

# Answering The Call:

Calls to Action from First Nations  
Community Members to Improve  
the Rural and Remote  
Birthing Journey

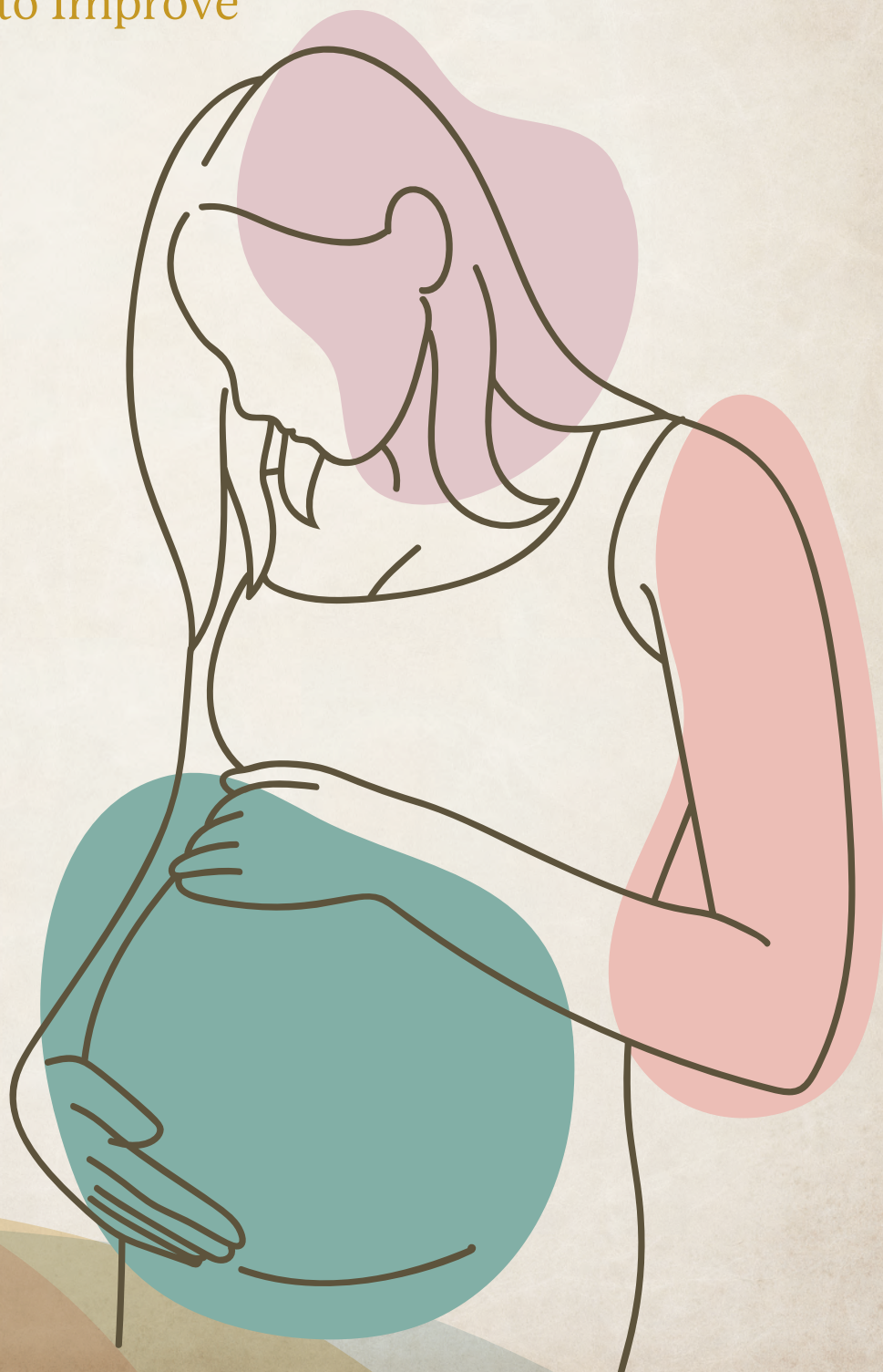
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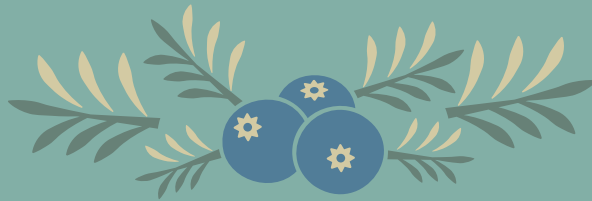
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## Opening prayer from Tsawaysia Spukwus, Squamish Nation Elder



Ha7lh Skwayel, good day! Thank the Creator for this beautiful day. Thank the four winds. Thank Mother Earth for all that she provides: fresh air, fresh water, mountains, plants, birds, animals, marine animals, trees and much more. There are so many teachings — 360 degrees around us. The cedar tree teaches us to stand tall and be proud of who we are. The cedar branches teach us to reach out as we don't know all the answers (it's okay to ask questions). The river teaches us to go with the flow. The killer whale teaches us to work as a team, as a unit, as one. The grizzly bear teaches us to protect. The majestic and powerful bald eagle flies the highest and passes our messages to our Creator. All the way down to the tiny ant, who teaches us to pull more than our own weight.



# Guidance and Gratitude

We acknowledge the decades of First Nations and other Indigenous leaders, researchers, birth workers, Elders and Knowledge Keepers who have directly and indirectly guided this good work. We recognize the shared commitment to the next Seven Generations, ensuring that equitable and sustainable access to culturally relevant and respectful maternity care is upheld.

The FNHA would particularly like to express our heartfelt gratitude and respect to Auntie Lucy Barney of the T'it'q'et Nation, who has led birth work for decades and served as a cultural advisor on this work. We hold up our hands in appreciation for her wisdom, knowledge and guidance, which informed this document immensely.

## Here is some of the work Auntie Lucy has led:

Perinatal Services BC Honouring Indigenous Women's and Families' Pregnancy Journeys

[cms.psbchealthhub.ca/sites/default/files/2023-09/Honouring\\_Indigenous\\_Womens\\_and\\_Families\\_Pregnancy\\_Journeys.pdf](https://cms.psbchealthhub.ca/sites/default/files/2023-09/Honouring_Indigenous_Womens_and_Families_Pregnancy_Journeys.pdf)

Perinatal Services BC Doula Services

[www.perinatalservicesbc.ca/health-professionals/professional-resources/indigenous-resources/doula-services](http://www.perinatalservicesbc.ca/health-professionals/professional-resources/indigenous-resources/doula-services)

Perinatal Services BC Pregnancy Passport

[www.perinatalservicesbc.ca/Documents/Resources/HealthPromotion/PregnancyPassport/PregnancyPassport.pdf](http://www.perinatalservicesbc.ca/Documents/Resources/HealthPromotion/PregnancyPassport/PregnancyPassport.pdf)

## Learn more about Auntie Lucy:

[www.youtube.com/watch?v=d7GWsiGpMUY](https://www.youtube.com/watch?v=d7GWsiGpMUY)

## Dedication:

This document is dedicated to the Lifegivers and their families, for whom system transformation will have the greatest impact. Health system partners must collaborate to transform the existing health care system so that it supports the self-determination of First Nations Lifegivers and provides high-quality, culturally safe services throughout the birthing journey, including prenatal care, delivery and the postpartum period.

**\*Content Warning\*** The content in this section may trigger unpleasant feelings and memories of negative experiences.

If you need emotional support, please call the 24-Hour KUU-US Crisis Line: **1-800-588-8717 (toll-free)**

First Nations people may find the content in this document distressing as it may reflect their experiences of harm and cultural unsafety. The content may also lead to unpleasant feelings for non-Indigenous readers who are asked to witness and think differently about experiences of systemic racism and discrimination that are often hidden from view. This information is intended to acknowledge the current state and the calls to action.



# Terminology

“Women are known as life givers.”

—Knowledge Keeper Lucy Barney, T’it’q’et Nation

While this document uses the term “Lifegiver,” other terms may be used in First Nations communities – including “birther” or “pregnant person.” The diversity of terms is acknowledged and respected.

For some people, pregnancy may be tied to the profound loss and pain related to miscarriage, stillbirth or infant death. This document does not address fertility or loss, but we honour those who carry these experiences.



*Art by Carla Joseph*



# Executive Summary

Health system partners have a shared responsibility to uphold the rights and self-determination of First Nations Lifegivers in British Columbia and bring culturally safe pre- and post-natal care closer to home for First Nations Lifegivers living in rural and remote communities. *Answering the Call* lifts up the collective voices of First Nations Lifegivers, Elders and system partners. Their truths call for change and highlight the need for system transformation to improve processes for birthing and maternity care.

Since time immemorial, First Nations grandmothers and matriarchs have passed down sacred knowledge and teachings around pregnancy, childbirth and the postpartum period. However, settler colonial policies, systems and structures have disrupted – and continue to intentionally disrupt and suppress – this vital knowledge from being shared and practised. For example, First Nations Lifegivers living in rural and remote communities are routinely “evacuated” (i.e., required to travel to a hospital or birthing centre weeks ahead of giving birth), which erodes the celebration, ceremony and protocols that traditionally surround birth. Exclusive birth evacuations have also limited the availability of pre- and post-natal services in or near rural and remote communities. This issue has been worsened by the closure of maternity services at over 20 regional hospitals over the past two decades, forcing First Nations Lifegivers to travel even farther from their home communities. These closures have had a particularly significant impact on communities in the Fraser, Interior and Northern Health regions.

Transportation services may be required for the Lifegiver and/or the child to receive medical care, including non-emergency and emergency transport. Emergency evacuations for birthing are complex and require greater First Nations involvement in operational and administrative planning and execution. Reducing the number of evacuations and the distance travelled to maternity services must be a shared priority for health system partners. The health system must collaborate and partner with BC First Nations communities to create safe plans and pathways for transportation. Connections and knowledge translation between partners and communities to increase First Nations leadership and staff can create a more sustainable model of care. Other successful transport programs, such as the ones used for cardiac evacuation and transplant harvesting, can serve as models to facilitate the transport of well-equipped maternal and child care teams into rural and remote communities. Technological improvements and the increased use of telemedicine also play an important role in the delivery of wraparound care. For example, virtual maternity services could link tertiary care centres to remote communities.

Birth workers are a fundamental part of a Lifegiver’s birthing journey and include everyone involved in the care of a pregnant person. This circle of care may include midwives, doctors, nurses, Elders, Indigenous liaisons or patient navigators, doulas, lactation consultants, family, friends and community members. Birth workers shape Lifegivers’ current and future birthing experiences, so it is necessary to provide culturally safe care that is wholistic, safe and relational. First Nations Lifegivers have a right to receive culturally safe, trauma-informed care that respects and upholds their autonomy and self-determination. It is essential to uphold the self-determination of Lifegivers and ensure their chosen circle of care is respected and has the capacity, resources and knowledge to provide the appropriate support during labour and delivery.

To achieve system transformation, the health system must collaborate and partner with First Nations communities to develop a targeted and community-driven plan to increase First Nations health and human resources. Increasing the availability of Indigenous family physicians, midwives, doulas, peer supports and liaisons in rural and remote communities can bring birth closer to home, and the revitalization of First Nations midwives and doulas further embeds culture, traditions and ceremony into the birthing journey. When First Nations Lifegivers must give birth far from their home communities, hospitals must provide wholistic, culturally safe care. The health care system has a duty to make First Nations people feel safe when giving birth, and more work is needed to ensure this standard of care is met.

The goal of reducing First Nations maternal and infant mortality must be a key provincial priority of all stakeholders involved in the work related to birthing. To improve maternal and infant outcomes, health system partners must increase access to programs that treat First Nations Lifegivers’ wholistic health and support their ability to access the social determinants of health. This includes providing dedicated support for First Nations Lifegivers who use substances and/or have substance use disorders, such as liaison and/or doula support, counselling support, opioid agonist therapy, safer pharmaceutical alternatives and referral services for withdrawal and relapse prevention. Health care providers must receive more education and training around medications, doses of opioids, and pain management during delivery for Lifegivers who use substances and/or have substance use disorders. The reclamation of birth for First Nations Lifegivers who use substances and/or have substance use disorders also includes increasing access to cultural supports, such as connecting with an Elder or being able to hold ceremony. The delivery of culturally safe care free from judgement, racism and discrimination has been shown to reduce birth complications such as preterm births.

Settler colonial policies, laws and practices have contributed and continue to contribute to systemic Indigenous-specific racism, stereotyping and discrimination in the BC health care system, resulting in substantial harms and even death. The risk of uninformed consent, coercion and forced sterilization remains an ongoing issue affecting First Nations Lifegivers in BC and Canada. This risk is heightened when First Nations Lifegivers are forced to receive care away from home. Bringing birth services closer to home is an act of self-determination. It allows family, friends and other supports, such as doulas, to surround the Lifegiver in celebration, and also allows loved ones to provide advocacy and safety for the Lifegiver.

First Nations Lifegivers may have an inherent distrust of the health care system due to being disproportionately targeted by birth alerts,<sup>i</sup> which give the child welfare system the power to apprehend children. As a result of this and other harmful mechanisms, First Nations and other Indigenous children are disproportionately represented in Canada's child welfare system. The duty to support First Nations families often gets lost within the duty to report. The provision of culturally safe care means that health care providers cannot lead with the threat of the child welfare system, but instead must lead by offering families the necessary supports required to thrive together whenever possible.

The *BC Declaration on the Rights of Indigenous Peoples Act (Declaration Act)* and the *Declaration Act Action Plan* demonstrate that the Province of BC is committed to recognizing and upholding the inherent rights of First Nations in BC. All system partners involved in this work have a shared responsibility to collaborate and prioritize this work to bring culturally safe birthing services that are free from racism and discrimination closer to home.

The FNHA calls on the BC Ministry of Health and the five regional health authorities to operationalize these calls to action and improve the birthing experience for First Nations Lifegivers in BC who live in rural and remote communities.

## **CALLS TO ACTION**

### **Uphold the inherent rights and self-determination of BC First Nations**

The *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* and the *BC Declaration Act* codify and legislate the inherent rights of First Nations people in BC.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Uphold First Nations Lifegivers' right to birth closer to home and to be self-determining individuals who may choose to include culture, traditional protocols or ceremony into their birthing experience.
- ▶ Involve First Nations communities in transport planning to ensure their voices and expertise shape transport operations for First Nations Lifegivers.
- ▶ Improve communication pathways between First Nations communities and the health care system, particularly community nursing and emergency transport services.

### **Increase the availability of services in First Nations communities or closer to home**

Collaboratively work to ensure that pre- and post-natal care is available closer to home so that First Nations Lifegivers can be surrounded by their chosen circle of care. Bringing services closer to home also ensures the best, healthy start for First Nations children in BC, where they are encircled in the care and love of their families and communities, and have the supports necessary to thrive.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Train and hire more First Nations midwives and doulas, and fund in-community training opportunities for doulas and Indigenous liaisons to build community capacity and supports.
- ▶ Employ will and creativity in the delivery of culturally safe health care operations, including the use of virtual care, to increase the accessibility of pre- and post-natal services closer to home, such as lactation support and point of contact ultrasounds.
- ▶ Create and/or strengthen relationships between First Nations communities and maternity referral centres through community outreach and the development of communication pathways.

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<sup>i</sup> Birth alerts are a practice in which social workers or hospital staff flag an expecting parent – often without their knowledge – as being unfit to care for their unborn child. Birth alerts are often issued without evidence of real risk, and primarily target people who face systemic racism, discrimination and stigma. First Nations and other Indigenous people are disproportionately affected.

- ▶ Dedicate the transport of well-equipped maternal child care teams to respond to obstetrical emergency evacuations, and mobilize specialized personnel and equipment into communities for non-emergency transport as well as pre- and post-natal care needs.
- ▶ Open birth homes near accessible emergency transport and begin to offer pre- and post-natal maternity and reproductive services in First Nations communities to re-establish health care capacity.

## Address Indigenous-specific racism and discrimination

First Nations Lifegivers have a right to obtain care free from racism, discrimination, stereotyping and stigma. This is particularly important to ensure the duty to support is leading the delivery of care.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Recruit and hire more doulas and Indigenous Patient Navigators to work in health care settings by partnering with local communities to build a sustainable health and human resources pathway.
- ▶ Create processes that integrate Elders into birthing and maternity programs in order to provide cultural support and healing for First Nations Lifegivers, ensuring that Elders are also encircled in cultural safety, dignity and respect.
- ▶ Establish culturally safe evacuation procedures and evacuation sites.
- ▶ Embed culturally safe care practices in all health care settings to ensure that pregnancy, labour and delivery, and postpartum care for all First Nations Lifegivers in BC is free from racism, discrimination and stigma.
- ▶ Ensure all maternity sites have evaluated their consent procedures to immediately end the coerced sterilization of First Nations Lifegivers in BC.

## Prioritize the social determinants of health in reproductive care

Pre-settler colonial contact, First Nations people controlled their own systems, including health, education and housing. Ongoing settler colonial policies have continued to erode these systems, and have negatively impacted the social determinants of health as well as the health of First Nations people in BC. Greater action is needed to reduce poverty, improve access to housing, increase food security and food sovereignty, prioritize early childhood development, and improve access to health services. The social determinants of health also play critical roles in maternal mortality, the toxic drug crisis and the disproportionate number of First Nations children apprehended by the Ministry of Children and Family Development. Particular attention must be given to Lifegivers who use substances and/or have substance use disorders.

To answer the calls made by First Nations Lifegivers, health system partners must commit to and action their role in the following:

- ▶ Embed First Nations voices and leadership into the operations of the Ministry of Children and Family Development, the Ministry of Health, and throughout the health system as per Recommendation 14 of the *In Plain Sight* report<sup>ii</sup> to ensure First Nations families receive the necessary supports required to thrive together whenever possible.
- ▶ Establish more culturally safe programs for Lifegivers who use substances and/or have substance use disorders, and ensure comprehensive community support services are available with a focus on housing, safety, food security and access to health services.
- ▶ Improve and expand health care provider education and training to more effectively support Lifegivers who use substances and/or have substance use disorders. A comprehensive, wholistic approach must be taken to addresses the barriers these Lifegivers experience when accessing care, such as stigma, housing instability and difficulty navigating complex medical services availability in rural and remote communities.

ii *In Plain Sight* Recommendation #14: "That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change."

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# Purpose and Truth

First Nations people have the right to birth safely at home in their communities, closer to home and away from home. First Nations people have the right to obtain sexual and reproductive health care and knowledge translation throughout their lifespan at home and closer to home.

The purpose of *Answering the Call* is to lift up the voices of First Nations in BC and challenge BC health system partners to improve prenatal, labour and delivery, and postpartum care for First Nations Lifegivers in BC who live in rural and remote communities. Upholding the rights of First Nations Lifegivers is at the heart of this work, including celebrating the ceremony of birthing and ceremonies surrounding birth and loss. Particular attention should be paid to the ongoing settler-colonial system that First Nations in BC are required to navigate, and the social and structural determinants of health affecting those who live in rural and remote communities.

The readers of this report must uphold First Nations Lifegivers' rights and self-determination in the geographical area colonially referred to as British Columbia. These Lifegivers are disproportionately evacuated from their communities to give birth, and often for the majority of their pre- and post-natal care. Commitment from all system partners and health care providers is needed to ensure that culturally safe, trauma-informed maternity care free from racism and discrimination is available closer to home for First Nations Lifegivers and their families. When this is achieved, families and communities can celebrate and welcome each new life into the world in ceremony, ensuring that the infant is surrounded by a network of loved ones.

This report is a call to action for health system partners. The voices of First Nations Lifegivers in BC are woven throughout this report; their truths and experiences illustrate the significant problems within the existing system. When learning from these truths, consider and reflect upon your role in birthing at home, closer to home and away from home – then commit to taking action. All people within health care operations, administration and leadership are responsible to work with and alongside First Nation communities, doulas, midwives, nurses and physicians towards system transformation while recognizing the priorities of each unique and distinct BC First Nations community.

The Provincial Working Group on Indigenous Birthing Rights and Reclamation has begun this work with the most vital first step: province-wide collaboration. It is with great humility that the members of this group share ideas, thoughts, processes, concerns and potential solutions. A broad and vital circle of members entails mutual respect for the purpose of the work and of each other's unique and important skillsets. *Answering the Call* requires all partners to provide open-mindedness, flexibility, dedication and a commitment to support First Nations Lifegivers in their journey.

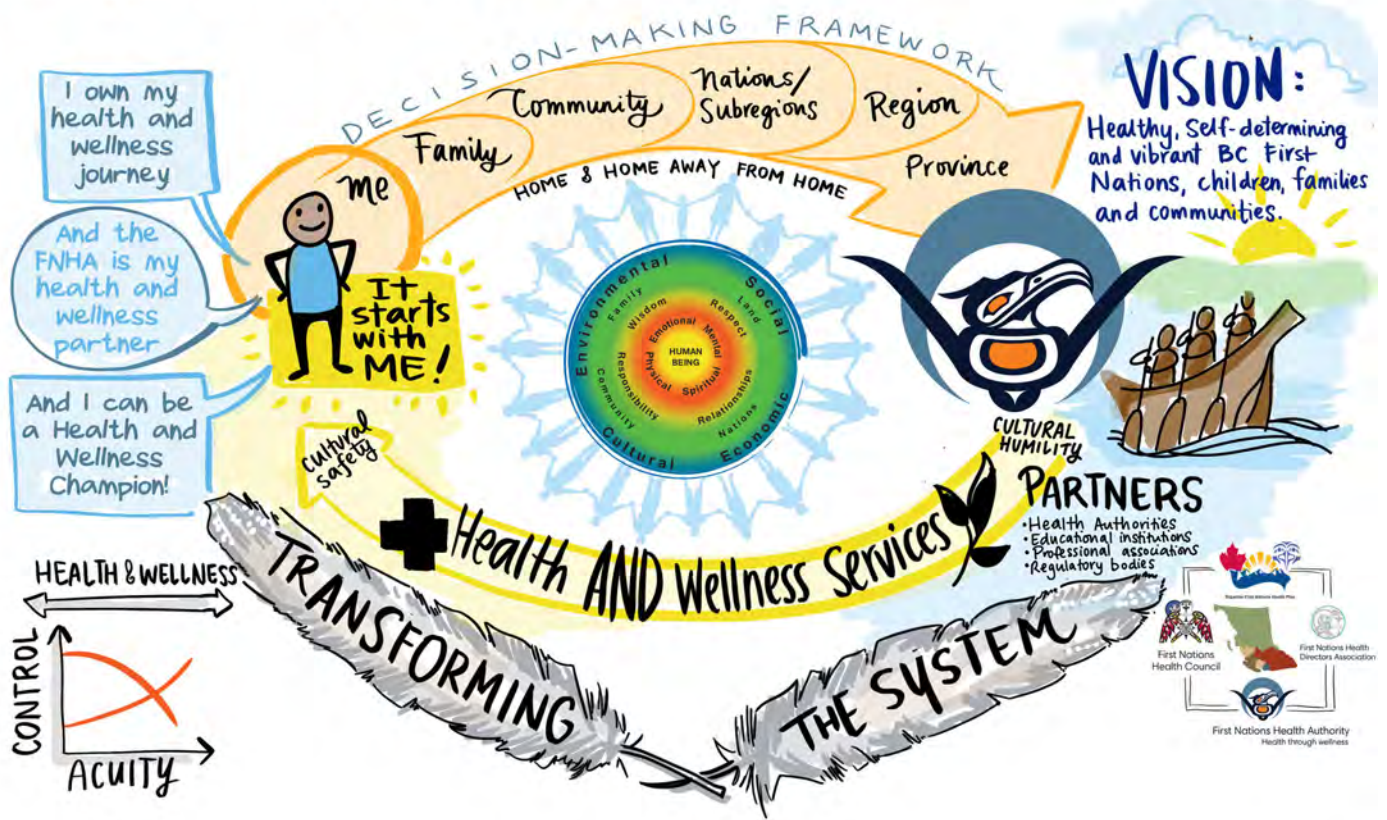
This report highlights three pillars: birthing at home and in community; birthing closer to home; and birthing away from home. However, it has been made clear through engagement that the entire reproductive health care journey along the lifespan must be the overarching priority. Numerous calls to action that align within each pillar are highlighted and clearly demonstrate the distinct yet intertwined priorities of First Nations community members when birthing in any location.

**Please read this report with the same humility in which it was created. Provincial leaders must come forward and work in the capacity of their roles to create culturally safe and trauma-informed birthing experiences for First Nations Lifegivers in BC. *Answering the Call* is a beginning. The FNHA looks to system partners to engage and collaborate with the First Nations people they serve to move forward in a good way.**



Figure 1: FNHA's Ecosystem of Health and Wellness

# Ecosystem of Health and Wellness



It is necessary for all parties responsible for the care of First Nations Lifegivers to ensure respectful communication and collaboration with First Nations Lifegivers. The FNHA's Ecosystem of Health demonstrates how the health care system can be a wellness partner to First Nations people.

The FNHA acknowledges that this work is not being done in isolation. The Midwives Association of British Columbia, with participation from Indigenous midwives working in British Columbia, have developed an [Indigenous Midwifery Strategic Plan: Seven Generations Sustainability + Growth Pathway](#). This document includes a vision, practice objectives and values for Indigenous midwifery intended to strengthen future planning and decision-making. The reclamation of birthing in communities (the delivery of care) is complex and the Indigenous Midwives of British Columbia are leaders in this work. Perinatal Services BC, in their role as a Health Improvement Network, is also creating a provincial framework offering further context on system coordination needs and operational requirements. The FNHA's focus is on cultural safety, access, equity, services closer to home, partnerships, lifelong longitudinal primary care, maternal mortality and transport/ seamless transitions of care for First Nations Lifegivers in British Columbia.

# 1. Grounding

*Answering the Call* is community-driven, Nation-based and aligns with the **First Nations Health Authority's 7 Directives**:<sup>1</sup>

1. Be Community-Driven and Nation-Based
2. Increase First Nations Decision Making and Control
3. Improve Services
4. Foster Meaningful Collaboration and Partnership
5. Develop Human and Economic Capacity
6. Be Without Prejudice to First Nations Interests
7. Function at a High Operational Standard

It is imperative that learners have knowledge of and a commitment to embed the BC Cultural Safety and Humility Standard, as well as the signed Declaration of Commitment to Cultural Safety and Humility,<sup>iii</sup> into their work. The *In Plain Sight* report proves there is widespread systemic racism, stereotyping and discrimination against First Nations and other Indigenous peoples in the BC health care system, and that it has led and continues to lead to a range of negative impacts, harms and even death. It is also important to understand the social determinants of health and how they impact First Nations people, as well as the settler colonial policies that intentionally dismantled First Nations systems that made people well. Below, we have included links to this information, along with a link to the incredible work being led by the Office of the Provincial Health Officer, specifically Dr. Danièle Behn Smith, Dr. Bonnie Henry and Dr. Kate Jongbloed, on unlearning and undoing systemic white supremacy and Indigenous-specific racism.

BC Cultural Safety and Humility Standard

[healthstandards.org/standard/cultural-safety-and-humility-standard/](https://healthstandards.org/standard/cultural-safety-and-humility-standard/)

*In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*

[engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf](https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf)

World Health Organization Social Determinants of Health

[www.who.int/health-topics/social-determinants-of-health](https://www.who.int/health-topics/social-determinants-of-health)

Office of the Provincial Health Officer Unlearning and Undoing Project

[www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project](https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project)

**As you embark on this work, return to this page as often as needed to ensure that the grounding information, reflections and teachings stay with you as you consider the changes that need to happen through your commitment and actions.**



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<sup>iii</sup> The BC health authorities, the BC health regulators, Doctors of BC, and the College of Family Physicians of BC have all signed a Declaration of Commitment to Cultural Safety and Humility with FNHA.



# PART 1:

## Capturing the Current System

This section captures the history and current state of birthing for First Nations Lifegivers in BC. Settler colonialism has fundamentally altered what pregnancy, birth and reproductive health care look like in BC First Nations communities. For First Nations living in rural and remote communities across BC, birthing far from one's home community has become standard. Routine birth evacuations, coupled with the medicalization of pregnancy and birth, has eroded First Nations knowledge around birth. A first step to action the reclamation of birth is for health care providers to ensure they are providing culturally safe, relational care that respects Lifegivers as unique, self-determining individuals. The health care system must respect the patient's decision on who is within their care team and accept that a birth worker can be a trusted friend, family member, doula, midwife or doctor. The main thing is to ensure that each member of the Lifegiver's care team has supported in their capacity and knowledge to provide the appropriate care during labour and delivery.

## 2. “A Natural Way of Being”

The ability to bring life into the world – to be a Lifegiver – is one of the Creator’s sacred gifts to women. Since time immemorial, BC First Nations women have held sacred knowledge around pregnancy, childbirth and the postpartum period.<sup>2,3,4</sup> Grandmothers and matriarchs passed down this important knowledge to girls and women in their communities by way of oral teachings and experiential learning.<sup>5</sup> Racist settler colonial policies that were implemented during colonization, and that are still in place today, have disrupted and suppressed this knowledge from being practised and shared.<sup>4,5</sup>

“Kokum, my grandma, came down from Fort Qu’Appelle. She was a midwife and she passed her skill of being a midwife on to my mom, it was a natural progression. She was renowned and she delivered many babies. It was a very natural way of being. We used plants and herbs. She had to travel in secret, because travel and the use of our medicine was illegal; it was outlawed for many years. It [Birth work] became a less natural way of being due to Catholicism and colonization. If we had been a part of the natural journey [of passing skills], we would have had the knowledge to help through pregnancy. I was delivered by my grandparents out of a hospital. I was born the year we became Canadian citizens. I was taught that the traditions and a spirit is helping a child come to life – it is sacred. Kokum was that person for so many; the midwife role is sacred. After birth, babies are given spiritual names. I was given an English name and later a spiritual name. Residential school took this away from us.”

– **kihci tēpakohp iskotēw iskwēw (Elder Emily Jane Henry), Ochapowace Cree First Nation**

“I was raised by an Elder; my kids call her great-great grandma. She was strict with me and she would come down to the house and tell me what to do. I thought she was a mean old lady, and now I see she was preparing me. She would walk me out to the bush to go through the trees and make my own trail; there was no going back on the trail I made. It had to do with the struggles in pregnancy. There were a lot of cultural teachings. She was building my body stamina to have an easy delivery, and to make sure I was strong enough. When I had my first child it was so simple and fast, I didn’t have any complications. There are not many people who can say they had that [experience]. I did that with my own children too, I passed down her knowledge and strength.”

– **Elder Doreen Peter, Cowichan First Nation**

“My grandma was a midwife in community and mentored all young women carrying a child. There was always an Elder in community ensuring their well-being. They have to monitor their food too; pregnant women aren’t allowed to eat certain kinds of herbal medicine. An example is that you can’t eat Indian ice cream, soapberry, until the end so you don’t get labour pains.”

– **Elder Lucy Duncan, First Nations of Binche Keyoh, Lhojaboo Clan**



## Impact of Settler Colonialism on Community, Traditions, Celebrations and Ceremonies

It is common practice for First Nations Lifegivers living in rural and remote communities to be “evacuated” to a hospital or birthing centre weeks ahead of giving birth. They may also be evacuated for much of their reproductive health care, pre- and post-natal. Childbirth is a significant event that is celebrated by the family and community.<sup>3</sup> The consequence of exclusive birth evacuations is multifold and has affected generations of First Nations families. Further details of the impact of settler colonialism on birthing practices, as well as the generational passing of ceremony and tradition, follow.

*“In 1892, the Government of Canada decided that two physicians should start providing obstetrical care on a reserve in Ontario” (Lawford & Giles, 2012a). This was not a benevolent decision; rather, it was a way to introduce “state-sanctioned medical authority over First Nations women with the intention to end long-standing First Nations pregnancy and birthing practices in favour of a Euro-Canadian biomedical model of care” (Lawford & Giles, 2012a, p. 332). The Government of Canada expanded obstetrical care to reserve communities all across Canada and also introduced other Euro-Canadian bio-medically trained providers such as [Field Matrons<sup>iv</sup>], midwives and nurse-midwives to those who lived on reserves. Over the decades, and in conjunction with national efforts to get rid of Canada’s “Indian problem” (Campbell Scott, 1920, para. 1), through assimilatory techniques such as mandatory attendance at an Indian Residential School (Truth and Reconciliation Commission of Canada, 2015), federal government bureaucrats and health care providers purposefully and methodically pressured First Nations to change their maternity care practices (Lawford & Giles, 2012a). At first, labour and birth were moved from the outdoors and within communities into nursing stations and then into federally run hospitals. When federal hospitals closed, labour and birthing services were shifted into provincially run hospitals, which were often at a great physical distance from reserve communities” (Lawford, 2017).<sup>6</sup>*

“We are never asked about what we want, we are told. We need dialogue. That [dialogue] is how you get young people to see doctors, otherwise they go when it’s too late.”

– Elder Cheryl Schweizer, Tl’azt’en Nation, UBC Indigenous Patient Led CPD

“It is up to communities to decide what is most important to them.”

– Dr. John Pawlovich, UBC Rural Doctors’ Chair in Rural Health

Evacuations outside of one’s home community are a common experience for most First Nations Lifegivers in BC – for birthing, and also for most sexual and reproductive health services. This is an ongoing form of colonization that devalues First Nations and other Indigenous medical knowledge and practices.

*“Birthing can be an empowering experience for women, but it can come with risks, including maternal and infant mortality. Mainstream medicine has attempted to reduce these risks by encouraging hospital births and introducing interventions such as inductions, optional caesarean sections, and various analgesics. While we must recognize that there is a place for necessary medical interventions, there are many cases in which such interventions have negative impacts.” (Hayward & Cidro, 2021, p. 213)<sup>7</sup>*

<sup>iv</sup> It should be noted that field matrons were not only in charge of births, but also in charge of making First Nations women (who were subject to the pass system) behave in ways that better complied to the ideals of the church and the nuclear family.

“We are working towards a vision to revitalize traditional wellness. We recognize a need to advance practices to ensure that both Indigenous and Western Knowledge will be present in more ways than solely through a two-eyed seeing approach to research. Communities not having birth knowledge as a result of colonization have created unsafe environments in rural and remote Indigenous communities. Restoring and revitalizing birth knowledge will not only increase the safety of rural and remote communities, it will also encourage Indigenous peoples to take on careers in health.”

– Marion Erickson, Lhts’umusyoo Clan, Research Manager, University of Northern BC

## Social Determinants of Health and the Absence of Ceremony

It is critical to realize that the burden of extensive travel can negatively impact the health of the Lifegiver. When Lifegivers are forced to leave their communities to give birth and obtain reproductive and sexual health care, they may experience stress, loneliness and isolation due to the loss of their social and spiritual supports, as well as significant financial costs for the time spent away from home.<sup>4,5</sup> What’s more, when childbirth is removed from the community, fathers, grandfathers and extended families may also be prevented from participating in the childbirth process.<sup>5</sup> Settler-colonial policies, including Western, urbanized maternity care systems, have resulted in decades of birth evacuations, which disrupt the traditional transfer of perinatal and postnatal knowledge. Celebration, ceremonies and traditions were also disrupted as they were banned by these policies. The ongoing practice of mandatory evacuations mean that First Nations Lifegivers have lost the ability to give birth on traditional and ancestral lands, in ways that honour their values, knowledge and birthing practices. When birthing is removed from a community, so much more is lost with it. For example, the health care provider who provided that service is removed along with their knowledge base/translation, expertise, and health care provision for gynecological and obstetrical care.

*“Women in rural and remote communities in Canada are less likely than their urban counterparts to have access to satisfactory care. They must usually leave their communities to give birth, and they often experience labour and delivery without the presence and support of family and community members. Childbirth has therefore become a stressful event that disrupts rather than strengthens families and communities. Transfer out of the community for birth is costly for the family and the community, as well as for the federal health care budget. The large economic and social costs to families include support for women living away from the community and childcare for the children left behind. Teenage girls may be in particularly vulnerable situations when left without their mothers for weeks at a critical time in their development.”* (Journal of Obstetrics and Gynaecology Canada, 2017)<sup>8</sup>

The consistent closure of birthing services in smaller communities in recent years in BC has increased the need for First Nations Lifegivers to travel away from their home community. Over the last two decades, rural and remote BC First Nations families have been profoundly impacted by the loss of maternity services at over 20 regional hospitals. The closures have occurred within communities holding some of the highest vulnerabilities and highest rates of maternal and infant mortality.

*“Indigenous people in Canada experience striking inequities in access to birth close to home compared with non-Indigenous people, primarily in rural areas and independently of medical complications of pregnancy. This suggests inequities are rooted in the geographic distribution of and proximal access to birthing facilities and providers for Indigenous people.”* (Smylie et al., 2021, p. 948)<sup>9</sup>

It has been found that “[...] in rural areas, 23.2% of Indigenous mothers travelled 200 km or more to give birth, whereas 2.1% of non-Indigenous mothers in rural areas travelled 200 km or more to give birth.” (Smylie et al., 2021, p. 953)<sup>9</sup>

### 3. “Where is the Care Available and Where Are People Living?”

The loss of traditional birthing, and subsequently care providers, along with the medicalization of birthing, has resulted in births being taken out of First Nations communities. The location and accessibility of provincial maternity services also has an impact on where Lifegivers from rural and remote First Nations communities must travel to in order to give birth. BC has seen a significant loss in maternity services over the period 1999-2019, particularly in the Fraser, Interior and Northern health regions.<sup>10</sup> These closures have negatively impacted the ability of First Nations families to birth closer to home, and have contributed to the inability of First Nations families to practise ceremony and tradition at the time of birth with one’s family and community nearby. The closures have also limited the availability of primary care obstetrics services for those living in rural and remote areas.

“[Lifegivers] would like to show their newest addition to their family and have their family with them.”

– Elder Doreen Peter, Cowichan First Nation

“When you have to leave community to give birth, it means you miss presenting the baby to community in a ceremony; this is the Carrier tradition.”

– Dr. Rebekah Eatmon, Indigenous Family Physician

#### ***United Nations Declaration on the Rights of Indigenous Peoples<sup>11</sup>***

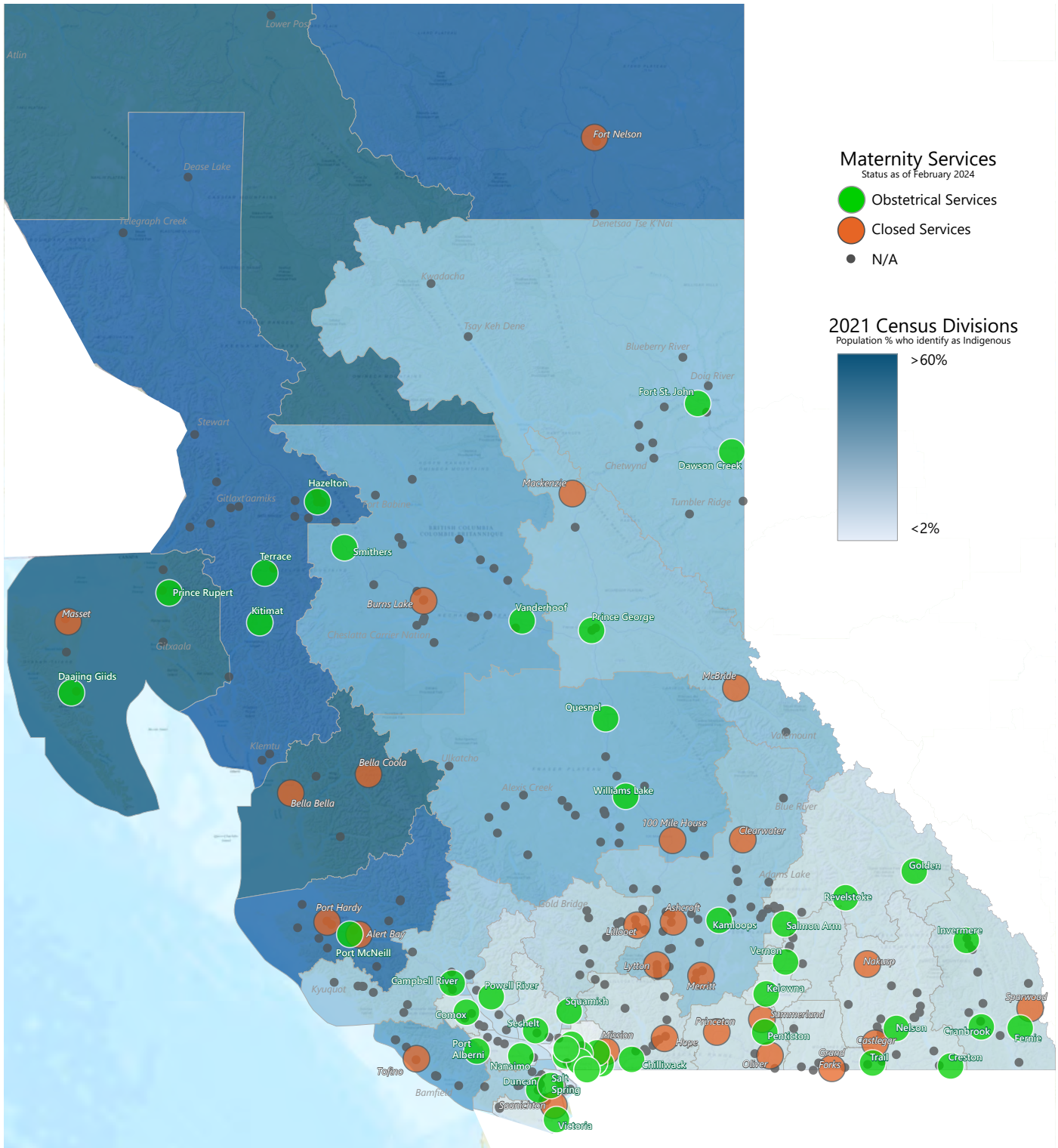
- ▶ **Article 11.1** Indigenous peoples have the right to practise and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present and future manifestations of their cultures, such as archaeological and historical sites, artefacts, designs, ceremonies, technologies and visual and performing arts and literature.
- ▶ **Article 12.1** Indigenous peoples have the right to manifest, practise, develop and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect, and have access in privacy to their religious and cultural sites; the right to the use and control of their ceremonial objects; and the right to the repatriation of their human remains.

The map below shows all the maternity-service closures across BC. These closures have had profound impacts on those wishing to birth closer to home; on pre- and post-natal care including but not limited to lactation supports, in- and out-patient prenatal substance use programming; on community training for roles in health care; and on sexual health services including contraception availability. All of these are highlighted in *Answering the Call* as necessary services to have within communities.

It is important to note that there are 204 distinct BC First Nations communities, each with their own unique traditions and history, including birthing customs, traditions and ceremonies. It is necessary for health system partners to establish birthing options in partnership with First Nations communities that reflect the diversity and self-determination of First Nations people in BC.



**Figure 2: Maternity Services Across all Regions in BC, 2024**



## 4. Creating Safe Plans and Pathways for Transportation

During the pregnancy, birth and postpartum period, transport may be required for the Lifegiver and/or the child to receive medical care. Transport relates to both emergency and non-emergency evacuation. Reducing evacuations and distance are key goals of system transformation. This enables fewer and shorter evacuations, provides the opportunity for ceremony and the passing of traditions, and prioritizes the mental health of Lifegivers. If a Lifegiver chooses to deliver in a higher level of care centre, or is required to, the receiving site must provide culturally safe care.

### Non-Emergency Transport

Non-emergency transport occurs when the Lifegiver is required to travel to receive care during any period of the pregnancy, for labour and delivery, and/or for postpartum care. This is most frequently due to the lack of services available locally. Most Lifegivers living in rural and remote communities are required to travel to their birthing hospital at approximately 36 weeks of pregnancy in anticipation of labour and delivery.

The FNHA is working internally and with external partners to continuously evaluate and ensure that non-emergency transport is comfortable and culturally safe. Ongoing work is being done to engage communities to form the best possible care for people's needs. The FNHA focuses on and aspires to ensure:

- ▶ Access
- ▶ Equity and cultural safety
- ▶ Partnership with transportation systems
- ▶ Services closer to home
- ▶ Virtual services proxy closer to home

### Emergency Transport

In any discussion about birthing closer to home, emergency evacuations must be considered. Should a medical emergency arise, the Lifegiver may require immediate transport to a hospital setting that has the staff and equipment to provide necessary and lifesaving care for herself and/or the baby. Emergency evacuations for birthing are complex, and require greater First Nations involvement in operational and administrative planning and execution. System partners must invest in the necessary human resource capacity, and ensure that necessary supplies to care for Lifegivers are readily available. Community consultation and collaboration is essential to ensure there is full understanding of transport limitations due to weather, daylight, coastal geography and accessibility.

Transport requires a great deal of knowledge surrounding the logistics of land, water and air travel in and out of rural and remote First Nations communities. While front-line staff are required to prioritize operational factors such as weight and fuel of an aircraft, communities need greater communication with transport operations. Being separated from one's family and care providers can cause significant distress. Community outreach and improved communication pathways that include nursing and community health representatives can better support the care team and the Lifegiver.

“When it comes to evacuation [for birth], more communication has to happen about who is being transported. For example, it's important to know if the significant other is being transported too because if the transport is not available for the partner it can be really upsetting!”

– Anonymous health care provider working in a BC First Nations community

Increasing First Nations and other Indigenous leadership and staff within transport models of care is a first step in system transformation. These roles can be filled through expanded employment to First Nations and other Indigenous people who live locally and are familiar with the region, as well as the people being transported. Upskilling within communities leads to a more sustainable model of care.

Further, maternity transport should model other successful transport programs such as the ones used for cardiac evacuation and transplant harvesting, which include a high-acuity team offering skilled, specialized, targeted care and equipment for emergency call-outs.<sup>12</sup> Engagement with subject matter experts has highlighted a need for increased communication between nursing stations and health care centres and transport services.

## Telemedicine

Virtual care, including virtual maternity services, can play an important role in the delivery of wraparound care and has proven invaluable for the care of people living in rural and remote communities. It links tertiary care centres to remote communities, and should be modelled as a supplementary way to bring services to people living in communities who are otherwise commonly evacuated to receive care.

Engagement with subject matter experts identified numerous examples of desired services that could be made available in rural communities to improve care, such as the use of remote ultrasounds and non-stress tests that could be completed in First Nations communities and read at tertiary care centres.<sup>13</sup> Upskilling local community members or having care providers visit communities with the ability to provide assessments increases safety, offers reassurance and may result in fewer evacuations.

Some of this work has already begun, but expanding the use of remote virtual connections is still essential. The ongoing efforts of the FNHA and the Ministry of Health to expand primary care also serve as an opportunity to offer connections closer to home while providing links to higher-level care. The FNHA operates the Virtual Doctor of the Day<sup>v</sup> service and was among the founders of the Maternity and Babies Advice Line (MaBAL).<sup>vi</sup>

“MaBAL is fantastic! It provides provincial-wide, virtual, real-time support for clients and clinicians.”

– **Shauna Buchannon, Registered Nurse in a BC First Nations community**

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v [www.fnha.ca/what-we-do/ehealth/virtual-doctor-of-the-day](http://www.fnha.ca/what-we-do/ehealth/virtual-doctor-of-the-day)

vi [rccbc.ca/initiatives/rtps/mabal/](http://rccbc.ca/initiatives/rtps/mabal/)



# 5. Birth Work and the Role of Relational Practice and Choice

## The most trusted person and the circle of care

The journey of care related to birthing is not a solitary event, and it is not isolated to birth alone. Rather, it is a life-long journey that begins with raising the person who will give birth and includes having conversations about periods, family planning, teaching and mothering, as well as offering a safe space for both joy and grief. This means the circle of care for a Lifegiver is wide, and care needs to be inclusive. The person most trusted by a Lifegiver also has the most significant role in their health journey and decision-making. This can be an auntie, sister, friend, nurse, doula, midwife and/or doctor.

The health care system has protocols and responsibilities that are vital to the provision of safe care, but the care team must also identify the most patient's most **trusted** and **trustworthy** person.

This person may be a community or family member providing support and advice; it may be a nurse or doula providing knowledge to the patient and offering system translation and advocacy; or it may be a direct care provider such as a midwife, nurse or physician.

As providers in this space, it is imperative that we look towards and lean on each other's strengths.

– Dr. Unjali Malhotra, Medical Officer, Women's Health, First Nations Health Authority

## Who are Birth Workers?

The journey of birth starts over the course of a lifespan. Community and family are all vital members of a pregnancy care team. Aunties, mothers and cousins, along with other family and friends, will be walking the life course journey alongside the Lifegiver; this is a critical component the health care system needs to acknowledge. Lifegivers will ultimately choose the best path for themselves based on recommendations by their health care providers, as well as their own comfort with risk, but they may also be influenced by the advice, guidance and teachings of loved ones. Health care providers must ensure inclusions of the broader circle of care.

The health care teams who are involved in the care of Lifegivers can be diverse and may include all or one of the following:

### Elders

Elders are critical in passing on knowledge, ceremony and tradition, as well as in preparing future Lifegivers for birthing and parenting.<sup>14,15,16</sup> The critical relationship between Lifegiver and Elder is one of protection, education, care, ceremony, comfort and advocacy.<sup>17</sup>

“We need a connection to Elders so babies can hear their language before they are even born.

“I had an Indigenous liaison who was there the whole time during my hospital stay and asked me what I would like; I asked for an Elder and they got one to come and have a ceremony. Ceremonies are important.”

– Elder Cheryl Schweizer, Tl'azt'en Nation, UBC Indigenous Patient Led CPD

“[It is important to] have a connection with an Elder to perform a ceremony, or even to just sit with us. Their presence is comforting. Welcoming ceremonies are important.

“Every First Nations person away [from home] needs a perinatal mentor to teach what to expect in pregnancy.”

– Elder Lucy Duncan, First Nations of Binche Keyoh, Lhojaboo Clan

“When you are only allowed one person in the delivery room, it means grandparents miss out on offering teachings during birth. We lose that family connection.”

– Elder Doreen Peter, Cowichan First Nation

“Having an ‘in-house’ Elder or Knowledge Keeper to be on-call can alleviate some of the stress for birthing families, and support ceremony if the family chooses.”

– Knowledge Keeper Lucy Barney, T’it’q’et Nation

### Indigenous Patient Navigators or Liaisons

Indigenous Patient Navigators (IPN) or liaisons can play a crucial role in a First Nations Lifegiver’s experience in the health care system. IPNs can build relationships between the Lifegiver and health care systems and workers; they can educate health care staff as well as the Lifegiver; they can help the Lifegiver navigate the system; and they can advocate for the Lifegiver and enable more culturally safe care.<sup>18</sup> Given the rampant Indigenous-specific racism and discrimination in the health care system, IPNs are necessary within the hospital setting, and specifically in maternity wards. The system goal should be to eliminate Indigenous-specific racism; if this could be achieved, the protective role of IPNs would no longer be necessary.

“Indigenous liaisons only work from 9 am to 5 pm. You’re out of luck if you need any kind of help after that. People need to be able to call someone if they have to go to the emergency room. A liaison needs to come, but they are not always available for the people who need them.”

– Elder Cheryl Schweizer, Tl’azt’en Nation, UBC Indigenous Patient Led CPD

### Doulas

Doulas work as childbirth companions who offer continuity of support and advocacy for women during their childbirth experiences. Doulas provide physical and emotional support to Lifegivers during labour and birth, as well the immediate postpartum period.<sup>19</sup> There are also First Nations and other Indigenous doulas, whose work is grounded in cultural practices and Indigenous knowledges, traditions and ancestors.<sup>20</sup>

Lifegivers’ stories repeatedly emphasize that the doula’s role is of the utmost importance, offering protection and support, as well as serving as a point of access to the health care system before and after pregnancy. Lifegivers understandably want a doula from their own community, one who understands their traditions and ceremony. While we work towards a transformed health care system that is free of racism, it is critical to have sustainable funding models for doulas and community partnerships for in-community doula training and employment.

“I was fortunate to have a First Nations doula with me for my first labour and delivery journey. As a First Nations mother, [it was scary] entering a hospital setting because of the history and ongoing instances of [hospitals] being unsafe for First Nations people due to settler colonialism and Indigenous-specific racism. It was extremely important to have a First Nations doula that I trusted to be an extra set of eyes during my labour. I immediately felt safer to have her in the room with me and my partner. I knew she was taking notes and that she was familiar with the medical terms and process of labour. She even helped ask the nurses to save and store the placenta so I could take it home with me for ceremonial purposes. There were some looks exchanged from this request, but the nurses stored the placenta in the shared fridge for me until I was discharged. There needs to be more First Nations doulas to support First Nations families during the sacred time of birthing. They not only provide comfort items or emotional support, but they are an extra set of eyes in the room to witness everything, which contributed to safety during the delivery.”

– Janelle Tom, Sḵw̱xwú7mesh Úxwumixw | Syilx

### Lactation Consultants and Postpartum Supports

Lactation consultants are health care professionals who specialize in supporting pregnant and parenting individuals with breast/chest feeding. For parents who choose to breast/chest feed, lactation consultants are able to facilitate the physical connection between parent and child, which allows for the innate, powerful bond between them to nurture.<sup>21</sup> Many First Nations parents specifically believe that breast/chest feeding provides the first traditional food for infants, therefore the right and ability to feed should be protected and supported when possible, knowing this is not always possible or desired.<sup>22</sup> First Nations Lifegivers actively call for increased feeding support in First Nations communities.

“As soon as I gave birth, I was expected to know how to breastfeed. I did not receive meaningful or helpful assistance until I was discharged. A health authority nurse did a home visit four days later and really helped with [my baby’s] latching, but not having assistance at the very beginning led to continuous pain and cracked nipples.”

– Anonymous BC First Nations mother

“First feeding is a ceremony in itself, and must be honoured as such. When the environment feels safe and calm – the mom and newborn can find each other and bond in breastfeeding more easily.”

– Knowledge Keeper Lucy Barney, T’it’q’et Nation

“There is an ongoing issue with not being able to afford things during the postpartum period [including lactation support]. There is a lack of community support for lactation for Indigenous people. When you go to the La Leche League [for support], it is obvious that you are a minority race or class because everyone there has \$2000 strollers and baby carriers but yours is from Walmart. You want to do what is best for your baby but don’t feel good at these places. More postpartum support is needed.”

– sḥa?q”alqs (Hailey Causton), Syilx



“Giving support in a good way is needed. We used to get a welcome basket with [a list of contacts] for who to call, and it made me happy. If you have a happy mom, your baby will be happy. You can deal with things in a better way. Project Parent in the North was good; you had a place to go to get parenting help. You learned about keeping a budget, about healthy eating. [Resources] like that for mothers are needed. We need a baby bundle and a mama bundle with teas for lactation and menstruation support too.”

– Elder Cheryl Schweizer, Tl’azt’en Nation, UBC-CPD IPL

“I was given no information on breastfeeding; it was a big unknown. Breastfeeding was so painful because [my daughter] had two teeth, so I ended up bottle feeding her. Pregnancy is scary, but it could be natural; there is so much information Indigenous women don’t know because we lost our traditional way of being due to racism and colonization.”

– Kahkakiw Nikamon, Treaty Four, Cree Nation

## Midwives

As primary care providers, midwives may be the first point of contact to perinatal services and are fully responsible for clinical decisions and the management of care within their scope of practice. First Nations midwives specifically honour and uphold First Nations peoples’ rights, languages, culture and traditions, and are considered the keepers of ceremonies who pass on these skills and values to the next generation. Many are maintaining and restoring traditional ways of birthing and celebrating births with the community as sacred events.

“I found my midwife to be nothing short of an ally, and I felt a deep sense of security and safety through our shared time in the maternal program. It was a breath of fresh air to observe her allyship among other First Nations and Indigenous people too – pregnant folks, as well as children and families. The maternal health supports on this team (including administrative staff and nurses) provided a welcoming space to enter and exit time after time, even though it was obvious they were run off their feet and could benefit from additional staff in the clinic.”

– Nadine Shaw, Wuikinuxv woman, proud mother, Registered Nurse

## Family Physicians

Family physicians are equipped to understand the comprehensive health and well-being of an individual as they take the time to build a detailed family history and understanding of each patient’s environment and the social determinants of health that may be affecting their health and wellness. They liaise with other health care professionals and specialists to develop comprehensive, coordinated patient-centred diagnosis and treatment plans.<sup>23</sup> In BC, there are a limited number of family physicians with obstetric skills (FP-OBs). Increasing the availability of FP-OBs, particularly in rural and remote communities, could facilitate greater care for First Nations Lifegivers.

“A family doctor is uniquely able to care for people over the lifespan, especially for complex care. ‘Fee for service’ is not the ideal payment model in these cases, and it is often the reason the patient is referred to obstetrics when, in fact, the social determinants of health need to be addressed.”

– Dr. Rebekah Eatmon, Indigenous family physician

## Obstetricians

Obstetricians are specialists who offer care to people who are pregnant or postpartum. They are able to diagnose, manage and treat medical conditions specific to pregnancy, as well as perform Caesarean sections and surgeries related to labour and delivery. There is a lack of culturally safe obstetrical facilities available and accessible to First Nations people across BC, both in urban and rural settings. This results in individuals having to leave their communities and travel far distances to access these specialty services.

## Pediatricians

Pediatricians are specialist physicians who care for newborns, children and youth. They are skilled to diagnose and assess physiological as well as psychological concerns related to child health and development. At the start of life in the care of newborns, pediatricians have a unique and special role. For any newborn requiring neonatal intensive care for both rare and common health challenges, pediatricians can offer life-saving interventions as well as ongoing monitoring and primary care for children.

“Pediatricians are pivotal to support the physical and spiritual journey of an infant to adulthood, and are positioned to help address the social determinants of health faced by many First Nations Lifegivers. They require continued support and learning on culturally safe practices.”

– Dr Mark Chilvers, Provincial Medical Director, Child Health BC

## Anesthesiologists

Anesthesiologists are specialist physicians who provide and manage pain relief during childbirth in hospital settings. The role of anesthesiologists in maternity and obstetrics care is part of the care team and related to patients’ wishes and needs.

## Nurses

Nurses are integral members of primary care teams. They are licensed and regulated by the BC College of Nurses and Midwives (BCCNM), which sets the standards of practice for its registrants to ensure the public receives safe, competent and ethical care.<sup>24</sup>

Most First Nations health centres and nursing stations in BC are staffed with one or more community health nurses (CHN) who focus on health promotion and prevention. At some, the nurse is employed by the FNHA, and at others, the nurse is hired locally by the Health Director or First Nations community (FNHASO site). The role of a nurse will vary depending on if they are working at a health centre or a nursing station and if it is an FNHA or FNHASO site. There are multiple nursing designations in BC that reflect different levels of education and training;<sup>vii</sup> a CHN can hold any of these licences. This means that although the CHNs in First Nations communities may have varying scopes of practice regarding prenatal and postpartum care, none of the nursing designations include training related to attending to a birth as a primary care provider.

CHNs can play an important role in the reclamation of birthing practices by bringing prenatal and postpartum care closer to home – for example in the provision of prenatal assessments, newborn care, feeding and mental health support, “well baby/child clinics,” and childhood immunizations. Performing duties related to caring for a person who is giving birth is not part of the CHN’s job description or scope of practice, although the BCCNM states that in the case of an unexpected and emergency birth of a baby, a nurse will provide care to the best of their ability (knowledge and skill). Some nurses provide “second-assist” services with a registered midwife, but specific training is required to perform this role.

Key supports for nursing – including continued medical education, easy access to specialty care, and acknowledgment of the deep relationship between nursing and community that spans beyond prenatal care – are required. As well, greater support for newly trained professionals is required to increase birthing services in First Nations communities in BC.

vii Nursing designations in BC include Nurse Practitioners (NP), Registered Nurses (RN), Licenced Practical Nurses (LPN) and Registered Psychiatric Nurses (RPN). Each nursing designation reflects different education and training, with a unique scope of practice.

“When a less-experienced RN is in community, and they don’t have the skill set to manage a delivery, I think the regional health authority needs to have a common-sense algorithm of who [the nurse] can call and what resources are available and needed in situations related to birthing in community. Nurses need back-up and support.”

– Michele Anderson, Community Health Nurse, First Nations Health Authority

“I think attention is needed on [patient] consent [when deciding to deliver in community]; do they [the patient] know there is a point when they can’t go back? It’s hard because if something goes wrong, the client may regret their decision [of having an in-community birth] and the nurse must do her best and also have to live with the outcome. If something does go wrong, the nurse may at times live in community but at the very least will definitely be back in community, and that can be really hard. Delivery is out-of-scope for most nurses; we are to help in an emergency, but that puts us in a hard position because we live and work in the community. Even when nurses have [the proper] education and experience, how do they stay competent when environments may not be able to sustain their skills necessary for birthing?”

– Michele Anderson, Community Health Nurse, First Nations Health Authority

“CHNs in community [need] continued support for education around maternal child health to ensure they feel confident and competent in supporting clients through their birthing journey.”

– Shauna Buchannon, Registered Nurse in a BC First Nations community

“[We must also offer] collaboration with our regional health authority partners in evaluating and improving the client journey through the health care system.”

– Shauna Buchannon, Registered Nurse in a BC First Nations community

“[There needs to be] advocacy and promotion of community health nursing and Indigenous midwifery. [There is] the need for many more Indigenous nurses and midwives; [they need to be] attending career fairs, presenting at nursing schools, etc.”

– Shauna Buchannon, Registered Nurse in a BC First Nations community

“I want to talk about safety. We can’t always keep a delivery safe because of the place of delivery and the resources [available], but health care providers sometimes need to change how they think – let it go that an intervention could have helped, even if something went wrong and a choice was made not to have it. Nursing has to use common sense and rely on expert help. We need call lists. We need to know who is on call, and it [the call list] has to be up to date. There should be meetings between nurses in remote communities and the people on call in hospitals so that we have back-up, and they know us and we know them.”

– Anonymous health care provider in a BC First Nations community



## Wraparound Care

In addition to birth workers, there are a number of roles involved in the wraparound care for a Lifegiver, their family and the newborn. The support of wraparound care is critical to ensure the health and well-being of new parents.

### Community Health Representatives

Community Health Representatives (CHR) spend a tremendous amount of time focused on the social determinants of health when supporting Lifegivers. This can involve supporting clients to find housing and access food (including formula and breastfeeding supplies), implementing care plans, and setting up well baby care and more.

“CHR training holds a key role in a health centre. A CHR holds valuable knowledge around cultural and birthing practices, and they work closely with the community health nurse in supporting maternal child health programming in community. Given the nursing shortage and heavy nursing workload, this is an invaluable role to help support clients through their birthing journey.”

– Shauna Buchannon, Registered Nurse in a BC First Nations community

### Health Directors

Health Directors are responsible for the delivery and coordination of health and wellness services in BC First Nations communities. The collective goal of Health Directors is to ensure safety, system collaboration and the support of community members. They are committed to improving the health and wellness of First Nations communities. Keeping the community safe is a key priority, and this includes facilitating positive birthing outcomes. The First Nations Health Directors Association (FNHDA) has expressed the need for improved communication between existing services, with attention paid to the circumstances and needs of remote communities and the impact of weather and transport on care. Health Directors have identified a need for more First Nations doula and Indigenous patient navigator services and greater supports for families interfacing with the Ministry of Children and Family Development. There is a collective desire to have choices available for each community, and for communities to determine their unique needs, services and plans.

## The Provision of Care

In addition to the importance of a Lifegiver’s care team and the availability of wraparound care, Lifegivers’ stories highlight numerous themes related to the provision of high-quality, culturally safe, trauma-informed care.

Culturally safe care is wholistic, relational and trauma-informed. It meets the Lifegiver where they are at, and respects them as unique, self-determining individuals. For example, one Lifegiver shared difficulty navigating prenatal appointments when also juggling the schedules of her older children. This Lifegiver needed her health care providers to be flexible and compassionate. Health care providers who are culturally safe become advocates and liaisons for their patients.

“When I was pregnant and had house visits, it felt less medicalized, more integrated into my life, and more comfortable. I really appreciated when pre- and postpartum care happened closer to home. In early pregnancy, no one connects with you early to work through fears. I also appreciated the creative ways to communicate [with my provider]. I could text [my provider] if needed and have check-ins. Of course, confidentiality has to be protected, but it was really helpful to at least tell someone I had a concern. My doula was the best person for touch points like these.”

– **Dr. Terri Aldred, Tl’azt’en Nation, Executive Medical Director for Primary Care, FNHA**

“More **relational practice** and more care closer to home [is needed], especially postpartum care. Having someone come the first week after delivery is especially important for a first-time mom. A more holistic perspective is needed because it allows providers to understand the patient and allows people to understand things like menstruation, becoming mothers and menopause. Women have unique needs, but how does the system support women? The best way may not need to be a medicalized approach. At times, the medicalized approach can minimize people’s experiences, like if they don’t meet the criteria for a diagnosis.”

– **Dr. Terri Aldred, Tl’azt’en Nation, Executive Medical Director for Primary Care, FNHA**

“There is a dual responsibility [for health care providers]: respecting the care wishes of the person giving birth and providing necessary care to keep them safe, while also ensuring the needs of the health care workers serving them are being kept safe as well.”

– **Anonymous First Nations community member**

“For the overall success of birthing transformation, it would be beneficial to ensure education is available for all providers to learn about traditional birthing practices and birthing closer to home, so they can be open to supporting clients in new ways that ensure culturally safe care.”

– **Shauna Buchannon, Registered Nurse in a BC First Nations community**

### **The Need for Knowledge Translation**

First Nations Lifegivers are self-determining decision-makers over their own health care journeys; it is imperative that they are fully informed of their options. In rural and remote communities, the provision of medical knowledge is especially important so that Lifegivers are aware of warning signs of when to seek immediate medical attention between routine visits. Medical information should be communicated clearly, in plain English, at an accessible reading level; the use of diagrams and infographics can be helpful. Health care providers must give space for Lifegivers to ask questions. The passing of intergenerational knowledge can be done through formal programming along with the repatriation of care closer to support systems.

“I met with about a dozen doctors and midwives, and the best I got out of that was one doctor who talked about medical stuff and whether a pregnancy is going to be in jeopardy. I don’t know why more information isn’t being passed on. My generation had doctors. Now there are midwives in our communities, but it takes time to trust them. If we do health promotion in our own community, then communities will be able to rise above their uncertainty and fear to build trust. It is about relationship building so that they feel comfortable enough to access the services.”

– **Elder Doreen Peter, Cowichan First Nation**

“We have really young moms and they don’t know what they are doing. We have ‘tea with an Elder’ in my health centre, and we hope to make headway, but we need more resources.”

– **Elder Doreen Peter, Cowichan First Nation**

“[I would] love someone to come in to community and share what your body does. I think it is important to give us a better understanding of our bodies [... and to offer] more medical knowledge in our language. I have had to tell doctors, ‘Can you say that in English now?’ They are so used to talking to their team, they forget to speak in a way that we can understand. There is a lot of racism and being labelled a ‘dumb Indian.’ I have set out to prove them wrong. I was determined and I refused to stay down. I went to university at 55 and it was the most fun year. I aced the program, and I built relationships; I stayed in the dorm and everyone called me ‘grandma.’”

– **Elder Doreen Peter, Cowichan First Nation**

“When I was at the hospital, I valued clinical competence and I trusted the expertise of the nurses and doctors. It is hard to advocate for yourself. It would have been helpful to walk through scenarios [in advance of giving birth] – then people can learn the level of risk with effective consent.”

– **Dr. Terri Aldred, Tl’azt’en Nation, Executive Medical Director for Primary Care, FNHA**

“There needs to be unbiased opinions, early consent, and more patient autonomy. A good provider-patient relationship should include more information about the possible outcome of each choice. For example, [one] could choose a normal vaginal delivery but it could end in an emergency C-section. [When patients have] all of the information, they can make a choice about where and how they wish to deliver and, no matter what, they feel heard.”

– **Dr. Terri Aldred, Tl’azt’en Nation, Executive Medical Director for Primary Care, FNHA**



*The support of the community is important, and women, community leaders, and Elders all need to be involved in promoting the return of birth to their communities. Their advocacy and the promotion of holistic care and spiritual, mental, emotional, and physical health will help to bring about normalization of giving birth in the community. Common factors in successful services are effective collaborative relationships and excellent communication among all caregivers: midwives, nurses, doulas, family physicians, and obstetricians. Rigorous training and protocols need to be established in each community. Ultimately each woman should decide where she wants to give birth once she is informed about the advantages and risks of giving birth in a community centre or unit that cannot provide emergency Caesarean section. (Journal of Obstetrics and Gynaecology Canada, 2017)<sup>8</sup>*



# PART 2:

## The Birthing Journey

Indigenous-specific racism and discrimination is widespread throughout the BC health care system, and negatively affects First Nations Lifegivers at multiple points in their birthing journeys. System partners and health care workers must recognize, acknowledge and humbly reflect on how settler colonial practices and policies are causing harm to First Nations Lifegivers. It is only through ongoing reflection that one can actively work against and begin to transform the system. This section describes the racism and discrimination many First Nations Lifegivers experience while giving birth. Health care providers must approach care holistically and address Indigenous-specific racism and discrimination, understanding the social determinants of health and how settler colonial policies intentionally dismantled First Nations systems that kept people healthy. To reduce higher maternal mortality rates among First Nations Lifegivers, programs and services for Lifegivers who use substances and/or have substance use disorders must be prioritized, building on existing programs such as the Families in Recovery program. Reclaiming traditional birthing practices and bringing birth closer to home upholds the rights of First Nations Lifegivers, and it can also reduce birthing complications and improve outcomes for infants.

## 6. “I Distinctly Remember Racism”

The report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*,<sup>25</sup> confirms the widespread systemic racism, stereotyping and discrimination experienced by First Nations and other Indigenous peoples in the BC health care system, and that Indigenous women and girls are disproportionately affected by racism. Settler colonialism continues to create inequitable barriers to First Nations peoples’ health and wellness resulting in substantial harms and even death. It is embedded deeply within settler colonial policies, laws, practices, and systems, and continues to permeate society.

For Lifegivers, racism and discrimination exist in many forms, such as the care received, how they must give birth, where they are able to give birth, who is able to attend the birth, and care received in the postpartum period. First Nations Lifegivers living in rural and remote communities must travel great distances away from home and give birth in isolation without the support of Elders, family and ceremony. This can be a time when a First Nations Lifegiver experiences racism, discrimination, stigma and coercion. Indigenous women specifically, may experience gender-specific discrimination and stereotyping such as being labelled promiscuous and bad mothers, thus devaluing their life-giving abilities and bodies.<sup>25</sup> This creates fear, apprehension and mistrust in health care providers resulting in avoidance and negative health outcomes. System transformation, including cultural safety and humility, is required to decrease the impacts of racism and discrimination on maternal morbidity and mortality.

The voices and experiences of First Nations Lifegivers spotlight the need for equitable, safe and trauma-informed care, and the lack of universal culturally safe care currently being provided in the BC health care system.

“My water broke, but I didn’t know what was happening; I thought something was really wrong. At the hospital, I was brought into a room that had the front door wide open and I was mortified. I had my feet in stirrups and in the room there was a doctor, a nurse and a janitor. How could you disrespect someone so much?”

“I distinctly remember racism. I wasn’t receiving the same care as others; I was in an open room. I felt like I was going into the world of the unknown and the only information I had was that I might die. I was frightened, and that’s what I spent the rest of my pregnancy feeling. I was afraid to ask for help or even food, though I was hungry. **I was not aware of my rights.** I ended up with a C-section, and when I awoke my son was presented to me in an incubator. I couldn’t touch him; I missed that natural bonding.

“I got very sick after that [delivery]. My temperature went up. Nothing was explained to me and I didn’t know what happened. Health care providers were telling me to be quiet.

“I didn’t want to have a second child [because of this experience]. I thought, ‘If I get pregnant again, I will kill the child.’ It was so scary. When I did get pregnant again, I didn’t want to be pregnant because I thought I was damaged goods. I was so scared.”

–kihci tēpakohp iskotēw iskwēw / (Elder Emily Jane Henry), Ochapowace Cree First Nation



*“[...] travelling outside of our community can be dangerous for pregnant Indigenous women, and anti-Indigenous racism is rampant in the health-care system,” said Ellen Blais,<sup>viii</sup> who is the Director of Indigenous Midwifery with the Association of Ontario Midwives. “Midwives would be intervening in those horrific colonial processes, like child apprehension, which asserts that taking children away from their parents is the right thing to do. And it’s not. We know that. In other cases, people have died waiting for care or not received the right kind of care. And there remains the spectre of decades of forced or coerced sterilization” (Beaulne-Steubing, 2022).<sup>26</sup>*

“My mother was away [when I went into labour] and was in a very racist hospital. The nurse was not pleased when I came in because I was 18; she wouldn’t check me. I was in a lot of pain and really felt like pushing, but she said no and didn’t check me. My mom was on the phone with me. When my water broke, they [hospital staff] were all so nonchalant. They took me into another room and I was 10 cm dilated. No one had believed me. Three pushes, ten minutes of hard labour, and he was out, but he was blue so they rushed him away with my husband. In my room there was a shower; the nurse told me to go over there and shower. There was blood on the floor, on my hands, on the wall. When I asked for help trying to get to the shower she said ‘You are almost there.’ I had never felt so much like I didn’t matter; to them I was just a knocked-up Indian. We need Elders who can pray with us, perform ceremony and be an Elder on call. We are scared in the moment and don’t want to feel so alone. It can be extremely scary. We need to work on strengthening our bonds.”

– Kahkakiw Nikamon, Treaty Four, Cree Nation

“Being a doula now, I have noticed age is a factor. Those who are young are not treated well – being talked around, not having things explained, not being included in a conversation, having procedures, such as an episiotomy, done with little information.

“I also remember at every visit I had a new nurse checking my blood pressure, and they would always ask, ‘Are you sure this is the dad?’ I was asked this seven to ten times.”

– sfa?q<sup>alqs</sup> (Hailey Causton), Syilx

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viii Ellen Blais is a Sixties Scoop survivor and the Director of Indigenous Midwifery with the Association of Ontario Midwives.

The time of delivery can be one of vulnerability, when Lifegivers should feel safe and receive compassionate care. During this time, Lifegivers need transparent information that respects their rights, autonomy and self-determination. Some Lifegivers wish to give birth in their community, but lack the resources or infrastructure to do so. This has resulted in Lifegivers travelling long distances away from home, being disconnected from their family and community supports, and having the innate fear of having an unsafe experience due to colonial processes and systemic racism and discrimination.

“My first son was born in 2016 and delivered by a midwife in hospital after four days of labouring at home. [My midwife] was keeping someone out of the room, she was protecting me. I am very thankful for her for delivering my baby. I had a pre-existing trust with her, we have similar values. I felt like I had a lot of choice about my delivery. I had taken hypnobirthing classes which I found really useful. I wanted a home birth, a water birth.

“[During the delivery of my second child] I could hear them [health care providers] whispering when they would check the monitors. Why couldn't they just talk to me? They decided to take me for a C-section. My partner was told to go to another room and I went to the OR. There were so many people [in the OR] and I didn't know any of them. They were strapping my arms down, stripping me down and yelling for me to push. I was feeling pressured. My birth doula was not allowed in the OR. First they said if I push now I don't have to have a C-section, but then they just started doing the section. It was with general anesthesia and I was fully under. I didn't sign a consent form. [The C-section was done by] an OB I had never met before, I had never ever seen her during my labour.

“At my six-week [postpartum] appointment, I went to the get the sign-off from the OB. I asked, ‘What could have been done differently? Why was I strapped down? What were the jaw thrusts for?’ And her response was, ‘Aren't you glad that you and your baby are here today?’ I was given no answers. I wanted my doula to be more vocal and hands-on, to protect me. I wanted things explained to me. I wanted the OB to be kind. I feel there are not enough Indigenous doulas.

“I chose to travel [for the births of my third and fourth children] because of my previous delivery experience. When I travelled, I missed my kids and I felt like I had less power because I had nowhere to go. I was also worried that I could be transferred to the place I had the bad experience, so I did everything I could to make sure that didn't happen. In the second centre, I had a good experience. I went in for a non-stress test and started shaking; I didn't realize the trauma I had been carrying from my last delivery. I had a full anxiety attack and they [doctor and RN] sat with me until I was ok. [During my delivery] all of the staff in the OR were women, and I felt like I got to be the driver.”

– *stā?q<sup>w</sup>alqs* (Hailey Causton), Syilx

“People [who are pregnant] aren’t going in to get care right away, they are only going in in their second trimester and I do believe a big part of it is because they are being treated badly [by the providers and system]. Racism is always going to be there because we want our land back. It [Indigenous-specific racism] is worse now that details about residential schools and the children<sup>ix</sup> have come to the surface. Racism is in all parts of health care. We want our own midwives and our own midwifery building so that people feel comfortable; so we can [give birth to] our babies with people we know. People [who are pregnant] sometimes get shipped to Victoria or Vancouver [to give birth] and there is a lack of transport funding; they don’t always have funding for a partner or support person. My boy was huge [when he was born], and I was a little thing; I have never felt so alone. If we can [birth] closer to home, even if we encounter a problem then we have family [close by]. Being shipped away means that people can’t visit easily, [and if they visit they will] need a place to stay. Family support is huge. My family came when they could, but when they couldn’t I felt helpless. Most moms want to be where they feel most comfortable, and for most people that is closer to home. [New parents] want to show their newest addition to their family. I had eight to ten people watching me give birth, and it was the best feeling ever; now it is one or two.

– Elder Doreen Peter, Cowichan First Nation

Addressing Indigenous-specific racism and discrimination requires health care providers and institutions to recognize, acknowledge and humbly reflect on how settler colonial practices and ways of doing are causing harm and impeding First Nations and other Indigenous peoples’ ability to access culturally safe care. This involves having a deep understanding of “the truth that Indigenous-specific racism is perpetuated through white supremacist policies and practices that remain hardwired into our systems and processes, and that impede the health and wellness of Indigenous Peoples.”<sup>27</sup> Colonialism contributes to the erasure of Indigenous culture, families, culture and ways of knowing, creating trauma – both intergenerational and compounding.<sup>28</sup> First Nations people have the right to receive culturally safe health care in their own lands and territories and assert their inherent right of self-determination, which is now enshrined in provincial, Canadian and international law. Transforming mainstream health services to ensure they are culturally safe and provide the highest-quality health care for First Nations people in BC requires resetting the relationship between First Nations and the whole health system in ways that are inclusive and respectful of First Nations rights and perspectives of health and wellness.

The health care system must do better to provide comprehensive care that is free of “racist language, imagery, behaviours or gestures”<sup>29</sup> and employ “immediate ‘stop-the-line’ interventions to address racism and discrimination.”<sup>28</sup> Those working in the health care system must commit to providing care that is free from Indigenous-specific racism and stigma. This includes trust-building, outreach and education to provide trauma-informed care, while also incorporating wholistic cultural healing practices that go beyond the traditional biomedical approach and reflect the mental, emotional, physical and spiritual aspects of health, wellness and healing. It is important that every person working in the health care system knows they can positively contribute to a new narrative moving forward and is dedicated to making these transformative, life-saving changes.

“For too long, the first people of this land have not been made to feel welcome on their own traditional territories.”

– Knowledge Keeper Lucy Barney, T’it’q’et Nation

<sup>ix</sup> In May 2021, Tk’emlúps te Secwépemc reported finding the remains of 215 children on the site of the former Kamloops Indian Residential School. Since then, First Nations communities across Canada have reported finding evidence of more than 2,300 children in unmarked graves at or near former residential school sites and Indian hospitals.



## 7. Consent and Coercion

The coerced sterilization of First Nations and other Indigenous women, both permanent and through the use of long-acting birth-control interventions, is an issue of ongoing concern in Canada and worldwide.<sup>30,31</sup> Uninformed consent or consent provided through any form of coercion may occur when a health care provider impacts a patient's autonomy and biases the patient's decision-making. Examples include: when a medical risk or benefit is overemphasized to alter a patient's decision; when patients are pressured to make decisions quickly or are not given adequate time to think through their options; when patients are under duress or experiencing subtle or outward threats; or when patients are under sedation.<sup>32</sup>

The risk of uninformed consent and coercion is heightened when First Nations Lifegivers are receiving care away from home and from health care providers who are unfamiliar with the Lifegiver's community, culture, norms and language.<sup>33</sup> Bringing birthing closer to home, when it is done with cultural humility and a trauma-informed lens, can have a positive impact on self-determination and ensure Lifegivers have ownership and control over their medical care. Birthing closer to home can allow for family, friends and other supports such as doulas to surround the Lifegiver, allowing for ceremony and celebration in addition to advocacy and safety.

"I was told that during my C-section they could also tie my tubes. I said, 'No, I don't ever want that.' I have learned to advocate for myself."

– Anonymous First Nations Lifegiver

"I had my oldest child in 2000. I met with an older doctor, who asked my age. I was 18. He found out that I was Indigenous and he was adamant that I should get an abortion. I had an ultrasound and they told me that my child's eyes are too far apart and advised me that he would not come out pristine and pressured me to have an abortion. I was told that I should not have the child. I was told that I was very young and he [the doctor] scared me a lot. I found out that this doctor talks many Indigenous women into getting abortions; I think there is a class action [lawsuit] now. I was not in a place to talk about it before."

– Kahkakiw Nikamon, Treaty Four, Cree Nation

Work is being done to end coerced sterilization of Lifegivers in Canada,<sup>x</sup> and the FNHA has developed resources on consent for health care providers who are working with First Nations patients.<sup>xi</sup>

x Senator Yvonne Boyer is also working towards the passing of Bill S-250, which would explicitly state that the act of sterilizing a person against their will and/or without obtaining proper consent is a criminal offence in Canada. The FNHA is working in consultation and partnership with Senator Boyer and Perinatal Services BC to continue to provide guidance and education surrounding consent.

xi See the *FNHA Coercion and Consent Guide* here: [www.fnha.ca/Documents/FNHA-Coercion-and-Consent-Guide.pdf](http://www.fnha.ca/Documents/FNHA-Coercion-and-Consent-Guide.pdf).

## 8. “There Needs to be More Support”: Stigma, Discrimination and the Toxic Drug Public Health Emergency

After being historically underreported, maternal mortality rates for First Nations women are now becoming more clearly understood. Maternal mortality rates for First Nations women are higher than those of non-First Nations women, especially First Nations women living in rural areas.<sup>16</sup> With the ongoing toxic drug crisis in BC, protecting the health and wellness of First Nations women needs to be a top priority. Addressing Indigenous-specific racism, stigma and discrimination is a critical step to saving the lives of First Nations and other Indigenous Lifegivers.

Many Indigenous people in BC reported that they avoid seeking health care due to negative experiences.<sup>25</sup> This is also evident in rates of First Nations patients leaving hospitals against medical advice; from 2015-2018, across all BC hospitals, First Nations patients left hospital against medical advice 2.6 times more than other (non-First Nations) residents.<sup>25</sup> At BC Women’s Hospital, First Nations patients left against medical advice at 11.3 times the rate of other residents.<sup>34</sup>

Over 60% of people accessing care for perinatal substance use in 2020 resided outside of Metro Vancouver, highlighting the importance of the availability of supportive services across BC. The rate of toxic drug poisoning deaths in BC continues to increase, and the gap between First Nations and other residents is widening, particularly among First Nations women, who died from drug poisoning at 11.2 times the rate of other female BC residents in 2022.<sup>34</sup>

**Over 60% of people accessing care for perinatal substance use in 2020 resided outside of Metro Vancouver, highlighting the importance of the availability of supportive services across BC.**

Birthing choices and self-determination for First Nations Lifegivers who use substances and/or have substance use disorders are challenged by tremendous stigma, discrimination and judgement, specifically from the child welfare and health care systems. Additionally, First Nations Lifegivers who use substances and/or have substance use disorders may be isolated without support from their families and communities, creating additional barriers to access support services. Substance use and/or substance use disorders among First Nations people, and women in particular, can be attributed to a complex interplay of factors including Indigenous-specific racism, historical and ongoing colonialism, intergenerational trauma, violence, loss of culture and barriers to accessing culturally safe services.<sup>28,35</sup> Trauma-informed care is needed.

“I was asked ‘Why are you having kids?’ I think that is just how it is: systemic racism and personal racism. Many times during my pregnancies, people weren’t kind. A college teacher said ‘If you can’t take care of yourself, how are you going to take care of anyone else?’ [At the time] I was looking for housing because we were homeless, but I did well [in school] – I got an A, A- and B. I was focused on finishing school.”

– **Anonymous First Nations Lifegiver**

“There is an element of stigma and judgement that moms are ‘doing harm’ to the baby. There needs to be more support.”

– **Emma Garrod, Clinical Nurse Specialist and parent, First Nations Health Authority**

“The way questions are asked [in health care settings] about using substances during pregnancy are like ‘You don’t use substances [e.g., alcohol], do you?’”

– **Emma Garrod, parent and Clinical Nurse Specialist, First Nations Health Authority**

The reclamation of birth for First Nations Lifegivers who use substances and/or have substance use disorders is particularly important. Having access to Elders, culture and ceremony, and the support of First Nations and other Indigenous midwives, doulas and birth workers can help strengthen and bring healing to these women during their birthing journey.<sup>28</sup> There is a need to develop an evidence base from traditional carers and matriarchs to support Lifegivers who use substances and/or have a substance use disorder to either stay in or transition back to community during the perinatal and postpartum phase. The resulting outputs can inform planning for perinatal substance use service delivery and support First Nations community calls to reclaim birthing practices and strengthen in-community supports for families experiencing substance use and/or substance use disorder, especially for Lifegivers in rural and remote areas.

“We need to keep people engaged in the health care system. The less they are, the more people are at risk of overdose. The impact on the child of losing their parent has to be a part of this conversation.”

– Emma Garrod, parent and Clinical Nurse Specialist, First Nations Health Authority

## Addressing the Social Determinants of Health and Wholistic Care

Lifegivers who use substances and/or have substance use disorders require wholistic support, as the pregnancy can be more medically complex. On top of this, child welfare services may require that the Lifegiver access treatment and housing services in order to maintain child custody or visitation rights. Well-documented barriers that compromise the accessibility of these services include stigma and discrimination, fear of involvement from child welfare services, mistrust of the health care system, racist policies and a lack of coordination between services.<sup>36,37,38,39,40</sup>

A provincial environmental scan of services conducted in 2022 found only 13 acute care beds for perinatal substance use treatment in BC – with only one located outside Metro Vancouver (Cedar Circle bed, Nanaimo Hospital).<sup>41</sup> Further, an estimated 18% of persons accessing care for perinatal substance use and/or substance use disorders reside in northern BC, where fewer than 4% of BC’s 127 supportive housing beds specifically for perinatal substance use are available to support this population.<sup>25</sup> In the current model, accessing help for perinatal substance use and/or substance use disorders, for many women in rural and remote areas, entails leaving one’s community.<sup>42</sup> However, services that take women away from their community likely increase the risk of harm as they may end up buying substances from people they do not know, thereby increasing risks from the toxic drug supply. A series of focus groups held across BC with over 50 women with lived experience and outreach workers corroborated the lack of available, culturally safe acute care and housing services for Lifegivers who use substances and/or have substance use disorders, particularly in rural and remote communities. The groups’ findings further underlined the challenges navigating the inadequate patchwork of supports and the impacts of child welfare services involvement on access to care and maternal-child health.<sup>25</sup> Provincial surveillance data on health care utilization among First Nations expectant women further indicates that compared to non-First Nations women, First Nations women received fewer antenatal visits, were less likely to access midwifery care, to have an obstetrician present during delivery, or to deliver at home.<sup>25</sup>

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**An estimated 18% of persons accessing care for perinatal substance use reside in northern BC, where fewer than 4% of BC’s 127 live-in community beds are available to support this population.**

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It is an imperative to improve the social determinants of health. Community health teams dedicate a tremendous amount of time and resources towards ensuring the social determinants of health are met in outpatient settings. This impacts the overall well-being of the family and community. Further to the resources being required, access to health care providers with adequate education and skill to serve effectively is necessary. This in turn requires further outreach education, service to communities and peer support.

“Since it takes [years] to see a psychiatrist, I was just offered medication at walk-in clinics. Then I called [The First Nations Virtual] Doctor of the Day services and I was able to see a psychiatrist in days. I knew something was going on and [the doctor] was able to explain it to me. I trusted my gut. But most people don’t even listen. I needed information, [I was vulnerable].”

– Anonymous First Nations Lifegiver

The Families in Recovery (FIR) Program<sup>xii</sup> at BC Women’s Hospital and Health Centre is the first program in Canada to offer care for Lifegivers who use substances and/or have substance use disorders, as well as care for their infants, who were exposed to substances within the same unit. This program takes a multi-disciplinary, team-based holistic approach to care from pregnancy to postpartum. The goals of FIR include improving perinatal maternal and infant health outcomes, supporting families to recover through harm-reduction approaches, and supporting Lifegivers with substance use and/or substance use disorders while addressing the social determinants of health impacting their recovery journey.

“There should be information for mothers about resources to help; I didn’t know where the food bank was.”

– Anonymous First Nations Lifegiver

“More programs are needed like FIR [Families in Recovery]. I didn’t trust them at first, I am very suspicious. I have learned you have to be vocal – ‘You guys are going to take my baby. I will just make an appointment at CARE [BC Women’s Abortion Clinic] and then no one can take my baby.’ But I decided not to get it [the abortion]. The program got to know me. I have been let down before so I didn’t trust anyone. When I got there [to FIR], I asked how many people are leaving with their babies? Where are people going after [giving birth]? I don’t want to live on [Hastings Street]. But this pregnancy is better, we have it better. FIR has helped me find a home; they set me up at Easter Seals. With FIR paying my rent, I can buy what I need; I could buy a nice stroller. Before, I was being evicted and I thought ‘What do I do now?’ My child benefit is \$400 a month, and that’s \$200 for BC Housing and the rest was [spent] on formula. I was so hungry. FIR has been really helpful and I am trying my best. With FIR, now I am fed three times a day and can sleep and we are safe.”

– Anonymous First Nations Lifegiver

## The Need for Dedicated Education for Health Professions

Health care professionals may be unfamiliar with the care required for Lifegivers who use substances and/or have substance use disorders. There is a gap in training and education for this population of Lifegivers, in both community and acute care settings, which can lead to poor-quality care and adverse health outcomes.

“I was given suboxone. The withdrawal on it was worse than anything else I have experienced. I ended up losing my kids. I told her [the doctor] that she should not be prescribing [suboxone] to people who are not avid opioid users.”

– Anonymous First Nations Lifegiver

In community settings, greater access to counselling support, opioid agonist therapy, pharmaceutical alternatives, and referral services for women are required. Specifically, more treatment is needed for withdrawal and relapse prevention.<sup>28</sup> Health care providers must receive more education and training around medications, doses of opioids and pain management during delivery for Lifegivers who use substances and/or have substance use disorders. The Perinatal Substance Use online modules<sup>xiii</sup> provide evidence-informed, culturally safe education on supporting Lifegivers using substances as well as their infants during pregnancy and postpartum.

xii [www.bcwomens.ca/our-services/pregnancy-prenatal-care/pregnancy-drugs-alcohol](http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/pregnancy-drugs-alcohol)

xiii [ubccpd.ca/learn/learning-activities/course?eventtemplate=41](http://ubccpd.ca/learn/learning-activities/course?eventtemplate=41)



“For perinatal addictions there are Indigenous addictions services, but it feels like a huge gap. Family doctors are best suited for addictions medicine because there is a lot of social care and care over time that is needed.”

– **Dr. Rebekah Eatmon, Indigenous family physician**

“There needs to be more clinical practice guidelines; there is a lack of information. Health care workers need a mindset shift around ‘what is success’ that goes beyond abstinence and dyads staying together; maybe the unit is separated but still in contact.

“The need for supports [for people who are pregnant and use substances and/or have substance use disorders] is even greater for rural and remote communities. There needs to be support for smaller centres, even if virtual, but also outreach teams and opportunities to see and learn that good work can be done, like Sheway and FIR.”

– **Emma Garrod, parent and Clinical Nurse Specialist, First Nations Health Authority**

“People need more education about the effects of substance use disorders; we don’t know enough about it.”

– **Elder Lucy Duncan, First Nations of Binche Keyoh, Lhojaboo Clan**

“Building a system of care is needed. There is a need for more peer support province-wide. There should be more live support like a race line, as well as the existing BCCSU line, which is great because nurses can call and it is 24/7.”

– **Emma Garrod, parent and Clinical Nurse Specialist, First Nations Health Authority**

## 9. “Child Removal is a Big Thing”

Indigenous children are disproportionately represented in Canada’s child welfare system. In 2021, 53.8% of children in the foster care system were Indigenous, yet only 7.7% of all children under 14 in Canada were Indigenous.<sup>43</sup> Racist, colonial laws and policies have displaced thousands of Indigenous children from their families and communities through residential schools, the Sixties Scoop, and now the ongoing and continuous apprehension of Indigenous children known as the Millennium Scoop.<sup>44</sup> These laws and policies were and are intended to undermine, assimilate and eradicate First Nations peoples – resulting in fear, loss and intergenerational trauma. First Nations Lifegivers have an inherent distrust of the health care system as they are disproportionately targeted by birth alerts, which gives the child welfare system power to apprehend children without their parents’ consent.

“We have always had our own laws and we have always had the right to care for our own families in our own ways. We never gave that up and Canadian laws can never change that.”<sup>xiv</sup> (Union of BC Indian Chiefs, 2024)<sup>45</sup>

Power must be relinquished from colonial systems and processes and instead be centred within First Nations Lifegivers, families, communities and Nations. In 2016, the Canadian Human Rights Tribunal ruled that Canada’s child welfare system was discriminatory against Indigenous children and ordered its reform. In 2020, the *Act respecting First Nations, Inuit and Métis children, youth and families* established the national minimum standards for the delivery of child and family services to Indigenous peoples, a pathway for Indigenous Nations to enact their own child and family laws, and reaffirmed their inherent right to self-determination and protect their children.<sup>45</sup> This federal law makes it possible for First Nations across Canada to legally take over full control and management of services to children, youth and families.

“This is one of the most important pieces of legislation for Indigenous peoples: it calls for strengthening and keeping families together rather than ripping our children away from their families and their cultures.”<sup>xv</sup> (Union of BC Indian Chiefs, 2024)<sup>45</sup>

The Ministry of Children and Family Development (MCFD) has an important goal of supporting all children and youth to have healthy, nurturing families. However, the duty to support First Nations and other Indigenous families and build their capacity often gets lost within the duty to report.<sup>46</sup> Child apprehension should be the last resort to keep First Nations and other Indigenous children safe. More concerted efforts must be made to address the underlying factors affecting a family’s wellness (i.e., the lack of social determinants of health; poverty should not be codified as neglect) and ensure they receive the necessary support. It is important that First Nations communities are recognized and invited to work in collaboration with MCFD leadership in all cases involving children in their community. This includes working in meaningful partnership to explore all options to keep First Nations children safe, such as staying with additional family members or within a safe place in the community. All policies and protocols related to First Nations communities should be co-developed and ensure the safety and well-being of their children. Some First Nations communities have signed co-created child welfare agreements with the MCFD, where the MCFD confirms their commitment to work with Indigenous communities to honour and affirm their inherent right to support and protect their children and families in ways that are aligned with their Nation’s beliefs, cultural practices, traditions and laws.

“The fear of child removal is a big thing. [Lifegivers] don’t trust certain health providers. We need 100 Harmony Houses in every community because of substance use by young people. Especially young people who are living on the streets and homeless. They don’t know that they are pregnant; they come in with pain and are shocked when they learn they are pregnant. Just because one First Nations person has a substance use disorder, we are all painted with one brush saying all of us have a substance use disorder.”

– Elder Lucy Duncan, First Nations of Binche Keyoh, Lhojaboo Clan

xiv Quoting Mary Teegee-Gray, Chair of the Our Children Our Way Society.

xv Quoting Cheryl Casimer, First Nations Summit Political Executive.

“I was taught before my first birth that to bring a soul over into this world is the most powerful ceremony there is. I was encouraged to seek loving and gentle support. I was cautioned about my little one’s first days in this world and how important time together is. I was taught that sometimes a child might not feel ready to be here, or might wish to go back to the other side if they aren’t bonded well and quickly with their Lifegiver. The first time I held each of my children I felt a bond deeper than I had ever known, and a love so expansive I was overwhelmed with gratitude and a little bit of fear. As an Indigenous mother, a former foster child, a foster parent, and a nurse who worked with families, I was all too aware of the overrepresentation of Indigenous families in child protection.

“My middle child was brought into the pediatric emergency department at four days old for jaundice, he was already very difficult to rouse. I remember that I could barely breathe, I was so scared to be apart from him; even beside my bed was too far. I felt a cold steel in my stomach that this might be the last night I hold him. The nurse scolded me for holding him on my chest. She told me that he and I would both sleep better apart and alone. I respectfully told her I would not be putting my son down. She bluntly told me I should listen to her and I was selfish for refusing to put him down. I didn’t feel selfish. I felt a mother’s certainty. I felt a hundred ancestors standing with me in that profound time of waiting. I was holding him to my heart, a comforting sound he had known in utero and I continued to whisper and plead with him to stay with me. Every breath and every little sound from him was a great gift. I imagined my love wrapping around him like a soft warm golden light. I imagined that love gently holding him in this plane of existence. Looking back now, I feel a deep and hollow terror run through me when I think of what might have happened if we had been separated.

“I knew there was chance that the nurse could report me. I had supported families who had been reported for less; their capacity, their love, and their dedication questioned in relation to the colour of their skin. In my heart, I know I held my son on this side. I know no one else could have. I know that in his weakest moment this was the only place he would survive. Yes in a hospital, but also in my arms with my heartbeat assuring him all was well and my love wrapped around him glowing brighter than that Billy blanket. I am tearing up writing this at the thought of the scale of a mother’s grief to not be there for that moment. I am tearing up thinking how many reports and removals have robbed both Lifegiver and baby of their right and need for each other.

“There is nothing in this world as powerful as birth — no ceremony, no natural wonder, no drums or song is more powerful. As a care provider, I hope that honour isn’t diminished by your access and repetition. I hope you are as in awe on your 300<sup>th</sup> delivery as your first. I hope you hold Lifegivers up and remember, as they are thanking you for your help, to thank them for the trust, the honour and the vulnerability that comes with bringing new life. If you should think a report is necessary for a child’s safety, please do remember the many colleague errors that you have turned a blind eye to as a professional courtesy; the times when a peer caught a dangerous mistake and helped you learn from it. Then turn towards that powerful Lifegiver and offer the same grace. Really look at that baby and consider if they might make it through a high-acuity night without their bond and ask yourself what holds someone.

You know from your practice that medicine is amazing, and it comes in many forms. At the best of times, the medicine you practice braids with the ancient power of life and the remarkable strength of that person who just pulled a soul into this plane of existence. Be certain before you make that call so that it doesn’t haunt you. Trust your gut, not your mind. Your mind is such a gift, but it can also be fooled and tricked by your own experiences, and unfortunately carries bias consciously and unconsciously. I hope you never ever have to make that call.

If you do, I hope you will have enough respect for that new life to do everything in your power to plan for safety and keep that family together. Give that baby the best of your modern medicine and then a good dose of the much older medicine of helper and healer that surely was a part of your draw to this work.”

– Ey Claney (Toni Winterhoff), Specialist, Healthy Children,  
Community Health & Wellness, FNHA

## Understanding and Supporting the Social Determinants of Health

Understanding a family's wholistic health and wellness requires taking the time to determine the conditions and environments where they are born, live, learn, work and play as this greatly affects a wide range of health, functioning and quality-of-life outcomes and risks. Individuals working in child welfare must hold a deep understanding of the community they serve in order to understand the impacts of the social determinants of health on community members' ability to thrive.

Health care providers must employ compassion and have the understanding and motivation to honour a family's capacity to care for themselves. Families need wraparound supports that address the social determinants of health in order to thrive. It is the responsibility of the health care system to provide culturally safe care and support for First Nations families who have been gravely impacted and continue to be impacted by settler colonialism.

If a report is required and is done without consideration of the impacts of the broader determinants of health, it can cause lasting harm and intergenerational trauma for all parties. Providing birthing services closer to home can positively impact communities. Care must be taken by the providers to understand the community and individual as a whole, in addition to being trained in cultural safety and trauma-informed care.



# 10. Birthing Complications and Reclaiming Birth<sup>xvi</sup>

*“The health of a nation’s infants is understood to be an important upstream indicator of the health of the population more generally, as well as a reflection of underlying social determinants of health. In many Indigenous societies, infants are regarded as sacred. Their nurturance and protection is a central community function and integrally linked to the rest of the life – death – life cycle. Despite recent international collaborations to document and address Indigenous child and adult health disparities, there is a gap with respect to an international review of Indigenous birth outcomes. We provide an overview of the major birth outcomes (infant mortality, stillbirth, birth weight, and pre-term birth) for Indigenous populations in Australia, Canada, New Zealand, and the United States.” (Smylie, Crengle, Freemantle, and Taualii, 2010)<sup>47</sup>*

The 2020 *In Plain Sight* report<sup>22</sup> found that the rate of preterm birth among First Nations in BC was two times higher than non-First Nations in BC (15.2% vs 7.5%, respectively). Preterm birth is any birth between 20 and 37 weeks of gestation and has long-lasting health impacts on the infant, parent and their family. While preterm birth is often viewed as a clinical event, preterm birth reflects suboptimal social determinants of health for Lifegivers and their communities.<sup>48</sup>

The causes of alarmingly high rates of preterm labour are being studied in Squw’utsun Tumuhw (land of Cowichan People). This work will further contextualize the importance of returning birth to the Land of Cowichan People, which reflects the priority of the community. Globally, programming to reduce infant and maternal morbidity and mortality has shown success. There is evidence that factors affecting success include: programs co-designed with the local community that include continuity of midwifery care and a First Nations workforce; partnerships between primary and tertiary services; cultural strengthening programs; and wraparound services to support pregnant women and their families.<sup>49</sup> This emerging work should be followed, and recommendations implemented in BC to reduce birthing complications for First Nations Lifegivers and their children.

*Having opportunities to practise their spirituality was important for the health of both the parents and infant born preterm. (Seymour et al., 2024)*

**Research from Australia and Aotearoa New Zealand indicates that increasing cultural support, Indigenous governance and the role of Indigenous midwives may reduce preterm birth in these Indigenous populations.**

<sup>xvi</sup> This chapter has been adapted from words gifted by Elder Lydia Seymour, Elder Doreen Peter, Jennifer Murray, Brenda Yuen and the Quw’utsun Preterm Birth Study Research Advisory Committee. Read more about their research into preterm births here: [www.healthlinkbc.ca/pregnancy-parenting/labour-and-birth/stages-labour/preterm-labour](http://www.healthlinkbc.ca/pregnancy-parenting/labour-and-birth/stages-labour/preterm-labour).

# **PART 3:**

## **Successful Experiences of Birthing Closer to Home and Away from Home**

Despite the many ongoing challenges related to birthing and maternity care for First Nations Lifegivers living in rural and remote communities in BC, there are also some successes. This section overviews positive success stories and programs of birthing closer to home and away from home. The aim of these stories is to inspire and challenge health system partners to uphold the self-determination and priorities of First Nations Lifegivers in BC.

# 11. Birthing at Home

In 2023, as described by the CBC, a Lifegiver gave birth in her home community of Wāglisla (Bella Bella), on the east coast of Campbell Island in BC's Central Coast region.<sup>50</sup> This marked the first birth within Wāglisla in 21 years. This Lifegiver's reclamation of her birthing journey and body sovereignty is important and highlights the fact that planned birth within rural and remote BC First Nations communities are not commonplace at this time.

“At times too, I had a deep desire to be able to return home, to Wuikinuxv, to deliver my baby, but knew that due to the state of our current system and impacts of colonization, we are not in a secure place for this and it could put my baby's health and mine at risk. I pray that one day, birthing at home can happen again safely for our people in Wuikinuxv.”

– Nadine Shaw, Wuikinuxv woman, proud mother, Registered Nurse



## 12. Birthing Closer to Home: “There Should Be More Like It Everywhere”

While birthing services remain largely unavailable for First Nations Lifegivers living in rural and remote communities in BC, there are numerous opportunities to improve the existing process for birthing and maternity care in order to bring birthing services closer to home.

### **Doulas for Aboriginal Families Grant Program<sup>51</sup>**

The FNHA, BC Ministry of Health and the BC Association of Friendship Centres fund the Doulas for Aboriginal Families Grant Program, which provides Indigenous families in BC funding to cover the cost of hiring a doula. The goal of this program is to increase healthy birth outcomes and remove cost as a barrier for Indigenous families to access doula services.

In addition to this work funding doula services, doula curriculums are being developed across BC to support in-community doula training.

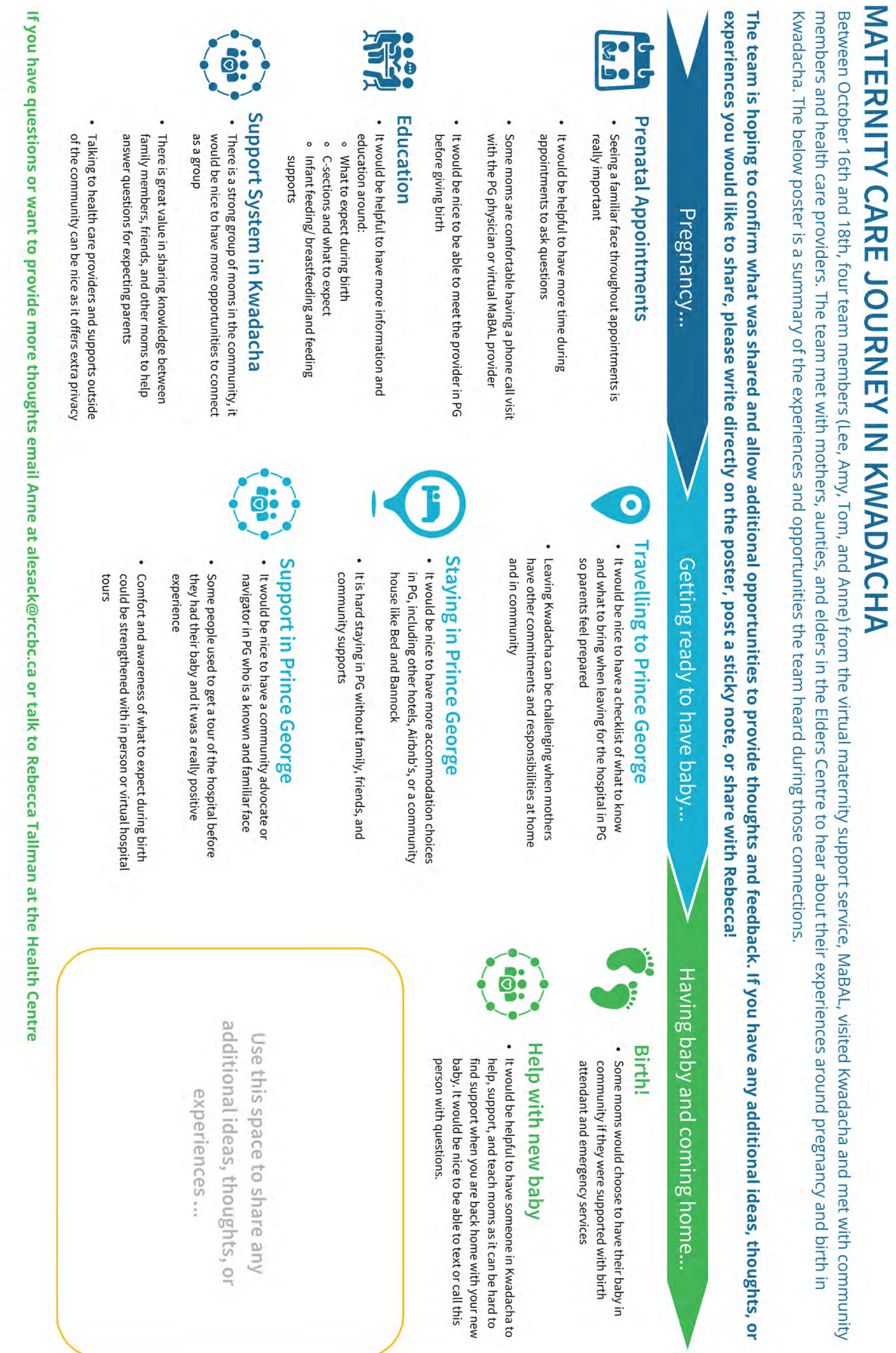
### **Maternity and Babies Advice Line (MaBAL)**

As previously mentioned in this report, the Maternity and Babies Advice Line (MaBAL) offers 24/7 virtual support for communities to connect with family physicians who specialize in obstetrics (FB-OB). MaBAL increases the availability of services at or closer to home by providing medical support around feeding, primary health care, social determinants of health and pre- and postpartum care. It can also offer peer support for rural centres to provide intrapartum care.

The outcome of a recent visit between MaBAL and the Kwadacha Nation highlighted opportunities for improved experiences, which are captured in Figure 3.



Figure 3: Maternity Care Journey in Kwadacha



## Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project

The Kwakwaka'wakw Primary Maternal, Child and Family Health Collaborative Project provides care to First Nations and other Indigenous families who are pregnant, birthing and/or parenting, and living in the Kwakwaka'wakw territory of Northern Vancouver Island. The team consists of three midwives, a family wellness care nurse, two health coaches and a medical office assistant. The team was developed in response to the challenges facing families who have to leave their community to give birth. First Nations communities were concerned about the poorer outcomes for Lifegivers and infants when families need to leave their community to give birth, and they expressed a priority for support to return birth closer to home.

The midwives provide culturally safe and humble prenatal, birth and postpartum care for families. They work with families to develop birth plans and determine each family's preferred birth location. Health coaches and the family wellness care nurse support families with goal-setting, addressing social determinants of care (such as housing, finances and access to services), accessing patient travel, and other needs that may arise. Families are supported to access doula care if needed. The program team works to make more seamless transitions between the family's home community and the site where they give birth. The program also works collaboratively with other organizations and programs to offer culturally safe care and support for birthing families.

From April 2021 to March 2024, the Kwakwaka'wakw Program saw approximately 366 midwifery clients and had 45 local births with midwives in both the hospital and at home.

Prioritizing community-based midwifery was a common theme from the stories of Lifegivers. Providing Lifegivers with information and options allows them to better understand their risks and feel more comfortable and confident in their choices.

"At my grandbaby's delivery, family was welcomed. [We] sang a traditional song to welcome the baby into the world and by one month old, they had traditional names."

— kihci tēpakohp iskotêw iskwêw (Cree Elder, Emily Jane Henry), Ochapowace Cree First Nation

“I am a 32-year-old First Nations woman of Wuikinuxv and Klahoose ancestry, and I accessed North Island Midwifery services out of Port Hardy from the beginning of my pregnancy journey.

“As an Indigenous person and first-time mother who experienced intergenerational trauma and racism from childhood through to current times, I was scared that I would receive unkind care from the [midwifery] team. Instead, I felt empowered, uplifted and had a brightly positive outlook on pregnancy and my life after each visit. I am so fortunate and I have deep gratitude that I got to spend months encircled in the care of this team. We carried on this client-caregiver relationship through to 12 weeks postpartum.

“I did not give birth on the north island for a few reasons, one being [that my midwife] would be away during my due date, and the limited health care resources here on the north island during the winter months. [My midwife and I] set up a wonderful plan to reduce my stress and bring baby earthside in Campbell River. This planning included many administrative bumps with the FNHA’s bureaucracy, policies and processes. I voiced these issues to both midwifery teams and suggested improvements to decrease stress for future First Nations families.

“During my time in Campbell River awaiting baby, I was fortunate to lean on my support system who showed up in ways I couldn’t plan for. Additionally, I fell back on many of the tips and tricks from [my midwife] as she guided me to continue on my healing path. One example stands out – [my midwife] shared her experiences advocating for others to decolonize the birthing space in hospital settings. I began to look more inward and discover what would be most important for me and baby during this sacred time. Given the hospital environment can often be sterile, care is put on you with little choice; intervention comes or goes too slow or quick; and these institutional spaces often hold negative bias, racism and traumatizing situations. I created a meaningful birth-plan. I hoped and prayed.

I Indigenous my birth space in a hospital room with the support of my ancestral strength, family and therapist.

I had the courage to bring forward my needs and wishes to the [hospital] staff. Several chosen family members (approximately 25-30 people) rotated through our delivery room during the day of the birth, and we were blessed to bring forward ceremonial culture, such as utilizing a beautiful cedar-woven birthing mat during birth, cleansing the room with burning sage during labour, having a candle lit, traditional music playing, the lights off, baby’s father present with compassion, strength and spirituality, storing baby’s placenta appropriately, prayer, song, story-telling, and traditional foods and broth. Given the creative support and expertise of my midwifery team in-hospital, I received only necessary nursing interventions and no physician or obstetrician intervention. I was able to voice my needs freely and felt supported; I believe this is another reason why things went so healthy and ‘smooth’ during birth. I was relieved, at times, during labour to be closer to a higher level of care, if needed. I had such a wonderful

labour in the sense that I was able to tap into my deeper spiritual self and call in my ancestors for guidance, especially my grandmother, Agnes Pielle (Hanuse), who I have never met in the physical world. I utilized calming techniques, I was held by my support people, and I could think back to significant events in my prenatal journey. With my voice, I communicated my needs with assertiveness to bring my newborn daughter, Wán’ái, earthside. A healthy, 7lb 6oz, baby girl was born November 19th, 2023, to the sunset in the window nearby the Salish Sea of my Coast Salish relatives. So much joy, so much love.

“Coming back to Port Hardy, I was met with the same gentleness of the North Island Midwifery team that I experienced earlier. I felt the utmost support during the most transitional time in my life, and it was through their empathy, knowledge and accountability to service delivery, alongside familial support, and my deep love and commitment to maintaining healthy ways of living that baby and I flourished during early postpartum.

“As I live in a small town, I get to see the maternal health team frequently. I admire how their team is growing with additional midwives, and it is so refreshing to see familiar faces and to receive warm hello’s frequently as baby and I attend community programs.”

– Nadine Shaw, Wuikinuxv woman, proud mother, Registered Nurse

# 13. Birthing Away from Home

In some instances, birthing away from home may be a necessity. First Nations Lifegivers may be required to access life-saving medical care for themselves or their infant in specialized hospital settings, such as BC Women's Hospital. Hospitals and other health care facilities must ensure that their programs and services fully meet the rights and medical needs of First Nations Lifegivers, which includes the provision of culturally safe care that is trauma-informed and non-coercive. Respecting and celebrating the Lifegiver's circle of care, culture, traditions and languages is imperative.

## BC Children and Women's Hospital Indigenous Health Program

The BC Children's and Women's Hospital (BCCW) Indigenous Health program delivers four goals: Indigenous-led health care practices and services, cultural safety, collaborative practice, and capacity-building. The program's mission is to build bridges in health care for Indigenous women, children, families and communities accessing care at BCCW. Grounded by the Seven Sacred teachings (Love, Respect, Courage, Honesty, Humility, Courage, Truth) as guiding principles, the program has a vision of Indigenous-led health care practices and services at BCCW. Services and supports offered by the Indigenous Health program include consultation, education and leading Indigenous-led services, such as ceremonial support, medical teachings, appointment companion, discharge planning and referrals to resources.

The Indigenous Health program leads work to decolonize services, co-create new processes and policies, and, most importantly, lead systematic change. Their Women's Anti-Indigenous Racism Steering Committee to build policy and systems to support First Nations, Métis and Inuit Lifegivers and their families who are evacuated to BC Women's Hospital.

BCCW Indigenous Health is based on a holistic care model that incorporates both Indigenous worldviews (for example, Coast Salish teachings, the teachings of Medicine Wheel and the Seven Sacred Teachings) and Western worldviews. The Indigenous Health team strives to examine all available options and determine the best solutions for each patient, family and their community, knowing that the solution may not fit within the current processes of the system. The team relies on collaborative efforts of Indigenous-led programs and system partners to align with the Ministry of Health's goals to build Indigenous cultural safety within all facets of care. The Indigenous Health program is also aligned with the BCCW's breakthrough goals and strategic imperatives, including embedding cultural safety and humility in all we do; creating safe environments; and empowering patients, families and staff to achieve optimal health wellness and outcomes.



# 14. Conclusion and Calls to Action

The landscape of birthing and maternity care for First Nations people in BC living in rural and remote communities is bleak. Settler colonial policies were intentionally created to eliminate the sovereignty and self-determination of First Nations people; this includes First Nations Lifegivers having choices regarding their own birthing journeys. *Answering the Call* lifts up the voices of First Nations Lifegivers in BC. Their stories highlight the actions needed to bring culturally safe birthing services that are free from racism and discrimination closer to home. The goal of reducing maternal and infant mortality should remain a key priority in all work related to birthing.

We call on all health system partners, particularly the BC Ministry of Health and the five regional health authorities, to adequately resource and operationalize these calls to action and improve the birthing experience for First Nations Lifegivers in BC who live in rural and remote communities.

## CALLS TO ACTION

### Uphold the inherent rights and self-determination of BC First Nations

The *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* and the BC Declaration Act codify and legislate the inherent rights of First Nations people in BC.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Uphold First Nations Lifegivers' right to birth closer to home and to be self-determining individuals who may choose to include culture, traditional protocols or ceremony into their birthing experience.
- ▶ Involve First Nations communities in transport planning to ensure their voices and expertise shape transport operations for First Nations Lifegivers.
- ▶ Improve communication pathways between First Nations communities and the health care system, particularly community nursing and emergency transport services.

### Increase the availability of services in First Nations communities or closer to home

Collaboratively work to ensure that pre- and post-natal care is available closer to home so that First Nations Lifegivers can be surrounded by their chosen circle of care. Bringing services closer to home also ensures the best, healthy start for First Nations children in BC, where they are encircled in the care and love of their families and communities, and have the supports necessary to thrive.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Train and hire more First Nations midwives and doulas, and fund in-community training opportunities for doulas and Indigenous liaisons to build community capacity and supports.
- ▶ Employ will and creativity in the delivery of culturally safe health care operations, including the use of virtual care, to increase the accessibility of pre- and post-natal services closer to home, such as lactation support and point of contact ultrasounds.
- ▶ Create and/or strengthen relationships between First Nations communities and maternity referral centres through community outreach and the development of communication pathways.
- ▶ Dedicate the transport of well-equipped maternal child care teams to respond to obstetrical emergency evacuations, and mobilize specialized personnel and equipment into communities for non-emergency transport as well as pre- and post-natal care needs.
- ▶ Open birth homes near accessible emergency transport, and begin to offer pre- and post-natal maternity and reproductive services in First Nations communities to re-establish health care capacity.

## Address Indigenous-specific racism and discrimination

First Nations Lifegivers have a right to obtain care free from racism, discrimination, stereotyping and stigma. This is particularly important to ensure the duty to support is leading the delivery of care.

To answer the calls made by First Nations Lifegivers, system partners must commit to and action their role in the following:

- ▶ Recruit and hire more doulas and Indigenous patient navigators to work in health care settings by partnering with local communities to build a sustainable health and human resources pathway.
- ▶ Create processes that integrate Elders into birthing and maternity programs in order to provide cultural support and healing for First Nations Lifegivers, ensuring that Elders are also encircled in cultural safety, dignity and respect.
- ▶ Establish culturally safe evacuation procedures and evacuation sites.
- ▶ Embed culturally safe care practices in all health care settings to ensure that pregnancy, labour and delivery, and postpartum care for all First Nations Lifegivers in BC are free from racism, discrimination and stigma.
- ▶ Ensure all maternity sites have evaluated their consent procedures to immediately end the coerced sterilization of First Nations Lifegivers in BC.

## Prioritize the social determinants of health in reproductive care

Pre-settler colonial contact, First Nations people controlled their own systems, including health, education and housing. Ongoing settler colonial policies have continued to erode these systems, and have negatively impacted the social determinants of health as well as the health of First Nations people in BC. Greater action is needed to reduce poverty, improve access to housing, increase food security and food sovereignty, prioritize early childhood development, and improve access to health services. The social determinants of health also play critical roles in maternal mortality, the toxic drug crisis, and the disproportionate number of First Nations children apprehended by the Ministry of Children and Family Development. Particular attention must be given to Lifegivers who use substances and/or have substance use disorders.

To answer the calls made by First Nations Lifegivers, health system partners must commit to and action their role in the following:

- ▶ Embed First Nations voices and leadership into the operations of the Ministry of Children and Family Development, the Ministry of Health, and throughout the health system as per Recommendation 14 of the *In Plain Sight* report<sup>xvii</sup> to ensure First Nations families receive the necessary supports required to thrive together whenever possible.
- ▶ Establish more culturally safe programs for Lifegivers who use substances and/or have substance use disorders, and ensure comprehensive community support services are available with a focus on housing, safety, food security and access to health services.
- ▶ Improve and expand health care provider education and training to more effectively support Lifegivers who use substances and/or have substance use disorders. A comprehensive, wholistic approach must be taken to addresses the barriers these Lifegivers experience when accessing care, such as stigma, housing instability and difficulty navigating complex medical services availability in rural and remote communities.

### Closing prayer from Tsawaysia Spukwus, Squamish Nation Elder

We are so blessed to understand the past, know the present and plan for the future. Thank you for taking time to read this booklet. The beauty of educating oneself is very empowering. “Our hands go up to you.” (That is our way of saying thank you: we raise both arms in the air.)

Bless all your hearts for being who you are and for the service you provide: whether you are a health worker, doctor, nurse, lab technician, first responder, counsellor and/or are being a friend and lending an ear to the patient. We respect and acknowledge your time. This is a good day for both the health care system and the FNHA to work together as a team. One Mind. One Body. One Spirit. All working together for the betterment of the Lifegiver and her newborn child. Thank you! Huy chexw!

<sup>xvii</sup> *In Plain Sight* Recommendation #14: “That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change.”

# APPENDIX A: Key Foundational Obligations to Indigenous Peoples

When evaluating and taking action in the reclamation of birth, each health authority and system partner must uphold their commitments to decolonization and respect the inherent rights of First Nations and other Indigenous Peoples.

## *United Nations Declaration on the Rights of Indigenous Peoples<sup>11</sup>*

- ▶ **Article 1:** Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the *Charter of the United Nations, the Universal Declaration of Human Rights* and international human rights law.
- ▶ **Article 2:** Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their Indigenous origin or identity.
- ▶ **Article 31:** Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

## *Truth and Reconciliation Commission of Canada Report: Calls to Action<sup>52</sup>*

- ▶ **Call to Action 19:** We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
- ▶ **Call to Action 22:** We call upon those who can effect change within the Canadian Health Care system to recognize the value of the Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

## *MMIWG Missing and Murdered Indigenous Women and Girls Report: Calls to Justice<sup>53</sup>*

- ▶ **3.2:** We call upon all governments to provide adequate, stable, equitable, and ongoing funding for Indigenous-centred and community-based health and wellness services that are accessible and culturally appropriate, and meet the health and wellness needs of Indigenous women, girls, and 2SLGBTQQIA people. The lack of health and wellness services within Indigenous communities continues to force Indigenous women, girls, and 2SLGBTQQIA people to relocate in order to access care. Governments must ensure that health and wellness services are available and accessible within Indigenous communities and wherever Indigenous women, girls, and 2SLGBTQQIA people reside.
- ▶ **3.4:** We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wrap-around services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA people.

## *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care<sup>25</sup>*

- ▶ **Recommendation #10:** That design of hospital facilities in B.C. include partnership with local Indigenous peoples and the Nations on whose territories these facilities are located, so that Health Authorities create culturally appropriate dedicated physical spaces in health facilities for ceremony and cultural protocol, and visibly include Indigenous artwork, signage and territorial acknowledgment throughout these facilities.
- ▶ **Recommendation #14:** That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change.

## *Sacred and Strong: Upholding our Matriarchal Roles<sup>54</sup>*

- ▶ A health system that is supportive, respectful and attuned to First Nations cultural beliefs, values, practices, and ceremonies during the sacred perinatal phase contributes to First Nations women's wellness at all stages of life.

# APPENDIX B: Regional Closures of Birthing Sites

Figure 4: Maternity Services in Vancouver Coastal Health, Fraser Health and Island Health Regions, 2024

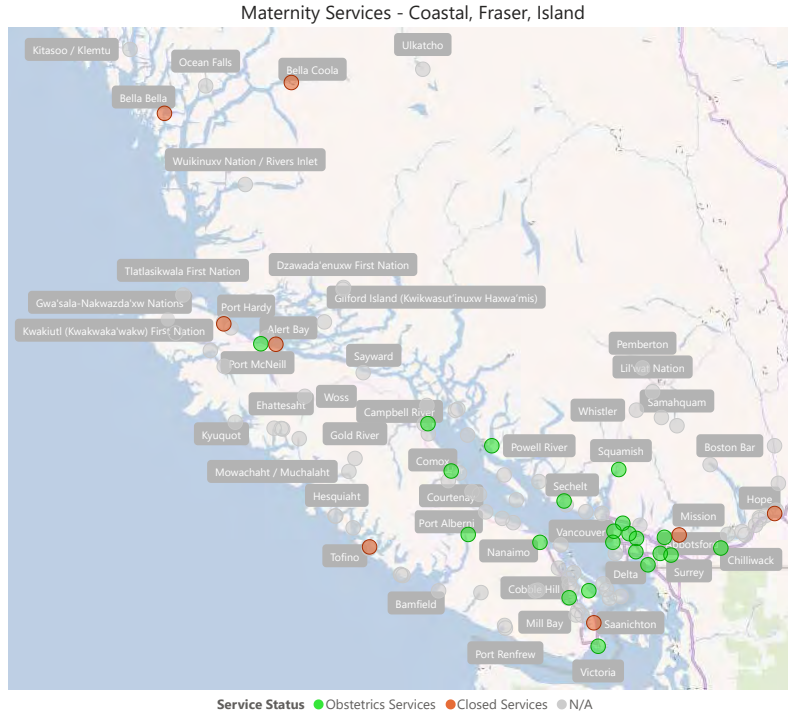
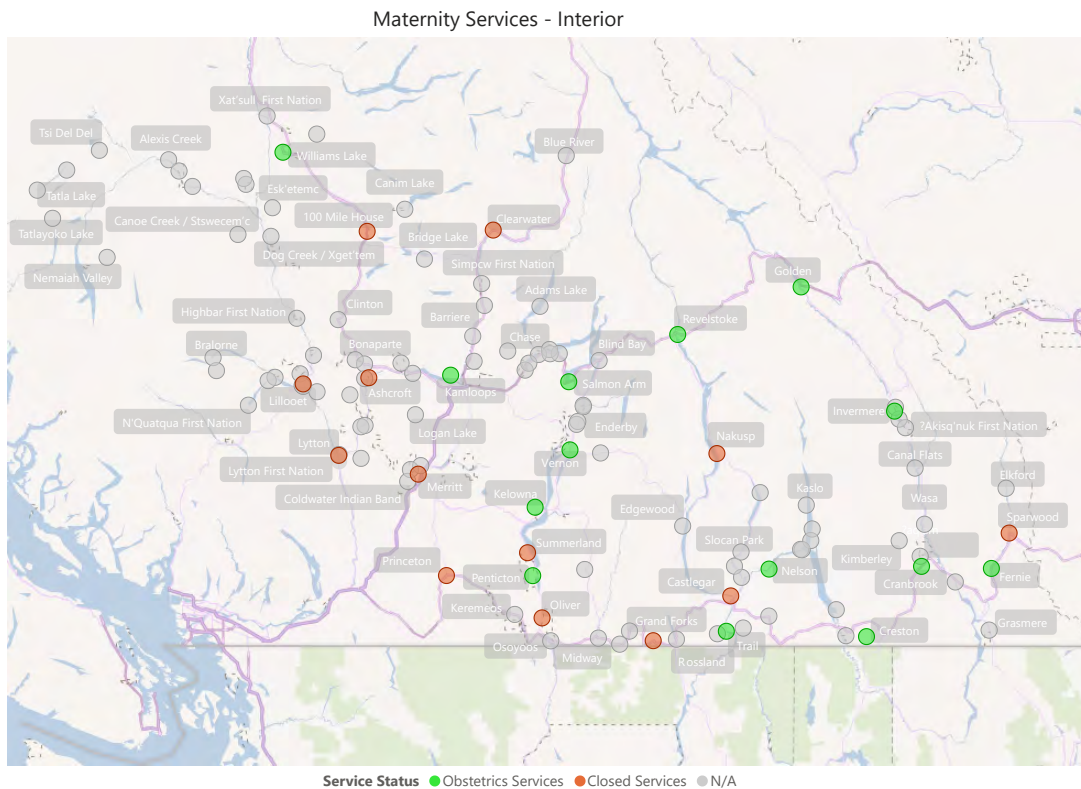
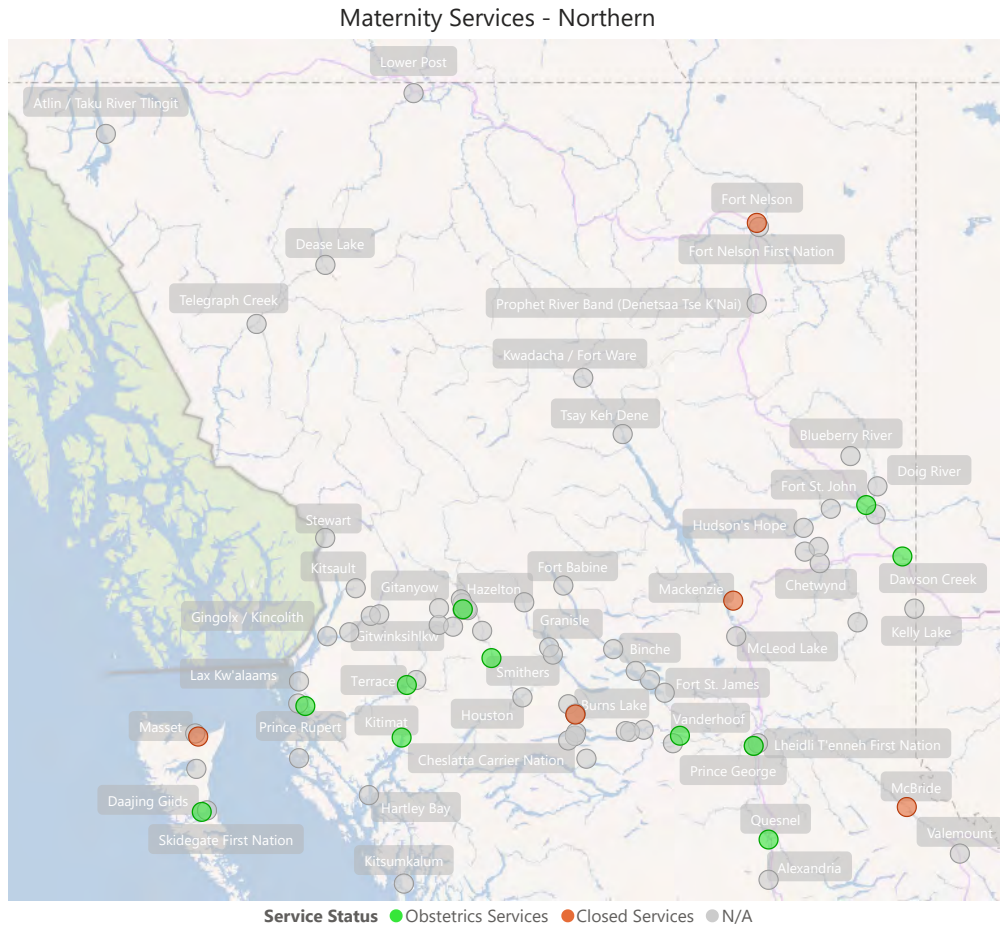


Figure 5: Maternity Services in Interior Region, 2024





**Figure 6: Maternity Services in Northern Region, 2024**



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