See the First Nation's Perspective on Health and Wellness section of this handbook for more information on all of the aspects First Nation's health and wellness.

See the following for more information:

- BC Government's Young Parent Program
- World Health Organization's fact sheet on adolescent pregnancy for stats and figures.
- Canadian Paediatric Society's position statement on meeting the needs of adolescent parents and their children.
- Government of Canada's information for Teen Pregnancy – Information for Teens webpage.

Relationship and Sex Positivity

There are many helpful resources to support youth in pregnancy regarding relationship safety, dating, safer sex, STI screening and sex positivity as follows:

- Nurturing Spirit with Safe Sex by Dr. Unjali Malhotra, FNHA Medical Officer, Women's Health
- Sexual Health Toolkit by National Aboriginal Health Organization
- Sexual Safety by BC Children's Hospital's The Foundry
- Dating by BC Children's Hospital's The Foundry

The Infants Act and Mature Minor Consent
It is important to always keep in mind the legal position of children under the age of 19.

"The Infants Act states that children may consent to a medical treatment on their own as long as the health care provider is sure that the treatment is in the child's best interest and that the child understands the details of the treatment, including risks and benefits. It is up to the health care provider to assess and ensure the child's understanding of the treatment." [(34)]

A child who is assessed by a health care provider as being capable to give consent is called a "*mature minor*". [(34)] A child who is a mature minor may make their own health care decisions independent of their parents' or guardians' wishes. In BC there is no set age when a child is considered capable to give consent. [(34)]

Legal age of consent for sexual activity in Canada [(35)]
In Canada, the legal age of consent for sexual activity is 16 years [(35)] In some cases, the age of consent is higher (for example, when there is a relationship of trust, authority or dependency).

There are two close-in-age exceptions:

- A *14 or 15 year old* can consent to sexual activity as long as the partner is less than five years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person.

- There is also a close in age exception for *12 and 13 year olds*. A 12 or 13 year old can consent to sexual activity with a partner as long as the partner is less than two years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person.

A 16 or 17 year old cannot consent to sexual activity if:

- Their sexual partner is in a position of trust or authority towards them, for example a teacher or coach
- The young person is dependent on their sexual partner for care or support, for example for care or support.
- The relationship between the young person and their sexual partner is exploitative

All sexual activity without consent is a criminal offence, regardless of age.

The preceding information was copied and pasted from the federal government's webpage: https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html

Here is a Brochure on Respecting Sexual Consent authored by the RCMP. It is a brochure intended to be given to those under the age of 19. It can be found by clicking on the embedded link above or by going to: https://www.rcmp-grc.gc.ca/en/brochure-respect-sexual-consent

Mental Health and Wellness and the Perinatal Period

Supporting mental health and wellness (MHW) throughout a person's lifespan is foundational to nursing. The perinatal period presents an opportune moment to nourish relationship, bolster safety, support cultural and traditional practices and check in with and support an individual's MHW - as well as their family's MHW.

> One of the greatest highlights of being in community a while is that when you are the lucky nurse who gets to support an individual who is pregnant during their pregnancy journey, you get this special and unique opportunity to build and grow a very close therapeutic relationship. It is such a special time and I honestly always just feel like the luckiest nurse to be working with these individuals and their families. You get 9 months of consistent one-on-one visits and ample time to talk about so many things in addition to routine prenatal care points.
>
> - Outpost Nurse, Northern BC

Key Messages

1. Mental health and wellness (MHW) is a key component of the First Nations Perspective on Health and Wellness.
2. MHW conversations are one of the most important actions you can prioritize as a nurse in serving and supporting the people with whom you are working. See section 5.1 of FNHA's Suicide Prevention Clinical Practice Guideline for more information on MHW everyday conversations.
3. Screening tools are an adjunct to MHW conversations. They do not replace clinical judgement nor critical thinking.
4. Screening is one aspect of supporting the person as a whole – it helps to ensure MHW supports are in place. We encourage you to go beyond the ticky boxes and scoring systems and to support the whole individual – their physical, mental, emotional, and spiritual health. You have the opportunity to support the individual in connecting or strengthening existing connections with community and culture such as through cultural and traditional activities and groups (E.g. beading, weaving, singing, dancing, physical activity, walking groups etc.).
5. It is important to perform screening in a trauma-informed way. Screening can bring up strong emotions, thoughts, and feelings and it is therefore important to do it in a safe environment with adequate supports in place. For example, some individuals may want to complete a screening questionnaire alone while others

may want to complete it with you. Some people may want to bring it home and complete it at home when they are near their family or friend-supports.

6. Risk of suicide remains a concern during this time. We recommend that you become familiar with risk factors and warning signs for suicide – see section 5.5 of FNHA's Suicide Prevention Clinical Practice Guideline *(Gathering Space > Mental Health and Wellness > Suicide Prevention > Guidelines).* The Columbia Suicide Severity Rating Scale (CSSR-S) is the recommended tool to use if you have identified risk factors and warning signs. Introduce this tool into the conversation in a transparent and trauma-informed way. The tool must be completed by you in partnership with the client. See the risk intervention table for guidance on next steps – section 6 of the FNHA's Suicide Prevention Clinical Practice Guideline *(Gathering Space > Mental Health and Wellness > Suicide Prevention > Guidelines).*

7. The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent/caregiver has symptoms that are common in individuals with depression and anxiety during pregnancy and in the year following the birth of a child. The EPDS is recommended to be completed at 28-32 weeks gestation and 6-8 weeks postpartum.
   See: http://www.perinatalservicesbc.ca/health-professionals/professional-resources/public-health/edinburgh-postnatal-depression-scale-(epds) for the questionnaire and scoring guide.

Mental Health Disorders in the Perinatal Period

Baby Blues [4,52]

Having mood swings right after childbirth is normal. A person may be happy one minute and sad the next. Even when baby is asleep, the birther may have difficulty sleeping, eating and feel a little depressed. This is normal after the birth of a baby. These feelings usually go away after 7-10 days and do not require treatment. It is short-lasting and occurs for 50-80% of individuals after birth.

Cause of Baby Blues

"An individual's body goes through sudden changes in hormone levels when a baby is born. Some hormones that were needed during pregnancy drop off quickly, while others rise. These rapid changes are normal but can make an individual feel out of balance." [52, p21]

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Baby Blues or Perinatal Depression?

"Most of the time, baby blues only last a few hours or a few days. The feelings and symptoms of baby blues usually go away on their own. But if they last longer than two weeks after the baby's birth, the individual may be experiencing a postpartum depression. If baby blue feelings or thoughts last for more than two weeks after childbirth, the individual needs further support and possibly treatment." (52, p22-23)

Perinatal Depression (PND) (43,52,79)

Perinatal depression is a more serious and longer lasting depression (>2 weeks) that can happen during pregnancy or after the birth. It can happen to the person who is pregnant or to the partner. It significantly impacts daily activities such as work, school, home and social activities or it can cause serious emotional distress.

- It is less common (up to 16% of individuals).
- May occur at any time during pregnancy or up to 1 year after birth or adoption
- The symptoms of PND can last for months.
- PND is a serious illness and can happen after a loss in pregnancy as well (miscarriage, neonatal loss, abortion).
- The individual may feel very sad, hopeless and worthless. They may have trouble caring for and bonding with their baby. Their ability to do their regular activities of daily living may be affected. Sometimes, it is the individual's partner, close friend, or family who notices this change first.
- PND requires treatment.

Anxiety during pregnancy (43)

"Everyone feels anxiety from time to time. At low levels, it can be helpful as a motivator to get things done, increasing the ability to focus or to be more alert or to avoid dangerous situations. However, when anxiety becomes intense or prolonged or stops us from doing the things that we would normally do, it is important to seek help. It is possible that an individual may have an anxiety disorder if anxiety symptoms have:

- Been excessive and difficult to control for an extended period of time
- Led to significant emotional distress and personal suffering
- Led to significant interference in work, school, home or social activities"

The following resources are from the BC Women's Hospital's (BCWH) Reproductive Mental Health Program and are intended for people experiencing MWH challenges as well as healthcare providers:

- Coping with anxiety during pregnancy and following the birth Module 1 and Module 2
- Cognitive behaviour therapy (CBT) self-management guide. This guide can serve as a resource for parents as well.

Postpartum Psychosis [53]:

- This is a rare mental health disorder that may occur within 72 hours of the birth but usually within two to four weeks after the birth.
- One to two individuals per 1,000 births experience an episode of postpartum psychosis.
- It requires immediate intervention and treatment and the individual should not be left alone, with or without baby, until assessment and treatment by a physician or NP has occurred and the individual is fully recovered.
- Individuals with a prior history of psychosis or other mental health conditions with risk factors for psychosis may have a recurrence in the postpartum period. Substance use can also bring on a psychotic episode.
- For some individuals, postpartum psychosis may be the only psychotic episode they will experience. For others, postpartum psychosis may be the first presentation of a psychiatric disorder.

Impact of Untreated Mental Health Disorders

"Mental health disorders in the perinatal period are particularly important because they occur at a critical time in the lives of the individual, baby, and family. Failure to treat promptly may result in a prolonged, negative effect on the individual, the relationship between the individual and baby, and on the child's psychological, social and educational development. The relationship between the individual and their partner may also be negatively affected." [54, p14]

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Treatments

Some, none or all of these treatments may be required for mental health disorders in the perinatal period. Treatment needs to be overseen by the individual's primary care provider. The following is not a comprehensive list of all treatments but rather some options to potentially anticipate:

- Counselling/therapy
- Pharmacotherapy
- Hospitalization

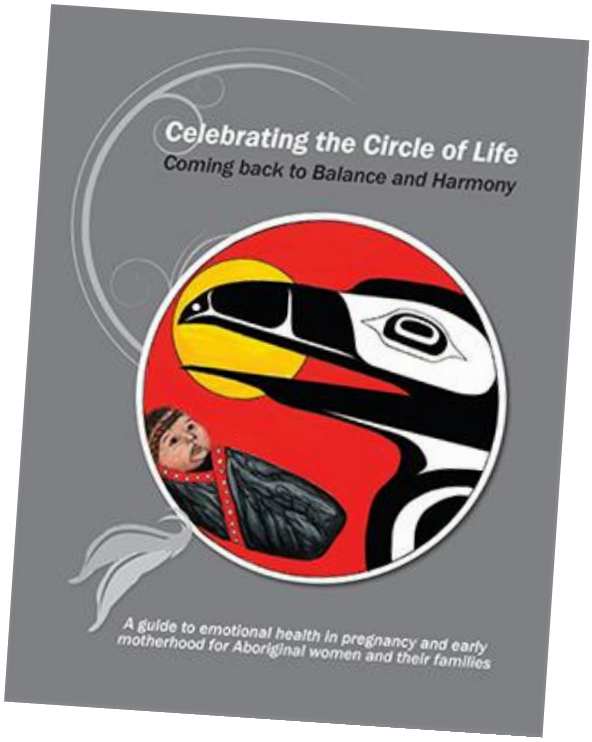
Remember you can always reach out to MaBAL to connect with a physician for a consult on an individual you're concerned for – please ensure you have obtained informed consent from the individual first.

Other resources

For individuals:

1. *A Guide to Emotional Health in Pregnancy and Early Motherhood for Indigenous Women and their Families. (2011)*

   This guide was created to support soon-to-be and new parents who are concerned about their mood and/or are experiencing depression. The guide is focused on emotional health and includes information on what to expect and how to cope with all of the changes that comes with pregnancy and a new baby.



2. "Coping with Depression in Pregnancy and Following the Birth" - A cognitive behaviour therapy-based self-management guide for individuals
   Free course/workbook through HeretoHelp BC, found at:
   https://www.heretohelp.bc.ca/workbook/coping-with-depression-in-pregnancy-and-following-birth

For individuals and care providers:

3. The FNHA created a 'Videos for New Moms' video series that aims to support life-givers and their families before and after the sacred ceremony of birth. This video series is also found in The Whole Person section of this handbook.

4. BC Womens Hospital's Reproductive Mental Health Program
   - Nurses can consult
   - Individual can self-refer

5. Help Lines:
   - Please see Appendix C for Health & Wellness Supports and Resources
   - Community Mental Health & Wellness teams – some communities have a designed MHW team or provider. Check with the Community Health Representative or Health Director in the community you are serving.
   - The Pacific Post Partum Support Society has phone and text lines for individuals as well as resources for care providers.

For care providers:

6. Best Practice Guidelines for Mental Health Disorders in the Perinatal Period by the BCWH's Reproductive Mental Health Program and PSBC (2014):

   http://www.bcwomens.ca/health-professionals/professional-resources/reproductive-mental-health

7. "Not Just the Blues – Perinatal Depression and Anxiety"
   Free course through UBC, found at:
   https://elearning.ubccpd.ca/enrol/index.php?id=101

8. "Journey to Perinatal Wellbeing: eTools and Resources to Identify and Support Women with Perinatal Depression and Anxiety"
   Free course through PHSA LearningHub, found at:
   https://learninghub.phsa.ca/Courses/6907

9. Remember to reach out to your FNHA Community Health Practice Consultant or FNHA Mental Health team at mhnursing@fnha.ca for additional support.

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Substance Use and the Perinatal Period

The following content may bring about unpleasant feelings or thoughts. Everyone has a unique background and lived experience.

Please take good care and know that you are not alone. See Appendix C for health and wellness supports and resources.

"Understanding how colonization, "Indian" hospitals, residential schools and systemic racism have impacted Indigenous Peoples and Indigenous family structures across British Columbia and across Canada is essential to creating changes that will support better health outcomes for Indigenous Peoples and future generations. Due to the impacts of colonization on Canada's health care system, Indigenous Peoples experience many barriers when accessing health services. **Colonization and racism in the health care system have resulted in negative health outcomes including increased substance use, impaired mental health and poor perinatal health outcomes**. The disproportionate impact of the opioid crisis and historical and ongoing colonial violence and discrimination against Indigenous women has instilled a deep sense of loss and intergenerational trauma for Indigenous lifegivers along with their families and communities. **Indigenous children and youth are disproportionally separated from their parents, extended families and cultures. Elders have identified that the responsibility lies with non-Indigenous people to educate themselves about the history of Indigenous Peoples, the root of the health care inequities they have endured and the intergenerational impacts these continue to create**." (65, p17)

For the purpose of this handbook, our intention is to create space for the discussion of substance use and perinatal health so that CHNs may feel better supported in providing culturally safe, trauma-informed, and strengths-based perinatal care to people who may be using substances.

It is important to remember that Indigenous-specific racism and discrimination in B.C. Health Care (see *In Plain Sight* report) exists. There is potential harm to the nurse-person therapeutic relationship and to the trust that people feel or don't feel with health care providers that can come from discussing substance use with individuals who are pregnant if not done in a trauma-informed and culturally safe way. It is crucial for CHNs to understand the history of Indigenous Peoples, the inequities in the health care system as well as the harmful policies, practices, tools, attitudes and encounters with health care people that Indigenous Peoples have endured and continue to endure. (65)
Your words, messaging, approach and environment matter. Is the clinic environment in which you work, safe and welcoming? What are some of the ways in which you could

complete standardized screening tools, such as the TWEAK alcohol screening tool in pregnancy, in a trauma-informed and culturally safe way?

As with other sections in this handbook, the following is an introduction to a broad topic that encompasses many foundational concepts such as practicing in a trauma-informed way, strengths-based nursing, and Indigenous harm reduction principles and practices. We encourage you to explore the resources listed, including who to contact and where to go for more information and education.

Here are a few thoughts and comments to start you thinking about how to approach the topic of substance use with the individuals you are supporting:

Empowerment and Self-Determination

Self-determination speaks to control by Indigenous peoples over their health and wellbeing, including through their own governing institutions, jurisdiction and laws. (66, p7) In using the 4 Rs of Cross-Cultural Dialogue and the 6 Practice Principles to support culturally safe, humble, trauma-informed perinatal care, (3, p22) CHNs empower individuals who are pregnant or parenting as well as their families to fully understand their options so that they can make informed decisions about their healthcare. (3, p26)

"Building Indigenous self-determination means ensuring patients understand their recommended treatment and enabling them to make their own decisions. It is helpful to **encourage** and **empower** patients to make decisions about their care. You can support the self-determination of Indigenous Peoples by using plain language when suggesting or recommending treatments or medications and asking patients whether they understand." (3, p26)

Safety and Hope

Safety is fundamental to practicing in a culturally safe and trauma informed way and it is foundational to building trust and relationship. When an individual who is pregnant discloses to you, that is a tender moment. Take that opportunity to build trust and rapport. Your language, messaging and environment matter. Your language and environment want to be friendly and welcoming.

Bring forward radical **hope** in your practice. What does that mean? Hope is fundamental to nursing. When you are operating in your best place as a nurse, you are operating in hope. Foster and elicit hope in the person you're serving because hope is fundamentally strengths-based.

Harm Reduction

Harm reduction strategies are an evidence based approach that reduces harms while meeting people where they're at. One example of an effective and positive harm reduction strategy is that of taking the time to build positive relationships. Please see the following harm reduction section to learn more about Indigenous harm reduction.

Strength and Resilience-Based Nursing

"A person with resilience can recover from a setback and move forward with their life. **Focus on the strengths and resources of Indigenous women**, rather than on their vulnerability and pathology. Resilience can be encouraged by providing care that focuses on a patient's positive experiences and supports their informed decisions. This approach shifts attention to resources, strengths, and positive outcomes.
Let your patient know their questions about their care help to understand their needs and identify a treatment plan together. Let them know their questions about their care are important and share that their positive and proactive approach is good for them and for their baby." (3, p30)

Practicing in a Trauma-Informed Way

People use substances for a variety of reasons including as a strategy for coping with experiences of trauma. (5, p7) Approaching substance use within the maternal child population with an open heart and as a co-partner and ally to the people whom you are serving, is the best way to move the work forward in a good way. Show up with your heart open and the desire to co-create a plan of care. You do not need to be an expert. Open up the conversation and then direct individuals to the right people. The individual who is using is the expert and there is great power in saying, "I don't know, let's call so and so," "How do you feel about that?" or, "Do you want me to do the homework first and then circle back to you?"

Please see the Practicing in a Trauma-Informed Way section of this handbook for more information.

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Resources and Supports:

1. Here is an excellent resource on Perinatal Substance Use from the BC Association of Pregnancy Outreach Programs:
    a. https://www.bcapop.ca/BCAPOP-Handbooks (This link will take you to two resources, one is a Handbook and the other is a Supplement to the Handbook. Both resources are excellent).

2. See the BC Pregnancy Outreach Program's Perinatal Substance Use section of their website https://www.bcapop.ca/Perinatal-Substance-Use-Resources for a multitude of helpful resources on:

- Best practice resources
- Harm reduction resources
- Tool cards such as a Breastfeeding Safety Plan
- Substance-specific resources for professionals (alcohol, cannabis, nicotine, opioids)
- Support for people who use substances
  (Eg. Peer Support Programs, Day and Bed-based Programs)
- Training and research opportunities

3. See PHSA's Elders Visioning Perinatal Substance Use Toolkit to learn more about "Indigenous Elders' teachings and perspectives on providing culturally safe health care and how to engage Elders in health care services in a good way." (65)

4. For FNHA resources specific to cannabis, see:
   - FNHA Cannabis Resources for Health Care People
   - FNHA Breastfeeding and Cannabis: Things you need to know
   - FNHA Pregnancy and Cannabis: Things you need to know

5. See Appendix A for virtual support pathways for both clinicians and community members and Appendix C for health & wellness supports and resources.

6. Reach out to your FNHA Substance Use Clinical Nurse Specialist or email the FNHA Nursing Practice Consultants for Substance Use at 4directions@fnha.ca for additional support.

Harm Reduction and the Perinatal Period

"People have the perception that harm reduction happens out there on the street. The fact is that every time you take the time to build a positive relationship with a person, you are practicing harm reduction" (Emergency Room Nurse). (6, p14)

The following is from the FNHA Indigenous Harm Reduction in Action Community Wellness Guide:

Indigenous Harm Reduction

"Indigenous harm reduction is a process of integrating cultural knowledge and values into the strategies and services associated with the work of harm reduction. Indigenous knowledge systems are strongly connected to spirituality, [w]holism, and the natural environment." Mainstream harm reduction often focuses on behavioural risks rather than examining the systemic changes required to support people on their healing journeys.

From a First Nations perspective, tackling systemic racism and other inequities are essential to a wholistic approach to harm reduction. Historical and ongoing colonialism, racism, intergenerational trauma and barriers to accessing health care

"Harm-reduction services can include supervised consumption sites, take-home naloxone kits and information about lower-risk use guidelines. **Access to food banks or regular meals as nutrition is also an important part of maternal fetal health**." (5, p15)

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Resources:

1. FNHA Fact Sheet on Indigenous Harm Reduction Principles and Practices
2. See the Overdose Prevention and Harm Reduction section of the FNHA website
3. Here is an excellent series of videos from BC First Nations peoples talking about the Toxic Drug Crisis - https://harmreduction.fnha.ca/
4. For further information, see the BC Harm Reduction Strategies and Services BC Harm Reduction Strategies and Services Policy and Guidelines
5. Remember to reach out to the FNHA Harm Reduction Practice Consultant or email 4directions@fnha.ca for additional support.

Complications in Pregnancy

This document highlights some of the more common complications in pregnancy as an introduction. If you are not familiar with the topics below or with other complications that are not described here, please reach out to the FNHA Maternal Child Health team at mchnursing@fnha.ca or your FNHA community health practice consultant for further support.

As with all advice in this guide, the sections below do not replace clinical judgement or critical thinking.

It is important to remain within your scope, therefore if you're unsure or have any concern that the pregnancy is moving away from a healthy pregnancy, consult with the Primary Care Provider. If the Primary Care Provider is unavailable, you could consult with MaBAL.

Nausea and Vomiting ("Morning Sickness")

"Nausea with or without vomiting is common in early pregnancy. Severe vomiting resulting in hypovolemia and weight loss is termed hyperemesis gravidarum. Symptoms usually resolve by mid-pregnancy regardless of severity and need for therapy." (10)

Nausea during pregnancy is known colloquially as "Morning Sickness" although symptoms can happen day or night.

The following are up-to-date and evidence-informed support and treatment measures for managing nausea in pregnancy:

Meals and Snacks

- Try to avoid an empty stomach or a full stomach
- Snack lots, every 1-2 hours, eat slowly
- Determine which foods are tolerated best
    - Common triggers: caffeine, spicy foods, odorous foods, high-fat/acidic/very sweet foods
- Peppermint tea or peppermint candies post-snack/meal may help

Fluids

- Consume liquids 30 minutes prior or post meals/snacks. Cold, clear and carbonated or sour (E.g., ginger ale, lemonade, popsicles) beverages are best

Ginger

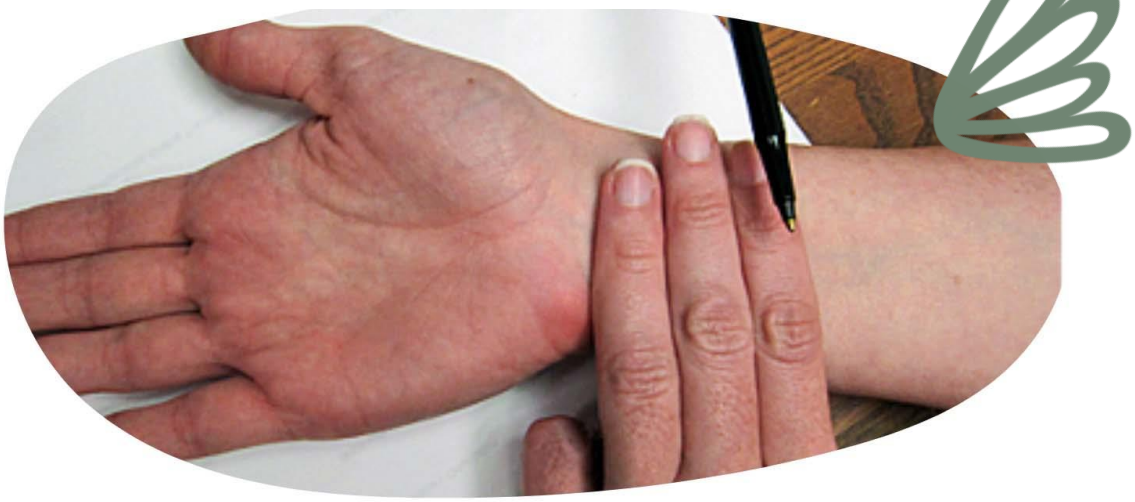
- Ginger-containing foods (E.g., ginger lollipops, ginger tea, foods or drinks containing ginger root or syrup) have proven effective at reducing nausea

Pharmacotherapy

- Doxylamine-pyridoxine (Diclectin) – speak with the Primary Care Provider, prescription-only

Other

- Acupuncture



Graphic courtesy of Judith A Smith, Pharm D, BCOP, FCCP, FISOPP.

"Pressure or massage at the P6 acupressure point is reported in some studies to relieve morning sickness. The point is found three of the patient's fingerbreadths proximal to the wrist fold, between the palmaris longus and flexor carpi radialis tendons, shown in this picture by the tip of the pen." Judith A Smith, Pharm D, BCOP, FCCP, FISOPP

See HealthLink BC's Nausea or Vomiting During Pregnancy for more information.

Hyperemesis gravidarum

This is a serious complication that can harm both the individual who is pregnant and the baby. It is important to consult with a primary care provider quickly.

- The definition of hyperemesis gravidarum is nausea and vomiting with weight loss greater than 5 per cent of pre-pregnancy weight
- Treatment is physician-directed and may include:
    - Hypovolemia treatment
    - Fluid therapy and nutrition/vitamins/minerals/electrolytes treatment
    - Diet modifications/avoidance
    - Medications E.g., anti-emetics (physician/nurse practitioner/midwife prescribed)
- If you cannot get ahold of the individual's Primary Care Provider, consult with MaBAL.

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Diabetes in Pregnancy (Pre-existing and Gestational)

Diabetes in Pregnancy

Diabetes is complex. In this section we provide some key considerations and information to support you in providing care for people living with diabetes during the perinatal period. We do not include an in-depth discussion of the lived experience for those with pre-existing diabetes during the perinatal period. We encourage you to be familiar with this section in its entirety.

Key Messages

- There are two types of diabetes to be aware of when supporting pregnancy: pre-existing diabetes mellitus (Type 1 - T1DM or Type 2 – T2DM) and gestational diabetes mellitus (GDM).
- The rates of T2DM and GDM are higher for First Nations people. [69,70,71] 8 in 10 First Nations people of young age will develop diabetes in their lifetime. [70]
- For individuals with additional risk factors, it is important to screen before pregnancy in order to identify undiagnosed diabetes cases and to establish a baseline during the preconception period.
- Hyperglycemia during pregnancy increases the risk of macrosomia (weight of baby >4500g regardless of gestational age), fetal and infant death, as well as metabolic and obstetrical complications at birth. [74]
- The key to a healthy pregnancy for an individual with diabetes is keeping blood glucose levels in the target range. [74] The target ranges are lower than the ranges for people who are not pregnant and living with diabetes.
- Diabetes during pregnancy is often managed by a combination of diet, physical activity and pharmacologic treatment such as insulin and metformin as needed.
- Individuals who experienced GDM are at increased risk of developing T1DM or T2DM after their pregnancy or later in life. These individuals should be screened for diabetes between 6 weeks and 6 months postpartum. [74,75]

- Diabetes Canada (DC) states that, "The causes of diabetes are complex. Learning about the medical, social and cultural contributions to diabetes is key to diabetes prevention. In particular, seek to understand the relationships between the history of colonization and the current high rates of diabetes in Indigenous peoples." (71, pS296)

Preconception Considerations

There are a variety of reasons that people may be living with undiagnosed diabetes including barriers to accessing healthcare and screening services, asymptomatic presentation, past bad experiences with the health care system and others. Diabetes can have mild to significant negative health outcomes for First Nations people of all ages therefore screening should be a regular and ongoing part of community health promotion activities. Information sessions at schools and youth groups can increase awareness of diabetes. These can be a fun and interactive opportunity to provide diabetes education.

Achieving optimal glycemic control before pregnancy is associated with a reduction of fetal congenital anomalies. (74)

Screening for diabetes in asymptomatic Indigenous adults (>age 19 years) should be considered every 6 to 12 months for those with additional risk factors such as people of childbearing age, positive family history of diabetes, or if there is obesity. (71) **It is important to offer this regular screening to adults as diabetes can often be asymptomatic.**

Screening for T2DM should be considered every 2 years for children (<19 years) who have additional risk factors such as having a first-degree relative with T2DM, exposure to hyperglycemia in utero, signs and symptoms of insulin resistance, prediabetes, obesity or if the individual is on atypical antipsychotic therapy. (71,73)

What is Gestational Diabetes Mellitus (GDM)?

GDM is hyperglycemia that is first detected or recognized during pregnancy. Hormones involved in pregnancy, such as growth hormone, prolactin and progesterone, naturally increase insulin resistance in the body. This is a protective factor that the body does so that the baby has plenty of nutrients. If there is too much insulin resistance and/or if the pancreas is not able to produce enough insulin, blood sugar increases. High sugar in the blood can cross the placenta to the fetus, potentially increasing fetal growth (macrosomia) and/or leading to overproduction of insulin by the fetus (hyperinsulinemia – increases risk of hypoglycemia in baby postpartum). (74)

Screening in Pregnancy

First trimester

It is important to always consider screening for diabetes in those with additional risk factors in the **first trimester**.

Some health centres and nursing stations have mobile A1C machines or point-of-care (POC) glucometers. Working together with the PCP and the individual you are supporting (remember to always obtain informed **consent**), an A1C and/or POC random blood sugar could be completed which will help to identify hyperglycemia and expedite diagnosis and treatment. An A1C greater than or equal to 6.5% is indicative of diabetes, compared to 7% for those who are not pregnant. (72) In the first trimester, a fasting blood sugar higher than 7.0 mmol/L or any random blood sugar above 11.1 mmol/L may indicate possible diabetes. (72)

You'll also notice that the FNHA Prenatal Checklist suggests completing a POC random blood sugar test at the initial CHN visit.

Second trimester

Universal screening for gestational diabetes occurs in the **second trimester** at 24-28 weeks (74,76) for all individuals without known pre-existing diabetes.

Diabetes Canada (DC) and the Society of Obstetricians and Gynaecologists of Canada (SOGC) generally recommend the 2 step method (screening initially with the 50g glucose challenge test (GCT). If the 50g test is abnormal, it is followed up on another day with a 75g oral glucose tolerance test (OGTT). (74,76)

DC and SOGC also identifies using the 1 step method (75g OGTT) as an "alternate" approach in certain circumstances. (74,76)

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Deciding between the 1 step method and 2 step method:

The 1 step method involves fasting, drinking a 75g glucose drink and 3 blood draws over 2 hours (fasting, 1hr and 2hrs after the drink). The 2 step method involves no fasting, drinking a 50g glucose drink and 1 blood draw one hour post drink. If the results from the 50g GCT are abnormal, the 75g OGTT is done another day.

Some might prefer the 1 step method for convenience and accessibility. If people have to leave community to have lab work completed, the 1 step method may be better in order to eliminate the risk of potentially having to leave community twice for lab work (in the case that the 50g GCT is abnormal and the 75g OGTT is required).

We recommend partnering with the individual in order to come up with a plan that works well for them as either the 1 step or 2 step methods are acceptable.

Diagnosis of GDM

1. For the 2-step method, a diagnosis of GDM is made if one plasma glucose value is abnormal (i.e. fasting ≥5.3 mmol/L, 1 hour ≥10.6 mmol/L, 2 hours ≥9.0 mmol/L). (74,76)

2. For the 1-step method, a diagnosis of GDM is made if one plasma glucose value is abnormal (i.e. fasting ≥5.1 mmol/L, 1 hour ≥10.0 mmol/L, 2 hours ≥8.5 mmol/L). (74,76)

Gestational Diabetes

- Usually occurs after 24 weeks gestation
- Screen at 24-48 weeks
- Diagnosed with **1 abnormal**:

2 step method:

1. **50g GCT and if >7.8 then:**
2. **75g OGTT**
   - Fasting ≥ 5.3
   - I hr ≥ 10.6
   - 2 hr ≥ 9.0

1 step method:

75g OGTT

1. Fasting ≥ 5.1
2. I hr ≥ 10.0
3. 2 hr ≥ 8.5

Management of Pre-Existing Diabetes and GDM During Pregnancy

Diabetes management includes education, support, nutrition, physical activity, pharmacology therapy, blood sugar monitoring and routine prenatal care that includes the monitoring of the person's pregnancy and the growth, development and health of the baby.

For people living with T2DM, they are the expert. They know their health best and are experienced with living with diabetes. How can you support them with the changes they are experiencing related to being pregnant?

Role of the CHN

Your role as the CHN is to support, educate, advocate and help to navigate the health care system for the people who are pregnant who you are supporting. As a CHN, you are uniquely positioned with the opportunity to spend more time with individuals living with diabetes. A diagnosis of GDM can be overwhelming and there may be multiple health professionals involved in the care team. We encourage you to build relationship and to schedule regular check-ins with the individual to assist with answering and discussing any questions, concerns and to review the treatment plan as needed.

Everyday mental health conversations (see the Mental Health and Wellness section of this handbook) and screening for depression should be initiated for any person at increased risk for T2DM or GDM as there is increased risk for depression related to hyperglycemia. (71)

Planning for Birth and Postpartum

- The goal during delivery is to prevent hypoglycemia while managing hyperglycemia. Occasionally a baby will experience hypoglycemia during the postpartum period. Let families know there will be additional monitoring for both baby and birther following birth such as blood sugar monitoring and possibly pharmacologic therapy such as insulin or IV fluids.
- In individuals with pre-existing diabetes, insulin requirements decrease rapidly immediately following delivery of the placenta. Insulin demands remain decreased in the weeks following delivery. It is important for those who use insulin or insulin secreting medications such as glyburide to monitor their blood sugars more frequently following birth in order to prevent hypoglycemia. (74)
- People who lived with GDM usually revert to their pre-pregnant blood sugar status. Follow up screening for diabetes should be offered at 6 weeks to 6 months postpartum to confirm. (74)
- It is important to support the individual in planning for breast/chestfeeding immediately following birth as this will reduce the risk of neonatal hypoglycemia amongst other benefits. Let the individual know that the nurses in hospital will support immediate breast/chestfeeding initiation as well.

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Resources

- Reach out to the FNHA Diabetes Educator via the FNHA Chronic Disease and Serious Illness team at CDSI@fnha.ca to support your practice needs, connect with your FNHA community health practice consultant, or speak with the FNHA MCH team at mchnursing@fnha.ca to learn more.
- See the FNHA N.A.M.E. handout to learn more about the "Four Pillars of Diabetes Management and prevention to support wholistic wellness for you, your family and community."
- The Diabetes Canada website is an excellent resource for providing information related to all aspects of care, screening, management, complications, etc. Some examples include the Clinical Practice Guidelines and the nutrition and fitness section of their website.
- See the diabetes section of HealthLink BC.
- Some communities may be connected with Mobile Diabetes Clinics (MDC). The MDCs usually come to community for screening, education, support and management once to twice per year. Check with the CHR or HD in the community you're serving.
- There are Diabetes Education Centers (DECs) within the Regional Health Authorities that may be able to provide support, education and resources as well.

To find the DEC closest to you, look through the links below:

- Fraser Health
- Interior Health
- Island Health
- Northern Health
- Vancouver Coastal Health
- St Paul's Hospital Diabetes Program (Providence Health Care)

SPOTLIGHT – Dallas Henry, Tsimshian

Dallas was diagnosed with gestational diabetes during her first pregnancy. She would like to share her story:

What was it like finding out you had gestational diabetes?

"I was upset when I found out I had gestational diabetes. I thought I did something wrong. I didn't know much about it and it scared me. But the nurse gave me information and supported me to start changing my eating habits and exercise more each day (15 or 30 mins) to manage my blood sugar."

How was it managing diabetes while pregnant?

"It took a while to manage my sugar levels because I had to learn to eat smaller portions and to have as many proteins and vegetables as I could. I had to look for ways to exercise each day."

What questions did you have?

"I had so many questions about gestational diabetes such as, "What food can and can't I have while pregnant?" "What is the safest exercise I can do while being pregnant?" "How much food should I eat to keep myself and my growing baby healthy?" "How did I come to have gestational diabetes?" "What could I have done differently to avoid having gestational diabetes?"

What was the most helpful support you received?

"The most helpful support I received was talking to my dietitian online via email. Researching also helped me. It was helpful knowing that some of my family members had also had gestational diabetes when they were pregnant. They shared their stories with me."

How did you feel?

"Knowing I had gestational diabetes while I was pregnant was scary but hearing that others (like family members) had it too and that it is common, helped me realize that I'll be okay."

What do you wish you had known or what would you tell friends of yours who are thinking of having children or who are pregnant?

"To the future ladies who are trying to get pregnant or are already pregnant, just know it's okay to have gestational diabetes. Many women have it while being pregnant. Think of it as your body's way of saying "it needs extra help making you and your unborn baby healthy." With the help of a little bit of exercise (like walking or a light workout) and changing your eating habits, you can help control your blood sugar levels. And not to worry, gestational diabetes will eventually go away after the delivery. But don't be alarmed when the nurse says that in the future you may develop diabetes. I did but others don't."

Hypertensive Disorders

Hypertensive disorders in pregnancy [(11)]:

1. **Pre-existing/chronic hypertension** - Hypertension that precedes pregnancy or is present on at least two occasions before the 20th week of gestation or persists longer than 12 weeks postpartum.

2. **Gestational hypertension** - Hypertension without proteinuria or other signs/symptoms of preeclampsia-related end-organ dysfunction that develops after 20 weeks of gestation.

3. **Preeclampsia** – New onset hypertension and proteinuria or new onset hypertension and significant end-organ dysfunction with or without proteinuria. 1/3 of women with preeclampsia are nulliparous (a person who has not given birth).

   Eclampsia - Occurrence of a grand mal seizure in a patient with preeclampsia

BLOOD PRESSURE RED FLAGS

Case: A woman who is pregnant presents to the clinic. She reports that she has a headache, blurry vision that comes and goes and she feels off. This started suddenly 2 days ago. What stands out and what do you do?

- **Headache**
- **Sudden onset**
- **Changes in vision**
- **Woman reports that she feels off**

Assess blood pressure (BP). Call and consult with Primary Care Provider (PCP) or MaBAL. Assess as your scope and work environment allows. If possible, perform a urine dip to test for protein. Any sign of elevated blood pressure in pregnancy is abnormal.

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For individuals with pre-existing hypertension or gestational hypertension – close monitoring of BP is important. Due to vascular changes during pregnancy, the individual's BP may become unstable or their condition could progress to preeclampsia. These individuals may be on medication for hypertension and will require close monitoring and possible titration (by the Primary Care Provider) of their medication. Your support and education for people living with these conditions are very important. Low dose aspirin therapy may be utilized for individuals with a history of preeclampsia; this type of therapy must be prescribed by and overseen by the PCP and it must be initiated before 20 weeks gestation. [(67)]

Signs and Symptoms of Preeclampsia:

- Elevated BP - systolic >140, diastolic >90 or any BP that is higher than the individual's norm
  - Tips and tricks for accurate BP:
    - Ensure correct cuff size (length should be 1.5x the circumference of arm)
    - Obtain 2 measurements 15 minutes apart using the same arm
    - Patient should be sitting with their arm at the same level as their heart
    - When in doubt, obtain a manual BP
- Swelling of hands and face
- Rapid weight gain >1 kg/week or 3 kg/month
- Headaches
- Vision changes (spots or flashes, photophobia, blurred vision, temporary blindness)
- Upper abdominal, retrosternal, or epigastric pain
- Altered mental status (confusion, agitation)
- New dyspnea, orthopnea
- Protein in urine
- Scrape or injury taking longer than usual to coagulate and clot

Actions for Signs and Symptoms of Preeclampsia:

Consult with the Primary Care Provider (PCP) or your local Emergency Physician at the nearest Hospital or consult with MaBAL

- Ultimately the definitive treatment for preeclampsia is delivery
- IV magnesium sulphate can prevent seizures in severe situations (prescribed by and overseen by the PCP)
- Take care with fluid management as excessive administration of fluids could lead to complications such as pulmonary edema.

Preeclampsia can be life-threatening to both the person who is pregnant and the baby. It can progress rapidly to eclampsia.

SPOTLIGHT – Sophia Mather, Ts'msyen

Sophia was diagnosed with preeclampsia for two of her pregnancies. She would like to share her story:

"I had high blood pressure which I took pills for. When they weren't helping a whole lot one of the nurses thought I had the beginning of helpp syndrome. **During this stressful time I was so thankful to all the nurses that actually listened when I didn't feel right.** They didn't shrug off what I was going through.

When I started to feel not so great and not really myself, you [author] listened and sent me into Rupert. I stayed in the hospital for a couple nights and had an ultrasound. The obstetrician discovered that my body was starting to reject the placenta, that my blood was not flowing to and from the baby properly any longer, and that my placenta was no longer looking healthy. He booked me for an urgent C section which took place the next day.

He also listened to me when I told him I didn't feel right and just wanted the baby to come out. I'm thankful.

I would say that every birth is different. Every mother has a different story. Each person is unique, should be listened to, and hopefully understood.

The least helpful thing I was ever told is "this is so common". Like, don't worry, your emotions don't matter."

Nutrition and Food Safety

Nutritional health is an important part of keeping birther and baby healthy. The Eating Healthy section on the FNHA website discusses four healthy eating strategies: balance, moderation, close to nature and variety. These also apply to people who are pregnant. In pregnancy there are some additional considerations such as vitamins, folic acid, certain foods that are not recommended, the need for extra calories for growing baby and challenges such as nausea, heartburn etc that can impact a person's ability to eat.

It is best for the birther to start taking folic acid two to three months before becoming pregnant and to continue to take it during pregnancy. Eating well and taking prenatal vitamins can help support the healthy development of baby. It is also a good idea for the birther to keep taking prenatal vitamins after giving birth. (12)

FNHA Health Benefits covers the cost of prenatal vitamins, iron, and folic acid. See p.5 and p.9 of the Health Benefits Pregnancy and Infant Care Guide. Some pharmacies may provide these without a prescription. Some health centres and most nursing stations will keep stock of these – inquire with the Nurse-In-Charge, Community Health Representative or Health Director.

Food Safety (14):

During pregnancy, the birther's body goes through many changes that can tend to weaken or suppress the immune system. This puts the birther and baby at an increased risk for foodborne illness.

Bacteria (such as listeria) can cross the placenta. If the individual who is pregnant becomes sick, there is an increased risk that baby could get infected too. Unborn baby's immune system is not developed enough to fight off harmful bacteria.

Foodborne illness (food poisoning) can be caused by bacteria, viruses, and parasites and can be more harmful to baby than to the birther. Foodborne illness during the first 3 months of pregnancy may result in a miscarriage. It if happens later in the pregnancy, it may cause premature birth. Foodborne illness can also cause stillbirth or a baby who is born very ill. Because baby depends on the birther for everything baby needs, food safety (what the individual eats, and the storage, preparation and cooking of food) is very important.

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Safe food alternatives for people who are pregnant [14]		
Type of food	**Food to avoid**	**Safer alternatives**
Hot dogs	Hot dogs straight from the package, without further heating.	Hot dogs that are well cooked to a safe internal temperature. The middle of the hot dog should be steaming hot or 74 °C (165 °F). Tip: Avoid spreading juice from hot dog packages onto other food, or to cutting boards, utensils, dishes and counters. Wash your hands after touching hot dogs.
Deli meats	Non-dried deli meats, such as bologna, roast beef and turkey breast.	Dried and salted deli meats, such as salami and pepperoni. Non-dried deli meats that are well heated and steaming hot.
Eggs and egg products	Raw or lightly cooked eggs, or egg products that contain raw eggs, including some salad dressings, cookie dough, cake batter, sauces, and drinks (like homemade eggnog).	Egg dishes that are well cooked to a safe internal temperature of 74 °C (165 °F). Cook eggs until the yolk is firm. Homemade eggnog heated to 71 °C (160 °F). Tip: Use pasteurized egg products when making uncooked food that calls for raw eggs.
Meat and poultry	Raw or undercooked meat or poultry, such as steak tartar.	Meat and poultry that are cooked to their safe internal temperature. (Refer to the Cooking temperatures chart.)

Seafood	Raw seafood, such as sushi. Raw oysters, clams and mussels. Refrigerated smoked seafood.	Seafood cooked to a safe internal temperature of 74 °C (165 °F). Oysters, clams and mussels that are cooked until the shell has opened. Smoked seafood in cans, or seafood that does not need to be refrigerated until it is opened.
Dairy products	a) Raw or unpasteurized dairy products. b) Unpasteurized and pasteurized soft cheeses, such as Brie and Camembert. c) Unpasteurized and pasteurized semi-soft cheeses, such as Havarti. d) All unpasteurized and pasteurized blue-veined cheeses.	• Pasteurized dairy products and any dairy products that are cooked, in a casserole or au gratin. • Pasteurized cheeses such as cheese curds, cheddar and cottage cheese. • Pasteurized processed/spreadable cheeses such as cream cheese. • Pasteurized and unpasteurized hard cheeses such as Romano and Parmesan.
Sprouts	Raw sprouts, such as alfalfa, clover, radish, and mung beans.	Thoroughly cooked sprouts.
Pâtés and meat spreads	Refrigerated pâtés and meat spreads.	Pâtés and meat spreads sold in cans, or that do not have to be refrigerated until they are opened.
Fruit juice and cider	Unpasteurized fruit juice and cider.	Unpasteurized fruit juice and cider that are brought to a rolling boil and cooled. Pasteurized fruit juice and cider.

See the following websites for more information:

1. FNHA's Food Safety for First Nations brochure: https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Food-Safety-For-First-Nations-Foodborne-Illness-Brochure.pdf#search=food%20safety

2. Food Is Medicine Recipe Book from the FNHA for delicious and nutritious traditional foods recipes.

3. Eating Well for Pregnancy (p.16 of Baby's Best Chance) for information on nutrition, foods to limit or avoid, food safety and supplements.

4. Setting the Table: Voices of South Island Elders & Communities on sugary drinks and children for teachings from Elders. Although this is intended for children, we include it here for the teachings shared from Elders.

5. BCCDC's website on food safety & pregnancy: http://www.bccdc.ca/health-info/prevention-public-health/food-safety-pregnancy

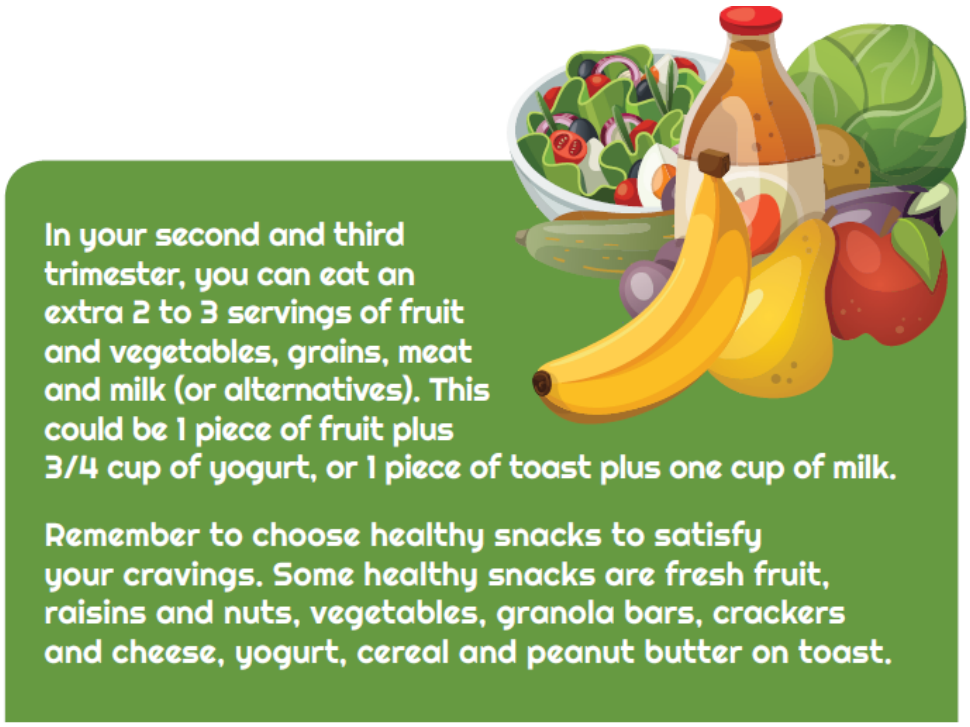
6. HealthLink BC's Healthy Eating Guidelines for Food Safety During Pregnancy: https://www.healthlinkbc.ca/pregnancy-parenting/pregnancy/healthy-eating-and-physical-activity/healthy-eating-guidelines-food

7. Health Canada's website on food safety: https://www.canada.ca/en/services/health/food-safety.html

8. Checklist for prenatal nutrition from the Indigenous Pregnancy Passport:

Indigenous Pregnancy Passport [6]

More messaging from the Indigenous Pregnancy Passport:



Indigenous Pregnancy Passport [(6)]

Prenatal Nutrition Program (PNP)

Most health centres and nursing stations will have the Prenatal Nutrition Program (PNP). Communities choose how to operationalize the funds they receive, so the PNP will look different from community to community. See below "Making Prenatal Nutrition Yours" for examples of different ways in which communities can operationalize the funds.

The following is messaging direct from the Public Health Agency of Canada's website regarding the PNP:

What is the Prenatal Nutrition Program [(13)]?

The goal of the Prenatal Nutrition Program is to improve the health of birthers and infants by supporting community members to:

- Eat well, so babies have the best chance to be healthy at birth and throughout their lives
- Breastfeed babies for up to two years and beyond
- Introduce healthy solid foods at 6 months of age, while continuing breastfeeding

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The PNP was formerly known as the Canada Prenatal Nutrition Program (CPNP). It was administered through Health Canada as a First Nations and Inuit on-reserve program. The PNP for BC First Nations is now administered through the First Nations Health Authority.

People who access the Prenatal Nutrition Program include:

- First Nations People who are pregnant
- Parents of infants
- Infants up to 12 months of age who live on reserve
- First Nations individuals of childbearing age on reserve (note: some communities choose to extend this program to infants up to 24 months old)

Making Prenatal Nutrition Yours

Most BC First Nations receive funds to offer the Prenatal Nutrition Program – and communities are encouraged to use these funds to meet their community goals. Depending on total health funding and community needs, this could mean many things - a youth cooking program, a traditional foods harvest program, a community garden, food baskets, good food bags, gift cards to a grocery store, weekly healthy lunch program, or a range of services that promote and support maternal and child health.

If you're unsure whether the community you are serving has a Prenatal Nutrition Program, ask your Health Director and/or Community Health Representative.

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General Safety (Seatbelts, Cats, Travel, etc)

Toxoplasmosis [(37)]

All of the following information is from HealthLinkBC's handout on Toxoplasmosis - https://www.healthlinkbc.ca/healthlinkbc-files/toxoplasmosis#:~:text=Toxoplasmosis%20is%20a%20disease%20found,the%20time%20they%20are%20adults.

What is toxoplasmosis? - An infection caused by the parasite *Toxoplasma gondii*. Approximately 20% of the population in North America will have had this infection by the time they're adults. For most people, there are no symptoms. Sometimes people will experience mild flu-like symptoms such as aches and pains or fever or swollen lymph nodes.

Effects of toxoplasmosis - This infection can result in miscarriage, poor growth, early delivery, or even stillbirth. If the baby is born with the infection, they could have eye issues, hydrocephalus, seizures, or mental disabilities.

How it is spread -

- Touching hands to mouth after cleaning a cat's litter box or after touching anything that has come into contact with cat feces.
- Eating raw or undercooked meats.
- Drinking unpasteurized milk.
- Touching hands to mouth after working in gardens or playing in sandboxes that contain cat or other feline animal feces.
- Accidentally swallowing contaminated dirt. E.g. While playing in a playground.

How to avoid it -

- If the individual has a sandbox, place a secure lid on it to prevent cats from using it as a litter box
- Do not eat raw or undercooked meat
- Wash hands, utensils and cutting boards after handling raw meat to prevent contaminating other foods
- Do not drink unpasteurized milk from any animal
- Wear gloves when gardening and wash hands afterwards
- Wash hands after patting, brushing or being licked by a cat
- Keep your cat indoors
- Clean out the litter box every day. The Toxoplasma parasite does not become infectious until 1 to 5 days after it is shed in a cat's feces
- Be careful not to accidentally swallow dust when cleaning the cat litter box

- **If possible, the individual should avoid cleaning a cat litter box if they are pregnant or trying to become pregnant. If no one else can perform the task, they can wear disposable gloves and wash their hands with soap and warm water afterwards**
- Wear gloves when cleaning the cat litter box and then wash hands
  - Dispose of cat feces in a plastic bag and put in the garbage
  - Do not compost the cat litter, or dispose of the litter near your garden
  - See a veterinarian if there are any signs of illness in your cat
  - Feed the cat commercial dry or canned food, not raw or undercooked meats

Travel

- See Baby's Best Chance p. 24

Car:

- Wear seat belt with the lap belt below baby and the shoulder belt against the chest
- Move the seat as far back as possible to make room for the air bag.
- Don't recline the seat
- Limit travel time
- Take breaks to stretch and move
- Let others drive when possible
- Often, upon request, the local fire department will come to a prenatal class or parent group to give a presentation on car seat safety – reach out and inquire if this is available in the community you are serving

Plane:

- Before buying a ticket, check with the airline as some will not allow an individual who is pregnant to fly after 36 weeks
- Check with the travel insurance broker to ensure they will cover the individual at their specific gestational age (in weeks) during travel
- Book an aisle seat for easier access to the bathroom
- Exercise while sitting and walk the aisle to prevent blood clots in legs
- Drink plenty of water and bring healthy snacks

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Labour Before 37 weeks (Preterm Labour) and Braxton Hicks

Preterm labour is labour that starts before 37 weeks of pregnancy.
The following information is from the BC Women's Hospital Threatened Preterm Labour Information for Care at Home handout.

"It is a normal part of pregnancy for your uterus to have some painless contractions. These are called **Braxton Hicks** contractions or tightenings. They help tone the uterine muscle for labour and prepare your baby for labour. If the contractions are regular or painful, they may signal labour. It is often hard to tell the difference between your baby moving and your uterus contracting." (80)

Many individuals tell the difference between their baby moving and their uterus contracting in this way:

- Get comfortable.
- Place the palms of their hands over top of their belly and keep them there.
- When their uterus contracts, they will feel their tummy become firm and slowly push into their hands and then as the contraction goes away their tummy will slowly become soft and return to its former shape.
- Count the contractions. Note the time, when one contraction starts and again when the next one starts.

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How to differentiate between Braxton Hicks ("practice contractions") and labour contractions:

Braxton Hicks	Term labour contractions
• Irregular • No pattern, they do not become longer or stronger or more frequent • No change in cervix • Improve or disappear with position change • Can talk through them • Remain in front, do not wrap around to back	• Regular • Become longer and stronger and more frequent • Change in cervix (effacement/thins, position change from posterior to anterior, length/shortens, consistency/firm to soft, dilatation/0 to 10 cm

Preterm labour contractions – These are more subtle and often these signs and symptoms are ignored by the individual who is pregnant as it is easy to think they are just a part of pregnancy aches. (See p.47 of Baby's Best Chance)

- Menstrual-like cramps – intermittent or constant
- Dull ache in lower back, lower abdomen, pelvic area or thighs, intermittent or constant
- Feeling of pressure in pelvic area or lower abdomen
- Leaking or gushing of fluid
- Bowel pressure with or without diarrhea
- Contractions occurring every 15 minutes (or more frequent) and lasting for an hour or greater
- Increase or change to vaginal discharge, may be bloody.
- Just not feeling well – tired, unexplainable fever, feeling "different"

What to do:

- Recommend that the individual be seen by a Health Care Provider right away
- Ask the person who is pregnant to document the frequency of the dull aches, cramps, pressure, contractions to see if there is a pattern

Pre-labour rupture of membranes (PROM) is when the amniotic sac breaks open causing amniotic fluid to either leak slowly or gush out.

Preterm pre-labour rupture of membranes (PPROM) is PROM that happens before 37 weeks.

PROM may occur well before labour and needs to be monitored as it presents an opportunity for increased risk of infection. If the individual you are supporting, experiences PROM or PPROM, consult the PCP or MaBAL right away.

Nursing Stations – the nitrazine paper or amniotic swab test [(36)]:

Normal vaginal pH is between 3.8 to 4.2.
Amniotic fluid has a higher pH of 7.0 to 7.3. Therefore, if the membranes have ruptured, the pH of the sample of vaginal fluid will be higher than normal.

Press a small (1-2cm long) piece of nitrazine paper or roll the tip of an amniotic swab into the leaked fluids on the individual's underwear, pad or blue pad on the stretcher and watch to see if the paper or swab turns blue. Blue indicates a higher pH and greater likelihood of amniotic fluid present. **Caution though as blood, semen and soap have a higher pH as well and could produce a false positive.**

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Here is an excellent poster from the FNHA on tips for preventing a birth before 37 weeks of pregnancy:
https://www.fnha.ca/Documents/FNHA-preventing-preterm-birth-8.5x11.pdf

Here is another informative poster from the FNHA on vaginal progesterone therapy to help prevent preterm birth:
https://www.fnha.ca/Documents/FNHA-Preventing-Preterm-Birth.pdf

First Nations Health Authority
Health through wellness

Tips on Preventing a Birth Before 37 Weeks of Pregnancy

Did you know..?

- In BC, up to 20% of babies are born prematurely, **but often this can be preventable.**
- Being born **after 37 weeks provides a great start** to a baby's life.
- Babies born before this time may have health issues right after birth. Some of these challenges may continue to affect them throughout their life.

There are many things you can do to help maintain a healthy, full-term pregnancy:

- Listen to your body. If something does not feel right ask for help.
- If you are prescribed medications, such as progesterone, it is important to take them. There are several safe options that can help prevent preterm labour. If you feel unsure, talk with your health care provider.
- Make the time to attend your scheduled prenatal visits with your health care provider (virtually or in person).
- Talk to your health care provider if you have a history of preterm births.
- Taking care of your mouth and teeth can help your overall health. Brush, floss, and see your dentist.
- Seek support if you smoke cigarettes or use cannabis, drugs, or alcohol. These will affect your baby's health.
- Ask for iron testing if you feel too tired.
- Ask your health care provider for information on all recommended vaccines to help keep you and baby healthy.

Seek help immediately if you feel increasing or unusual lower abdominal or back pain, and/or pelvic pressure, or experience fluid leaking or bleeding.

QUESTIONS OR CONCERNS?
please contact your health care provider or call **8-1-1 IF SYMPTOMS ARE URGENT**

Created in partnership with Campbell River and Dis Division of Family

First Nations Health Authority
Health through wellness

Preventing Preterm Birth

VAGINAL PROGESTERONE THERAPY

What does preterm birth mean?
A preterm birth (also called early or premature birth) means a baby is born *before* 37 weeks during a pregnancy. Most babies are born full term (37-42 weeks), but some women experience preterm birth.

How do I know if I am at risk?
- If you have had a previous pregnancy where your baby was born before 37 weeks.
- If your health care provider identified you are at a high risk for preterm birth based on the results of your ultrasound or other medical conditions.

There is medication that can help reduce preterm birth for people who are at risk, called Vaginal Progesterone Therapy.
Progesterone is a hormone made naturally by the ovaries and the placenta. People who are at risk for preterm birth can use progesterone in pill form to lower their risk.

How does it work?
Your health care provider will have you start this therapy between 16 and 24 weeks and continue until 37 weeks of your pregnancy. Once a day at bedtime you will need to insert the small tablets of progesterone into your vagina.

Vaginal Progesterone Therapy is a non-benefit item; however, BC PharmaCare Drug plan will cover it under an exception. Your health care provider will need to complete a Special Authority request.

If the pharmacy wants you to pay for this medication, ask the pharmacist to call you when they get the Special Authority approval.

If you have questions, call FNHA Health Benefits at 1-855-550-5454 or access online at fnha.ca/benefits. If there is a long delay in getting your medication, please notify your health care provider.

Extended Learning – Fetal Circulation

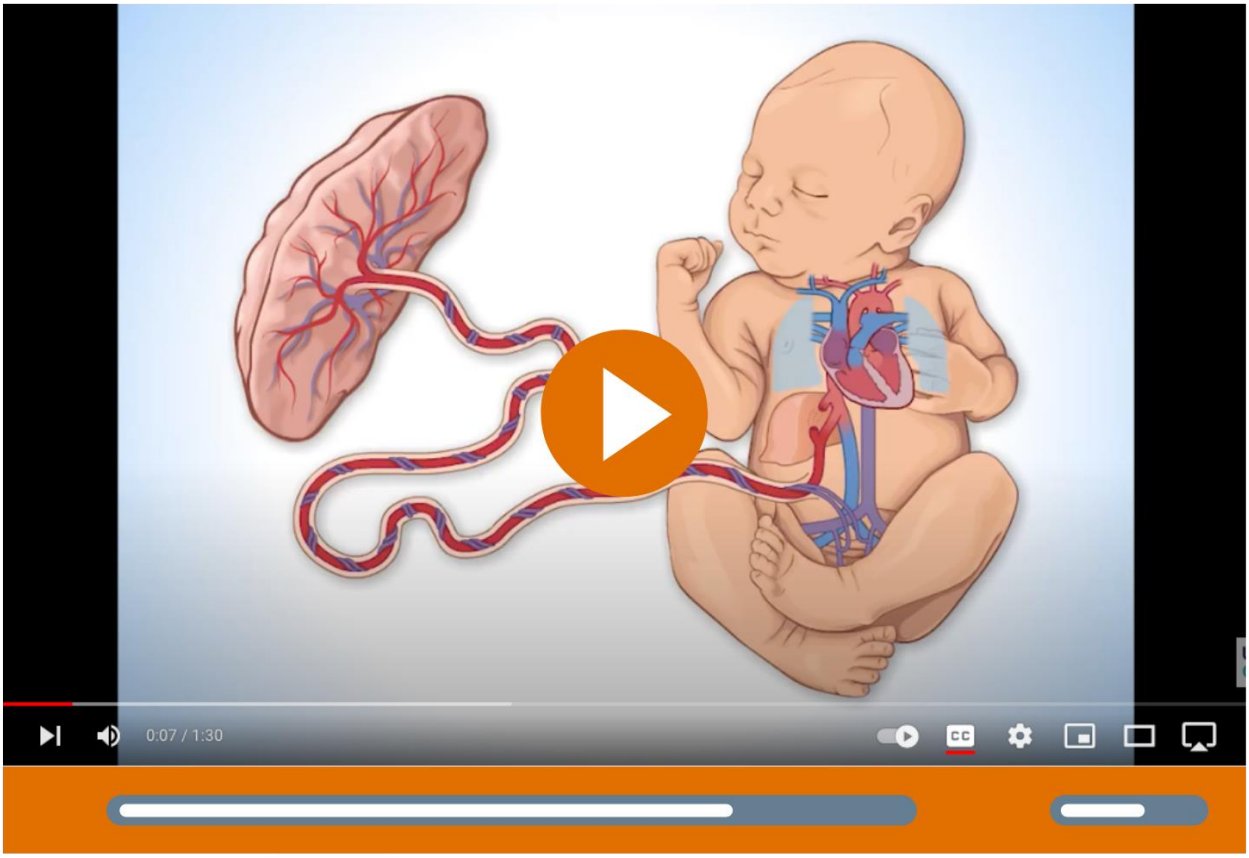
Baby's Circulation While in the Womb

1. How many shunts are there in fetal circulation? Bonus points for the names and description of these shunts. Hint: Shunts cause fetal blood to flow differently than in an adult.

2. Do the umbilical arteries or the umbilical vein carry deoxygenated blood from the baby back to the placenta?

Watch this interesting video on fetal circulation for the answers: Fundamentals of Fetal Health Surveillance - Fetal Circulation
(https://www.youtube.com/watch?v=Mdid3gLfzBk)

Also see Appendix D Fetal Circulation **for the answers.**



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Birthing (37 – 42 weeks)

Self-Reflection

Is there a birthing story, family story or adoption story you are familiar with? Have you been a part of someone else's birth?

Open your journal and take some time to write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts and reflections on a birthing story, family story or adoption story you are familiar with:

_____
_____

Birth Plan

Ideas for topics to include in a Birth Plan:

- Who would they like to be present at birth
- Are there any birthing ceremonies they feel are important and that they want the health care team to respect? For example, do they wish for a silent birth – a very quiet room for all entering the sacred space? Ask how you can support.
- Preferences regarding IV insertion
- Under what circumstances they would want membranes ruptured
- Thoughts on baby monitoring in labour
- Pain relief preferences during labour
- When and by whom the umbilical cord will be cut
- Any other issues they feel are important
- Fears or concerns
- How they plan to feed baby
- Newborn procedures they would like (Vitamin K, erythromycin eye ointment)
- Skin to skin immediately after birth – can be done with the birther's partner or support person as well
- See p. 26 of the Aboriginal Pregnancy Passport
- See here for a sample birth plan template: https://www.healthlinkbc.ca/sites/default/files/healthwise/documents/form_abl1753.pdf and here for a sample birth plan: https://www.babycenter.ca/a544477/sample-birth-plans
- Also see the BC Women's Hospital's Labour & Birth Guide

What to bring to the Hospital:

- See p. 37 of Baby's Best Chance
- See Appendix B for a ready-to-print list of 'What to bring to the hospital' from p. 37 of Baby's Best Chance

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Birthing Support

See doulas + perinatal support

Ceremony

Birthing is Ceremony
Ceremony is sacred
Ceremony varies Nation to Nation
Ceremony was stolen and misappropriated through colonial violence in Canada

- Lucy Barney, T'it'q'et Nation

As health care people we have a responsibility to support and honour individuals who are pregnant and their families in their right to shape their perinatal journey how they wish which may or may not include birthing ceremonies.

This handbook will not be listing nor describing examples of birthing ceremonies as these are sacred and belong to their respective Nations and cultural traditions. Instead, we recommend continuing your journey of building relationship with the community you are serving and you will undoubtedly learn more about birthing ceremonies.

Here is an excellent video by Northern Health. It showcases First Nations individuals from the North of BC as they gift us stories of some of the birthing traditions and ceremonies practiced in their respective Nations.

Placenta

Sometimes people will want to keep their placenta for traditional or cultural purposes. Engage with individuals to support and honour their choices. For example you could provide them with information related to the choices they are making such as keeping their placenta, consuming their placenta, burying their placenta or other practices with their placenta. Be sure to support the individual by communicating to the delivery and health care team, their wishes regarding their placenta.

Placentophagy is the practice of consuming the placenta. Sometimes people will dry and encapsulate the placenta and consume it later.

If this is something that is important to the individual who is pregnant, provide information on the benefits and risks of what is known about the practice in order to support them in informed decision-making.

Placenta burial – Another practice is to bring the placenta home and to bury it outside and then plant something overtop. Most hospitals have a policy in place to release a placenta. These policies involve discussing the relevant risks and safety considerations.

See BC Women's Hospital's Patient Information Handout on taking a placenta home.

Here is some information to potentially guide your responses if asked for more information on practices with a placenta:

- It is not recommended to eat the placenta in any form due to risk of infection from bacteria.
- It is recommended to bury the placenta no less than 1 metre deep and to bury it away from water sources.
- Keep the placenta cool in a fridge no more than 2 days. Transfer it to the freezer after 2 days.
- It cannot be thrown out in the regular garbage.

For more detailed information from a western medicine perspective, see BCWH's statement on placentophagy.

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What to Expect When Giving Birth

A few things that may occur once an individual is admitted in labour:

Mental and emotional preparation

Birthing is an intense experience that can bring up strong emotions and feelings. Support the birther in preparing for this coming intense experience. Draw from other times in the birther's life when they experienced strong emotions – what worked well for coping during those times?

Urinary catheterization as needed

Medical procedures such as epidurals may make it difficult to continue voiding without assistance. The nurse may need to support the laboring individual by way of urinary catheterization. Provide information to the individual about how an empty bladder allows for baby to move down into the birthing canal and supports the labour process. After delivery, an empty bladder is necessary in order to allow the uterus to contract to stop bleeding.

Clear fluids

Once the individual is admitted in labour, they will be restricted to clear fluids only. The rationale for this is that it decreases the risk of aspiration should the individual experience complications and require surgical intervention with anaesthesia. If it is important to them to be able to eat throughout labour, encourage them to discuss this with their PCP.

IV (intravenous) insertion

IVs are often inserted to help with fluid and medication management. Encourage the individual to talk about it with the labour and delivery nurse and team.

Induction or oxytocin augmentation

Provide information to the individual that sometimes labour needs to be induced due to risk factors. Other times, labour slows down and needs support (augmentation) from a medication called oxytocin. Oxytocin stimulates the uterus to contract and thus supports the progression of labour.

Immediately following delivery

- Let the individual and partner know to anticipate a wet squirmy newborn to be placed on their chest immediately following delivery, including in the operating room. See the skin to skin section of this Handbook.

- The nurse will support the individual to initiate breastfeeding immediately following delivery.
- The nurse will discuss two newborn medications that are typically given within the first hour of life. Please note that parents typically need to opt out if they do not want the medications:
    - Erythromycin – eye ointment for prophylaxis of ophthalmia neonatorum (acute inflammation of the eyes and inner eyelids caused by bacteria or viruses)
    - Vitamin K – IM injection – babies are born with low levels of vitamin K, an important blood clotting factor. A vitamin K injection is given to help prevent hemorrhagic disease of the newborn. (Must be given within first 6 hours of life).
      See BC Women's Hospital's handout Vitamin K and Your Newborn

Syphilis screening at time of delivery [(81)]

Time of delivery refers to time of admission for delivery to a health care facility or any time after 35 weeks gestation for those planning home births. Screening is recommended in order to best prevent and detect maternal and congenital syphilis. Please see:
https://www.fnha.ca/about/news-and-events/news/new-guidelines-for-syphilis-testing-in-pregnancy
http://www.perinatalservicesbc.ca/about/news-stories/stories/new-recommendations-for-syphilis-screening

For more information on early tests for newborns, see BC Healthlink File:
https://www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/newborns/early-tests-and-treatments-newborns

Labour 101

All of the following information is paraphrased from the Society of Obstetricians and Gynaecologists of Canada (SOGC) Pregnancy Info webpage.

What are the early signs of labour?

- Sometime in the last several weeks leading up to delivery, the baby will 'drop'. This means that the baby's head will descend into the pelvis. The belly looks lower, breathing is a bit easier, and the need to urinate increases. For some individuals this doesn't happen until just before labour.
- Sometime in the last several days, vaginal discharge may change as the mucus plug that has sealed the cervix releases. This will look like a brownish or bloody discharge.
- There may be diarrhea.
- The water (membranes) may break (although for most this happens during labour). If water breaks at term, induction of labour may be recommended. This balances the benefit of having ruptured membranes for a shorter period of time before delivery (thus potentially decreasing risk of infection) against the benefit of spontaneous labour.
- There may be irregular contractions. Once the contractions are regular and less than or equal to five minutes apart, labour is beginning. A tip is to wait until there have been at least 10 contractions in an hour.

What happens over the course of labour and delivery?

While labour can be fast and furious, or slow and steady, all labours go through the same stages. For a first birth, **the process usually lasts around 12-14 hours**, once regular contractions are established. Subsequent labours and deliveries are usually shorter. The length of the first stage of labour (opening of the cervix) increases with the age of the birther and body mass index.

See Penny Simkins' Comfort in Labour guide for birthers and their partners. It gives excellent advice and recommendations for comfort measures such as:

- Rhythmic breathing or moaning with tension release
- Movement and positioning
- Shower or Bath
- Heat and cold
- Touch and massage

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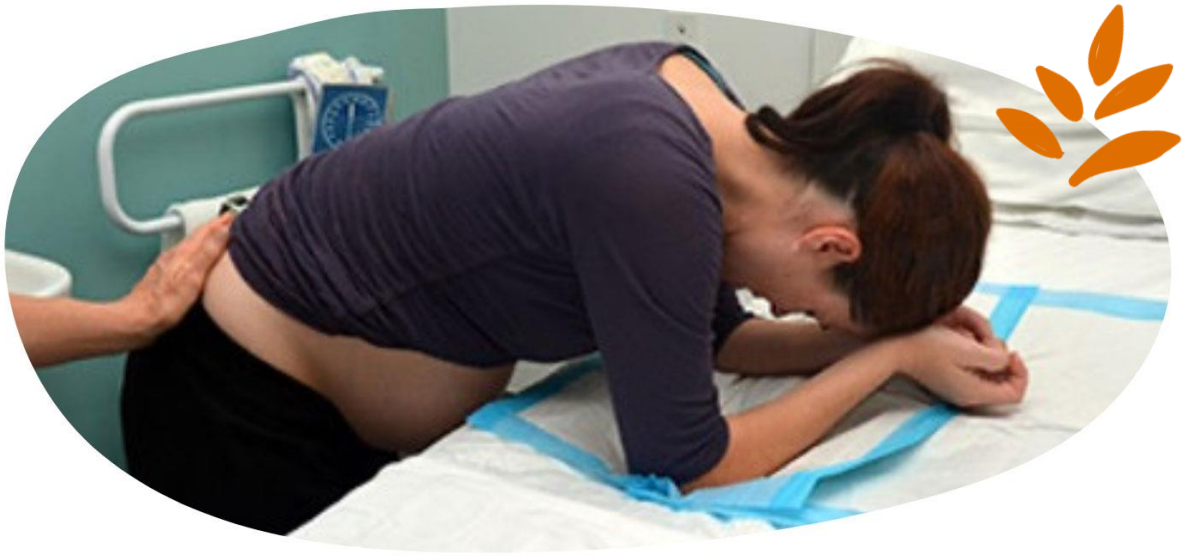
Stages of Labour [16]:

All of the following information is paraphrased SOGC's Pregnancy Info webpage.



Stage 1 of Labour – Opening of the Cervix

There are three parts to this stage of labour:

1. **Latent phase (0-4 cm)**.
    - There will be regular and increasingly frequent contractions to efface (thin) and dilate the cervix.
    - This is the longest stage of labour.

2. **Active phase (4-8 cm)**.
    - The cervix dilates more quickly.
    - Contractions become regular and more intense.
    - May feel strong pain or pressure low in abdomen or back.
    - For those delivering their first baby, progress of at least 0.5 cm per hour is considered normal.
    - Admission to hospital is usually at 4cm.

3. **Transition (8-10 cm)**.
    - The final phase of stage 1 involves full dilation of the cervix to 10 cm.
    - Contractions are very strong, intense, frequent, 2-4 minutes apart and last from 60-90 seconds.
    - The laboring person may start to feel the urge to push or feel strong pressure.

Stage 2 of Labour – Pushing the Baby out

All of the following information is paraphrased from the SOGC's Pregnancy Info webpage.

- Once the cervix is fully dilated, it is time to push.
- Push with the contraction and relax as best as possible between contractions.
- Delivery takes around 1-2 hours for first babies and less time for subsequent deliveries.
- Individuals often want to know what pushing is like. It is like having a bowel movement. One pushes down into their gluteus maximus or buttocks, not into their feet as some people think (when they visualize the McRoberts position with hips flexed, knees flexed and feet pushing against resistance).

Cutting the cord

- Once the baby is born, the baby is placed on the birther's chest to stay warm and to bond.
- Delaying clamping of the cord will give the baby an extra supply of iron-rich blood.
- When it is time to cut the cord, this can be done by the partner or health care provider.

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Stage 3 of Labour – The Placenta

After the baby is delivered, mild contractions continue to help the placenta to come out. The routine administration of oxytocin (intramuscular injection upon presentation of baby's anterior shoulder) to stimulate these contractions at this time decreases the chance of major bleeding after delivery.

Pain Management [(18)]

All of the following information is paraphrased from the SOGC's Pregnancy Info webpage.

Pain management without medications

Continuous support - friend, family member, doula, partner or health care provider
Breathing -

Slow breathing is good for early labour. Breathe in 4 counts then out 4 counts.
Rapid breathing, or light and quick breaths, may help during active labour. As the contraction intensifies, make breaths shorter and faster and then lengthen them again as the contraction subsides.
Transition breathing may help for when labour is most intense and it is difficult to breathe slowly, some may find a 'pant-pant-blow' style of breathing helps.

Surroundings – make the birthing room feel like home. Pillows and blankets, dim lighting and a playlist can all help the body to relax and do what it needs to do.
Guided imagery and visualization - These techniques involve shifting attention away from pain through yoga, relaxation, visualization, breathing and/or self-hypnosis.

- Positions **-** Moving around and changing positions can help make labour easier. Shifting between standing, sitting upright, lying on your side, squatting, kneeling on all fours. One can also try sitting on a birthing ball or stool. As labour progresses the position that seems best may change. Keep trying alternative positions.
- **Water -** Warm water can help ease labour pain, especially in the early parts of labour. A whirlpool, bathtub, birthing pool, or shower can be used. Be sure the water isn't too hot, as this can cause an increase in blood pressure
- **Vocalizing -** Use the voice! Encourage the individual to cry out, moan, groan, chant, sing or make whatever sounds feel right to them.
- **Massage** - The birth support partner can provide comfort by using touch. This can include massage, pressure, or gentle touch. Firm pressure on the sacrum can be helpful. Practicing massage techniques ahead of time can help the birther to figure out what they like and don't like.

Pain management with medications

All of the following information is paraphrased from the SOGC's Pregnancy Info webpage.

- **Nitrous oxide** (Entonox) – This is a 50/50 mix of nitrogen and oxygen also known as 'laughing gas'. The individual self-administers it because it can cause nausea, vomiting, dizziness. Entonox may be particularly helpful in situations such as when labour is progressing rapidly and there isn't enough time for an epidural, when a person wants to take the edge off of the peaks of the contractions or it may work well for someone who does not want to have any other types of pain medication. It is important to be aware that it may also impair memory.
- **Narcotics** - They are very effective. The risks associated with using narcotics for pain relief include nausea, vomiting, dizziness, hallucinations, low blood pressure and slow or fast heart rate. There is also a risk that narcotics may affect the baby's heart rate. Babies born to birthers who have taken narcotics later in labour may be slower to breathe well on their own or begin breastfeeding. This is why narcotics are usually given during the early stages of labour in order to avoid these side effects.
- **Epidural -** An epidural is a very effective form of pain relief for those in labour. An epidural involves the insertion of a needle between two vertebrae in the back and into the space surrounding the spinal column. A tiny catheter is inserted through the needle and the needle is removed. A medication (either a narcotic or an anesthetic or both) is injected into the epidural space, through the catheter. Once the epidural is in place, it remains until after delivery of the placenta.

Some of the risks with epidural use in labour include:

- A decreased ability to walk and move around
- Lower back pain (although many people who don't have an epidural experience low back pain during and after labour and delivery)
- Low blood pressure (BP) (nurses monitor BP closely during labour)
- Difficulty voiding
- Prolonged labour
- Headache
- Fever

See BC Women's Hospital's (BCWH) Information about Epidurals patient handout and BCWH's general information on pain relief during labour for more information.

Birthing Positions

Refer to this resource for pictures alongside descriptions:
https://www.lamaze.org/Portals/0/docs/infographics/LamazeInternational_LaborPositions.pdf

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Birthing Interventions (Vacuum, Forceps, Caesarean) [17]

Assisted delivery:

Deliveries require assistance when baby is experiencing stress (decreased oxygen), the birther has a condition that prevents voluntary pushing, the uterus is not contracting well or the birther is too exhausted to effectively push baby out.

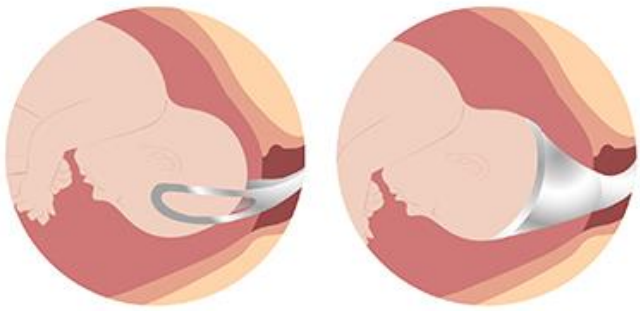
Vacuum

- Plastic cup that uses gentle suction on baby's head

Forceps

- Slim, curved, tong-like instruments that slide around baby's head inside birth canal
- Sometimes, but not always, episiotomy (incision between anus and vagina) needed

These procedures may cause bruising to baby's head. The healthcare providers will monitor baby closely during the postpartum period.



Forceps **Vacuum**

For more information see:

1. BC Women's Hospital on Caesarean Deliveries and Vaginal Birth After Caesarean (VBAC)
2. Healthlink BC file on Caesarean Section.
3. Baby's Best Chance p.44 for information on caesarean sections, forceps, and vacuum.
4. The SOGC website on assisted deliveries.

Perinatal Services BC Decision Support Tools

Perinatal Services BC (PSBC) has an excellent set of Decision Support Tools (DST) to support labour management in a rural setting when there is no Primary Care Provider present. Please note that these DSTs are from 2011 and are currently being updated. They are included here as reference tools however they do not replace clinical judgement nor critical thinking.

Nursing Stations – It is important to be prepared for urgent scenarios and emergencies. Take some time to familiarize yourself with the above DSTs. They should be printed out and contained in a binder alongside the emergency labour and delivery equipment bag. If there is no binder, let your FNHA community health practice consultant or the MCH team (mchnursing@fnha.ca) know so that they can support you in making one.

You should also have a binder with the following PSBC documentation tools in the case of managing labour when a Primary Care Provider isn't present:

- **Partogram**
  Guide for completing the partogram – familiarize yourself with this well in advance
- **Newborn record parts 1 + 2**
  Guide for completing the newborn records
- **Triage and assessment form**
  Guide for completing the triage form
- **Postpartum clinical path**
  Guide for completing the PP clinical path
- **Newborn clinical path**
  Guide for completing the newborn clinical path

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Extended Learning – Perineal Massage Before Birth

Perineal massage before birth helps to reduce the risk of tearing or the need for an episiotomy. It is recommended to practice perineal massage during pregnancy because this type of massage may help make the tissue around the vagina more flexible and reduce the chance of having a perineal tear or an episiotomy. (68)

The perineum stretches and tears sometimes during delivery. Studies show that individuals who are pregnant who did regular perineal massage for a few weeks before their due date, reported less perineal pain in the postpartum weeks. For people having their first vaginal delivery, there were lower rates of episiotomy. (38)

Episiotomy: an incision between the vagina and anus to help baby come out. They are not routine practice and are only performed if the Primary Care Provider deems it necessary and in the best interest of the birther and baby. After delivery, the incision is sutured. Episiotomies can be to different depths (perineal tearing is described with the same degree scale below):

Classification for perineal tears and episiotomies:

- **1st degree** – mucosa and perineal skin only
- **2nd degree** – extends into the fascia and musculature of the perineum including underlying subcutaneous tissue. Does not involve the anal sphincter
- **3rd degree** – extends through the fascia and musculature of the perineum, extends to the anal sphincter
- **4th degree** – extends past anal sphincter to anal mucosa

For more information, see HealthLink BC's Episiotomy and Perineal Tears.

The Time After Birth

Self-reflection

Do you or anyone you know have a breast/chestfeeding story or experience they are willing to share with you?

How comfortable are you teaching breast/chestfeeding? Assessing breast/chestfeeding?

Open your journal and take a few moments to write down, draw, say out loud, or acknowledge in a way that is meaningful to you, some of the things that come to mind when you think of breast/chestfeeding:

_____

It is important to note your personal comfort level and confidence with supporting, assessing and teaching breast/chestfeeding. If you are feeling uncomfortable, what do you feel you need to increase your comfort and confidence level? It is important for all nurses to support breast/chestfeeding as it is a public health priority.

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Newborn/Infant/Child

Assessment (Physical, Growth, Development, Emotional)

- Informed Consent – remember to always keep in mind the importance (and due diligence) of obtaining informed consent prior to any physical examination or assessment.
- PSBC recommends that health assessments of the well birther and baby should occur:
  - Within 24-48 hrs of leaving the hospital
  - One week later
  - One month after birth and
  - Two months after birth
- Well-baby assessments are usually completed at the same time as the 2, 4, 6, 12, 18 month and 4-6 year old routine childhood immunization appointments.
- Book at least 1 hour for your immunization and well-baby assessments – relationship building is key and baby's parents or guardians will likely have questions or concerns to discuss.
- The need for a more in-depth assessment or more assessments than the minimum number listed above, will depend on the baby's condition and history. Here are a few examples of when birther and baby would need more assessments than the minimum number above:
  - The baby is consistently slow to gain weight. This requires a thorough feeding assessment, close monitoring and follow-up with the Primary Care Provider.
  - The birther or parent is unsure about breast/chestfeeding or the parent had a negative experience with feeding in the past. They will require more assessments than the minimum number. The CHN could encourage daily feeding assessments for the first week followed up with phone assessment the second or third weeks.
  - The baby presents with signs of illness such as decreased appetite, decreased number of wet diapers, crankiness or other signs of potential illness. In these cases, a full head-to-toe physical exam should be completed with Primary Care Provider follow-up as needed.

Guides for completing the assessments:

- Physical Assessment - Use the PSBC Newborn Nursing Care Pathway and the Baby Rourke to guide you. Best practice is to always do a full head-to-toe physical assessment (with the parent's or guardian's consent).
- **Biliary Atresia Stool Colour Card** – This is a helpful resource intended for parents and caregivers. It is also helpful for CHNs to use when assessing a newborn's stool during the first month postpartum. It is a quick reference guide to use when comparing a newborn's stool colour against both normal and abnormal stool colours. Newborns are born with a surplus of red blood cells. The liver metabolizes and excretes these red blood cells. If there is liver disease present resulting in the blockage of the bile duct, bile will back up. One of the ways to assess for this is infant stool colour and it is important for parents and caregivers to do so every day for the first month.
- Growth – Use the WHO growth charts to document weight, head circumference and length. It is important to measure all three areas.
- Development – Use the ASQ3 and ASQ:SE These may be completed by the parent/guardian, CHN or an Early Childhood Care and Education (ECCE) worker.

The PSBC Newborn Nursing Care Pathway covers:

- Newborn physiological stability
- Newborn pain
- Physiological health
  - Head
  - Chest
  - Abdomen
  - Musculoskeletal
  - Neurological
  - Integumentary
  - Genitourinary and more
- Behaviour
- Screening etc

To access, please click on either the embedded link above or click on this url:
http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Newborn/NewbornNursingCarePathway.pdf

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Here is an example of part of the Newborn Nursing Care Pathway (p.7) for assessment of the 'Head':

Physiological Assessment	0 – 12 hours Period of Stability (POS)	>12 – 24 hours	>24 – 72 hours	>72 hours – 7 days and beyond
HEAD **Assess:** • Shape • Size • Fontanelles • Circumference prn Assess mother's/family/ supports understanding of newborn physiology and capacity to identify variances that may require further assessments **Refer to:** • **Behavior** • **Postpartum Nursing Care Pathway: Bonding & Attachment**	**Norm and Normal Variations** • Head round, symmetrical • May have moulding, some overlapping of sutures • Anterior & posterior fontanelles flat and soft • Neck short and thick • Full range of motion **Parent Education / Anticipatory Guidance** • Place baby skin-to-skin • Discuss variances and when they should resolve (caput succedaneum, cephalohematoma etc.) – refer to variance >12 – 24 hr ▪ Care when handling infant's head • Refer to >12 – 24 hr	**Norm and Normal Variations** Refer to POS **Parent Education / Anticipatory Guidance** • Anterior fontanel: 2 – 4 cm long, diamond shape, closes at 12 – 28 months • Posterior fontanel: smaller than anterior, triangular shape • Supine (back) sleep position • Carry baby and alternate head positions (to avoid flattened head) • Prevention of SIDS **www.healthlinkbc.ca/healthfiles/ hfile46.stm**	**Norm and Normal Variations** • Refer to POS **Parent Education/ Anticipatory Guidance** • Refer to >12 – 24 hr	**Norm and Normal Variations** • Refer to POS • Moulding resolves ~ 3 days • Average head circumference 33 – 35 cm once moulding disappears (ensure consistent way of measuring)[14] **Parent Education / Anticipatory Guidance** • Refer to >12 – 24 hr • Prevent plagiocephaly (flat spots on head) and strengthen neck muscles by placing baby on abdomen when awake (tummy time) for several short periods each day • Carrying infant in arms (vs. in infant seat) assists with prevention of flat head ▪ And promotes bonding

Please note that this pathway is from 2015 and is currently being updated. It is included here as a resource however it does not replace clinical judgement or critical thinking.

Safer Sleep

British Columbia has taken a strong harm reduction and empowerment approach regarding information on safe infant sleep.

"Sudden, unexpected infant death during sleep is an umbrella term used by the British Columbia Coroner's Service to refer to all unexpected infant deaths that occur during sleep as the result of undetermined causes (formerly referred to as SIDS, SUDI, or SUID), accidental causes, and natural causes." (25, p7)

"As a health-care provider, you have the opportunity to share safer infant sleep messages with parents/caregivers to help reduce the risk of sudden, unexpected infant death during sleep." From PSBC's Safer Infant Sleep, a Practice Resource for Health Care Providers

Please note that there has been an important change in terminology and it is no longer best practice to use the terms SIDS (sudden infant death syndrome), SUID (sudden unexpected infant death), or SUDI (sudden unexpected death in infancy). Instead, there is a movement toward using the term, "**sudden unexpected infant death during sleep.**" [(25, p3)]

For more information on the change in terminology, please read this update (p.4) (2022) from PSBC:

"In 2009, the BC Coroners Service along with the Canadian Medical Examiners and Chief Coroners across the country shifted the language of what was previously described as SIDS/SUDI/SUID to being classified as deaths that are "undetermined." According to the BC Coroner's Service this change in terminology is due to the limitations of the term SIDS/SUDI/SUID in understanding, classifying and preventing infant sleeping deaths. SIDS/SUDI/SUID is not useful in understanding the risk factors and preventative measures associated with infant sleeping deaths; rather, they are categories of exclusion in the absence of another explanation and, ultimately, are not helpful in understanding infant deaths." [(25, p3)]

The following information comes from PSBC's Safer Infant Sleep – Practice Resource for Health-Care Providers (2022):

The 3 main considerations for safer sleep are (see p.5 of the Safer Infant Sleep resource):

1. **Sleep environment** – no tobacco/substances, temperature no more than 20 degrees C, share room with baby for first 6 months

2. **Sleep position** – put baby on back for sleep. Use TICKS acronym (p.26 of the Safer Infant Sleep Resource) when positioning baby in sling, carrier, or wrap

3. **Sleep surface** – a separate sleep surface is recommended for those infants at risk of sudden unexpected infant death during sleep

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Three key messages: [(25, p5)]

1. "**Breastfeeding is a protective factor** in reducing sudden unexpected infant death during sleep, regardless of sleeping arrangement."
2. "**Swaddling is an unsafe sleep practice** that may increase the risk of overheating and may increase the risk of sudden, unexpected infant death during sleep. We encourage you to have open, respectful discussions with individuals who are parenting/caregiving about swaddling to promote families to make informed decisions that meet their cultural preferences, values and needs."
3. "**Promoting the wellbeing and mental health of parents/caregivers helps to support safer sleep practices for their infants**."

Honouring Our Babies: Safe Sleep Cards & Guide is an educational toolkit that supports healthcare providers to discuss and provide information on safe sleep practices with First Nations and Indigenous families to reduce the risk of sudden, unexpected infant death during sleep. [(82)]

The toolkit is interactive, evidence-informed and incorporates cultural beliefs, practices and issues specific to First Nations and Indigenous communities. The toolkit consists of a facilitator's guide and 17 illustration cards that can be used to facilitate conversations with families about safer infant sleep. [(82)]

- **FNHA - Honouring our Babies Toolkit: Safe Sleep – A Summary for Families (this resource is currently being updated March 2024):** https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Honouring-Our-Babies-Summary.pdf

- **PSBC – Honouring Our Babies – Safer Sleep Toolkit for Facilitators:** http://www.perinatalservicesbc.ca/Documents/Resources/Aboriginal/SafeSleep/HOB_SafeSleep_FacilitatorsGuide.pdf

- **PSBC – Honouring Our Babies – Safer Sleep Cards for use with the Toolkit:** http://www.perinatalservicesbc.ca/Documents/Resources/Aboriginal/SafeSleep/HOB_SafeSleep_IllustratedCards.pdf

Bonding and Attachment

Attachment

A healthy attachment is key to promoting the lifelong health of baby. It teaches baby that they are safe and loved. As they grow, it helps them develop good emotional and mental health, build strong relationships and have the confidence to explore the world around them. Each time the parent responds to their baby's needs in a warm and consistent way, they're building attachment. For example, if they cuddle and soothe them each time they cry, they're showing them that they can depend on the parent for comfort. [(4, p69)]

How to Build a Healthy Attachment With Baby: [(4, p69)]

- Listen, watch and try to understand how they communicate their needs
- Respond to their needs in a loving way
- Respond to their needs as quickly as you can
- Respond to their needs in a consistent way
- Cuddle, smile and talk to your baby often

Skin to Skin [(85)]

Skin to skin is when baby is placed directly on parent's bare chest. This happens immediately after birth, including in the operating room, and is encouraged during breast/chestfeeding or at any other time for bonding. It is recommended for anyone wanting to grow and foster close connection and bonding with baby, for example – partner, auntie, grandma, sister, etc. In the NICU, this is known as kangaroo care. Skin to skin also has numerous physiological, physical and developmental benefits for baby:

- Calms and relaxes both the person who gave birth and the baby
- Regulates temperature, heart rate and breathing
- Stimulates digestion and feeding
- Stimulates release of hormones to support breast/chestfeeding
- Improves oxygenation
- Reduces stress/cortisol release
- Helps baby adapt to extrauterine life (life outside of the uterus)

Tummy time

Supervised tummy time a few times per day helps to avoid flat areas on baby's head, helps baby to learn to roll and crawl and strengthens the muscles in baby's neck, back and arms. [(4)]

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"Make sure your baby has time to play on their tummy each day; during 'tummy time', babies should be awake and monitored by an adult." (24, p19)

"Prevent plagiocephaly (flat spots on head) and strengthen neck muscles by placing baby on abdomen when awake (tummy time) for several short periods each day." (26, p7)

Oral Health

The FNHA Children's Oral Health Initiative (COHI) is an early childhood tooth decay prevention program for children 0-7 yrs old, their caregivers and individuals who are pregnant who are living on reserve. (27)

- **COHI's goal**: Improve oral health and well-being.
- **COHI's aim**: Promote a lifetime of oral health by preventing tooth decay, treating and restoring teeth that have tooth decay, improve oral health knowledge, change oral health-related behaviours and reduce number of children that require general anesthesia for dental surgeries.

The COHI webpage provides many resources related to oral health care for babies, children, people who are pregnant and healthy eating and nutrition. https://www.fnha.ca/what-we-do/maternal-child-and-family-health/childrens-oral-health-initiative

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Planning for Immunizations

The postpartum period is an ideal time to create space for and start to discuss the topic of immunizations. Baby's first routine immunizations are due at 2 months of age (with the parent's or guardian's informed consent), therefore the best time to start to discuss immunizations is during pregnancy and early on in the period of time after the baby is born. Opening a discussion with hearing what the parent's thoughts and perspective on immunizations is a good starting point.

- Remember to reach out to the FNHA Immunization Team at immunize@fnha.ca for more information and for support with any questions you may have.
- You can also visit the FNHA Immunization Program webpage at: https://www.fnha.ca/what-we-do/communicable-disease-control/immunization-vaccine-preventable-diseases
- Please see relevant HealthLink BC files here: https://www.healthlinkbc.ca/more/health-features/vaccinations and Immunization Schedule for BC Infants and Children
- Immunize BC has excellent resources as well:
  - Reasons to vaccinate
  - Tips for reducing pain, stress and anxiety with vaccinations
  - FAQs on vaccine safety
- See the BCCDC Immunization Manual for more detailed information.
- See Appendix G Immunizations and Pregnancy for more information as well.

Routine immunizations were found to potentially have a protective effect against sudden, unexpected infant death during sleep but there is a lack of sufficient evidence to suggest a causal relationship. [(25)]

Documentation (WHO growth, Rourke, ASQ)

World Health Organization (WHO) growth charts

The WHO growth charts help to [19]:

- Monitor a child's growth.
- Confirm a child's healthy growth and development.
- Identify early a potential nutritional or health challenge.

You can access the WHO growth charts at: https://www.dietitians.ca/growthcharts

- It is important to select the correct gender and age range – *Birth to 24 months* or *2 to 19 yrs*.
- Ensure you measure weight, length and head circumference!
- Remember that the 'x' axis (the left-to-right axis) is plotted in months, not weeks.

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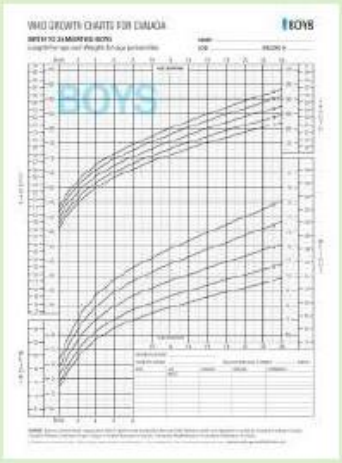
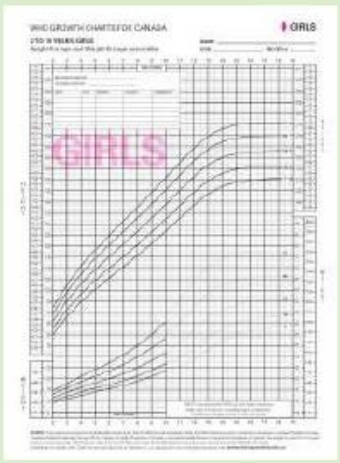
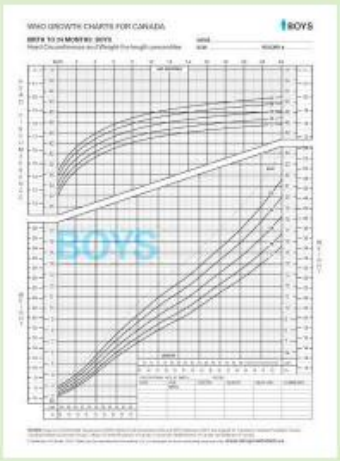
Here are some WHO growth chart examples:

Birth–24 Months*	2–19 Years*
 Length-for-age and Weight-for-age	 Height-for-age and Weight-for-age
 Head circumference and Weight-for-length	 Body Mass Index (BMI) -for-age

* The Growth Charts in Table 1 have been adapted for Canada with permission from the World Health Organization. (19)

Here is the Health Professional's Guide for using the WHO growth charts for Canada:
https://www.dietitians.ca/DietitiansOfCanada/media/Documents/WHO%20Growth%20Charts/2014-A-Health-Professionals-Guide-to-Using-the-Charts.pdf

The Health Professional's Guide reviews important advice such as how to plot a preterm infant's growth:

It is recommended that preterm infants' measurements be plotted using their corrected age.

- **Example:** a baby who was born at 30 weeks, presents for a Well-Baby visit at 12 weeks postnatal/postpartum time. This baby would have a corrected age of 2 weeks. How did we come up with a corrected age of 2 weeks? See below:
  40 weeks = due date
  30 weeks = baby's birthday
  10 weeks = the difference between the due date and baby's birthday

  12 weeks (the age at presentation) – 10 weeks (the length of time needed to have reached the due date) = **2 weeks corrected age**

What is a percentile?

The curves on the growth chart represent selected percentiles of the measurements of large numbers of children in the reference population that were studied to develop that growth chart. These percentile curves are measured from 1 to 100 and can be used to identify the child's growth relative to other children of similar age and sex. **For example, if a child's weight is on the 85th percentile, it means that 85 of 100 children weigh less and 15 weigh more.** [(19)]

Important considerations with growth charts:

- It is less about which percentile the child is in and more about monitoring to ensure the child follows their percentile. If there is a sharp incline or decline in growth, or if there is a growth line that remains flat, the child should have follow-up with their Primary Care Provider (PCP).
- If the child is outside of the 3% - 97% range, follow-up with the child's PCP.
- Growth charts are only one part of monitoring and supporting a child's growth and development. Keep in mind the overall picture including the child's health history etc.

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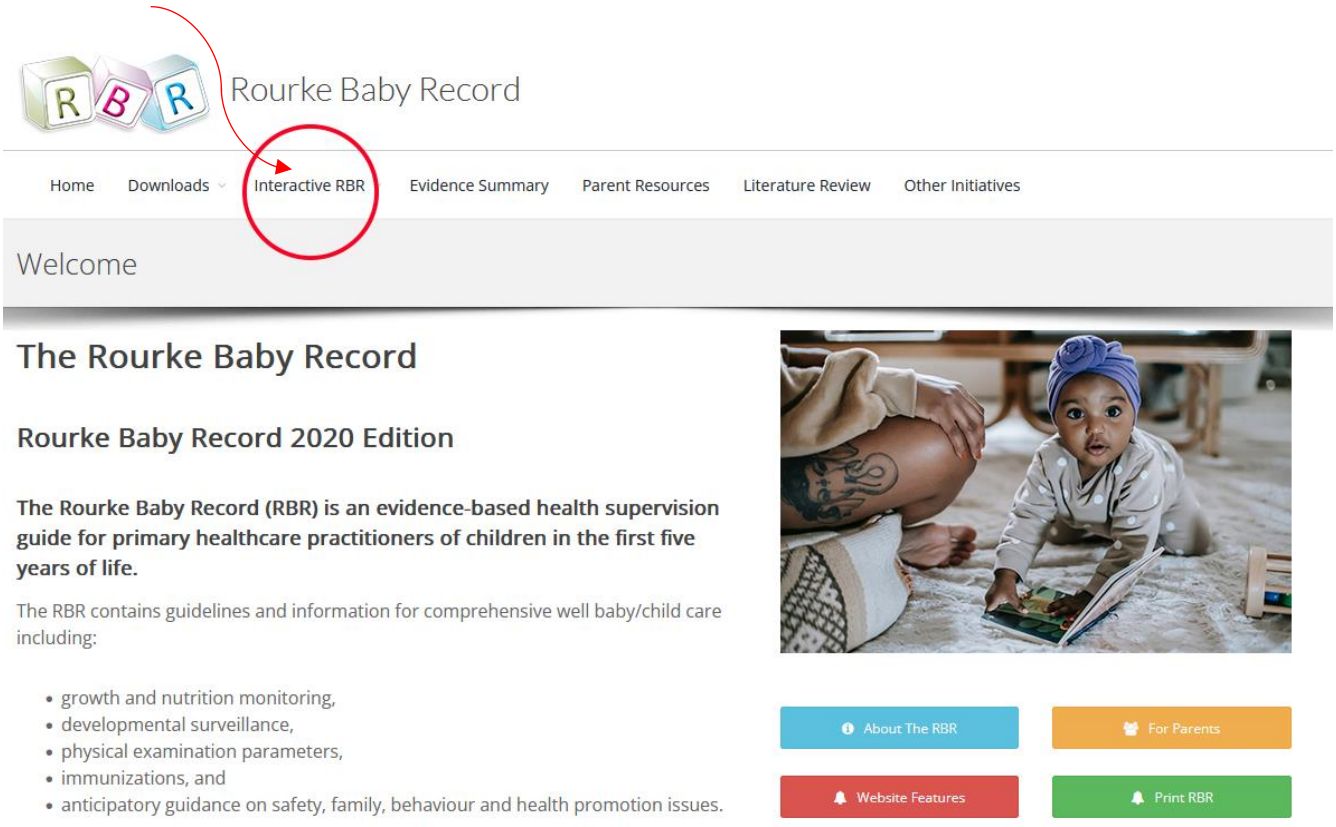
Rourke Baby Record

"The Rourke Baby Record (RBR) is a system that many Canadian doctors and other healthcare professionals use for well-baby and well-child visits for infants and children from 1 week to 5 years of age." [(21)] As per PSBC, the RBR is the gold standard for assessment and documentation of the baby. [(83)] As well, the RBR is up to date, evidence informed, and provides user support.

"It includes forms (Guides I to V) for charting the well-baby visits and Resources (pages 1 to 4) that summarize current information and provide links to supporting resources for healthcare professionals." [(21)]

See: https://www.rourkebabyrecord.ca/rbr2020/default for more information. We encourage you to use the interactive section on the RBR website. You will be able to click on the different topics within the assessment forms and a pop-up window will appear with an explanation and resources for that which you are assessing.



Here is an example of an RBR for 0-1 months of age (https://www.rourkebabyrecord.ca/walk1):

Rourke Baby Record:
Evidence-Based Infant/Child Health Maintenance
www.rourkebabyrecord.ca | See RBR parent web portal for corresponding parent resources
©2020 Drs. L Rourke, D Leduc and J Rourke. Revised Jan. 22, 2020

GUIDE I: 0 –1 mo (National)

NAME: _____ Birth Day (d/m/yy): _____/_____/ 20____ M ☐ F ☐
Gestational Age: _____ Birth Length: _____ cm Birth Weight: _____ g
Birth Head Circumference: _____ cm Discharge Weight: _____ g

Pregnancy/Birth remarks/Apgar: | Risk factors/Family history:

WITHIN 1 WEEK	2 WEEKS (OPTIONAL)	1 MONTH
DATE OF VISIT _____/_____/20____	DATE OF VISIT _____/_____/20____	DATE OF VISIT _____/_____/20____

GROWTH[1] use WHO growth charts. Correct age until 24–36 months if < 37 weeks gestation

Length	Weight	Head Circ. (avg 35 cm)	Length	Weight (regains BW 1–3 weeks)	Head Circ.	Length	Weight	Head Circ.

PARENT / CAREGIVER CONCERNS

NUTRITION[1] For each ❍ item discussed, indicate "✓" for no concerns, or "X" if concerns

❍ **Breastfeeding (exclusive)**[1]	❍ **Breastfeeding (exclusive)**[1]	❍ **Breastfeeding (exclusive)**[1]
❍ **Vitamin D 400 IU/day**[1]	❍ **Vitamin D 400 IU/day**[1]	❍ **Vitamin D 400 IU/day**[1]
❍ *Formula feeding/preparation*[1] [150 mL(5 oz)/kg/day[1]]	❍ *Formula feeding/preparation*[1] [150 mL(5 oz) /kg/day[1]]	❍ *Formula feeding/preparation*[1] [450–750 mL(15–25 oz) /day[1]]
❍ Stool pattern and urine output	❍ Stool pattern and urine output	❍ Stool pattern and urine output

EDUCATION AND ADVICE Repeat discussion of items is based on perceived risk or need

Injury Prevention[1]
- ❍ **Motorized vehicle safety/Car seat**[1]
- ❍ **Safe sleep (position, room sharing, avoid bed sharing, crib safety)**[1]
- ❍ **Firearm safety**[1]
- ❍ *Pacifier use*[1]
- ❍ *Hot water <49°C/Bath safety*[1]
- ❍ *Falls (stairs, change table)*[1]
- ❍ Carbon monoxide/*Smoke detectors*[1]
- ❍ Choking/Safe toys[1]

Behaviour and Family Issues[2]
- ❍ **Night waking**[2]
- ❍ **Healthy sleep habits**[2]
- ❍ Crying[2]
- ❍ Soothability/Responsiveness
- ❍ **Parenting/Bonding**[2]
- ❍ Family conflict/Stress
- ❍ Parental fatigue/**Postpartum depression**[2]
- ❍ **Inquire re: difficulty making ends meet or food insecurity**[2]
- ❍ **High risk infants/Assess home visit need**[2]
- ❍ Siblings

Environmental Health[1]
- ❍ **2nd hand smoke**/E-cigs/Cannabis[1]
- ❍ Sun exposure[1]

Other Issues[1]
- ❍ **Supervised tummy time while awake**[1]
- ❍ **No OTC cough/cold medicine**[1]
- ❍ *Inquiry on complementary/alternative medicine*[1]
- ❍ *Temperature control and overdressing*
- ❍ Fever advice/Thermometers[1]

Staff may wish to adapt the RBR in order to ensure it is a culturally safe and relevant resource.

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Ages and Stages Questionnaire

The Ages and Stages Questionnaire (ASQ3) 3rd edition is a screening tool for young children's development. Please note that communities may want your support in adapting it to ensure it is culturally relevant (think back to *relevance* as one of (the 4 R's of cross-cultural dialogue). There is also the ASQSE 2nd edition that focuses on screening for social-emotional development and challenges.

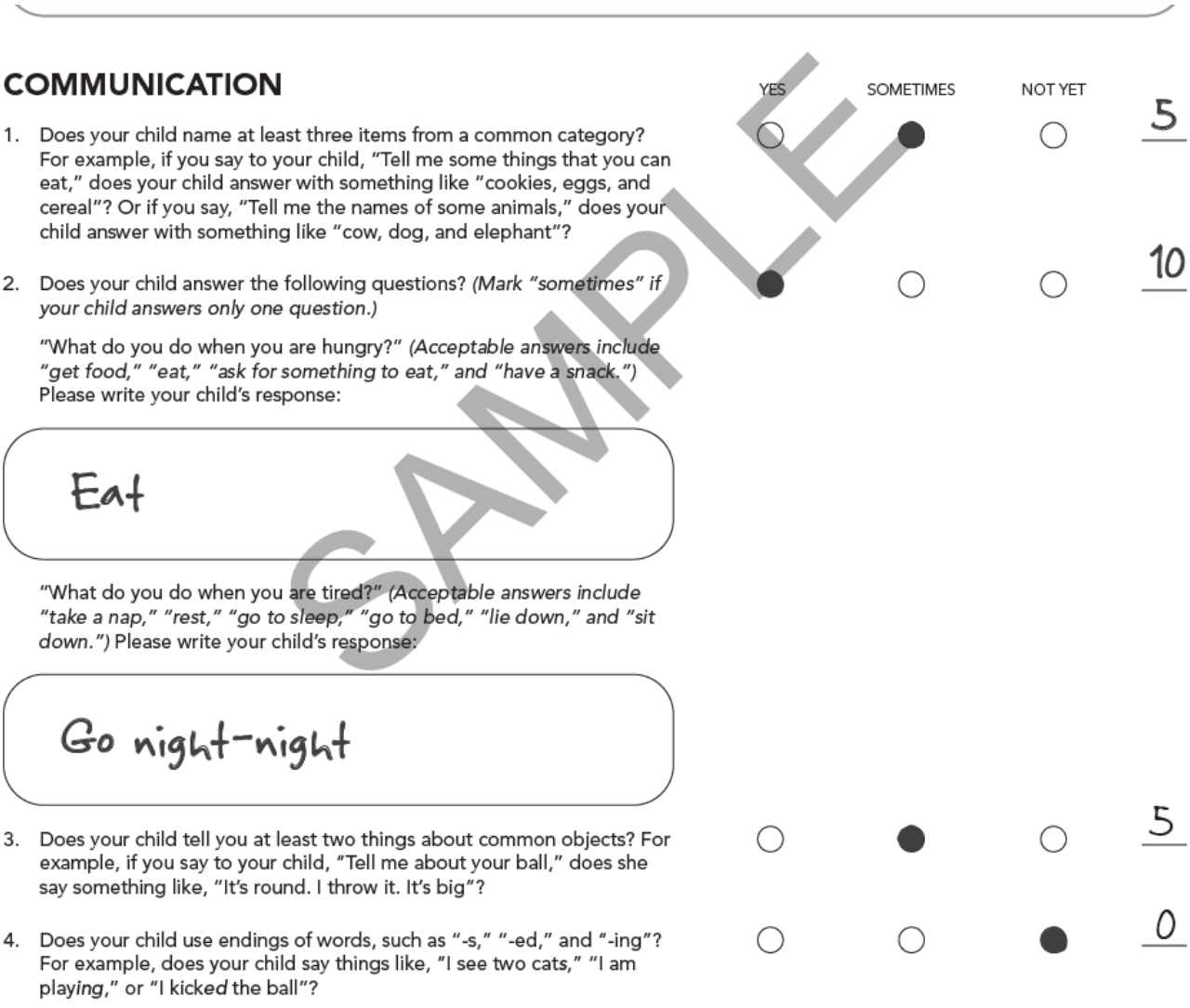
See agesandstages.com/ for more information.

If there are no forms available at the health centre or nursing station, please check with the HeadStart Program in community or check with the Community Health Representative as sometimes there are people in community who are already facilitating the ASQ with parents and children. If still unable to locate the forms, please contact the FNHA Maternal Child Health team at mchnursing@fnha.ca.

How to use the ASQ [22]:

1. **Select the questionnaire** that matches the child's age.
2. **Ask the parent to complete the questionnaire** or complete the form with the parent.
3. **The parent answers the questions.** ASQ's items are easy for parents to try with their child and respond to. Questions such as "Does your baby pick up a crumb or Cheerio with the tips of his/her thumb and a finger?" The parent answers *yes*, *sometimes*, or *not yet* then moves on to the next item. This process takes about 10–15 minutes.
4. **Score the questionnaire.** Then, compare the child's scores to the cutoff points listed on the scoring sheet.
5. **Discuss results with parents and determine next steps.** Communicate the screening results to the child's parents and suggest resources for follow-up, monitoring, or further assessment if needed.
6. **Share activities with parents.** Help parents encourage the child's development by sharing fun, fast ASQ learning activities: https://agesandstages.com/products-pricing/learning-activities/.

Here is a sample of a filled out ASQ for 48 months of age:



COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your child name at least three items from a common category? For example, if you say to your child, "Tell me some things that you can eat," does your child answer with something like "cookies, eggs, and cereal"? Or if you say, "Tell me the names of some animals," does your child answer with something like "cow, dog, and elephant"?	○	●	○	5
2. Does your child answer the following questions? *(Mark "sometimes" if your child answers only one question.)*	●	○	○	10

"What do you do when you are hungry?" *(Acceptable answers include "get food," "eat," "ask for something to eat," and "have a snack.")* Please write your child's response:

Eat

"What do you do when you are tired?" *(Acceptable answers include "take a nap," "rest," "go to sleep," "go to bed," "lie down," and "sit down.")* Please write your child's response:

Go night-night

3. Does your child tell you at least two things about common objects? For example, if you say to your child, "Tell me about your ball," does she say something like, "It's round. I throw it. It's big"?	○	●	○	5
4. Does your child use endings of words, such as "-s," "-ed," and "-ing"? For example, does your child say things like, "I see two cats," "I am playing," or "I kicked the ball"?	○	○	●	0

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Feeding and Nutrition

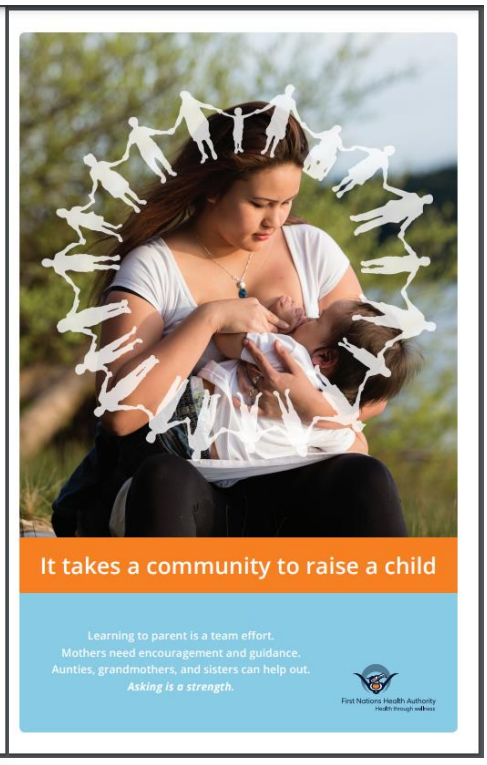
"Breastmilk is the first traditional food." (45)

Exclusive breast/chestfeeding is recommended up to 6 months of age and to continue in conjunction with foods up to and beyond 2 years of age. Although breastmilk is the first traditional food, it is important to remember that a parent may not breast/chestfeed for a variety of reasons. **It is their choice** and the CHN is there to ensure the family has the respectful and relevant information they need in order to make an informed decision on how they prefer to feed their baby.

Please see Appendix E for great, fun, and easy-to-use breast/chestfeeding resources such as videos and songs, academic papers, tools, and courses.

Also please see Baby's Best Chance pages 90-99 for more breast/chestfeeding information.

The following posters can be found at:
https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Breastfeeding-Wellness-Tips-For-Mothers.pdf



Brief overview of breast/chestfeeding fundamentals

What to Expect

Breast/chestfeeding can be challenging, especially in the first few weeks. It is a learned skill that both parent and baby go through. No two babies are alike so although a parent may have had success breastfeeding their first child(ren), they may encounter issues with their new baby. Parents may become frustrated and need additional support and encouragement. Let them know that it will become easier with time and practice.

How Often to Feed

See Baby's Best Chance page 92

How Do You Know Baby is Getting Enough?

See Baby's Best Chance page 92

1. Number of bowel movements, consistency and colour of stool – Baby's Best Chance page 70
2. Number of wet diapers – Baby's Best Chance page 70
3. Feeding frequently – 8 or more times in 24hrs
4. Baby is sucking effectively –wide open mouth, correct latch and making swallowing sounds
5. Breast/chestfeeding should not be painful. There may be a strong uncomfortable tug or pull when baby first laches, but once baby is sucking, the uncomfortable sensation should subside. Pain may indicate baby is not latched well. An ineffective latch results in ineffective milk transfer (baby not receiving enough milk).
6. Baby's weight gain - 20-35g/day in the first two weeks until birth weight regained by day 14. After two weeks, the baby will gain 120-240g/week (see graphic on next page).

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Breastfeeding My Baby

Breastfeeding is the normal and healthiest way to feed your baby. It is the only food your baby needs.
How do I know if my baby is getting enough breast milk? The best way is by the number of wet and soiled diapers and your baby's weight gain.

Your Baby's Age	1 week					2 Weeks	3 Weeks
	1 Day	2 Days	3 Days	4 Days	5, 6, 7 Days		
How often do I breast feed? Per day, on average, over 24 hours	I am feeding my baby 8 or more times per day (every 1-3 hours), including 2-3 night time feeds						
How big is my baby's tummy? **approximately*	5-7 ml • Size of a Marble		22-27 ml • Size of a Ping Pong Ball			60-80 ml • Size of an Egg	
How many wet diapers will my baby have? Per day, on average, over 24 hours **Clear pale yellow urine*	At least **1 WET**	At least **2 WET**	At least **3 WET**	At least **4 WET**	At least **5 WET**	At least **6 WET**	
How many soiled diapers will my baby have? Per day, on average, over 24 hours	At least **1-2** black or dark green		At least **2-3** brown, green or yellow		At least **2-3** soft and seedy yellow		
How much will my baby weigh?	Your baby may lose 7-10% of its birth weight in the first 3 days after birth			Your baby gains 20-35 grams (2/3 to 1 1/3 oz.) per day and regains his/her birth weight by 10-14 days		Your baby now gains 120-240 grams (4-8 oz.) per week	
Other Signs	Your baby has a strong cry, moves actively, and wakes easily. Your breasts feel softer and less full after a feeding. After a few weeks it is normal for your breasts to feel soft and still have lots of milk.						

This graphic can be found at:
http://www.perinatalservicesbc.ca/Documents/Resources/Breastfeeding/BreastfeedingMyBabyGuide.pdf

Please see Appendix E for great, fun, and easy-to-use breast/chestfeeding resources such as videos and songs, academic papers, tools, and courses.

Different Holds/Positions

Baby's Best Chance page 93

Here are 3 common positions (but there are many more!)

Effective Latch + Evidence of Milk Transfer

- Latch and position are two of the most important pieces to successful breast/chestfeeding.
- An effective latch supports milk production, the let-down reflex (release of breastmilk from the breast) and supports milk transfer from parent to baby.
- We encourage you to start to discuss breast/chestfeeding fundamentals with the parents or guardians in the prenatal period. This will give them important knowledge and support them in feeling empowered and more confident when initiating breast/chestfeeding.
    - Encourage them to practice different positions with a stuffed animal or baby doll.
    - Teach them good ergonomics such as ensuring they are comfortable and relaxed – E.g., feet up on a stool, a chair with good back support, pillows on lap/behind back/under an arm, bring baby to breast/chest – not the other way around.
    - Discuss how a position may work one day and not the next. Encourage them to experiment with all of the positions until one fits for that day or for that feeding.
- There are excellent videos to help the CHN and parent to visualize and learn the fundamentals of an effective latch – please see https://breastfeedinginfo.ca/table-of-contents/indigenous-families/
- An effective latch consists of: Chest to chest, nose to nipple, wide open mouth, flanged lips, no dimpling of cheeks, may hear audible swallow, rhythmic sucking, baby doesn't easily slide off the breast and no nipple damage or distortion after feed.
- Evidence of milk transfer consists of: Audible swallowing, rhythmic sucking, adequate output and appropriate weight for age.

How to get an effective latch (Baby's Best Chance p. 94):

1. Unwrap baby and remove any blankets. Skin to skin is best.
2. The parent holds baby close to their body with all of baby's body facing the parent's body so that they are tummy to tummy and hips to parent's ribs.
3. Keep fingers well back from the areola so that baby has access to a larger amount of breast.
4. Touch the baby's chin to their breast and point the baby's nose to their nipple and then wait for baby to open their mouth wide like a big yawn. It is important not to rush this step. Wait for baby to open their mouth wide. The partner can support this too by waiting with the breast/chestfeeder.
5. Once baby's mouth is wide open, bring baby to breast, not breast to baby. Roll the areola onto the baby's tongue so that the nipple is brought deep into baby's mouth.
6. Now that baby is latched on, have the parents take a look. The baby should have all of the nipple and as much areola as possible inside their mouth, ideally the baby's lower jaw has more areola in their mouth than the upper jaw. Baby's chin will be touching the breast and baby's nose will be in the air as if in a sniffing position. If just the nipple or tip of the nipple is in baby's mouth, break the latch and start over.
7. There may be an uncomfortable tugging or pulling sensation. This will subside. If there is pain, break the latch and try again. Break the latch by gently inserting a pinky finger into baby's mouth to break the seal.
8. Have in mind that the goal is to have an effective latch and it therefore may take several attempts before feeling comfortable. This is a normal part of the learning process for both parent and baby.

Baby-Led Breastfeeding

Another method of breast/chestfeeding is baby-led breastfeeding. This is an approach to infant feeding that takes advantage of a baby's innate ability to locate and latch on to their parent's breast when placed skin-to-skin. It is a technique that can be used with babies who are having difficulty breast/chestfeeding. Watch this video for a demonstration by Stephanie George, Oneida Nation Indigenous Midwife and Lactation Consultant: https://www.youtube.com/watch?v=N0-ycyUwVQQ

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Breast Pumps

Manual pumps, electric pumps and nipple shields – they're all covered!

- See p.9 and p.12 of the FNHA Health Benefits Coverage for Pregnancy and Infant Care for more information.
    - There is a specific process for a person to receive a pump through their health benefits plan. Nurses can have an active role in supporting this process. Registered nurses, along with physicians, midwives and nurse practitioners, can provide the required prescription, also referred to as a written recommendation.
    - Appendix I – Breast Pumps – Flow Chart – Process for Acquiring Breast Pumps Through Health Benefits explains the process that must be followed and the paperwork that is required.
    - Plan ahead! In the rural/remote context, it can take time to receive a pump.
    - Recommend to families that they look into pumps during the prenatal time. They can figure out where to purchase one, what type of pump they would like, who carries them, are they in stock, etc.
    - As the CHN, you may want to find out the local details on purchasing pumps so you can facilitate and support the process with families.
    - Pumps that allow double pumping are ideal. All double pumps require predetermination paperwork.
- Ensure you connect with the Community Health Representative or Health Director as there may be breast pumps available for loan in community.
- If you, or the family you are supporting, encounter problems, please email mchnursing@fnha.ca

Please see Appendix E for great, fun, and easy-to-use breast/chestfeeding resources such as videos and songs, academic papers, tools, and courses.

Breast/Chestfeeding and Caffeine, Medications, Tobacco, Cannabis, Alcohol

Baby's Best Chance page 102

When discussing substances and breast/chestfeeding, it is important to take the time to build relationship, to practice in a trauma-informed way, and to approach these topics from a harm reduction and strengths-based perspective.

Medications

- Most are safe but you can check with a pharmacist, 811, or MaBAL
- Codeine can harm baby

Alcohol

- Can lead to low blood sugar for baby
- Can decrease milk supply
- Can harm baby's growth, development and sleep

Caffeine

- Some babies are fine with it while others may become restless or fussy
- Try to limit daily intake to 300mg or 1.5 cups coffee or 4 small cups caffeinated tea per day

Smoking/Vaping

- Smoking can affect milk supply, make baby fussy, affect baby's sleep and put baby at higher risk of asthma, ear infections and Sudden Unexpected Infant Death during sleep (formerly referred to as SIDS)
- Vaping is full of harmful chemicals (nicotine, solvents) that can harm baby

Cannabis – see FNHA's Breastfeeding and Cannabis: Things you need to know and see the substance use section of this handbook

- THC stays in milk up to 30 days
- Can make baby drowsy, can decrease supply

There are various harm reduction measures that can be discussed with families. See Baby's Best Chance (p. 102) for more details and suggestions as well as https://www.bcapop.ca/Perinatal-Substance-Use-Resources for numerous helpful resources.

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Briefly, some examples of harm reduction include:

- Smoke/Vape after breast/chestfeeding. Change top/shirt before cuddling, holding or feeding baby.
- Smoke/Vape outside the house if possible or in a room the baby does not occupy.
- Pump and store milk for the baby if planning to drink alcohol.
- If consuming alcohol, wait 2 to 3 hours per drink before breast/chestfeeding or expressing milk for your baby.
- A note on "pump and dump" – Pump and dump refers to the act of maintaining one's milk supply and comfort while waiting for the body to clear a substance (Eg., alcohol, contrast mediums, short term use of a contraindicated medication – when in doubt, call the BC Poison Control Centre at 1.800.567.8911, 811 or MaBAL). Pump and dump does not clear a substance more quickly from the body.

Please also see Appendix E for great, fun, and easy-to-use breast/chestfeeding resources such as videos and songs, academic papers, tools, and courses.

Expressed Breastmilk (EBM)

See Baby's Best Chance p. 96 and HealthLink BC's video here.

EBM is human milk that has been hand expressed or pumped from the breast so that it can be given to the baby by spoon, cup or bottle.

- There are many reasons to express including but not limited to:
  - Expressing a few drops to keep nipples healthy
  - Softening full breasts to help the baby latch on
  - Storage of breastmilk if the breast/chestfeeding individual is going to be away from baby for some time
  - To get the baby interested in latching on
- Just like breast/chestfeeding, expressing is a skill that takes some time to learn. Gently support the birther in having patience and self-compassion

How to self-express:

1. Wash hands, make yourself comfortable
2. Bring the baby skin to skin
3. Can place warm cloth over breast ahead of time, not mandatory
4. Gently massage breast first
5. Place hand on breast with thumb and fingers opposite each other, about 2-4cm away from nipple
6. Press back toward the chest wall. Have a clean container or spoon or cup or bottle ready to catch and collect

Safe Storage/Handling

See Baby's Best Chance p.97

See p. 97 of Baby's Best Chance for milk storage (fridge/freezer/room temp) milk transportation recommendations.

Herbs and Galactogogues

Galactogogues – Synthetic or plant-based molecules used to induce, maintain and increase milk production. See https://kellymom.com/bf/can-i-breastfeed/herbs/herbal-ref/ for more information.

It is important to remember that due to a lack of research, the effect that natural medicines, herbs, and other galactogogues may have on breastmilk composition and supply, is not well known at this time.

We encourage anyone who wants to use herbs, natural medicines, galactogogues, non-pharmacologic or pharmacologic medications to increase milk supply, to first discuss this with their Primary Care Provider or a Lactation Consultant and possibly along with a Knowledge Keeper, if available, in their community.

- **Non-pharmacologic:**
  - Fenugreek (*Trigonella graecum foecum*)
  - Fennel (*Foeniculum vulgare*)
  - Goat's rue (*Galega officinalis*)
  - Asparagus (*Asparagus racemosus*)
  - Anise (*Pimpinella anisum*)
  - Milk thistle (*Silybum marianum)*
  - Raspberry leaf
  - Mother's Milk' tea – a combination of some of the above.
- **Pharmacologic** (requires prescription and management by a Physician, Nurse Practitioner or Midwife):
  - Domperidone
  - Metoclopramide

For more information on pharmacologic galactogogues, see:

1. **UpToDate -** https://www.uptodate.com/contents/common-problems-of-breastfeeding-and weaning?search=galactogogue&source=search_result&selectedTitle=1~7&usage_type=default&display_rank=1

2. **AskLenore** https://www.asklenore.info/breastfeeding/induced_lactation/domperidone_reglan.shtml

Herbs to avoid (not evidence-based) as they may decrease breastmilk supply (from kellymom.com and UpToDate):

- Black walnut
- Chickweed
- Herb Robert (*Geranium robertianum*)
- Lemon balm
- Oregano
- Parsley (*Petroselinum crispum*)
- Peppermint/Menthol
- Periwinkle herb (*Vinca minor*)
- Sage (*Salvia officinalis*)
- Sorrel (*Rumex acetosa*)
- Spearmint
- Thyme
- Yarrow

Breast/Chest Complications and Challenges

See Baby's Best Chance p. 98

1. **Sore nipples - Cracked, bleeding, scabbed, blistered**
   - Ensure effective **deep** latch (common to have some soreness for the first week)
   - Express until nipple heals and feels less painful
   - Gently rub on some drops of expressed breastmilk (let dry)
   - Feeding baby before baby cries
   - Breast/chestfeed on the less sore side first
   - May need to hand express or use a pump until nipple is healed
2. **Engorgement – Heavy painful breasts, nipples flattened**
   - Feed early and often
   - Can try icepacks for relief
   - Place warm compress on breast or take warm shower prior to feeding
   - Express breastmilk to reduce engorging, followed by self-massage. If baby will nurse, breast/chestfeeder can offer breast. Breast/chestfeeder will likely need to express first in order to soften the breast and areola enough to help with obtaining an effective latch.
   - Lying on back and using hands to exert gentle pressure on areola toward chest wall for a count of 50 may help
   - Breast/chestfeed on the engorged breast first

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3. **Plugged duct – Sore red spot, lump, firm area**
    - Breast/chestfeed often
    - Position baby with their nose or chin pointed toward the sore spot
    - Try different positions in order to drain all areas of breasts
    - Massage breasts while in the shower or place warm, wet compresses on them before feeding
    - Drain one breast well before switching to the other breast
    - Express if breast still lumpy after feeding
    - Follow-up with Primary Care Provider required if lump doesn't go away in a couple days

4. **Mastitis – Painful breast (firm, swollen, hot, red) and flu-like symptoms**
    - Requires treatment right away – consult with the individual's Primary Care Provider or MaBAL if the PCP is unavailable
    - Safe to continue breast/chestfeeding – the infection and antibiotics will not harm baby
    - Breast/chest feed or express or pump often
    - Position baby with their nose or chin pointed toward to the sore area
    - Ensure effective latch and milk transfer

5. **Yeast infection (thrush) – Itchy and burning nipples, rash on areola**
    - Baby may have white patches inside mouth or red diaper rash
    - Baby may refuse to feed, have slow weight gain or be gassy and cranky
    - Both baby and breast/chestfeeder will require treatment with antifungal cream
    - Wash bras daily
    - Keep nipples dry
    - Encourage use of probiotics by breast/chestfeeder
    - Avoid soothers or boil them for 5-10 mintues daily and replace them often
    - Only use breast pads without plastic lining, change often
    - If using reusable breast pads, change and wash them after each feeding

6. **Flat or inverted nipples – nipples are depressed inward or don't stick out when stimulated**
    - Encourage the breast/chestfeeder to try gently rolling their nipple with their fingers or to use a breast pump on a low setting to draw the nipple out just before latching.
    - Can try feeding baby expressed milk until baby is able to latch on effectively.

7. **Breast/chest surgery**
   Some individuals who have had breast or chest surgery are able to breast/chestfeed and others are not. It depends on the surgery and where incisions were made. From Baby's Best Chance, "Breast or chest surgery. If you've had breast or chest surgery, you'll likely be able to breastfeed. If you have implants, you'll probably produce enough milk. But if you've had breast reduction or top surgery, you may not. And if a surgical cut was made along the edge of your areola, you may have nerve damage and produce less milk. See the Resources section for places you can go for support" (p.100).

8. **Tongue tie**
   From Baby's Best Chance, "If the connection between your baby's tongue and the floor of his mouth is too short, it may limit how he can move his tongue and may make feeding difficult. Try different breastfeeding positions (see Breastfeeding Positions) and get support from someone familiar with tongue-tie. If it's still causing a problem, see your health care provider; if it interferes with feeding, tongue-tie can sometimes be fixed." (p.100)

You can consult with MaBAL for breast/chestfeeding issues as well – Please ensure informed consent is obtained prior to consulting.

Lactation Consultants (LC)

There are presently no FNHA Lactation Consultants and LCs are not covered by FNHA health benefits. If you feel there is a breast/chestfeeder and/or baby who may need an LC, we encourage the following in no particular order:

- If not familiar with breast/chestfeeding, spend some time reading the information provided in this handbook. The videos suggested in Appendix E will visually support you to see the techniques a parent can try as well as what an effective latch looks like. You may be able to assist the parent yourself or you could even watch the videos together.
- Reach out to mchnursing@fnha.ca.
- Reach out to your local Public Health Unit to find out which breast/chestfeeding supports are available in the region you're working in.
- Let the individual you are supporting know about La Leche League Canada and the virtual meetings for peer-based breast/chestfeeding support that they host.
- Check out the British Columbia Lactation Consultants Association website for more information and for a directory of LCs working near you.

- Reach out to the BC Women's Breastfeeding Clinic. LCs offer virtual consultations for nurses as well as parents and no referral is necessary. We high recommend this resource as well as consulting with MaBAL for breast/chestfeeding support.

Nipple Shields

Please see Appendix F for more information on nipple shields.

Nipple shields are covered by FNHA Health Benefits. See the Breast Pumps section of this handbook as well as pages 9 and 12 of the FNHA Pregnancy and Infant Care Health Benefits Coverage Guide. We also encourage you to reach out to the FNHA MCH team (mchnursing@fnha.ca) for support in navigating maternal supplies and Health Benefits.

Mixed Feeding/Supplementing

See Baby's Best Chance p. 104

Some families may need to supplement their breast/chestfed baby for medical reasons, while others may choose to supplement for personal reasons. Supplementing is giving baby expressed milk, donated human milk or formula, in addition to breast/chestfeeding. In situations when the parent is providing a bottle - the method shown in the following video is suggested for the breast/chestfeeding baby. Not all babies will need to use a bottle. This video explains why the method is beneficial. (< 4min): https://www.youtube.com/watch?v=OGPm5SpLxXY

Formula

See Baby's Best Chance p. 106

Deciding how to feed baby isn't always easy. Breast/chestfeeding is best for a child's growth and development. But sometimes, for medical or personal reasons, store-bought infant formula is used instead of, or in addition to, human milk.[4]

There are important considerations to choosing, making, storing and providing formula for and to babies.

Resources:

1. Infant Formula: What you need to know by Perinatal Services BC is a resource that was created for health care professionals: http://www.perinatalservicesbc.ca/Documents/Resources/Breastfeeding/Infant-formula-booklet-BC.pdf

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This Infant Formula: What you need to know resource covers:

- Choosing formula - making an informed decision
- Different formula products - cow-based and other alternatives
- Types of formula - ready-to-feed, liquid concentrate and powdered
- Important considerations such as ready-to-feed and liquid concentrate are sterile until opened whereas powdered is not sterile.
- Formula preparation, disinfection, sterilization (water and bottles), storage and transportation
- Warming milk and how to bottle feed a baby

2. Feeding Your Baby webpage by HealthLink BC: https://www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/feeding-your-baby

Health Benefits and Formula:
An important conversation to have with families, preferably during pregnancy, is around the cost of formula and to ensure they are aware that formula is not automatically covered by health benefits. Formula is not listed on the PharmaCare Plan W formulary. It may be covered for specific medical reasons, however these exceptions are granted on a 'case by case' basis, and the request must be submitted using an 'Exception Request Form'. It clearly states on this form that nutrition products will not be approved for the following conditions: colic, constipation, fussiness, gas, prevention of allergies, sleeping problems, spitting up, or as a supplement to breastfeeding or replacement of breastfeeding.

Contact mchnursing@fnha.ca and FNHA Health Benefits at 1-855-550-5454 if you or the family have further questions or are needing support.

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Jordan's Principle (JP):

JP may cover the cost of formula - it is decided on a case-by-case basis.

Jordan's Principle requests can be submitted by:

- A parent or guardian of a First Nations child
- A First Nations child over the age of 16
- An authorized representative of the child, parent or guardian

See: https://jordansprinciplehubbc.ca/

The Jordan's Principle Enhanced Service Coordination (ESC) Hub for British Columbia (BC) or "the Hub" is hosted by the BC Aboriginal Child Care Society (BCACCS) and delivered in partnership with Indigenous Services Canada (ISC).

The Hub provides a centralized support network for Jordan's Principle Service Coordinators working across the province. Service Coordinators are based in community and work directly with children and families to help access existing products, services, and supports, and to submit Jordan's Principle and Inuit Child First Initiative requests where appropriate.

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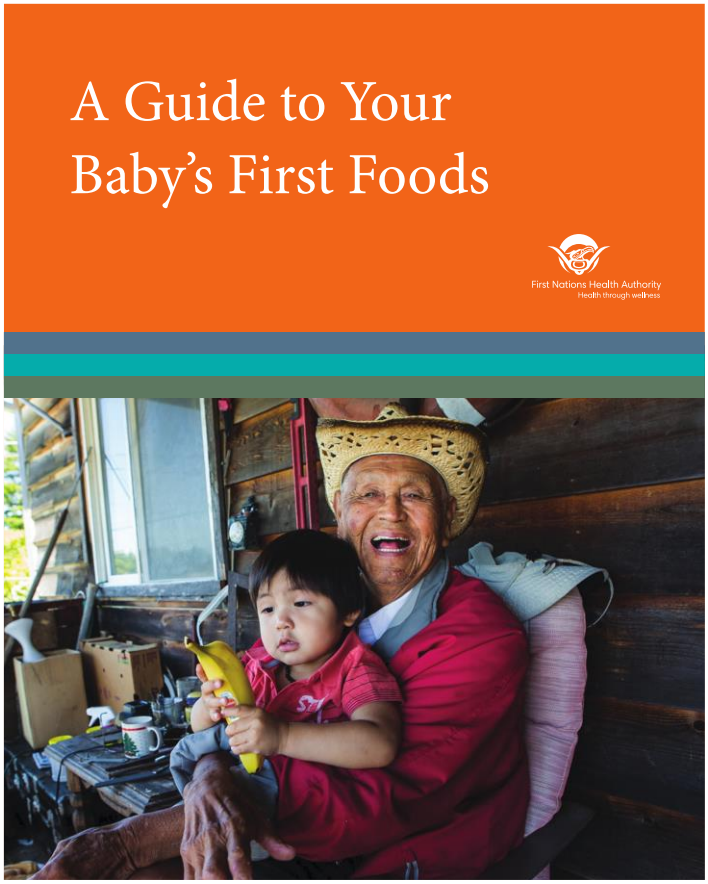
Baby's First Foods

See FNHA's A Guide to Your Baby's First Foods (https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-A-Guide-to-Your-Babys-First-Foods.pdf)



Includes:

- Introducing solid foods
- Feeding baby safely as well as information on food allergens
- Making and storing your own baby food
- Recipes

  Check out Rhubarb Pears, Baby Pemmican, Rice and Dandelion Greens and so many more!
- Helpful tips and tricks

  "My sons used to love the soups I would blend up and freeze in ice cube trays. Freezing them this way made portioning and accessibility so much easier." — Lori Gauthier, Lower Similkameen Indian Band in Keremeos, BC

See Baby's Best Chance p. 109 for more information.

CPT1a variant [(84)]

What is Carnitine Palmitoyltransferase 1A (CPT1a)?

CPT1 is an enzyme that breaks down long fatty acids. It is important to fat metabolism (converting fat to energy). It is an autosomal recessive trait.

The CPT1a variant is a normal variance that happens to occur in anywhere from 1 in 5 (Coast Salish) to 1 in 25 (Interior) First Nations babies.

It is important to know that, in general, these babies are healthy and will grow and develop normally.

Babies who have the CPT1a variant may be at risk of low blood sugar if they are sick and not feeding well, are fasting for a medical or dental procedure or have gone a long time without feeding. Very low blood sugar can cause brain injury in babies and children.

Remember - If a baby presents unwell with no obvious signs of illness or if the parents/guardians are reporting that the baby is not like their usual self, please ensure the baby's blood sugar is checked.

Since babies are not routinely screened for CPT1a, it can easily go missed.

Part of a trauma informed and culturally safe and humble approach to caring for sick children is to remember and understand that there could be fear and hesitancy to bring one's sick child to the clinic. Parents and caregivers may fear judgement or even potential apprehension from the Ministry of Children and Family Development or delegated authority.

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Here is a helpful [brochure] from ChildHealth BC that is designed to be reviewed by the CHN with the parents/caregivers:

Are some First Nations babies and young children more likely to get low blood sugar?

Yes, a genetic change called the CPT1a variant is common to some B.C. First Nations people and it may increase the chances of a baby or young child having low blood sugar, but it doesn't seem to cause any other health problems.

Along the coast of B.C. and Vancouver Island, 1 in 5 First Nations babies are born with the gene variant. In the interior region of B.C., 1 in 25 First Nations babies are born with the variant.

In general, children with the CPT1a genetic variant are healthy and will grow and develop normally.

Babies born in B.C. are not screened for the CPT1a variant because it is so common and the vast majority of people born with it are healthy and have no health problems. Doctors also believe that as a child grows older, the risk of low blood sugar will lessen.

Where can I get more information?

*Families can call **HealthLinkBC at 8-1-1** from anywhere in British Columbia to speak with a nurse any time of the day or night. On weekdays, you can speak to a dietitian about nutrition and ideas for healthy eating and snacks for your baby or young child.*

Perinatal Services BC

First Nations Health Authority
Health through wellness

island health

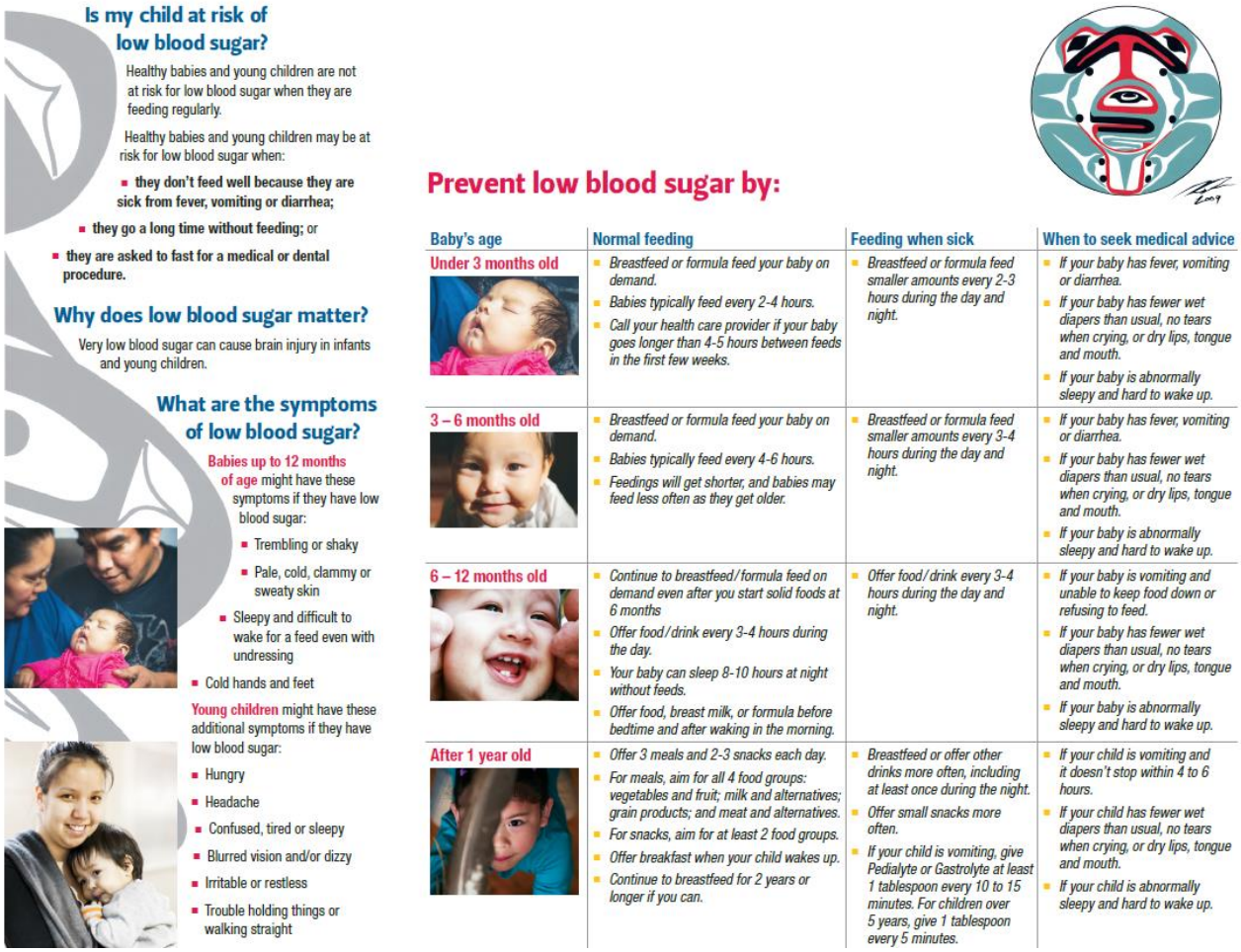
BRITISH COLUMBIA Ministry of Health

Version 3, March 2016

First Nations Parent Resource:

Preventing low blood sugar in healthy First Nations babies and young children

https://childhealthbc.ca/sites/default/files/FNR_Low%20Blood%20Sugar_print.pdf



Is my child at risk of low blood sugar?

Healthy babies and young children are not at risk for low blood sugar when they are feeding regularly.

Healthy babies and young children may be at risk for low blood sugar when:

- they don't feed well because they are sick from fever, vomiting or diarrhea;
- they go a long time without feeding; or
- they are asked to fast for a medical or dental procedure.

Why does low blood sugar matter?

Very low blood sugar can cause brain injury in infants and young children.

What are the symptoms of low blood sugar?

Babies up to 12 months of age might have these symptoms if they have low blood sugar:

- Trembling or shaky
- Pale, cold, clammy or sweaty skin
- Sleepy and difficult to wake for a feed even with undressing
- Cold hands and feet

Young children might have these additional symptoms if they have low blood sugar:

- Hungry
- Headache
- Confused, tired or sleepy
- Blurred vision and/or dizzy
- Irritable or restless
- Trouble holding things or walking straight

Prevent low blood sugar by:

Baby's age	Normal feeding	Feeding when sick	When to seek medical advice
Under 3 months old	▪ Breastfeed or formula feed your baby on demand. ▪ Babies typically feed every 2-4 hours. ▪ Call your health care provider if your baby goes longer than 4-5 hours between feeds in the first few weeks.	▪ Breastfeed or formula feed smaller amounts every 2-3 hours during the day and night.	▪ If your baby has fever, vomiting or diarrhea. ▪ If your baby has fewer wet diapers than usual, no tears when crying, or dry lips, tongue and mouth. ▪ If your baby is abnormally sleepy and hard to wake up.
3 – 6 months old	▪ Breastfeed or formula feed your baby on demand. ▪ Babies typically feed every 4-6 hours. ▪ Feedings will get shorter, and babies may feed less often as they get older.	▪ Breastfeed or formula feed smaller amounts every 3-4 hours during the day and night.	▪ If your baby has fever, vomiting or diarrhea. ▪ If your baby has fewer wet diapers than usual, no tears when crying, or dry lips, tongue and mouth. ▪ If your baby is abnormally sleepy and hard to wake up.
6 – 12 months old	▪ Continue to breastfeed/formula feed on demand even after you start solid foods at 6 months ▪ Offer food/drink every 3-4 hours during the day. ▪ Your baby can sleep 8-10 hours at night without feeds. ▪ Offer food, breast milk, or formula before bedtime and after waking in the morning.	▪ Offer food/drink every 3-4 hours during the day and night.	▪ If your baby is vomiting and unable to keep food down or refusing to feed. ▪ If your baby has fewer wet diapers than usual, no tears when crying, or dry lips, tongue and mouth. ▪ If your baby is abnormally sleepy and hard to wake up.
After 1 year old	▪ Offer 3 meals and 2-3 snacks each day. ▪ For meals, aim for all 4 food groups: vegetables and fruit; milk and alternatives; grain products; and meat and alternatives. ▪ For snacks, aim for at least 2 food groups. ▪ Offer breakfast when your child wakes up. ▪ Continue to breastfeed for 2 years or longer if you can.	▪ Breastfeed or offer other drinks more often, including at least once during the night. ▪ Offer small snacks more often. ▪ If your child is vomiting, give Pedialyte or Gastrolyte at least 1 tablespoon every 10 to 15 minutes. For children over 5 years, give 1 tablespoon every 5 minutes.	▪ If your child is vomiting and it doesn't stop within 4 to 6 hours. ▪ If your child has fewer wet diapers than usual, no tears when crying, or dry lips, tongue and mouth. ▪ If your child is abnormally sleepy and hard to wake up.

https://childhealthbc.ca/sites/default/files/FNR_Low%20Blood%20Sugar_print.pdf

Here is another great handout for parents on CPT1 from BC Children's Hospital:
http://www.bcchildrens.ca/Resource-Centre-site/Documents/C/BCCH1547_CPT1Deficiency.pdf

Here are the Clinical Practice Guidelines for Prevention of Hypoglycemia in First Nation Infants for health care professionals from ChildHealth BC:
https://www.childhealthbc.ca/sites/default/files/FINAL%20April%205%202016%20Medical%20guideline%20prevention%20and%20management%20of%20hypoglycaemia%20in%20First%20Nations%20infants_0.pdf

Common Childhood Illnesses and Diseases

See the BCCDC's A Quick Guide to Common Childhood Diseases for excellent information and resources for both CHNs and parents.

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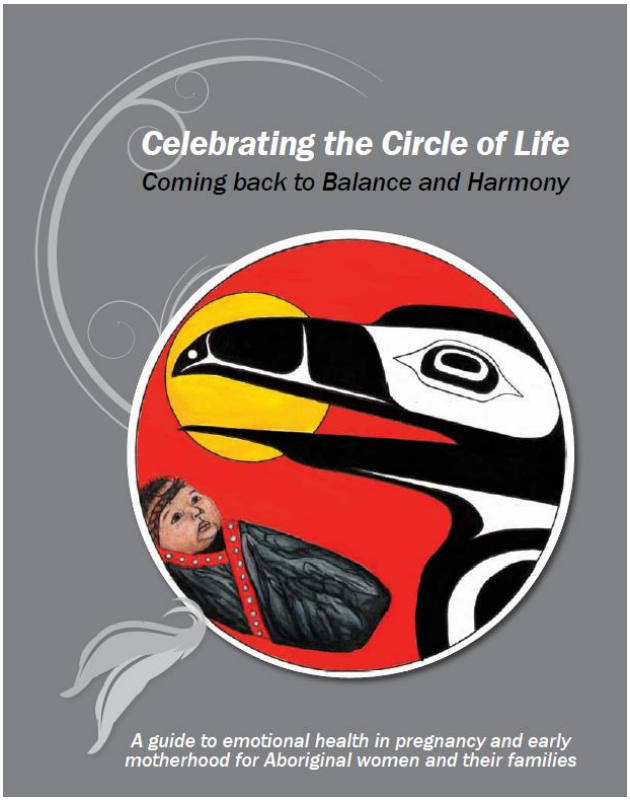
Fatherhood/Partners



http://www.perinatalservicesbc.ca/health-professionals/professional-resources/indigenous-resources/emotional-health

This guide was written for Indigenous individuals who are pregnant or postpartum to support them to enjoy good emotional health.

Partners, Families and Friends - Part five of this guide is written for partners, families and friends and includes information on how to support an individual during pregnancy, childbirth and the early months of being a parent.

There are also 4 resource booklets available from FNHA for parents and families:

- Growing up Healthy: www.fnha.ca/Documents/growingup.pdf
- Parents as First Teachers: www.fnha.ca/Documents/parentteacher.pdf
- Fatherhood is Forever: www.fnha.ca/WellnessSite/WellnessDocuments/fatherhood-is-forever.pdf
- Family Connections: www.fnha.ca/Documents/familyconnections.pdf

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Other resources available to support partners:

Dads In Gear Indigenous: The focus of this website (supported by UBC) is a program for "men who want to be involved, healthy, and smoke free dads". The website also has great resources that are not related to quitting smoking.

Heads Up Guys: Website (supported by UBC) for people who identify as men with depression. The information is not specific to depression and anxiety before or after the birth of a baby, but many messages may be helpful and the information is discussed from a male perspective.

Pacific Post-Partum Support Society: Information on anxiety and depression for partners.

Birther

The Whole Person – Emotional, Spiritual, Mental and Physical Wellness

See The Whole Person – Emotional, Spiritual, Mental and Physical Wellness

Physical Assessment

Physical assessment components and considerations:

- Consent – remember to always keep in mind the importance (and duty) of obtaining informed consent prior to any physical examination or assessment piece.
    - There is the possibility that the individual recently had a physical examination with their Primary Care Provider and doesn't want to have another physical examination at this time. It is best practice for the CHN to do their own head-to-toe, however this may not necessarily be what works best for the individual in that moment.
    - The individual might not be comfortable with a perineum assessment or a breast/chestfeeding assessment. In these cases it would be important to discuss what is normal, and what is not, and to describe what the individual can look for at home such as red flags, etc.
- **Assessment of newborn and birther should occur within 24-48 hrs of leaving the hospital, 1 week later, 1 month after birth, 2 months after birth and as needed.**
- Here is an excellent checklist summary resource from PSBC, to guide postpartum assessments of the birther and baby.

- The first visit should include a full head-to-toe and health history with a focus on:
  - Mental health (How are they feeling? Coping? Support?)
  - Nutrition (Breast/chestfeeders need an extra 300-500 calories per day for the increased metabolic demands of breast/chestfeeding).
  - Breast/chestfeeding (assess latch and milk transfer)
  - Breasts (sore/painful/cracked/bleeding nipples? Engorgement?)
  - Fundal height
  - Perineum (Sutures? Pain? Infection? Hemorrhoids?)
  - Blood pressure (headaches? Edema? Vision changes? Right upper quadrant/abdominal pain? – preeclampsia can start in the postpartum period although it is rare)
  - Lochia
- Visits after 2 weeks won't necessarily need to include a full head-to-toe, fundal height (won't feel the fundus after 2 weeks), perineum, or a breast/chestfeeding assessment. These pieces may be assessed as needed.

RED FLAGS

this list is not exhaustive

- Flat affect
- Passing clots larger than a loonie
- Soaking through a pad every 2 hours or less
- Headache
- Breast or nipple pain
- Perineal malodour

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Documentation:
We suggest the following resources to document your postpartum assessments of the birther:

- PSBC Community Postpartum Assessment and PSBC two page checklist resource (please note that these forms are being updated. They are included here as a resource. They do not replace clinical judgement or critical thinking.)
- Nurses Notes/Progress Notes

Postpartum and Newborn Care Summary Checklist for Primary Care Providers

*Hyperlinks, shown in **blue**, are embedded throughout this document.*

This checklist is a summary of the recommendations for postpartum care based on a review of best evidence and consensus opinion.

Health assessments of the well mother and baby should occur:

- Within 2-4 days of leaving the hospital
- One week later
- One month after birth
- Two months after birth

The 10 Bs

1) BABY

Physical Examination and History:

- Gold standard for assessment and documentation is the **Rourke Baby Record** for relevant history, developmental milestones, focused physical exam, growth charts, and education topics for parents.

Feeding:

Canadian Paediatric Society recommends:

- Exclusive breastfeeding until six months and continued breastfeeding with complementary foods for up to two years and beyond.
- All breastfed infants in Canada should receive Vit D 400 IU/day. In the North (>55° lat.), breastfed infants should receive 800 IU/day in Oct-Apr; Formula fed infants in the North should receive Vit D 400 IU/day in Oct-Apr.
  www.cps.ca/en/documents/position/vitamin-d

- Consider referral to a lactation consultant, public health nursing services, breastfeeding clinic, maternity care provider, or pediatrician.
- Supplementation with expressed breast milk or formula may be required after full assessment of feeding and corrective measures are unsuccessful.
- Expect a minimum of ~20 grams/day weight gain after the first week.
- Expect return to birth weight by 10-14 days of age.

Hyperbilirubinemia (Jaundice):

- Follow recommendations from hospital discharge regarding neonatal hyperbilirubinemia.
- Use **BiliTool** to interpret serum bilirubin and guide management.

Lochia

Lochia is the bloody vaginal discharge that occurs after delivery. It turns pinkish within the week and becomes white/yellow closer to 2 weeks. It can last for 4 – 6 weeks and can even come and go for two months. Average volume of lochia discharged is 200-500mL. (48)

Pads should be used during this time and if the individual has a perineal tear or healing episiotomy, the pad should be changed every 4 hours in order to prevent infection.

Lochia rubra:

- Consists mainly of blood, decidual and trophoblastic debris
- Occurs during the first 1-3 days. Flows like a heavy period
- Red colour

Lochia serosa:

- Consists of old blood, serum, leukocytes and tissue debris
- The flow decreases each day
- Colour becoming pink or brown
- Occurs from days 3-4 to day 10

Lochia alba:

- Consists of leukocytes, decidua, epithelial cells, mucus, serum and bacteria.
- Yellow, cream to white-ish colour. Amount small to scant
- Approximately 10 days after birth and may continue for 2 to 6 weeks after the birth

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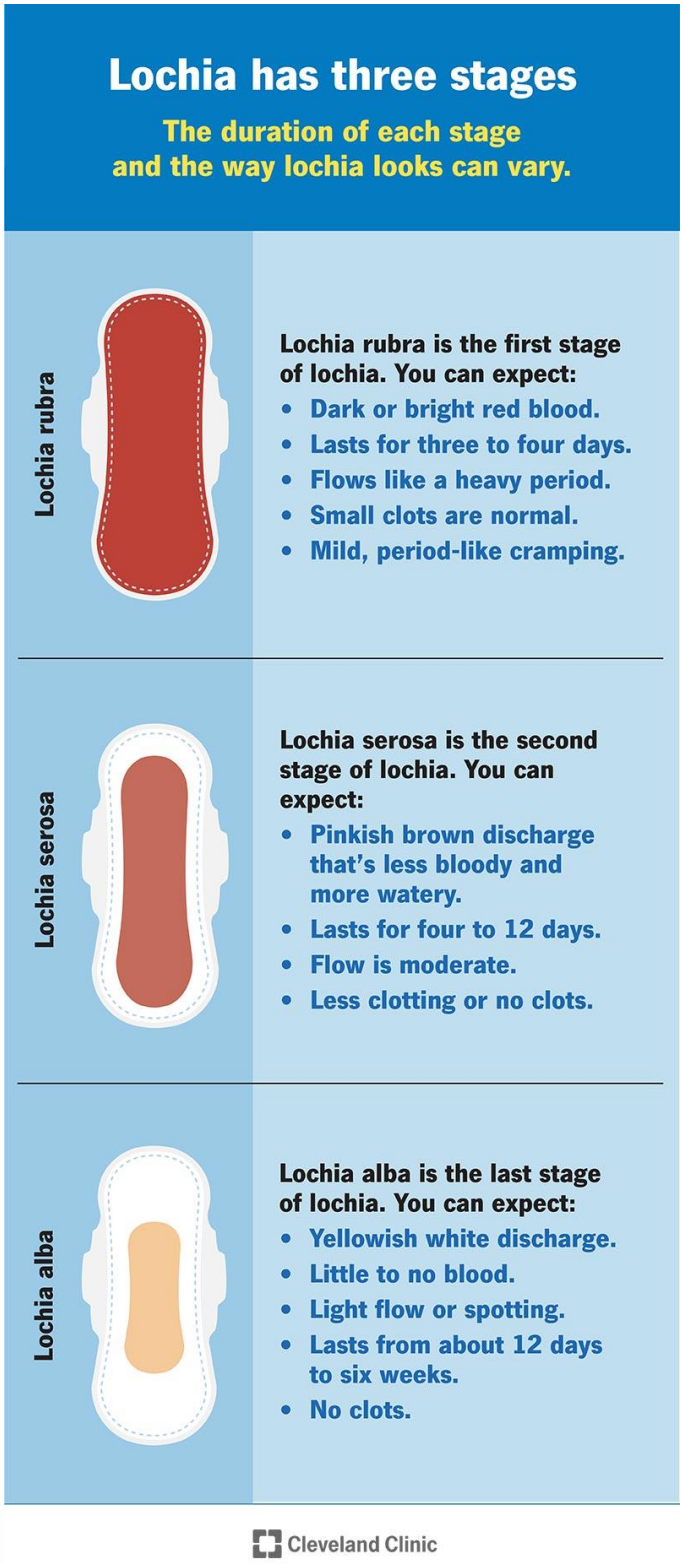
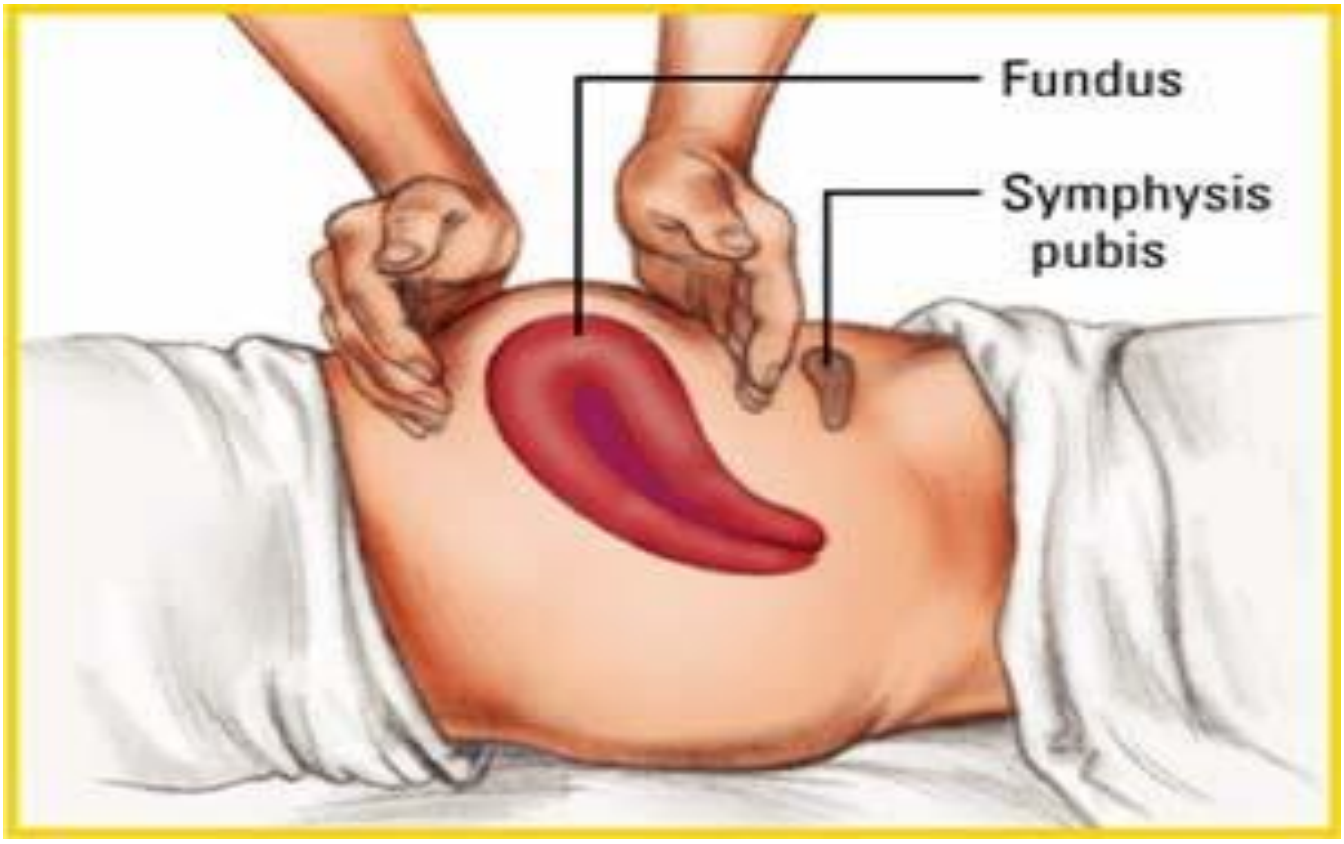


https://my.clevelandclinic.org/health/symptoms/22485-lochia

Fundus

The fundus is the superior portion of the uterus.

How to do a fundal check in the first week:



Nursekey.com

Important considerations:

- Ensure the birther empties their bladder first
- Must be supine, not semi-fowlers
- The fundus descends 1-2 cm every 24 hrs
- By day 6 postpartum, fundus is normally halfway between umbilicus and symphysis pubis (pubic bone)
- By day 7, the uterus returns to lying in the pelvis
- By day 9, uterus should not be palpable in the abdomen region

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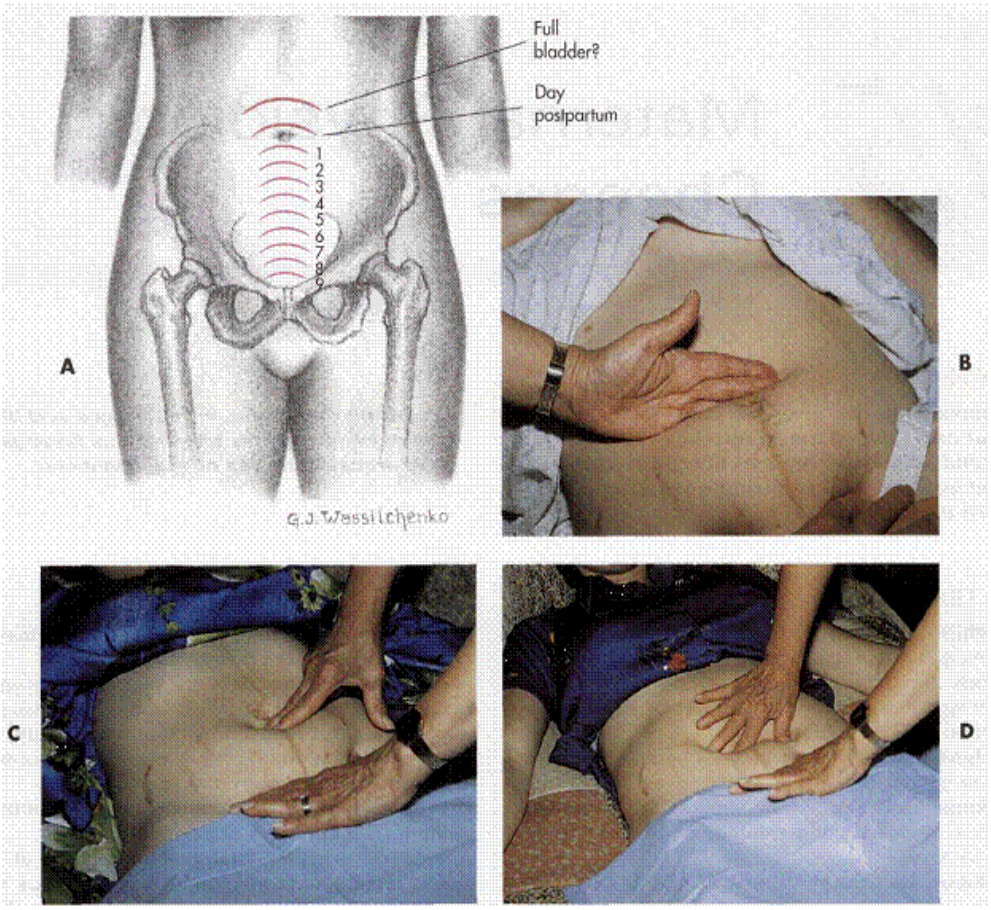

B through D, Courtesy Marjorie Pyle, RNC, Lifecircle, Costa Mesa, CA. – from Maternal Child Nursing Care in Canada textbook [(49)]

Instructions:

1. Place one hand at the superior edge of the symphysis pubis (pubic bone) and press in with moderate pressure.
2. The top hand starts palpating at level of umbilicus and works its way down until it feels a hard object (uterus).
3. The level of the uterus is calculated based on the number of centimeters (cm) below the umbilicus. (1 cm is generally the same as the width of a finger – so if 3 finger widths below = 3 cms below).
4. If a hard uterus is not palpated, massage the abdomen firmly. If the uterus is "soft," generally it will firm up with massaging. If this is required, it must be charted.
5. If the uterus is "soft" and needs to be massaged, please ensure a full assessment is completed including vital signs and lochia (increased flow, clots, or change in colour?). A soft uterus could be a sign of a postpartum hemorrhage starting. If you are concerned, you must consult with the PCP or MaBAL to plan a course of action.

Postpartum Hemorrhage (PPH)

Secondary PPH is when heavy bleeding occurs 24 hrs - 12 weeks postpartum. It is not as common as **primary PPH** which occurs in the first 24 hrs. [(28)]

If there are clots larger than a Loonie, ask the birther to keep them and bring them in. If they disintegrate easily between your gloved thumb and fingers then they are likely coagulated blood whereas if they don't break apart easily, they are more likely placental issue.

Frank red blood and/or a rapid increase in bleeding calls for an assessment and a consult with an MD/NP/RM right away. If you cannot quickly get ahold of the birther's Primary Care Provider, consult with MaBAL.

Perineum

Things to assess for:

- Are there **sutures**?
  - Review importance of no wiping for the first couple weeks. Best to use a peri-bottle or squeeze bottle with warm water and to pat dry.
- Any signs of **infection**? (Redness? Discharge? Pain? Malodour?)
- Does the birther report pain?
  - Is there pain with voiding or with bowel movements (BM)?
  - If pain only with BMs, there may be rectal hemorrhoids.
  - **Rectal hemorrhoids** may be treated with a prescription ointment – consult with the birther's Primary Care Provider (PCP).
  - If pain only with voiding, it could be from trauma to the vagina/birth canal or the birther may have another issue such as a urinary tract infection – consult with the birther's PCP.
- See the lochia section of this handbook for additional information.

Mental Health and Wellness and the Perinatal Period

See Mental Health and Wellness and the Perinatal Period

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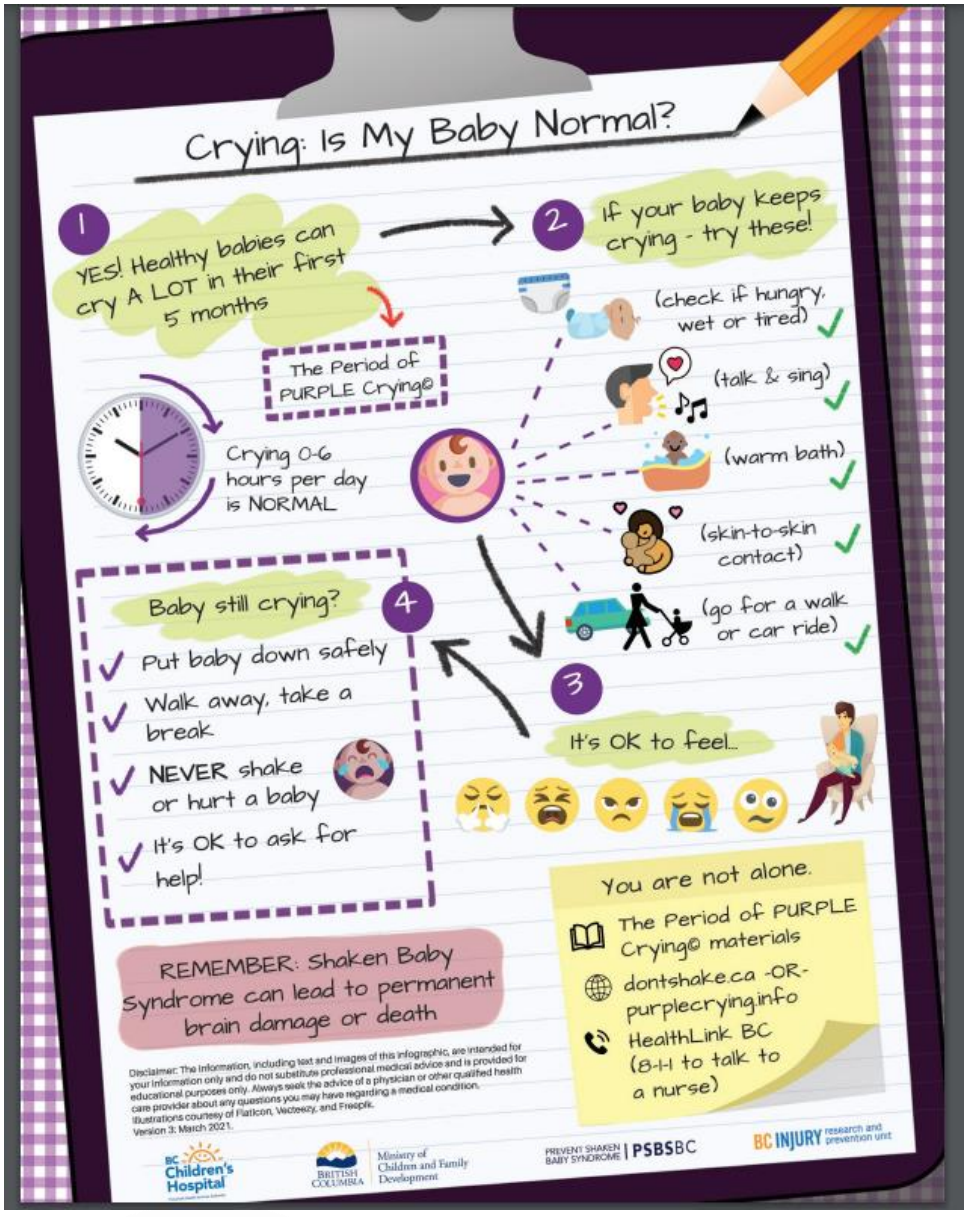
The Period of Purple Crying

- Purple Crying is a program to inform families about crying and babies.
- Although it is a trademarked program from the USA, ChildHealth BC adapts the information in order to be aligned with BC-specific messaging such as harm reduction and empowerment.
- See http://purplecrying.info/what-is-the-period-of-purple-crying.php for more details.
- Every birther in BC should be given information in the hospital (CD to watch or a link to an online version).
- There is also a program at BC Children's Hospital: Prevent Shaken Baby Syndrome BC that promotes and educates parents about purple crying and preventing shaking baby syndrome. See https://dontshake.ca/
- There is a free online course CHNs can take to learn how to teach this subject as well as to increase their knowledge about the subject.
    - Contact Karen Sadler if you are interested in taking the course. She can facilitate group sessions and she can send out information to communities.
    - Prevent Shaken Baby Syndrome BC (SBS) is dedicated to providing a primary prevention program that is ultimately aimed at achieving a substantial reduction in the incidence of shaken baby syndrome in British Columbia. Their goal is to provide timely, relevant and scientifically sound articles and reports that give parents, caretakers and the whole array of professionals involved in SBS cases the information they need.

Contact information for this program:

Karen Sadler (she/her), BID, MCP
Manager - Prevent Shaken Baby Syndrome BC
BC Children's Hospital
4480 Street, F503, Vancouver, BC, V6H 3V4
Cell: (604) 351-0670
Email: Karen.Sadler@bcchr.ca
Website: https://dontshake.ca



https://dontshake.ca/wp-content/uploads/2021/04/PURPLE-Infographic-Mar-29-v2.pdf

Life Post-Pregnancy

Resuming Sexual Activity After Delivery [(61)]:

The following suggestions for individuals in the postpartum period is from BC Women's Hospital: "You may feel like having sex days after delivering or much later - weeks or months after delivering. However, it is best if you wait until stitches or tears have healed and vaginal bleeding has lessened before having any sex involving the vagina.
If you are not planning on getting pregnant, it is important to use birth control if you are having vaginal sex. You can still get pregnant after giving birth, even if you are breastfeeding or before your period starts again." [(61)]

How you can help yourself:

- Use a lubricant during vaginal sex to help relieve vaginal dryness, which is common.
- Breastfeed your baby before sex if you want to lower the chance of your breasts leaking.
- Explore other ways to be sexual or intimate with your partner if you do not want to have intercourse.

Call your healthcare provider if you have:

- Severe, ongoing pain during sex more than six weeks after birth." [(61)]

For more information

- SOGC - Contraception info (https://www.sexandu.ca/contraception/)
- Omama. Postpartum Contraception (www.omama.com/en/postpartum/contraception.asp)
- Options for Sexual Health Birth Control Methods (www.optionsforsexualhealth.org/facts/birth-control/methods/lam/)
- BCWH – Resuming sexual activity after delivery (http://www.bcwomens.ca/health-info/pregnancy-parenting/caring-for-yourself-after-birth#Sex--+--birth--control)
- MaBAL can assist with birth control options as well

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Body Changes

See BCWH's webpage: http://www.bcwomens.ca/health-info/pregnancy-parenting/caring-for-yourself-after-birth#Your--body for information on changes to:

- Breasts
- Bowel
- Bladder
- Belly
- Vagina
- Bleeding
- Physical Activity

Mood Changes

See BCWH's webpage : http://www.bcwomens.ca/health-info/pregnancy-parenting/caring-for-yourself-after-birth#Your--mood

Also see the Mental Health and Wellness section of this handbook.

Programming (AHSOR, FASD, MCH)

Aboriginal Head Start on Reserve (AHSOR)

"AHSOR is a program that supports activities focused on **early childhood learning** and development for First Nations children from birth to age six and their families.

The goal of the program is to support activities that are designed and delivered by First Nations communities to meet their unique needs and priorities.

Early life is critical to lifelong health. AHSOR focuses on **early childhood development**, in a culturally appropriate manner, to support the spiritual, emotional, intellectual and physical growth of a child.

AHSOR **supports and encourages children** in enjoying life-long learning and **supports parents, guardians and extended family members as the primary teachers**.

The program also encourages parents and the broader First Nations community to play a role in planning, implementing and evaluating the AHSOR program. It **builds partnerships** with other community programs and services to enhance the program's effectiveness and encourages the best use of community resources for children, parents, families and communities." [(46)]

The Fetal Alcohol Spectrum Disorder (FASD) Program

"The Fetal Alcohol Spectrum Disorder (FASD) program supports the development of culturally appropriate evidence-based prevention, promotion and early intervention programs related to FASD.

The program implements prevention programs through mentorship, using a home visitation model, the Parent–Child Assistance Program. The program is an evidence-based, home-visitation, case-management model for individuals who use alcohol or drugs during pregnancy. Its goals are to help people who are pregnant and parenting to build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.

For a complete description of program objectives and components, see **Fetal Alcohol Spectrum Disorder** in the **FNHA Programs and Services Guide** (page 33)." [(41)]

Maternal and Child Health Program (MCH)

"The Maternal and Child Health program aims to support First Nations women who are pregnant to experience healthy pregnancies and to support parents of infants and young children and their families in helping children to develop optimally into adulthood.

For a complete description of the program, including objectives and components, see the FNHA Programs and Services guide (page 35)." [(42)]

Extended Learning – Map of Communities

See if you can find the community you are working in on the map below. This map will tell you if the community you are working in has AHSOR, the FASD program and/or an MCH Program.

Some communities have all of the programs while others have some or none of the programs.

AHSOR, FASD, and MCH Communities – Regional Maps:
www.fnha.ca/Documents/Aboriginal-Head-Start-on-Reserve-Sites.pdf

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Loss in pregnancy

Content Warning

The following content may trigger unpleasant feelings or thoughts of past loss. This information is intended to help prepare and to support the Community Health Nurse in giving culturally safe and humble, trauma-informed and compassionate care for the individual experiencing perinatal loss.

Please take care of yourself and know there are resources to support you:

See Appendix C for Wellness and Cultural Supports.

Self-Reflection

Think back to a time you experienced grief.
What feelings and emotions did you experience?

What helped and what did not?

Open your journal and take a few minutes to reflect and write down, draw, say out loud, or acknowledge in a way that is meaningful to you, your thoughts and reflections on grief:

_____

Perinatal Grief and Loss: Resources for Health Care Providers

This is a resource that provides information to nurses to assist them when providing support to families experiencing the various types of perinatal loss. It also provides resources for families and for health care people. Please explore this document when navigating perinatal loss resources and in supporting the people, families and communities with whom you are working.

See:
https://partners.fnha.ca/sites/HomeandCommunityCare/Prenatal_Clinical_Resources/Perinatal%20Grief%20and%20Loss%20-%20Resources%20for%20Health%20Care%20Providers-March%2011%202021.pdf

To access this document, click on the embedded link above in the title or click on the url above. If you click on the link and a message appears saying that you do not have permission to access the document, please contact your FNHA Community Health Practice Consultant or the FNHA Maternal Child Nursing Team at mchnursing@fnha.ca. The link works for Community Health Nurses who have access to FNHA Nursing Resources on Gathering Space.

In this document you will find:

Think back to the First Nation's Perspective on Health and Wellness for yourself. It is important to keep all four areas of the 2nd circle (physical, mental, emotional, spiritual) balanced so that you are healthy and well to support others experiencing loss. See Appendix C for Health and Wellness Supports.

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Abortion

Abortion is when a pregnancy ends early. Sometimes an abortion happens spontaneously - this is called a **miscarriage**. Individuals who are pregnant can also choose to end a pregnancy early with medication or a surgical procedure.

Abortion is covered by MSP for MSP-enrolled BC residents.

The Pregnancy Options Line: 1-888-875-3163 throughout BC, provides a confidential line to support people in BC who are experiencing an unintended or unplanned pregnancy. Short-term phone counselling and current information on services available in community is offered.

- Individuals may self-refer to any of the abortion clinics in BC or may call the Pregnancy Options Line for referral to a doctor in their area.

- **Medical abortion (<63 days)** (with pills) can happen up to 63 days from the start of the last period.
    - "Mifegymiso" or "mifepristone - misoprostol is given to the individual to stop the pregnancy from developing. *Mifepristone* belongs to the class of medications called progesterone receptor modulators. It works by disrupting the way the hormone progesterone works in the body. *Misoprostol* belongs to the class of medications called prostaglandins. It works by causing muscle contractions in uterus, relaxation of the opening of the cervix and shedding of the endometrium." [(20)]
    - Facilitated through a Family Doctor, Nurse Practitioner or through MaBAL

- **Surgical abortion (<24 weeks)** - the CARE program at BCWH provides surgical abortions up to the 24th week for unintended pregnancies or due to genetic or medical reasons. [(20)] For surgical abortion providers in other areas of BC, see here.
    - Surgical abortion in first trimester (5-12 weeks)
        - Manual Vacuum Aspiration Abortion – mild pain medications and local anesthetic to freeze cervix then small tube attached to a syringe used to empty the uterus. [(20)]
    - Surgical abortion in second trimester (up to 24 weeks)
        - Dilation and evacuation (D&E) – combination of vacuum aspiration, dilation and curettage (D&C) and use of instruments such as forceps to clear uterus of fetal and placental tissue. [(23)]

- **Non-surgical abortion** – second trimester – uses medication to start or induce contractions which then push fetus out from the uterus. "If the fetus has severe medical problems, a woman may choose to have an induction abortion." [(23)]

Resources:

1. See HealthLink BC's – Abortion for more information including a table that compares the differences and considerations between the different procedures: https://www.healthlinkbc.ca/pregnancy-parenting/planning-your-pregnancy/ending-pregnancy

2. BC Women's Hospital + Health Centre CARE Clinic
   Women's Health Centre, door #77
   Room E3 4500 Oak Street
   Vancouver, BC, V6H 3N1
   Hours: Mon-Fri, 7:30 a.m. to 4 p.m.
   Tel: 604-875-2022 or 1-888-300-3088 (ext 2022) (toll free)
   Fax: 604-875-3274
   www.bcwomens.ca/our-services/gynecology/abortion-contraception

Please note that FNHA Health Benefits covers transportation costs for going to a hospital for a surgical abortion. The paperwork does not require a specific reason therefore the paperwork doesn't have to mention pregnancy or abortion.

Extended Learning – Stories of Abortion Across the Globe

Sept. 28 is International Safe Abortion Day

Read eye-opening, emotional and hopeful abortion stories shared by people across the globe here: https://www.doctorswithoutborders.org/what-we-do/news-stories/story/my-abortion-story

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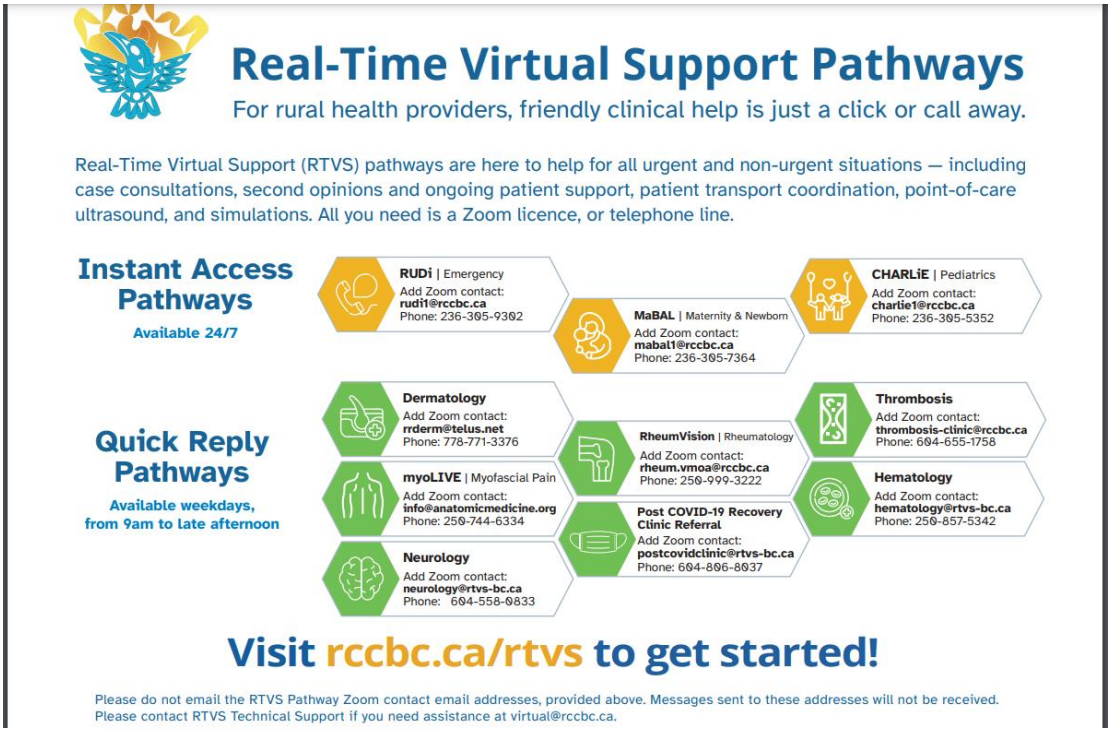
Appendices

A Virtual Pathway Resources for CHNs and Community Members

Real-Time Virtual Support (RTVS) pathways, initiated and supported by the Rural Coordination Centre of BC, serve BC rural, remote and First Nations communities. Rural and remote healthcare providers such as nurses, physicians, midwives and nurse practitioners, can contact the RTVS pathways by Zoom or telephone. The RTVS providers are friendly physicians, midwives and specialists who understand the remote and rural context. Three of the RTVS pathways – RUDi, MaBAL, CHARLiE – are available 24/7/365 while the others (quick reply pathways) are available weekdays. This service provides support for all urgent or non-urgent cases including consultations, second opinions, support with patient transport and simulations. See https://rccbc.ca/rtvs/ for more details.

There are two types of pathways—those for healthcare providers and those for community members (see below).
Rural Coordination Centre of BC (RCCBC) Real-Time Virtual Support Pathways for Health Care Providers:



For Health Care Providers:

- Maternity, Newborn, Sexual & Reproductive Health - Mothers and Babies Advice Line (MaBAL)
    - MaBAL provides sexual and reproductive care support as well as maternity and newborn care support.
- Pediatrics – Child Health Advice in Real-Time Electronically (CHARLiE)
- Emergency – Rural Urgent Doctor in Aid (RUDi)
- Substance use – FNHA/BC Centre on Substance Use 24/7 Addiction Medicine Clinician Support Line
    - For frontline staff who are caring for individuals with existing or past substance use disorders.
    - Call 778-945-7619. All day, every day of the year.
    - Or visit https://www.bccsu.ca/24-7/

For Community Members:

- First Nations Virtual Doctor of the Day
- First Nations Substance Use and Psychiatry Program
- Healthlink BC Emergency iDoctor-in-Assistance (HEiDI)

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B Handout - What to Bring to the Hospital

The following information is from p. 37 of Baby's Best Chance

Pack everything in advance so you'll be prepared before you go into labour. Helpful items might include:

- Lip balm
- Hand held massager
- Music
- Flip flops for the shower
- Slippers
- Snacks and drinks for you and your personal support team
- Pajamas (ideally front-opening for breast/chest feeding)
- Toothbrush
- Underwear
- Loose clothing to wear home
- Canada Motor Vehicle Safety Standards (CMVSS) approved car seat (take the time well before the due date to install the car seat as installation varies car to car and can take a little time to figure out the first time)
- Pajamas for baby
- Newborn diapers
- Blanket for baby

Partners:

- Let your work know you may have to leave on short notice.
- Ensure there's always a full tank of gas.
- Always be reachable within 2 weeks of the due date.
- Have your own bag packed including a toothbrush, spare clothes, sleeping bag and swimsuit (if you'll be helping in the shower).

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C Health & Wellness Supports and Resources

Supports:

- **Tsow Tun Le Lum**: Counselling and cultural support services offered. Call toll-free 1-888-403-3123 or visit www.tsowtunlelum.org
- **KUU-US Crisis Line Society**: A 24-hour provincial Indigenous crisis line. Adults and Elders can call 250-723-4050, children and youth can call 250-723-2040, or anyone can call toll-free 1-800-588-8717. Learn more at www.kuu-uscrisisline.com
- **Indian Residential School Survivors Society (IRSSS):** Call toll-free 1-800-721-0066 or visit www.irsss.ca
- **First Nations and Inuit Hope for Wellness Help Line**: Call toll-free 1-855-242-3310 or chat online at hopeforwellness.ca.
- **The Métis Crisis Line**: Available 24 hours a day at 1-833-MétisBC (1-833-638-4722).

Other supports:

- For FNHA employees: Employee & Family Assistance Program (EFAP) www.lifeworks.com

- Occupational & Critical Incident Stress Management services (OCISM) provided by the First Nations and Inuit Health Branch (FNHIB) to all nurses serving First Nations communities:

    - **OCISM - Critical Incident Stress Reaction Services**. Nurses or their leaders can call 1-800- 268-7708 and ask for OCISM - state you are a nurse working with First Nations communities or that you are supporting a nurse working with First Nations communities.
    - **Peer Assistance Line (PALs):** Non-crisis support (debriefing, coping, mentoring, etc) via telephone. PALS doesn't have a set amount of sessions, it can be an ongoing service. Contact hc.ocism-gspic.sc@canada.ca
    - **Support to Promote and Assess Resiliency Coping Skills (SPARCS)** (Resource and Services): A working guidebook with optional telephone support for nurses to improve overall wellbeing and resiliency. Contact hc.ocism-gspic.sc@canada.ca
    - **Resiliency coaching for nursing leaders:** For those in leadership roles with high demands. This service provides a link to a mental health professional in order to build resiliency as a leader. Contact hc.ocism-gspic.sc@canada.ca

Provincial mental health supports:

- **Virtual mental health services:** https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/virtual-mental-health-supports

- **310 Mental Health Support.** Call 310-6789 for emotional support, information and resources specific to mental health.

- **Crisis Centre of BC:** Call 1-800-SUICIDE (1-800-784-2433) if you experiencing feelings of distress or despair, including thoughts of suicide.

- **Crisis Services Canada**: If you need support, call this toll free number 1.833.456.4566. This service is available 24x7x365. Support is offered to anyone concerned about suicide. See https://www.crisisservicescanada.ca/en/call-us/

- **SAFER - Suicide Attempt Counselling Service** (604-675-3710). Counselling for people with suicide risk and support for family/friends concerned about loved ones. Mon - Fri, 8:30am - 4:30pm.

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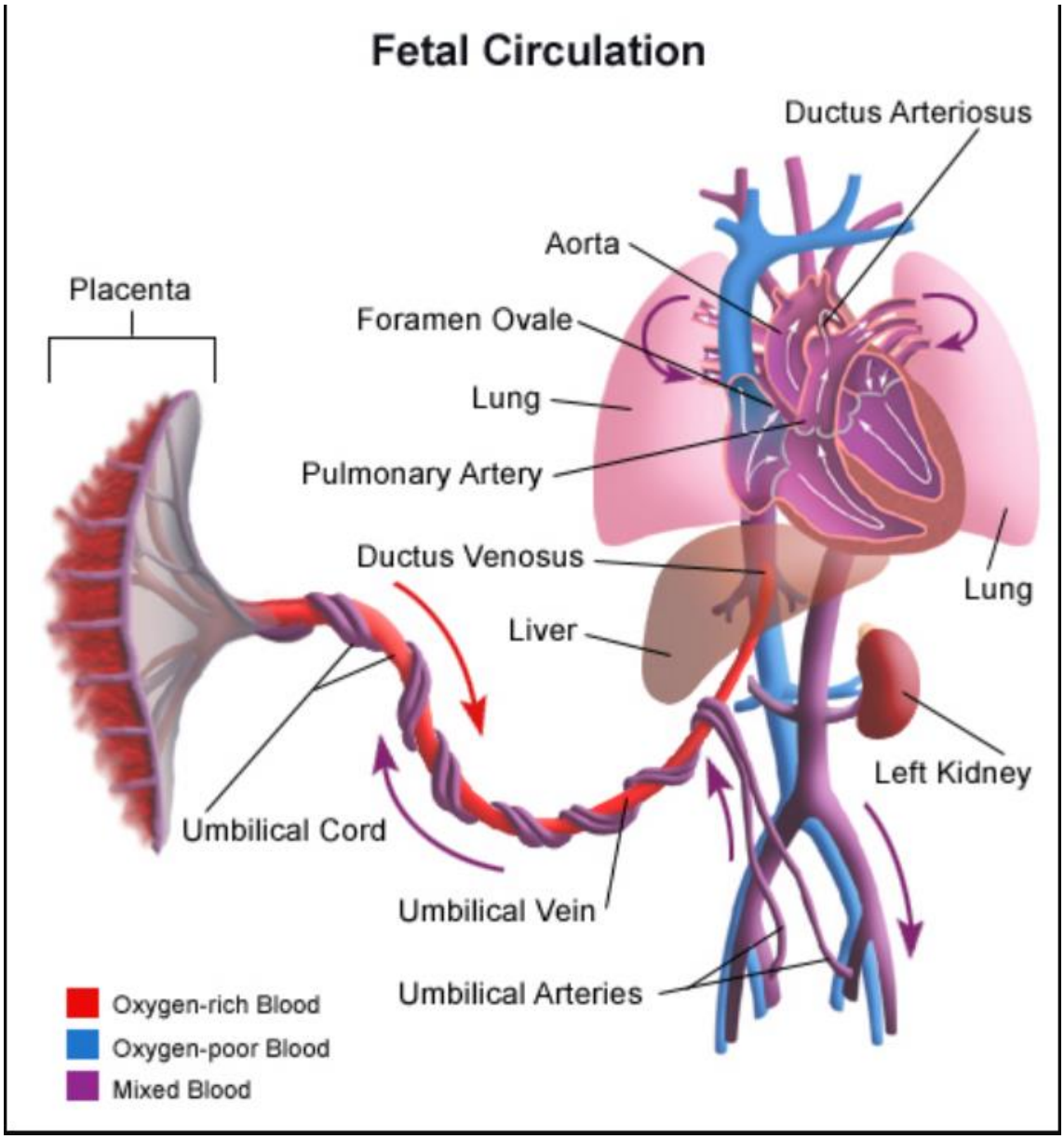
D Fetal Circulation



https://www.stanfordchildrens.org/en/topic/default?id=fetal-circulation-90-P01790

- "The fetus is connected by the umbilical cord to the placenta. This is the organ that develops and implants in the mother's uterus during pregnancy.
- Through the blood vessels in the umbilical cord, the fetus gets all needed nutrition and oxygen. The fetus gets life support from the mother through the placenta.
- Waste products and carbon dioxide from the fetus are sent back through the umbilical cord and placenta to the mother's circulation to be removed." (50)

"The fetal circulatory system uses **3 shunts**. These are small passages that direct blood that needs to be oxygenated. The purpose of these shunts is to bypass the lungs and liver. That's because these organs will not work fully until after birth. The shunt that bypasses the lungs is called the **foramen ovale**. This shunt moves blood from the right atrium of the heart to the left atrium. The **ductus arteriosus** moves blood from the pulmonary artery to the aorta." (50)

"Oxygen and nutrients from the mother's blood are sent across the placenta to the fetus. The enriched blood flows through the umbilical cord to the liver and splits into 3 branches. The blood then reaches the inferior vena cava. This is a major vein connected to the heart. Most of this blood is sent through the **ductus venosus**. This is also a shunt that lets highly oxygenated blood bypass the liver to the inferior vena cava and then to the right atrium of the heart. A small amount of this blood goes straight to the liver to give it the oxygen and nutrients it needs." (50)

Answers to trivia questions:

1) ***How many shunts are there in fetal circulation?***

   Answer: There are 3 shunts in fetal circulation:

   1. The foramen ovale: moves blood from the right atrium of the heart to the left atrium. (50)
   2. The ductus arteriosus: moves blood from the pulmonary artery to the aorta. (50)
   3. The ductus venosus: lets highly oxygenated blood bypass the liver to the inferior vena cava and then to the right atrium of the heart. (50)

2) ***Do the umbilical arteries or the umbilical vein carry deoxygenated blood from the baby back to the placenta?***

   Answer: There are two umbilical arteries that carry deoxygenated blood from baby to mother via the placenta. There is one umbilical vein that carries oxygenated blood from mother to baby.

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E Breast/Chestfeeding Videos, Tools, Songs, Resources

The following information is on Gathering Space at:
https://partners.fnha.ca/sites/HomeandCommunityCare/BreastfeedingAD/Forms/Document%20Type1.aspx under "Information for promoting and teaching breastfeeding"

Information for Promoting and Teaching Breast/Chestfeeding

Important Videos:

1. Multiple videos for supporting Indigenous families with breast/chestfeeding: https://breastfeedinginfo.ca/table-of-contents/indigenous-families/
2. Why breastfeeding is helpful for trauma survivors by Dr. Kathleen Kendall-Tackett. An excellent video about how breastfeeding can be helpful for trauma survivors: https://www.youtube.com/watch?v=uh9SuYgfRoE
3. "Your baby knows how to latch." Excellent video showing how to obtain a deep latch: https://www.youtube.com/watch?v=9bCxD0gQ8zo
4. "Baby led latching." Video by Aboriginal Midwife and Lactation Consultant Stephanie George of the Oneida Nation: https://www.youtube.com/watch?v=N0-ycyUwVQQ
5. Hand expression by HealthLink BC: https://www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/breastfeeding/video-hand-expressing-breastmilk

Research:

The Right to Breastfeed: https://ibconline.ca/right-to-breastfeed/. This article discusses the messages and information birthers receive and how it is not always correct or helpful. There are also some video clips to support what breast/chestfeeders need to know and what breast/chestfeeding should look like.

Breastfeeding mothers and babies have a special relationship:
https://ibconline.ca/uat/good-is-bad2/

Both articles are written by Jack Newman, MD. Dr. Newman was the first person to open a breastfeeding clinic in Canada. This clinic was located at Sick Kids Hospital in Toronto in 1984.

Guides, Posters and Apps:

1. The *"Breastfeeding My Baby"* guide is a helpful one-page poster that can be printed and posted in health care facilities to promote breast/chestfeeding. It can also be used with families for group education sessions on the fundamentals of breast/chestfeeding. http://www.perinatalservicesbc.ca/Documents/Resources/Breastfeeding/BreastfeedingMyBabyGuide.pdf
2. The *"Breastfeeding Buddy"* is a web-based app that has tips, tools and videos to support new breast/chestfeeders with breastfeeding and more, from pregnancy to baby's first six months and beyond. It provides parents with information and links to health resources in their community and helps them keep track of breastfeeding, baby's sleep schedules, diaper changes and scheduling if mothers express breast milk or provide alternate feedings. It's an easy, fun and educational tool designed to help parents give their baby the very best start in life. https://www.healthlinkbc.ca/breastfeeding-buddy
3. There are a couple perinatal crossword puzzles available – please email mchnursing@fnha.ca if you would like a copy.

Websites (For Professionals and Parents/Guardians/Families/Communities):

1. Breastfeeding Information for Parents: https://breastfeedinginfo.ca/table-of-contents/indigenous-families/ - (Ontario) There is a section for Indigenous families that includes an excellent series of educational videos by Indigenous Midwife and Lactation Consultant Stephanie George of the Oneida Nation.
2. HealthLink BC: www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/breastfeeding - Great information and several short videos on:
    - Positions
    - Latch your baby
    - Hand expression
    - Cues and behaviour
    - Poor weight gain
    - Storing milk
    - Feeding methods
3. La Leche League Canada: www.lllc.ca/ - Breastfeeding information for families
4. International Breastfeeding Centre: https://ibconline.ca/ - Informative videos and fact sheets for CHNs and families
5. Canadian Breastfeeding Foundation: http://www.asklenore.info/ - Information on breast/chestfeeding, pregnancy and parenting
6. British Columbia Lactation Consultants Association: http://www.bclca.ca/ - Directory of lactation consultants in BC

Education and Courses for CHNs:

1. UBC School of Nursing: https://nursing-sim.sites.olt.ubc.ca/home/lactation/telehealth-simulations/
   Four free lactation modules for health professionals and students:
   1. Lactation 1: Prenatal Anticipatory Guidance
   2. Lactation 2: Cesarean Section in Hospital
   3. Lactation 3: Effective Breastfeeding
   4. Lactation 4: Midwifery Clinic, Low Milk Supply (LMS)
2. Michigan Breastfeeding Network: https://mibreastfeeding.org/webinars/ - Relevant, high quality, and free webinars

Songs:

1. “Boob Not The Bottle” by Shy-Anne Hovorka. A song to support breastfeeding: https://www.youtube.com/watch?v=wxEUZ4tcJj4

2. “Creators Gift to Mothers” by the Shibogama First Nations Council. A short video clip (6:42min) discussing breastfeeding with pictures: https://www.youtube.com/watch?v=rkaxLGI5WBw&feature=youtu.be

3. “Teach Me How to Breastfeed.” A short hip hop song (3 min): https://www.bing.com/videos/search?q=teach+me+how+to+breastfeed&&view=detail&mid=82199736D809426CC2D182199736D809426CC2D1&&FORM=VDRVRV

4. "All About That Breast" by Lori Burke. A parody of Meghan Trainor’s "All About That Bass" (2:28min): https://www.youtube.com/watch?v=rBG1Dl9hEY4

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F Nipple Shields

Nipple shields are soft, flexible, thin and usually silicone covers (picture a little hat) that go over top of the nipple and areola. HealthLinkBC describes this as the top of the hat goes over the nipple while the brim of the hat covers most or all of the areola. Nipple shields are used sometimes when a baby is not sucking well. There are small holes in the nipple shield that allow the baby to suck and draw out the nipple as best as the baby can while milk flows out from the nipple and through the holes into the baby's mouth.

For more information on nipple shields see:

HealthLinkBC file - Nipple Shields for Breastfeeding Problems
https://www.healthlinkbc.ca/pregnancy-parenting/parenting-babies-0-12-months/breastfeeding/nipple-shields-breastfeeding

Toronto Public Health Breastfeeding Protocols #4 Sore Nipples
https://www.toronto.ca/wp-content/uploads/2017/11/96a9-tph-breastfeeding-protocol-4-sore-nipples-2013.pdf

The Use of Nipple Shields: A Review
Front Public Health. 2015; 3: 236.
Published online 2015 Oct 16. doi: 10.3389/fpubh.2015.00236

Fraser Health Authority Breast/chestfeeding modules. Intended for parents but useful for CHNs who want an introduction to nipple shields.
https://www.fraserhealth.ca/health-topics-a-to-z/pregnancy-and-baby/breastfeeding/breastfeeding-online-modules#.Y7Ro8nbMI2z

La Leche League UK – Nipple Shields
https://www.laleche.org.uk/nipple-shields/

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G Immunizations and Pregnancy

Key Messages:

- Vaccines are an important part of a healthy pregnancy. They help protect both birther and baby against serious diseases.
- Vaccine conversations with parent(s)/guardian(s) are important. We encourage you to start these conversations specific to infant and child vaccines during the pregnancy. Caregivers will make their own choices around health topics and it is our duty to ensure they have relevant information that is up to date and evidence informed.
- Some diseases are particularly harmful to pregnant people and their babies and can cause birth defects, premature birth, miscarriage, and death. Many of these diseases can be prevented through vaccination.
- It's important to know which vaccines are needed before, during, and after pregnancy. A listing of suggested vaccines are located in the BC immunization Manual here: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part2/Pregnancy.pdf
- Vaccination for infants is the best way to keep them safe from many serious and potentially deadly diseases. It is important that babies are vaccinated on time and that they are up-to-date for age—get them all, get them on time.

Also see Vaccines before, during and after pregnancy by ImmunizeBC at: https://immunizebc.ca/pregnancy

Resources for nurses:

Websites:

It is important to get the facts about vaccination from reliable sources. Trusted healthcare providers such as doctors, nurses, or pharmacists can provide accurate and fact-based information about vaccines.

Here are some trusted websites where you can find information on vaccination:

- Public Health Agency of Canada
- Canadian Paediatric Society
- Immunize Canada
- The Society of Obstetricians and Gynaecologists of Canada
- Immunization Manual (bccdc.ca)
- Immunization Clinical Resources (bccdc.ca)
- Immunize BC | Evidence-based immunization information and tools for B.C. residents
- Immunization Courses (bccdc.ca)
- COVID-19 vaccination toolkit for health professionals (bccdc.ca)
- Immunization Communication Tool: A Resource for Health Care Providers: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Safety/ICT-2021.pdf

FNHA Immunization Team

FNHA has a team of immunization nurses with specialized immunization practice, including immunization programing and clinical expertise. The immunization team provides educational immunization updates, clinical resources, oversees the Immunization Competency program for Community Health Nurses and is available to support immunization programing and clinical skills including 1:1 nurse support. Resource documents and tools to support your practice are posted on the Gathering Space at Immunization Resources - Document Type (fnha.ca).

Nurses can contact the immunization team at immunize@fnha.ca with any immunization consults or program inquiries (scheduling, incidents/errors, Immunization Competency program registration, etc.).

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H Two-Spirit, Gender-Affirming, Gender-Diverse, Trans, Queer, Non-Binary, Gender Identity and Sexual Orientation Resources

Two-Spirit [60]

The following is from Trans Care BC:

"Two-Spirit" is a term used within some Indigenous communities, encompassing cultural, spiritual, sexual and gender identity.

The term reflects complex Indigenous understandings of gender roles, spirituality, and the long history of sexual and gender diversity in Indigenous cultures. Individual terms and roles for Two-Spirit people are specific to each nation. The word "Two-Spirit" was created in the early 1990s, by a group of Two-Spirit community members and leaders. Due to its cultural, spiritual, and historical context, the concept of "Two-Spirit" is to be used only by Indigenous people. However, not all Indigenous people who hold diverse sexual and gender identities consider themselves Two-Spirit, many identify themselves as LGBTQ+.

Before colonization, Two-Spirit people were included and respected as valued community members, often holding revered roles such as healers, matchmakers, and counsellors, among many others. **As part of the colonization process, there has been an attempted erasure of Two-Spirit people**. The western religious values and belief systems that were imposed on Indigenous people condemned any sort of sexual or gender diversity, and Two-Spirit people were killed or forced into assimilation and hiding. One of many lasting impacts of colonization on Two-Spirit people, is an increased level of homophobia and transphobia within many Indigenous communities, which can often cause Two-Spirit people to leave their home communities (and subsequently, their families, land, and culture).

The role of Two-Spirit people in Indigenous communities is now being reclaimed, and it is becoming increasingly recognized that homophobia and transphobia are in direct contradiction with most traditional Indigenous values. Reclaiming the traditional roles and value placed on Two-Spirit people's gifts, is part of a larger healing process taking place within Indigenous communities. As part of this reclamation, there has been a resurgence of Two-Spirit leadership, resources, community organizations and events, as well as recognition and representation within LGBTQ+ communities and Indigenous communities. Please have a look at our resources section below to find out more about

some of the work being done. [(60)]

Resources for Individuals:

1. Pacific Post Partum Support Society

A message from the Pacific Post Partum Support Society:

"No matter how your baby comes to you, if you are 2SLGBTQIA+ and are experiencing mental health challenges during your pregnancy, postpartum, or during your adoption or surrogacy journey, support is available to you and your family".

- **Telephone or Text Support: Weekdays from 10am-3pm**
- **Weekly Two Spirit, Queer, & Trans Postpartum Support Group:** Tuesdays 10:30-Noon
  - Lower Mainland 604-255-7999
  - Toll-Free 1-855-255-7999
  - Texting Support 604-255-7999"

Resources for both CHNs and Individuals:

1. Trans Care BC - http://www.phsa.ca/transcarebc/

On their website, you will find:

- Courses and educational tools
- Support for "coming out"
- Sex and gender
- Care and support
- Hormone therapy
- Gender-affirming surgery
- Gender creative, trans or questioning children and youth
- Supports for health professionals

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2. **Here is an excellent resource on making mistakes and correcting them:**

Making Mistakes

And correcting them

TRANS CARE BC
Provincial Health Services Authority

If you make a mistake in your choice of words, terms, names, or pronouns:

1. **Apologize briefly**
2. **Use the correct word, term, name, or pronoun**
3. **Move on**

If you make repeated mistakes, then check-in with the client to address any negative feelings that arise. Flip the page over for more information.

Helpful reminders

- Don't let fear of making mistakes stop you from providing care to diverse people.
- Mistakes are inevitable. More importantly:
  - ☑ Do we learn from our mistakes?
  - ☑ Do we incorporate these learnings?
  - ☑ Does it improve the care we provide?
- Many people avoid accessing care due to past negative interactions in care settings. An apology after making mistakes can make a difference.
- Relationship building with clients is a key ingredient to providing positive health care experiences, leading to repeat visits and better long-term health outcomes.

www.transcarebc.ca

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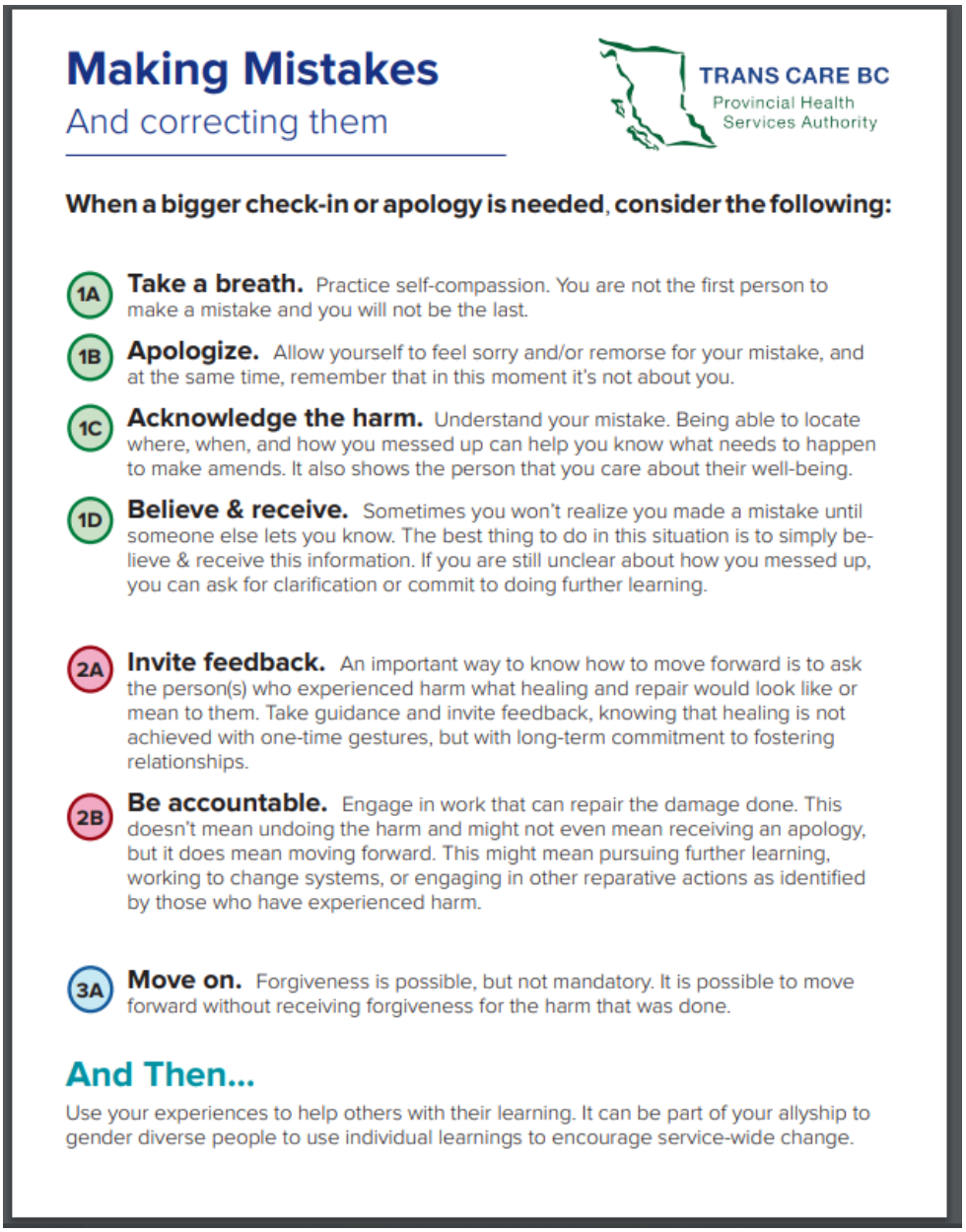

Making Mistakes

And correcting them

TRANS CARE BC
Provincial Health Services Authority

When a bigger check-in or apology is needed, consider the following:

1A **Take a breath.** Practice self-compassion. You are not the first person to make a mistake and you will not be the last.

1B **Apologize.** Allow yourself to feel sorry and/or remorse for your mistake, and at the same time, remember that in this moment it's not about you.

1C **Acknowledge the harm.** Understand your mistake. Being able to locate where, when, and how you messed up can help you know what needs to happen to make amends. It also shows the person that you care about their well-being.

1D **Believe & receive.** Sometimes you won't realize you made a mistake until someone else lets you know. The best thing to do in this situation is to simply believe & receive this information. If you are still unclear about how you messed up, you can ask for clarification or commit to doing further learning.

2A **Invite feedback.** An important way to know how to move forward is to ask the person(s) who experienced harm what healing and repair would look like or mean to them. Take guidance and invite feedback, knowing that healing is not achieved with one-time gestures, but with long-term commitment to fostering relationships.

2B **Be accountable.** Engage in work that can repair the damage done. This doesn't mean undoing the harm and might not even mean receiving an apology, but it does mean moving forward. This might mean pursuing further learning, working to change systems, or engaging in other reparative actions as identified by those who have experienced harm.

3A **Move on.** Forgiveness is possible, but not mandatory. It is possible to move forward without receiving forgiveness for the harm that was done.

And Then...

Use your experiences to help others with their learning. It can be part of your allyship to gender diverse people to use individual learnings to encourage service-wide change.

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3. Qmunity
   (BC's Queer, Trans, and Two-Spirit Resource Centre)'s queer glossary: a to q terminology
4. See Community-Based Research Centre's (CBRC) website for a multitude of resources.

"The Community-Based Research Centre (CBRC) promotes the health of people of diverse sexualities and genders through research and intervention development." (69)

Resources for CHNs:

1. See the FNHA's Sexually Transmitted and Blood Borne Infections Team's resources on Gathering Space at: https://partners.fnha.ca/sites/HomeandCommunityCare/Sexual_Health_Wellbeing/Forms/Document%20Type1.aspx
    a. Specifically:
    b. Gender Guiding Resources for Nursing Care – Resources on Gender Identity
    c. Inclusivity Guiding Resources for Nursing Care - Resources for Gender Inclusivity

2. Here is an excellent 8 page resource from La Leche League Canada (LLLC) –

Transgender/transsexual/genderfluid Tip Sheets – General Information (https://www.lllc.ca/sites/default/files/REVISED-Trans-Nursing_Tip-Sheet.pdf)

This is an outstanding resource intended for those who are providing lactation or breast/chestfeeding support to transgender men and transgender women as well as general information. Excellent suggestions and support are provided for areas of practice such as language, top surgery, binding, testosterone use, chestfeeding goals, inducing lactation and potential gender dysphoria and chestfeeding. The resource also talks about gender and sex as well as gender identity and sexual orientation.

Additional Resources identified by LLLC:

"Trans Women and Breastfeeding: A Personal Interview" by Trevor MacDonald, available at http://www.milkjunkies.net/2013/05/trans-women-and-breastfeeding-personal.html

"Trans Women and Breastfeeding: The Health Care Provider" by Trevor MacDonald, available at http://www.milkjunkies.net/2013/07/trans-women-and-breastfeeding-health.html

Facebook-based Birthing and Breastfeeding Transmen and Allies group welcomes trans women interested in nursing their infants.

Defining Your Own Success: Breastfeeding After Breast Reduction Surgery by Diana West www.bfar.org

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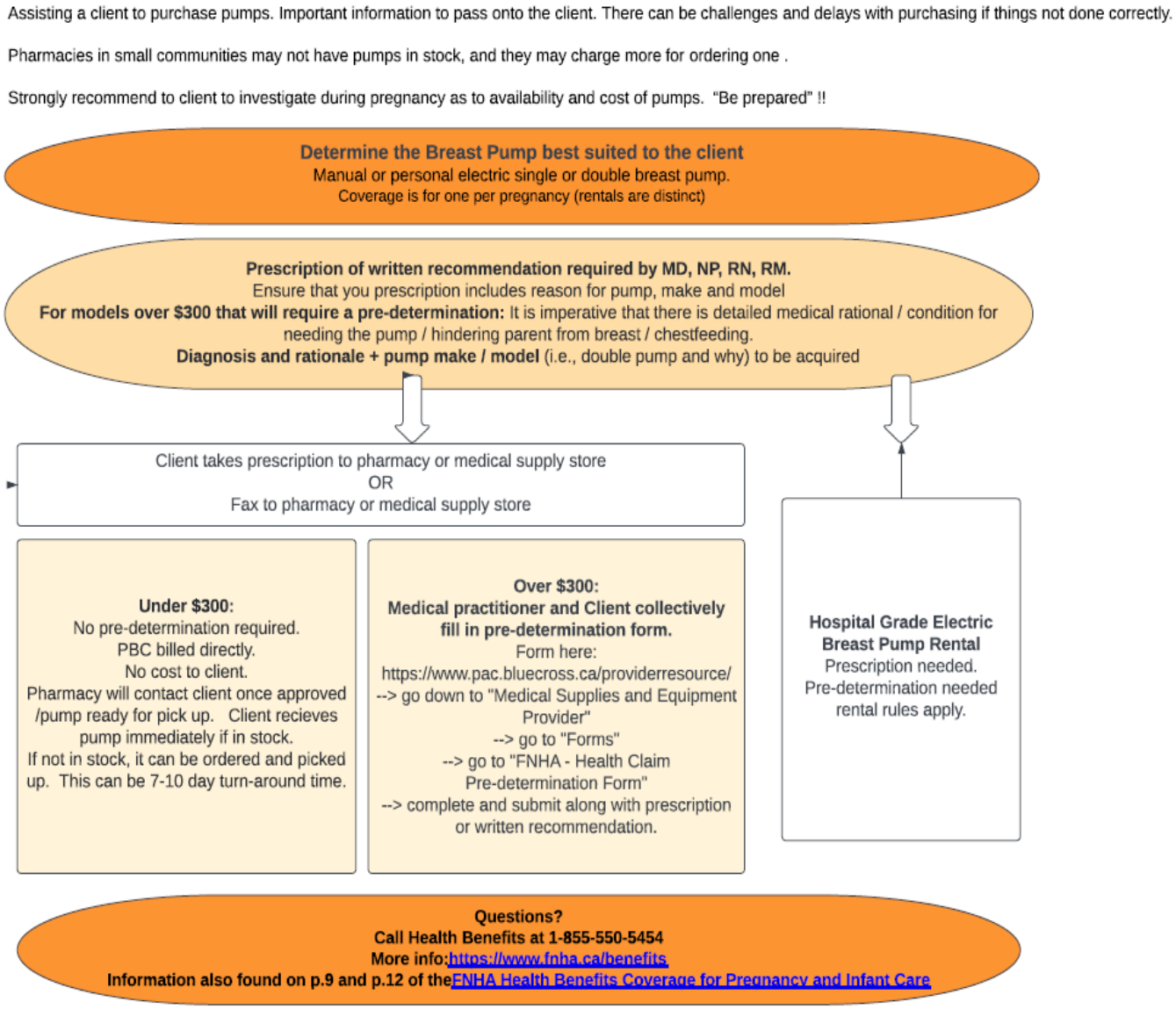
I Breast Pumps – Flow Chart – Process for Acquiring Pumps Through FNHA Health Benefits

You can find the flowchart below in the MCH section of Nursing Resources on Gathering Space at:
https://partners.fnha.ca/sites/HomeandCommunityCare/Postpartum/Breast%20pump%20access%20flowchart.pdf

(FNHA Nursing Resources > Maternal/Child Health > Postpartum Clinical Resources > Breastfeeding & Feeding > Breast pump access flowchart)



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