EPILOGUE

Public Health Agency of Canada
Agence de la santé publique du Canada

Canada

TO PROMOTE AND PROTECT THE HEALTH OF CANADIANS THROUGH LEADERSHIP, PARTNERSHIP, INNOVATION AND ACTION IN PUBLIC HEALTH.

—Public Health Agency of Canada

Également disponible en français sous le titre :
Épilogue

To obtain additional information, please contact:

Public Health Agency of Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9
Tel.: 613-957-2991
Toll free: 1-866-225-0709
Fax: 613-941-5366
TTY: 1-800-465-7735
E-mail: publications-publications@hc-sc.gc.ca

Publication date: July 2022

PRINT Cat.: HP15-30/9-2022E
ISBN: 978-0-660-42971-7

PDF Cat.: HP15-30/9-2022E-PDF Pub.: 220024
ISBN: 978-0-660-42970-0

EPILOGUE

Family-centred maternity and newborn care (FCMNC) is the most rational and justifiable framework for organizing health care services for mothers, babies, and families. Although patient-centred care is generally the focus of all health care, the unique experiences of pregnancy, labour, birth, and newborn care enhance the argument for the personalization of health care services for the family as a whole. The defining events of pregnancy, motherhood/fatherhood, birth, and infancy require that health care providers (HCPs) be additionally diligent in order to address the needs of women, their newborns, and their families, whether these are physical, emotional, cultural, spiritual, or knowledge.

This fifth edition of the *Family-Centred Maternity and Newborn Care National Guidelines* presents 17 principles to guide FCMNC. Some of these carry over from the previous edition, while others are new or have some differences in detail and points of emphasis.[1]

The principles will continue to evolve, particularly given the demographic and societal changes taking place in Canada. The current set can be summarized as the following key guidelines of FCMNC:

- Pregnancy and birth are normal, healthy processes.
- Early parent–infant bonding is critical for growth and development of the newborn, child, and family.
- Women and their families require knowledge about their care and play an integral role in the decision-making about the care they receive.
- Holistic approaches, respect for reproductive rights, collaboration among care providers, and recognition of the family-centred approach applies to all care environments.
- Psychological support for families is needed in conjunction with evidence-based clinical care.
- The attitudes and language adopted by HCPs impact the experience of care.
- Care is:
  - culturally appropriate and addresses the distinct needs of Indigenous Peoples;
  - individualized and provided as close to home as possible;
  - informed by research-based evidence and best practices in global settings, while functioning within a system that is continually evaluated.

The FCMNC principles provide a broad framework that HCPs, managers, and institutions can use to improve families' experiences of pregnancy, childbirth, and newborn care. HCPs can apply them to make their care more responsive to the needs of women, newborns, and their families. Familiarity with these principles can also empower women as they navigate the health care system.

HISTORY OF FAMILY-CENTRED MATERNITY AND NEWBORN CARE

The impetus for FCMNC began with a demand for changes in obstetric management in the 1960s and 1970s.[2] The implementation of family-centred care started with husbands being invited to participate in prenatal care, being present during labour and birth, and being a part of newborn care. Over the years, this has evolved to treating birth as a normal and healthy process, placing emphasis on the appropriate use of intervention, considering the unique needs of families and culturally safe care, focusing on informed choice and knowledge needs, and protecting, promoting, and supporting breastfeeding.

Canadian guidelines for maternity and newborn care were first published in 1968. They became explicitly family-centred in 1987. The family-centred framework has been instrumental in enlarging the scope of maternity and newborn care beyond a focus on morbidity and mortality. By involving the family as a whole, and by highlighting the importance of the experience of pregnancy and childbirth, FCMNC reframed the pregnancy, childbirth, and postpartum periods as the beginning of a family's growth. Thus, FCMNC changed the perspective through which the health care system viewed pregnancy and childbirth.

The evolution in FCMNC over recent decades represents a reaction to advances in research and technology; increases in women's and family's participation in care; health care system restructuring; and changes in population composition in terms of culture, ethnicity, and maternal age.[3] The current edition of the *Family-Centred Maternity and Newborn Care National Guidelines* expands the meaning of family to include lone parents as well as couples and heterosexual, lesbian, gay, bisexual, transgender, queer, and questioning parents.

The guidelines emphasize the need for sensitivity when addressing preferences. Requests that arise, such as the desire for surrogacy or adoption, are discussed in connection with care during pregnancy, labour, birth, and newborn care. Family-centred care is also responsive to the needs of diverse high-risk populations and special circumstances. These include newborns who require complex or high-risk care and women with physical disabilities, mental illness, a history of substance use, obesity, a history of violence, or experience of female genital mutilation/cutting.[4]

THE CURRENT LANDSCAPE IN CANADA

The increasing complexity of maternity and newborn care, the changing perinatal landscape in Canada, and demographic and societal changes, including increasing diversity, are reflected in this edition of the guidelines. The principles of FCMNC apply to all women and newborns, irrespective of risk status. Increasing complexity of care requires a stronger commitment to family-centred principles. Maternal characteristics—for example, smoking, age, and obesity—have changed substantially in recent decades. The changes to the delivery of maternity and newborn care across Canada have also altered the childbirth experience.

Smoking

Perhaps the most encouraging change has been the steady decline in maternal smoking rates in pregnancy, from 22% in 1993–96 to 12% in 2005–08 and then to 8.2% in 2017.[5,6] The decline is largely attributed to public health interventions and the growing awareness of the negative impacts of smoking on pregnancy outcomes.[7] Evidence suggests that these declines in smoking rates have also contributed to reducing the number of small-for-gestational age live births in Canada.[8,9] These reductions in maternal smoking rates reflect a substantial social and cultural change that have benefited the health of both mothers and babies.

Advanced maternal age

The second half of the 20th century has resulted in a steady decline in family size and an increase in the number of births to women 35 years and older.[10,11] One notable difference between past and recent decades is that fertility of older women relates to parity and family size: older women in the past had their second, third, or subsequent child in their early and late 30s (having started their families at an earlier age), whereas nowadays, women increasingly choose to have their first child in their 30s. In 1996, the average age of a mother at birth was 28.4 years. By 2017, it had increased to 30.5 years. In addition, 47.0% of first births in 2017 were to women aged 30 to 49, up from 30.4% in 1996.[12] The main reason for the rising number of first births among women of advanced maternal age is that they are prioritizing education, professional competence, and financial independence over motherhood.[13]

While HCPs may be aware of the increased medical and obstetric risks and adverse pregnancy outcomes (including higher rates of chromosomal and other congenital anomalies, preterm birth, growth restriction, and perinatal and maternal morbidity and mortality) in women of advanced maternal age, they also need to be cognizant of the psychosocial vulnerabilities they may experience.[14–17]

Obesity

The frequency of overweight and obesity among men and women in Canada has increased substantially since the 1980s.[18] These increases have translated into increases in pre-pregnancy weight and pre-pregnancy body mass index (BMI). While no recent published national data exist, in 2005, 20.9% of women had an overweight pre-pregnancy BMI (25.0–29.9 kg/m^2) and 13.1% had an obese pre-pregnancy BMI (≥30 kg/m^2).[19]

Although women who are overweight or obese have a higher risk for hypertension, diabetes, miscarriage, preeclampsia, gestational diabetes, fetal macrosomia, stillbirth, and severe maternal morbidity, HCPs need to reassure overweight or obese women that they are likely to have healthy pregnancy outcomes, even if they require additional interventions during pregnancy, labour, and birth.[20–22] HCPs need to treat women with a high BMI in a sensitive and non-judgmental manner so that women feel supported and respected, and pregnancy complications are managed optimally.

Delivery of maternity and newborn care

Substantial changes in maternity and newborn care that have affected the childbirth experience over the past decades include the following:

- **Increasing midwife-led deliveries:** Midwifery, which was first regulated in Ontario in 1994, is now publicly funded in most of the provinces and territories. The widespread impact of midwifery regulation and acceptance in Canada is evident from the number of midwife-assisted births—42 000 (11% of births) in 2017 (22% in British Columbia)[23]. Some provinces have established midwifery goals; for example, the Midwives Association of British Columbia has set a goal of midwife involvement in 35% of births by 2020.[24] In 2018, the Markham Stouffville Hospital opened Canada's first in-hospital midwifery birthing unit, to allow midwives to care for more families in the community.[25] Midwifery-led births have lower rates of interventions and less use of analgesia or anesthesia; women are more likely to experience a spontaneous vaginal birth.[26]

- **Redesign of neonatal intensive care units (NICUs):** The move away from open bay units in NICUs to single family units is particularly relevant within the context of FCMNC and has resulted in increased staff and parental satisfaction with care. The single family room setting has a number of benefits—with equal, or possibly even reduced, cost of care—such as providing optimal environmental support to parents; reducing neonatal sepsis; improving infant weight gain and breastfeeding rates; allowing control of excessive noise and light; reducing parental and HCP stress and anxiety.[27–32] Single family rooms are in use in a few centres in Canada, for example, IWK Health Centre in Halifax, which recently built a new NICU using the single-room model, as well as in the USA and Europe.
- **Increased travel to give birth:** Maternity care hospitals in rural areas have been closing, which means that mothers and newborns sometimes need to travel to a distant hospital to access appropriate care.[33] This problem can be particularly acute for women with young families and those who have to travel far. Although maternity care has historically prioritized medical risk over social risk, women and their families may evaluate these risks differently.[34–36] Both medical and social risks have to be addressed if maternity and newborn care is to be family-centred and if birth close to home is promoted as a principle of family-centred maternity care.[3] Organizations and communities have been lobbying for the return of birthing options in rural and remote communities, and in some circumstances they have been successful.[37]

THE FUTURE OF MATERNITY AND NEWBORN CARE

We can learn a lot from past and current ways of providing FCMNC in Canada. The following areas of focus show how care has evolved and where the future of maternity and newborn care is heading:

Supporting breastfeeding

The Baby-Friendly Hospital Initiative (BFHI) incorporates the continuum of care between hospital and community health services. The BFHI includes recommendations for breastfeeding the older infant and young child.[38] Hospitals or community health facilities that provide maternity services are designated Baby-Friendly if they meet the criteria for achieving the *Ten Steps to Successful Breastfeeding* and adhere to the *International Code of Marketing of Breast-milk Substitutes*. Despite the recommendations and the endorsement of many professional health organizations, hospitals and community health facilities have a poor record of implementing the BFHI.[39,40] Currently, 21 hospitals, 8 birthing centres, and 117 community centres in Canada have been designated as Baby-Friendly.[41] The World Health Organization (WHO) emphasizes strategies to scale up BFHI implementation to universal coverage to ensure sustainability.

Caring for women who use substances

Cannabis is now legal in Canada and, in 2018, 3% of women who knew they were pregnant reported using cannabis.[42] Although many pregnant women do not think use of cannabis is harmful during pregnancy and breastfeeding, studies indicate related increases in the risk of preterm labour for the mother, and issues for the child tied to low birth weight, short- and long-term learning and development, as well as behaviour.[43,44] Educating and supporting women and families regarding cannabis use during pregnancy and breastfeeding is critical.

When a pregnant woman lives with problematic opioid use, her newborn will be born having been exposed to opioids. In 2018, 1% of women who knew they were pregnant reported using opioids.[42] New approaches to caring for newborns with neonatal abstinence syndrome (NAS) have proven to be helpful, including caring for the mother-baby dyad together in a low-stimuli environment and moving away from pharmacological approaches as the first line of treatment.[45] The best person to settle a baby is the mother herself, and it is important to encourage mothers to hold and feed their baby. Programs and protocols need to be developed in Canada that better support a family-centred approach to caring for babies born with NAS.[46]

Ensuring uninterrupted skin-to-skin contact

Uninterrupted skin-to-skin contact profoundly affects infant and child development and the health of the family. In 2005, while the majority (89.2%) of Canadian mothers who had vaginal births held their babies within 5 minutes of birth, this was not the case for mothers who had caesarean births (29.0%). Furthermore, fewer than a third of women (31.3%) held their babies skin-to-skin when first holding their baby. A majority (71%) of women report 24-hour rooming-in after vaginal birth, but less than half (46.5%) of mothers who gave birth by caesarean birth did so.[47] We can improve the rates in Canada by implementing institutional policies and practices that support the practice irrespective of the birth method, as well as supporting skin-to-skin beyond the first hours after birth.

De-medicalizing maternity care

There are both positive and negative aspects with respect to trends in de-medicalizing maternity care in Canada. Episiotomies are no longer routine, with rates decreasing from 23.8% nationally in 2001 to less than 10% in 2016 in British Columbia, for example[48,49]. On the other hand, rates of epidural anesthesia among Canadian women delivering vaginally have increased from 45.4% in 2001 to 59% in 2016, while caesarean birth rates increased from 22.5% to 28.2% over the same period.[49–51] Rates of intervention in labour and birth vary (often significantly) across the provinces and territories, suggesting that use of interventions is not always based on evidence or on medical need.

Environments where intervention rates are lower because of appropriate use are generally safer for mothers and babies, and Canadian mothers express higher rates of satisfaction with their birth experience when fewer interventions are used. The net benefits of de-medicalizing care during pregnancy and childbirth are included in the *WHO Principles of Perinatal Care*. Decreasing unnecessary intervention during pregnancy and birth is an area that requires additional and ongoing effort in Canada.

Using inclusive language

Recognition of the importance of using language that supports diversity and creates an open and inclusive environment is growing. Inclusive language demonstrates respect for everyone. Merely avoiding offence is only the first step—the goal should be to treat everyone with dignity and to celebrate differences. Also important to remember is that language is not static but is dynamic and evolves over time.

A number of organizations are considering the use of gender-neutral language in pregnancy, birth, and parenting to avoid stereotyping people according to their gender identity. For example, when the Ontario Perinatal Record was updated in 2017, the language was changed to be respectful of gender identity and the different ways people may identify as a parent.[52] The British Medical Association recently stated that: "A large majority of people that have been pregnant or have given birth identify as women. We can include intersex men and trans men who may get pregnant by saying 'pregnant people' instead of 'expectant mothers'." [53] The Midwives Alliance of North America has revised their core competencies in order to make their language inclusive and welcoming to all who seek midwifery care.[54]

Conversations about inclusive language are important—communities, organizations, professional groups, and the various levels of government need to reflect on their language and work with their clients and stakeholders to ensure that all are treated with respect and dignity.

Providing culturally safe care for Indigenous families

Many Indigenous people have to travel far from their communities for health care services. In order to help keep families close to home for birth and to provide culturally safe care, community birthing centres that offer traditional techniques, allow for diversity in design and implementation, and integrate with biomedical support have been established in some Indigenous communities. Some of these centres offer community-based training of Indigenous midwives, integrating both traditional and modern approaches to care and education. The programs are integrally linked to community development, cultural revival, and healing from the effects of colonization. They focus on effective teamwork between midwives, physicians, and nurses working in remote areas and at the regional and tertiary referral centres.[55] Evaluative research has shown improved outcomes for this approach—which requires broader support and application across the country.[56]

Surveillance of maternal and newborn health

Sound perinatal care policies and practices rely on data from multiple sources that is timely and regularly updated. The current guidelines apply many perinatal indicators throughout the various chapters, including data pertaining to the experiences of women who gave birth and the policies of hospitals offering maternity services. Providing a more fully-rounded picture of FCMNC requires encouraging efforts to collect timely data on the pregnancy and childbirth experiences of women and their families, in tandem with traditional perinatal data on maternal/fetal outcomes.

CONCLUSION

Families in Canada benefit from excellent maternity and newborn health care. This is evident from the low national rates of perinatal and maternal morbidity and mortality, across varying sociodemographic groups. Although Canadian HCPs can be proud of working within a comprehensive, universal, portable, and accessible publicly-administered health care system, more can be done to improve outcomes and ensure care is family-centred.

The emphasis on FCMNC in Canada has enlarged the scope of care in pregnancy and childbirth. Such care not only maximizes the chances of a healthy woman and a healthy baby, but also helps to ensure that birth is the celebration of a normal and healthy process. Empowering women and their families to take responsibility for their informed choices through a mutually respectful and trusting relationship with their HCPs makes the experience of pregnancy and childbirth a strong foundation for family growth and development.

REFERENCES

1. Public Health Agency of Canada. Family-centered maternity and newborn care: National guidelines. Preface [Internet]. Ottawa (ON): PHAC; 2017 [cited 2019 Mar 7]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care/preface-eng.pdf.
2. Enkin MW. Family centred maternity care. Can Fam Physician. 1973;19(4):45–8.
3. Public Health Agency of Canada. Family-centered maternity and newborn care: National guidelines. Chapter 1: Family-centred maternity and newborn care in Canada [Internet]. Ottawa (ON): PHAC; 2017 [cited 2019 Mar 7]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care/maternity-newborn-care-guidelines-chapter-1-eng.pdf.
4. Public Health Agency of Canada. Family-centered maternity and newborn care: National guidelines. Chapter 4: Care during labour and birth [Internet]. Ottawa (ON): PHAC; 2018 [cited 2019 Mar 7]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care/maternity-newborn-care-guidelines-chapter-4-eng.pdf.
5. Public Health Agency of Canada. Perinatal health indicators for Canada 2013 [Internet]. Ottawa (ON): PHAC; 2013 [cited 2019 Jan 22]. Available from: http://publications.gc.ca/collections/collection_2014/aspc-phac/HP7-1-2013-eng.pdf.
6. Public Health Agency of Canada. Perinatal health indicators (PHI) [Internet]. Ottawa (ON): PHAC; 2020 [cited 2021 Aug 10]. Available from: https://health-infobase.canada.ca/PHI.
7. Gagne T. Estimation of smoking prevalence in Canada: implications of survey characteristics in the CCHS and CTUMS/CTADS. Can J Public Health 2017;108(3):e331–4.
8. Kramer MS, Morin I, Yang H, Platt RW, Usher R, McNamara H, et al. Why are babies getting bigger? Temporal trends in fetal growth and its determinants. J Pediatr. 2002;141(4):538–42.
9. Metcalfe A, Lisonkova S, Joseph KS. The association between temporal changes in the use of obstetrical intervention and small-for-gestational age live births. BMC Pregnancy Childbirth. 2015;15(1):233.
10. Statistics Canada. Table B1–14: live births, crude birth rate, age-specific fertility rates, gross reproduction rate and percentage of births in hospital, Canada, 1921 to 1974 [Internet]. Ottawa (ON): SC; 1999 [cited 2019 Jan 25]. Available from: https://www150.statcan.gc.ca/n1/en/catalogue/11-516-X198300111299.
11. Statistics Canada. Fifty years of families in Canada: 1961 to 2011 [Internet]. Ottawa (ON): SC; 2012 [cited 2019 Mar 5]. Available from: https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_1-eng.pdf.
12. Statistics Canada. Births, 2015 and 2016 [Internet]. Ottawa (ON): SC; 2018 [cited 2021 Aug 10] Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/180430/dq180430f-eng.htm.
13. Koert E, Daniluk JC. When time runs out: reconciling permanent childlessness after delayed childbearing. J Reprod Infant Psychol. 2017;35(4):342–52.
14. Spence NJ. The long-term consequences of childbearing: physical and psychological well-being of mothers in later life. Res Aging. 2008;30(6):722–51.
15. McMahon CA, Boivin J, Gibson FL, Fisher JRW, Hammarberg K, Wynter K, et al. Older first-time mothers and early postpartum depression: a prospective cohort study of women conceiving spontaneously or with assisted reproductive technologies. Fertil Steril. 2011;96(5):1218–24.
16. Bayrampour H, Heaman M, Duncan KA, Tough S. Advanced maternal age and risk perception: a qualitative study. BMC Pregnancy Childbirth. 2012;12(1):100.
17. Muraca GM, Joseph KS. The association between maternal age and depression. J Obstet Gynaecol Can. 2014;36(9):803–10.
18. Tremblay MS, Katzmarzyk PT, Willms JD. Temporal trends in overweight and obesity in Canada, 1981–1996. Int J Obes Relat Metab Disord. 2002;26(4):538–43.
19. Dzakpasu S, Fahey J, Kirby RS, Tough SC, Chalmers B, Heaman MI, et al. Contribution of prepregnancy body mass index and gestational weight gain to caesarean birth in Canada. BMC Pregnancy Childbirth 2014;14(1):106.
20. Liu P, Xu L, Wang Y, Zhang Y, Du Y, Sun Y, et al. Association between perinatal outcomes and maternal pre-pregnancy body mass index. Obes Rev. 2016;17(11):1091–102.
21. Mission JF, Marshall NE, Caughey AB. Pregnancy risks associated with obesity. Obstet Gynecol Clin North Am. 2015;42(2):335–53.
22. Lisonkova S, Muraca GM, Potts J, Liauw J, Chan W, Skoll A, et al. Association between prepregnancy body mass index and severe maternal morbidity. JAMA. 2017;318(18):1777–86.
23. Canadian Association of Midwives. Annual report 2017–2018 [Internet]. Montreal (QC): CAM; 2018 [cited 2019 Mar 6]. Available from: https://canadianmidwives.org/wp-content/uploads/2018/10/Annual-Report-2017-2018.pdf.
24. Midwives Association of British Columbia. Progress report October 2016 [Internet]. Vancouver (BC): MABC; 2016 [cited 2019 Feb 18]. Available from: https://www.bcmidwives.com/_Library/PublicDocuments/MABC-ProgressReport-Web.pdf.
25. Markham Stouffville Hospital. Canada's first in-hospital midwifery unit opens at Markham Stouffville Hospital [Internet]. Markham (ON): MSH; 2018 [cited 2021 Aug 10]. Available from: https://www.oakvalleyhealth.ca/about-us/news/canadas-first-hospital-midwifery-unit-opens-markham-stouffville-hospital.

26. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2016;4.

27. Banerjee J. Are single family rooms the future for neonatal units? Lancet Child Adolesc Health. 2019;3(3):130–1.

28. Banerjee J, Aloysius A, Platonos K, Dejerl A. Family centred care and family delivered care—what are we talking about? J Neonatal Nurs. 2018;24(1):8–12.

29. O'Brien K, Robson K, Bracht M, Cruz M, Lui K, Alvaro R, et al. Effectiveness of family integrated care in neonatal intensive care units on infant and parent outcomes: a multicentre, multinational, cluster-randomised controlled trial. Lancet Child Adolesc Health. 2018;2(4):245–54.

30. Stevens D, Thompson P, Helseth C, Pottala J. Mounting evidence favouring single-family room neonatal intensive care. J Neonatal Perinatal Med. 2015;8(3):177–8.

31. van Veenendaal NR, Heideman WH, Limpens J, van der Lee JH, van Goudoever JB, van Kempen AAMW, van der Schoor SRD. Hospitalising preterm infants in single family rooms versus open bay units: a systematic review and meta-analysis. Lancet Child Adolesc Health. 2019;3(3):147–57.

32. Harris DD, Shepley MM, White RD, Kolberg KJS, Harrell JW. The impact of single family room design on patients and caregivers: executive summary. J Perinatol. 2006;26:38–48.

33. Hutten-Czapski P. Abridged version of the Society of Rural Physicians of Canada's discussion paper on rural hospital service closures. Can J Rural Med. 2009;14(3):111–4.

34. Barclay L, Kornelsen J, Longman J, Robin S, Kruske S, Kildea S, et al. Reconceptualising risk: perceptions of risk in rural and remote maternity service planning. Midwifery. 2016;38:63–70.

35. Chamberlain M, Barclay K. Psychosocial costs of transferring indigenous women from their community for birth. Midwifery. 2000;16(2):116–22.

36. Kornelsen J, Grzybowski S. Is local maternity care an optional service in rural communities? J Obstet Gynaecol Can. 2005;27(4):329–31.

37. Society of Obstetricians and Gynaecologists of Canada. Returning birth to aboriginal, rural, and remote communities. J Obstet Gynaecol Can 2017;39(10):e395–7.

38. Breastfeeding Committee of Canada. The BFI 10 steps and WHO code outcome indicators for hospitals and community health services [Internet]. Drayton Valley (AB): BCC; 2017 [cited 2019 Feb 18]. Available from: http://breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf.

39. Public Health Agency of Canada. Canadian hospitals maternity policies and practices survey. Ottawa (ON): PHAC; 2012.

40. Breastfeeding Committee of Canada. Baby-friendly initiative (BFI) in Canada status report [Internet]. Drayton Valley (AB): BCC; 2014 [cited 2019 Feb 18]. Available from: http://www.breastfeedingcanada.ca/documents/BFI%20Status%20Report%202014%20with%20WHO%20Country%20report.pdf.

41. Breastfeeding Committee of Canada. Baby-friendly facilities in Canada [Internet]. Drayton Valley (AB): BCC; 2018 [cited 2019 Feb 18]. Available from: http://breastfeedingcanada.ca/documents/DesignatedFacilitiesinCanada.pdf.

42. Statistics Canada. Maternal mental health in Canada, 2018/2019 [Internet]. Ottawa (ON): SC; 2019 [cited 2021 Aug 10]. Available from: https://www150.statcan.gc.ca/n1/en/daily-quotidien/190624/dq190624b-eng.pdf?st=TXmP1HnW.

43. Bayrampour H, Zahradnik M, Lisonkova S, Janssen P. Women's perspectives about cannabis use during pregnancy and the postpartum period: an integrative review. Prev Med. 2019;119:17–23.

44. Society of Obstetricians and Gynaecologists of Canada. Things you need to know about cannabis, pregnancy and breastfeeding [Internet]. Ottawa (ON): SOGC; 2019 [cited 2019 Feb 18]. Available from: https://www.pregnancyinfo.ca/wp-content/uploads/2019/02/CannabisPoster_EN.pdf.

45. Grossman MR, Lipshaw MJ, Osborn RR, Berkwitt AK. A novel approach to assessing infants with neonatal abstinence syndrome. Hosp Pediatr 2018;8(1):1.

46. Lacaze-Masmonteil T, O'Flaherty P, Canadian Pediatric Society, Fetus and Newborn Committee. Managing infants born to mothers who have used opioids during pregnancy. Paediatr Child Health. 2018;23(3):220–6.

47. Public Health Agency of Canada. What mothers say: the Canadian Maternity Experiences Survey. Ottawa (ON): PHAC; 2009.

48. Perinatal Services BC. Perinatal health report: deliveries in British Columbia 2016/17 [Internet]. Vancouver (BC): PSBC; 2018 [cited 2019 Jan 22]. Available from: http://www.perinatalservicesbc.ca/Documents/Data-Surveillance/Reports/Perinatal%20Health%20Report_BC_201617.pdf.

49. Canadian Institute for Health Information. Giving birth in Canada: a regional profile [Internet]. Ottawa (ON): CIHI; 2004 [cited 2019 Mar 5]. Available from: https://secure.cihi.ca/free_products/GBC2004_regional_e.pdf.

50. Canadian Institute for Health Information. Inpatient hospitalizations, surgeries, newborns and childbirth indicators, 2016–2017 [Internet]. Ottawa (ON): CIHI; 2018 [cited 2019 Mar 5]. Available from: https://secure.cihi.ca/free_products/hospch-hosp-2016-2017-snapshot_en.pdf.

51. Health Canada. Canadian perinatal health report 2003 [Internet]. Ottawa (ON): HC; 2003 [cited 2019 Jan 29]. Available from: http://publications.gc.ca/collections/Collection/H49-142-2003E.pdf.

52. Provincial Council for Maternal and Child Health, Better Outcomes Registry & Network. A user guide to the Ontario Perinatal Record [Internet]. Toronto (ON): PCMCH; 2018 [cited 2019 Feb 20]. Available from: http://www.pcmch.on.ca/wp-content/uploads/2018/08/OPR_UserGuide_2018Update_Final_18-08-22.pdf.

53. British Medical Association. A guide to effective communication: inclusive language in the workplace. London (UK): BMA; 2016.

54. Midwives Alliance of North America. Overview of the MANA core competencies revisions [Internet]. Montvale (NJ): MANA; 2016 [cited 2019 Feb 20]. Available from: https://mana.org/blog/Overview-MANA-Core-Competencies-Revisions.

55. National Aboriginal Council of Midwives. Bringing birth back: Aboriginal midwifery toolkit [Internet]. Montreal (QC): NACM; 2014 [cited 2021 Aug 10]. Available from: https://indigenousmidwifery.ca/wp-content/uploads/2018/10/Aboriginal-Midwifery-Toolkit.pdf.

56. Van Wagner V, Epoo B, Nastapoka J, Harney E. Reclaiming birth, health, and community: midwifery in the Inuit villages of Nunavik, Canada. J Midwifery Womens Health. 2007;52(4):384–91.