



many Aboriginal women living in rural and remote communities now have to leave their families and communities to give birth in hospitals hundreds or thousands of miles away from home (Sweetwater & Barney, 2009; Couchie, & Sanderson, 2007; Smylie, Daoud, O'Brien, & Yu, forthcoming).

The adverse impacts of historic and current colonial policies and the ongoing social, economic, and political marginalization of Aboriginal communities in Canada have also resulted in disparities in underlying social determinants of health, including levels of poverty and lower education, unemployment, poor housing, homelessness and food insecurity. These disadvantages are generally more severe for Aboriginal women compared to Aboriginal men (Statistics Canada, 2010). Not surprisingly, given these adverse social and economic conditions, Aboriginal women experience a disproportionate burden of adverse maternity experiences, including higher rates of gestational diabetes (Harris, Caulfield, Sugamori, Whalen, & Henning, 1997; Rodrigues, Robinson, & Gray-Donald, 1999), birthing long distances from home (Couchie & Sanderson, 2007; Smylie et al., forthcoming), and post-partum depression (Daoud, & Smylie, 2013) compared to non-Aboriginal women.

This fact sheet will: 1) provide some background information on why maternal health is important to Aboriginal communities, 2) review what is known about Aboriginal maternal health and maternity experiences in BC, and 3) describe two promising practices in Aboriginal maternity care – Aboriginal doula training and Aboriginal midwifery.

## Why Focus On Aboriginal Maternal Health

In British Columbia (BC), as in the rest of Canada, Aboriginal peoples represent a sizeable, youthful, and growing population group. According to the 2006 census, the median age of the Aboriginal population in BC was 28.1 years, compared to a median age of 40.8 years for the general BC population (Statistics Canada, 2006a, 2006b). While the total population of infants, children and youth (aged 0-18 years) has declined by 4.4% between 2001 and 2010 for BC as a whole, for Aboriginal peoples this population group has increased by almost 11% over this same period (Ministry of Children and Family Development, 2011). The large and growing populations of First Nations, non-status Indians, Inuit, and Métis<sup>2</sup> infants, children, and youth in BC and Canada are linked to birth and fertility rates that are higher for these populations compared to the non-Aboriginal population. According to the 2006 Census the Aboriginal birth rate is 1.5 times the non-Aboriginal rate (Statistics Canada 2008). Likewise, between 1996 and 2001, the fertility rate was 2.9 children for First Nations/ Indian women, 2.2 for Métis women, and 3.4 for Inuit women, compared to a rate of 1.5 among all Canadian women (Statistics Canada, 2005). Aboriginal women also give birth at a younger age than non-Aboriginal women. For example, in 2006/7 the rate of pregnancy among women under the age of 20 years in BC was nearly four times higher for First Nations women compared to other BC women (British Columbia [BC] Provincial Health Officer, 2009).

Globally, there has been a movement

towards recognizing and enshrining basic human rights, including the right to health, women's rights, and the rights of Indigenous peoples; all of which are relevant to Aboriginal maternal health and experiences (Mann, 2013). Maternal health is a global priority highlighted by the United Nations in their millennium development goals (United Nations, 2000).

The social and economic disadvantages and subsequent health inequities experienced by Aboriginal women and their families compared to non-Aboriginal Canadians are by definition unacceptable,<sup>3</sup> particularly for a relatively rich country such as Canada. These adverse conditions are in tension with a number of international covenants and treaties including:

- Article 12 of the United Nations' International Covenant on Economic, Social and Cultural Rights, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." The Covenant states that health is a fundamental human right and is dependent upon the realization of other human rights, as contained in the International Bill of Rights, including, among others, the rights to food, housing, work, education, human dignity, non-discrimination, and equality (Office of the High Commissioner on Human Rights, 1966; United Nations Economic and Social Council, 2000).
- The United Nations Declaration on the Rights of Indigenous Peoples which sets out the individual and collective rights of Indigenous peoples, as well as their rights to culture, identity, language, employment, health, and education.

<sup>2</sup> In an effort to be inclusive of all Aboriginal peoples as well as respectful and historically accurate, the terms 'First Nations' (referring to Status Indians living on- and off-reserve), 'non-Status Indians', 'Inuit', and 'Métis' are used in this document unless a specific reference is being cited, in which case the original terms as used in the reference will be utilized.

<sup>3</sup> A health inequity is defined as an unnecessary, avoidable, unfair and unjust difference between the health or healthcare of one person, and that of another (Whitehead, 1991).



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Among other things, the Declaration emphasizes the rights of Indigenous peoples to maintain and strengthen their own institutions, cultures and traditions, prohibits discrimination against Indigenous peoples, promotes their full and effective participation in all matters that concern them, and recognizes their right to remain distinct and to pursue their own visions of economic and social development (United Nations, 2008; United Nations Permanent Forum on Indigenous Issues, n.d.; United Nations News Centre, 2007). With respect to women, Article 22 of the Declaration states that: “Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.” It also seeks to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination (United Nations, 2008).

- The United Nations Convention

on the Elimination of All Forms of Discrimination against Women (Office of the High Commissioner for Human Rights, 1979).

### What We Know and Don't Know About First Nations/ Indian, Inuit, and Métis Maternal Health and Maternity Experiences in British Columbia

Unfortunately there are significant gaps in health information regarding the maternal health status and maternity experiences of Aboriginal women in BC. Often, ethnicity-specific information is not gathered for measures of maternal health status, and what does exist is generally not disaggregated to reveal differences among First Nations, non-Status Indian, Inuit and Métis populations, but rather addresses these populations collectively as ‘Aboriginal’ or excludes one or more of these groups. These Aboriginal health information

challenges are not unique to BC, and occur across Canada.

The information we do have demonstrates that Aboriginal women in BC and across Canada have poorer maternal health status and maternity experiences compared to non-Aboriginal women. It also documents major disparities between Aboriginal and non-Aboriginal women with respect to accessing culturally secure maternity care that is close to home and family. This section will provide an overview of available information regarding maternal health status, maternity experiences, and access to maternity care for Aboriginal women in BC and in Canada. The core data sources drawn on in this section include the Provincial Health Officer’s 2007 Report on the Health and Well-being of Aboriginal People in British Columbia, the First Nations Regional Longitudinal Health Survey, the 2006 Aboriginal Maternity Experiences Survey, and the Canadian Maternity Experiences Survey. For information regarding the social determinants of Aboriginal maternal

*A disproportionate burden of poverty and food insecurity and the lack of access to healthy foods in northern and remote Aboriginal communities mean that today many Aboriginal families are not able to eat healthily.*



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and child health and Aboriginal birth outcomes, readers should refer to the fact sheets *Our babies, our future: Aboriginal birth outcomes In British Columbia* (Smylie, 2012) and *Addressing the social determinants of Aboriginal infants, children, and families in British Columbia* (Smylie, 2013).

### Maternal Health Status and Maternity Experiences During and After Pregnancy

#### Physical activity, nutrition and body weight

Traditional First Nations, Indian, Inuit, and Métis cultural teachings regarding pregnancy almost always promoted physical work and activity in moderation during pregnancy as a healthy practice that contributes to the strength required during pregnancy (Eni, 2005). There are also many teachings regarding the importance of maternal nutrition, which was commonly regarded as a community responsibility. The disruption of traditional lifestyles and diets brought on by colonization and

associated environmental degradation has been linked to a growing epidemic of obesity among Aboriginal peoples (Young, Reading, Elias, & O'Neil, 2000; Lix, Bruce, Sarkar, & Young, 2009). A disproportionate burden of poverty and food insecurity and the lack of access to healthy foods in northern and remote Aboriginal communities mean that today many Aboriginal families are not able to eat healthily. Not surprisingly, First Nations women in BC both on- and off-reserve are more likely to be overweight before they get pregnant, compared to other BC residents (53% of First Nations women living on-reserve and 46% of First Nations women living off-reserve compared to 30% of other women) (BC Provincial Health Officer, 2009).

#### Gestational diabetes (GDM)

GDM is glucose intolerance that develops during pregnancy and is associated with a higher incidence of negative maternal and child outcomes, both short and long term (Cleary, Ludwig, Riese, & Grant, 2006). Research has shown that children born to

mothers who had gestational diabetes during pregnancy are at greater risk of becoming overweight or developing gestational diabetes and type II diabetes themselves (Committee on the Impact of Pregnancy Weight on Maternal and Child Health, 2007). Research has also shown that gestational diabetes is more prevalent among First Nations and Métis women compared with other Canadian women (Cleary et al., 2006; Dyck, Klomp, Tan, Turnell, & Boctor, 2002; Harris et al., 1997; Dyke, Osgood, Hsiang Lin, Gao, & Stang, 2010; Johnson, Martin, & Sarin, 2002). Data regarding the prevalence of gestational diabetes for First Nations, non-status Indian, Métis and Inuit women in BC is currently not available.

In addition to a family history of diabetes or gestational diabetes, risk factors for GDM include: being overweight/obese before pregnancy, eating an unbalanced diet that is high in sugar and carbohydrates, and not exercising. As mentioned in the previous section, data indicates that First Nations

women living in BC do experience a disproportionate burden of these risk factors. The diagnosis of GDM can be a big challenge for Aboriginal women (who experience disproportionate poverty compared to non-Aboriginal women) since the recommended diet may be too expensive or otherwise inaccessible (i.e. for women living in remote communities where fresh produce is not readily available).

#### Abuse and intimate partner violence (IPV)

The Maternity Experiences Survey (MES) is a national population based survey of new Canadian mothers. Drawing on the MES dataset, Daoud, Smylie, Urquia, Allan, and O'Campo (2013) found that any abuse and IPV were almost four times higher among Aboriginal women (excluding First Nations women living on-reserve) compared to non-Aboriginal women. Taking poverty into account reduced this disparity significantly, however Aboriginal women were still over twice as likely to experience abuse compared

to non-Aboriginal women. These numbers are particularly disturbing given the respected and valued roles traditionally held by Aboriginal women within their families and communities.

#### Maternal smoking during pregnancy

Three quarters (75%) of First Nations children surveyed on-reserve in British Columbia as part of the 2008-2010 First Nations Regional Longitudinal Health Survey were born to mothers who did not smoke cigarettes at all during their pregnancies (First Nations Health Authority, 2012). Further, 14% of children were born to mothers who smoked throughout the pregnancy and just over 10% to mothers who quit during their pregnancy for a total maternal smoking rate of just under 25%. This is higher than the general BC rate for smoking during pregnancy, which was 10% in 2005/2006 (British Columbia Reproductive Care Program, 2006). A similar rate of smoking during pregnancy for First Nations mothers living on-reserve in British Columbia was identified by the Ministry of

Health between 1998-2004 (28.9%) (BC Provincial Health Officer, 2009). This same report found that 23% of First Nations mothers living off-reserve smoked while pregnant. Just under 25% of First Nations children living on-reserve in British Columbia were reported to have lived in a household where someone else smoked while the child's mother was pregnant (First Nations Health Authority, 2012).

#### Other substance use during pregnancy

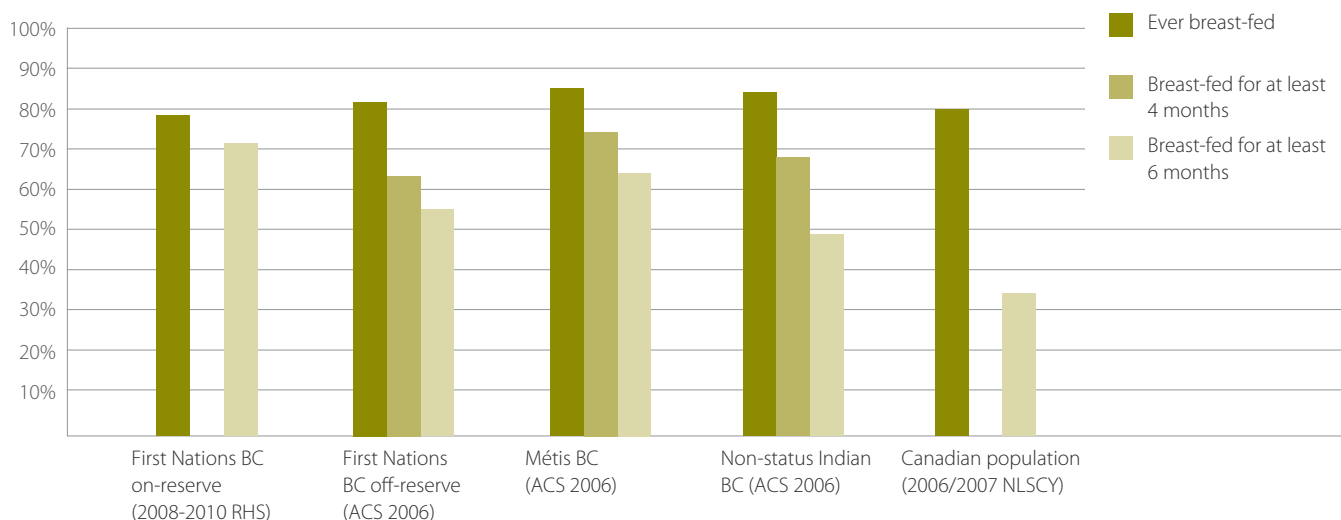
Between 1998-2004, approximately one in 20 First Nations mothers reported to their prenatal care providers that they drank alcohol while they were pregnant. Rates were similar for women living on- (4.8%) and off-reserve (5.7%) (BC Provincial Health Officer, 2009). These rates are lower than the rates of alcohol consumption during pregnancy reported for the general population of British Columbia in 2006-2007 by the Canadian Maternity Experiences Survey (7.7%) (Public Health Agency of Canada, 2009).

Self-reported rates of drug use for First



Credit: FreeImages.com, ID 1260743

Figure 1: Breastfeeding – initiation and sustained for Aboriginal children in BC and in Canada



Source: Statistics Canada, 2006c, 2009; First Nations Health Authority, 2012.

Nations mothers living on- and off-reserve during pregnancy were 4.4% and 6.9% respectively between 1998-2004 (BC Provincial Health Officer, 2009). The rates are slightly lower than the rates of drug use for the three months before and during pregnancy for the general population of British Columbia in 2006-2007 by the Canadian Maternity Experiences Survey (8.3%) (Public Health Agency of Canada, 2009).

### Breastfeeding

Rates of breastfeeding initiation are comparable for Aboriginal families in BC compared to Canada generally. Rates of sustained breastfeeding (for at least six months) are higher for Aboriginal peoples in BC than for the Canadian population (Figure 1) (Statistics Canada, 2006c, 2009; First Nations Health Authority, 2012). This suggests that Aboriginal mothers who decide to breastfeed are receiving ongoing support from within their families and/or health care providers to continue.

### Post-partum depression

The Canadian Maternity Experiences survey found that Aboriginal women were twice as likely to be depressed compared to non-Aboriginal women (Daoud & Smylie, 2014). This disproportionate burden of post-partum depression for Aboriginal compared to non-Aboriginal women has also been documented in another study of inner-city women (Bowen, & Muhajarine, 2006). Further research is currently underway to better understand the causes of post-partum depression among Aboriginal women (Daoud, & Smylie, 2014). Data for Aboriginal women in BC specifically is currently unavailable.

### Access to Maternity Services for Aboriginal Women in British Columbia

Access to quality maternity services is a significant challenge for many Aboriginal women in BC. It is important for Aboriginal mothers that maternity

services are culturally relevant and community controlled. Aboriginal people in BC are often reluctant to use health care services because the health care system is based in a world view that does not recognize many of their beliefs, values, or practices.<sup>4</sup> Indigenous ways of providing for the health of mothers have been devalued over the years in Canada as a whole, both by societal attitudes and by legislation restricting their use (Laliberte et al, 2000). Attitudinal racism, discrimination and structural inequities further disadvantage First Nations women in their health care encounters (Brown, & Fiske, 2001).

The geographic distribution of maternity care services and facilities is heavily weighted to urban areas. For the significant numbers of Aboriginal people in BC living in northern and remote areas, the result is a disproportionate burden of mandatory travel in order to access health services. The Aboriginal Maternity Experiences survey found that Aboriginal women are more than four

<sup>4</sup> See, for example, Hampton et al. (2010), McCormick (2009), and Browne (2000).

times more likely than non-Aboriginal women to travel more than 200 km to give birth (Smylie et al., forthcoming). In BC, the impacts of having to leave home to give birth are most acutely felt in several health areas, including the Bella Coola Valley, Queen Charlotte Islands, South Cariboo and Nisga'a where in 2003/2004, 59.4%, 20.6%, 8.0% and 7.4% of women, respectively were required to give birth outside of their health authority (BC Reproductive Care Program, 2004). The textbox below highlights the experiences of Heiltsuk Women in Waglisla (Bella Bella) with respect to the importance of giving birth at home rather than being forced to travel a long distance to a tertiary obstetrical centre.

In addition to geographic barriers, a number of other barriers have been identified that may impede Aboriginal women's access to prenatal care and services, including financial and psychosocial barriers, the nature of programs, and individual perceptions (BC Perinatal Services, 2006). Examples of financial barriers can include the cost of transportation, child care, prenatal classes, etc., while psychosocial barriers can include stress, depression, ambivalence or fear about pregnancy, among others. Programs might be focused towards married rather than single women, may not be inclusive of native traditions and teachings, or lack provider availability. Women may also have perceptions of pregnancy that may limit their access to prenatal care

and services such as the perception that pregnancy is a natural event requiring no intervention or negative perceptions about health care providers and services based on their previous experiences (Ibid.). Aboriginal women in urban areas have also voiced concerns regarding access to culturally secure and community relevant services, notwithstanding the geographic proximity to advanced care obstetrical facilities that urban residence provides (Su, 2009; Smylie, Wolfe, & Senese, 2012).

Not surprisingly given these barriers and concerns regarding care, research indicates that many Aboriginal women do not receive adequate prenatal care in the form of visits to family physicians

### The Importance of Giving Birth at Home – The Experiences of Heiltsuk Women in Waglisla (Bella Bella)

This study examines the importance of local birth for Aboriginal women in the remote Heiltsuk community of Waglisla/Bella Bella, BC. A number of First Nations communities in British Columbia have lost local maternity services in recent years, forcing women to travel significant distances to give birth. The decisions leading to these closures have been ad-hoc and typically without community consultation.

The Heiltsuk have always birthed in their home community, but since 2001 it is been a policy that all women must leave to have their babies. Women usually travel to Vancouver, over 600 km away, and give birth at the BC Women's Hospital.

Although all rural women experience the impact of reductions in local maternity services, qualitative evidence suggests that these impacts are felt more acutely in

Aboriginal communities. This is due in part to the historical place of birth in Aboriginal life where it was a community event that strengthened ties within families and nations. It is also important to recognize the significance of having a child born on traditional lands and the involvement and support of the whole community in welcoming the child, thereby providing a ceremonial beginning to the child's life through the naming, the potlatch, and the passing on of important traditional knowledge from Elders. These events may still occur, but there is a disconnect when a woman must leave the community to give birth in a distant, often unfamiliar place. The social significance of birth was not something considered when decisions were made to remove local maternity care from the community.

The importance of support from family and community when giving birth was best summarized by one participant:

And I couldn't believe the support – you get a lot of support here. If something happens, something goes wrong in one family, the whole community pitches in and helps out to support them, whether

it's financial or, you know, if it's death, there's going to be food sent over.

Another participant spoke of the importance of family support from a care giving perspective:

I think it makes a big difference to have our babies here, because you have all that family support and you really do need it because some mothers go through the post-partum blues here, and just to have all the support.

Other concerns include the fact that having women leave their communities to give birth has been linked to increased perinatal morbidity and mortality as well as increased anxiety, stress, and preterm delivery.

The recommendations that emerged from this study, which were formally ratified by the Heiltsuk Band Council, emphasize the importance of community involvement in the decision-making around allocation of resources for maternity care and the importance of place and community in giving birth.

Source: Kornelsen et al., 2010.

or obstetricians, or prenatal classes (BC Perinatal Services, 2006), although they may be receiving prenatal care in other forms within their communities. For example, First Nations women living on-reserve in BC are significantly less likely to make at least nine prenatal visits to a doctor during the term of their pregnancy and initiate prenatal care with a doctor later than non-Aboriginal mothers (Ibid.). Unfortunately data was not available regarding visits to multidisciplinary reproductive healthcare providers including midwives, nurse practitioners, and nurses to better understand the exact nature of these gaps in care.

## How Do Current Aboriginal Maternal Health and Maternity Experiences Data Link to Health Determinants, Health Services, and Health Policy?

The Aboriginal maternal health and maternity experiences data presented suggests that a wide range of health services, programs, and policy responses are required. Special attention needs to be paid to the amelioration of Aboriginal/non-Aboriginal disparities in the social and environmental determinants of health across gender. In addition, there is evidence to support the need for tailored Aboriginal community led maternity services and programs located where Aboriginal women live (ie. in both rural areas and in urban areas).

## Best and Promising Practices in Aboriginal Maternal Health Assessment and Response

### Aboriginal Doula Training Project

The Aboriginal Doula Training Project is based on a partnership between the First Nations Health Council and British Columbia's Provincial Health Services Association. In 2009, 26 Aboriginal

women received doula training and certification in Secwepemc and Gitksan territory (Kamloops and Hazelton) using an Aboriginal specific doula curriculum. These Aboriginal doulas will provide support for women and their families before, during, and after the birthing process. This includes support throughout the entire labour and birthing process and assistance with newborn care.

The Aboriginal Doula Training Project is intended to bridge the gap left by the disruption of traditional birthing practices in BC's Aboriginal communities. According to Indigo Sweetwater and Lucy Barney (2009) who developed the pilot project, an "aboriginal doula can help families and the birthing mothers bring the childbirth process back to our communities where it began and where it belongs." Plans are underway to expand this project and finalize the Aboriginal doula training curriculum.

### Sheway

The Sheway program, established in Vancouver's Downtown Eastside in 1993, is a model of a successful program targeted at improving maternal and infant health in urban areas, specifically for pregnant women struggling with substance abuse and addictions. While not specifically targeted at Aboriginal women, this population group represents approximately 70% of their clientele (Sheway, n.d.). The program is woman-centred, culturally focused, and based on the philosophy of harm-reduction. It receives its funding from multiple sources, both government and non-government, and is a partner of the Vancouver Native Health Society. A range of pre- and post-natal medical and nursing care is provided including: daily hot nutritious lunches; food coupons, food bank hampers and nutritional supplements; bus fare for transportation to appointments; formula, diapers, clothing, equipment and other items for newborn infants; outreach services and

home visits; recreational and creative programming; nutrition counselling and support; alcohol and drug counselling and methadone prescribing; support in developing/improving parenting skills; and advocacy on housing and legal issues (Poole, 2000).

An evaluation of the program undertaken by Poole (2000) noted improvements in maternal and newborn outcomes including: improved nutritional status, decreased substance misuse, improvement in housing, lower rates of child apprehension by the Ministry of Children and Family Development, healthier birth weights, and up-to-date immunizations. The successes of the program have been attributed to a number of features of the program, including a team approach to providing continuous, seamless, and integrated services; a welcoming, non-judgmental approach to service delivery; a non-hierarchical organization of services with an open and informal atmosphere; the opportunity to socialize with women in similar life situations; access to non-medical essentials; and the ability to control security and anonymity (Benoit, Carroll, Lawr, & Chaudhry, 2001; Benoit, Carroll, Chaudry, 2003).

### Aboriginal Midwifery

*Canada's oldest midwifery traditions stem from aboriginal peoples. Midwives have been part of virtually every aboriginal community and some midwives continue to practice today (Shroff, 1997).*

Aboriginal communities across Canada have always had midwives (National Aboriginal Council of Midwives [NACM], 2012). Colonization and the associated changes in Aboriginal community health services, including the medicalization of childbirth, actively undermined Aboriginal midwifery practice in Canada for many years (NACM, 2012; NAHO, 2008). Since 1986, however, there has been a





Credit: Glenbow Archives, ID NA-3672-4, “Three Inuit midwives, Wassagamack., August 1970.”

*A midwife is the keeper of ceremonies for young people like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation.*

resurgence of Aboriginal midwifery in remote, rural, and urban regions across Canada, with eight current practices listed on the NACM website.

Aboriginal midwifery has been identified as a best practice in the literature (McNeil et al., 2010; Van Wagner, Epoo, Nastapoka, & Harney, 2007; Health Council of Canada, 2011). According to the National Council of Aboriginal Midwives (NACM, 2012) an Aboriginal midwife is:

*a committed primary health care provider who has the skills to care for pregnant women, babies, and their families throughout pregnancy and for the first weeks in the postpartum. She is also a person who is knowledgeable in all aspects of women’s medicine and she provides education that helps keep the family and the community healthy. Midwives promote breastfeeding, nutrition, and parenting skills. A midwife is the keeper of ceremonies for young people like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation. (para. 1)*

The NACM website listed in the Additional Resources section on the following page includes additional information about Aboriginal midwifery in Canada, including governance, educational pathways and a midwifery toolkit for communities interested in developing midwifery services.

## Conclusion

This paper opened with the wisdom of Mohawk midwife and Elder Katsi Cook urging Indigenous people to take up their responsibilities and “re-awaken our women to the power...inherent in...birth.” Ensuring that the physical, mental, emotional, and spiritual needs of pregnant women and breastfeeding mothers are met has always been and still is a family and community priority for Aboriginal peoples. Unfortunately, historic and ongoing colonial policies have undermined the rich, diverse, and socially embedded Indigenous systems that supported and empowered our women as mothers. The subsequent social disadvantage that currently challenges many Aboriginal women at a time when they are most vulnerable in turn translates into a disproportionate

burden of ill health (gestational diabetes, obesity, post-partum depression) and stress related behaviours (smoking) for Aboriginal women compared to non-Aboriginal women. Despite all of these challenges, however, Aboriginal women, families and communities are working hard to support optimal health and well-being. For example, rates of sustained breastfeeding for Aboriginal families in BC are higher than those of the general Canadian population. Also, there are a number of important community driven initiatives, including Aboriginal doula and midwifery care, that have been implemented to improve access to culturally relevant maternity care. All in all, it is an exciting and transformative time for Aboriginal maternal health in BC.

## Additional Resources

- BC Perinatal Health Program (BCPHP): [www.bcphp.ca](http://www.bcphp.ca)
- Canadian Perinatal Surveillance System: [www.phac-aspc.gc.ca/rhs-ssg/](http://www.phac-aspc.gc.ca/rhs-ssg/)
- First Nations Health Council: [www.fnhc.ca](http://www.fnhc.ca)
- First Nations Regional Longitudinal Health Survey: [www.rhs-ers.ca/english](http://www.rhs-ers.ca/english)
- National Aboriginal Council of Midwives (NACM): [aboriginalmidwives.ca](http://aboriginalmidwives.ca)

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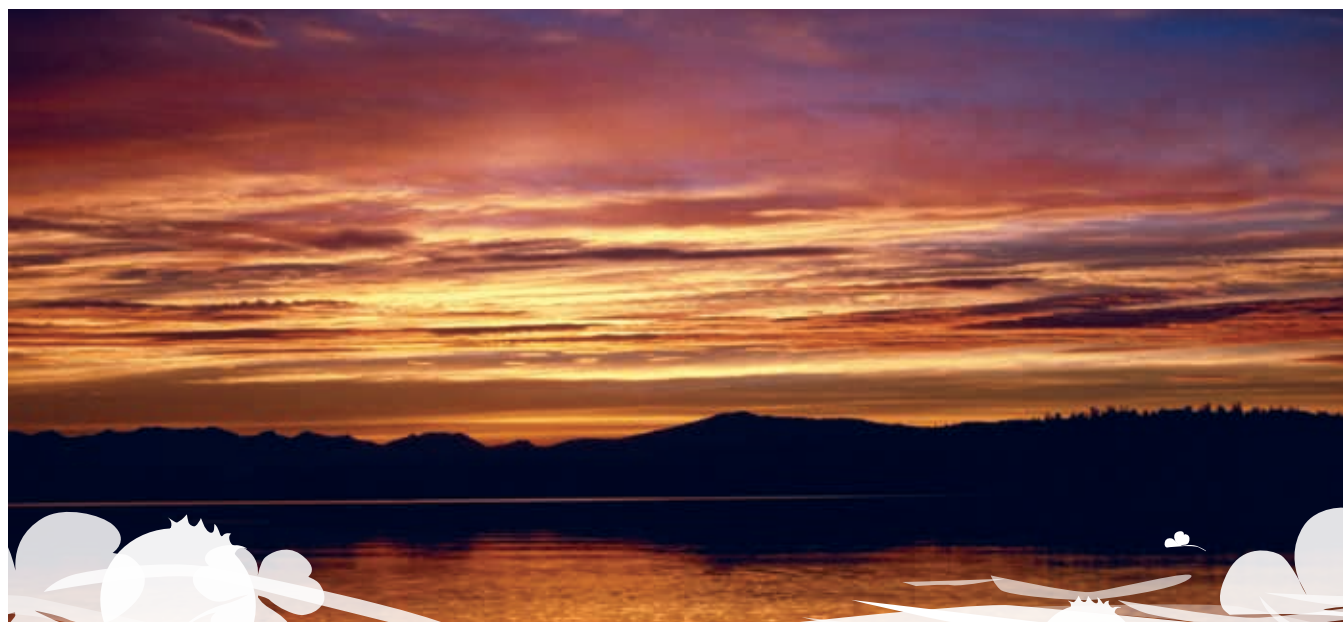
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