



CHAPTER 1

FAMILY-CENTRED MATERNITY AND NEWBORN CARE IN CANADA: UNDERLYING PHILOSOPHY AND PRINCIPLES



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CHAPTER 1

FAMILY-CENTRED MATERNITY
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PRINCIPLES OF FAMILY-CENTRED MATERNITY AND NEWBORN CARE

Family-centred maternity and newborn care (FCMNC) is a complex, multidimensional, dynamic process of providing safe, skilled and individualized care. It responds to the physical, emotional, psychosocial and spiritual needs of the woman, the newborn and the family. FCMNC considers pregnancy and birth to be normal, healthy life events and recognizes the significance of family support, participation and informed choice. The Public Health Agency of Canada along with maternal and newborn health experts developed the following evidence based guiding principles for FCMNC in Canada:

1. A family-centred approach to maternal and newborn care is optimal
2. Pregnancy and birth are normal, healthy processes
3. Early parent-infant attachment is critical for newborn and child development and the growth of healthy families
4. Family-centred maternal and newborn care applies to all care environments
5. Family-centred maternal and newborn care is informed by research evidence
6. Family-centred maternal and newborn care requires a holistic approach
7. Family-centred maternal and newborn care involves collaboration among care providers
8. Culturally-appropriate care is important in a multicultural society
9. Indigenous peoples have distinctive needs during pregnancy and birth
10. Care as close to home as possible is ideal
11. Individualized maternal and newborn care is recommended
12. Women and their families require knowledge about their care
13. Women and their families play an integral role in decision making
14. The attitudes and language of health care providers have an impact on a family's experience of maternal and newborn care
15. Family-centred maternal and newborn care respects reproductive rights
16. Family-centred maternal and newborn care functions within a system that requires ongoing evaluation
17. Family-centred maternal and newborn care best practices from global settings may offer valuable options for Canadian consideration

For references consult **Chapter 1: Family-Centred Maternity and Newborn Care in Canada: Underlying Philosophy and Principles** in: Public Health Agency of Canada. Family-Centred Maternity and Newborn Care: National Guidelines. Ottawa (ON): PHAC; 2017.

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TABLE OF CONTENTS

PRINCIPLE 1: A FAMILY-CENTRED APPROACH TO MATERNAL AND NEWBORN CARE IS OPTIMAL	1
PRINCIPLE 2: PREGNANCY AND BIRTH ARE NORMAL, HEALTHY PROCESSES	2
PRINCIPLE 3: EARLY PARENT-INFANT ATTACHMENT IS CRITICAL FOR NEWBORN AND CHILD DEVELOPMENT AND THE GROWTH OF HEALTHY FAMILIES	4
PRINCIPLE 4: FAMILY-CENTRED MATERNAL AND NEWBORN CARE APPLIES TO ALL CARE ENVIRONMENTS	5
PRINCIPLE 5: FAMILY-CENTRED MATERNAL AND NEWBORN CARE IS INFORMED BY RESEARCH EVIDENCE	7
PRINCIPLE 6: FAMILY-CENTRED MATERNAL AND NEWBORN CARE REQUIRES A HOLISTIC APPROACH	8
PRINCIPLE 7: FAMILY-CENTRED MATERNAL AND NEWBORN CARE INVOLVES COLLABORATION AMONG CARE PROVIDERS	11
PRINCIPLE 8: CULTURALLY-APPROPRIATE CARE IS IMPORTANT IN A MULTICULTURAL SOCIETY	12
PRINCIPLE 9: INDIGENOUS PEOPLES HAVE DISTINCTIVE NEEDS DURING PREGNANCY AND BIRTH	14
PRINCIPLE 10: CARE AS CLOSE TO HOME AS POSSIBLE IS IDEAL	16
PRINCIPLE 11: INDIVIDUALIZED MATERNAL AND NEWBORN CARE IS RECOMMENDED	17
PRINCIPLE 12: TO MAKE INFORMED CHOICES, WOMEN AND THEIR FAMILIES REQUIRE KNOWLEDGE ABOUT THEIR CARE	18
PRINCIPLE 13: WOMEN AND THEIR FAMILIES PLAY AN INTEGRAL ROLE IN DECISION MAKING	19
PRINCIPLE 14: THE ATTITUDES AND LANGUAGE OF HEALTH CARE PROVIDERS HAVE AN IMPACT ON A FAMILY'S EXPERIENCE OF MATERNAL AND NEWBORN CARE	21



PRINCIPLE 15: FAMILY-CENTRED MATERNAL AND NEWBORN CARE RESPECTS REPRODUCTIVE RIGHTS	21
PRINCIPLE 16: FAMILY-CENTRED MATERNAL AND NEWBORN CARE FUNCTIONS WITHIN A SYSTEM THAT REQUIRES ONGOING EVALUATION	23
PRINCIPLE 17: FAMILY-CENTRED MATERNAL AND NEWBORN CARE BEST PRACTICES FROM GLOBAL SETTINGS MAY OFFER VALUABLE OPTIONS FOR CANADIAN CONSIDERATION	25
CONCLUSION	26
REFERENCES	27

Overall, family-centred maternity and newborn care (FCMNC) is about increasing the participation of women and their families in the decision-making process concerning their pregnancy, birth, and early postpartum experiences, in order to promote optimal health and well-being for both mother and child.¹ It is sustained by an environment that promotes collaboration, partnership, respect, and information-sharing between women/families and their health care providers (HCPs).

FCMNC in Canada is based on the following 17 principles, some of which have underpinned the guidelines since their first edition, while others have been added as additional concepts and needs have emerged.



PRINCIPLE 1

A FAMILY-CENTRED APPROACH TO MATERNAL AND NEWBORN CARE IS OPTIMAL

Family-centred maternity and newborn care is a complex, multidimensional, dynamic process of providing safe, skilled and individualized care. It responds to the physical, emotional, psychosocial and spiritual needs of the woman, the newborn and the family. Family-centred maternal and newborn care considers pregnancy and birth to be normal, healthy life events and recognizes the significance of family support, participation and informed choice. This care reflects an approach rather than a protocol.²

Family-centred care, as described by Rush, has become a familiar phrase in today's maternity and newborn services; however, it can be difficult to consistently define and challenging to implement.^{2,3} A recent and ongoing American initiative to strengthen family-centred care states: "The goals for maternity care are best met by implementing a holistic, relationship-based model of care that is woman-centered, inclusive, and collaborative. Caregivers are included as dictated by the health needs, values, and preferences of each womanⁱ, taking into

account her social and cultural context as she defines it, and given consideration for evidence of effectiveness, value, and efficiency."^{4, pS13}

These Canadian guidelines endorse and promote further application of this concept to maternity and newborn care services. They incorporate recent approaches that focus not only on preconception, pregnancy, labour, birth and postpartum care of the healthy mother and child, but also on the specialized or intensive care that mothers or newborns may require. Most critically, they emphasize the importance of the family in conjunction with the mother-baby pair.

ⁱ For the purposes of these guidelines, the term *woman/women* refers to people who were assigned female at birth, recognizing that a participant's gender identity may differ from their anatomical, physiological or genetic assignment.

Indeed, FCMNC recognizes the support and participation of all those who the woman considers to be her significant others. The concept of *family* is broadly defined and not limited to those with a biological or matrimonial relationship. For example, families may vary from nuclear to multigenerational, from single-parent to those headed by couples (including same-sex couples), and incorporate additional support people who may include friends. Family-centred care is not a singular intervention, but an approach to care that recognizes the strengths and needs of women and their families and the essential roles that family members and friends play in promoting health and managing illness.⁵

Canadian families are increasingly diverse.⁶ Many women who give birth in Canada were themselves born outside of the country and speak languages other than English and French. Many also belong to visible minority groups, are not married but cohabiting, or are part of a lone-parent family.⁷ Women are having babies

at an older age, and the Canadian fertility rate continues to decline except among Indigenous populations. Indigenous Peoples represent the fastest growing young demographic in the country and have a fertility rate twice that of the non-Indigenous population.⁸ More and more mothers of young children are in the work force, and although mothers still provide the bulk of the care of young children, fathers are playing a rapidly expanding role, with 11% of stay-home parents being fathers.⁷

In addition, many Canadian families are experiencing stress due to economic insecurity and a lack of balance between their work and family life. Some Canadian families are at higher risk of poorer health due to poverty, such as Indigenous families, female lone parents, parents with disabilities and some recent immigrant families. Children from these families are up to 2.5 times more likely to live in poverty than all other children in Canada.⁹



PRINCIPLE 2

PREGNANCY AND BIRTH ARE NORMAL, HEALTHY PROCESSES

Family-centred maternal and newborn care is based on respect for pregnancy as a state of health and for childbirth as a normal physiological process. It is a profound event in the life of a woman and her family. HCPs are encouraged to support this normal physiological process. The use of medical interventions should be judicious and appropriate.

For most women, pregnancy is a normal, healthy process that will progress smoothly to the birth of a much-welcomed baby. Supported by family and friends, pregnancy, birth and the arrival of a newborn into the family is most often a fulfilling, happy experience. It is well acknowledged that medication and interventions should be used judiciously during pregnancy. Interventions

in labour and birth have, however, become increasingly common in recent decades and require special consideration.¹⁰

In 2008, a joint policy statement to “support best practice and serve to promote, protect, and support normal birth” was issued by the SOGC, the College of Family Physicians of Canada,

the Canadian Association of Midwives, the Association of Women's Health, Obstetric and Neonatal Nurses-Canada, and the Society of Rural Physicians of Canada.^{11, p1163} This statement expressed concerns about the increasing use of interventions during childbirth. These concerns are consistent with position statements from professional organizations in other countries and regions, including the United Kingdom (UK), Europe and the United States (US).^{12,13}

The NICE Guidelines for intrapartum care of healthy women and their babies conclude that healthy women are safer giving birth at home or in a midwife-led unit than a hospital, where the use of interventions in labour and birth is likely to be higher.¹⁴ Comparisons of intervention rates between the UK, the US and Canada indicate that North American intervention rates are considerably higher than in the UK.^{15,16} Not only is an environment where intervention rates are lower potentially safer for mothers and babies, but rates of maternal satisfaction with their birth experiences among Canadian mothers are higher when fewer interventions are used.^{14,17} As a foundational piece promoting normal childbirth, the Regional Office for Europe of the World Health Organization (WHO) included the need to *de-medicalize* care during pregnancy and childbirth as the first of its *10 Principles of Perinatal Care*.¹⁸

There is, however, disagreement among and within professional organizations about the definition of *normal birth*. For example, the joint Canadian statement specifies that:¹¹

- *Natural childbirth* involves little or no human intervention;
- *Normal birth* excludes elective induction before 41 weeks, spinal analgesia, general anesthetic, forceps or vacuum assistance, caesarean section, routine episiotomy, fetal malpresentation and continuous electronic fetal monitoring for low-risk birth;
- *Normal labour* is spontaneous in onset at 37–42 weeks and results in a normal delivery, can include analgesia and routine oxytocic for the third stage;

- *Normal delivery* refers only to the vaginal delivery of the infant and may include interventions such as induction, augmentation, electronic fetal monitoring, and regional analgesia.

On the other hand, in their joint statement on making normal birth a reality, the UK-based Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives and the National Childbirth Trust:¹²

- Does not distinguish between *natural* and *normal* delivery;
- Refers to normal labour and birth as *normal delivery*;
- Defines *normal delivery* as without (before or during delivery):
 - > Induction;
 - > Use of instruments;
 - > Episiotomy;
 - > Caesarean section;
 - > Epidural, spinal or general anesthesia.

Even with the broad definition used by the joint Canadian statement, most Canadian women do not experience *normal birth*. According to the recent *Maternity Experiences Survey (MES)*, 26% of the women surveyed had experienced caesarean births; among those who attempted or had a vaginal birth, 21% had experienced episiotomies and 63% had experienced continuous electronic fetal monitoring.¹⁹ In the UK, 48% of women who gave birth in England and 40% in Scotland met the more stringent RCOG definition of *normal birth*.¹²

Striving for an ideal of health care and a definition of normal birth that minimizes unnecessary interventions, optimizes judicious use of effective and proven interventions, and promotes natural events as the norm remains a goal for Canada.



PRINCIPLE 3

EARLY PARENT-INFANT ATTACHMENT IS CRITICAL FOR NEWBORN AND CHILD DEVELOPMENT AND THE GROWTH OF HEALTHY FAMILIES

Promoting attachment is central to family-centred care and is facilitated by encouraging early parent-infant interaction, initiating skin-to-skin contact at birth and breastfeeding. Supporting early attachment will have immediate and lasting effects on the health of mothers, infants and families.

The development of parent-infant attachment begins long before birth and continues long afterwards. The psychological transition to parenthood is influenced by a number of factors including maternal and paternal characteristics, sibling and grandparenting relationships, diverse cultural practices, and emotional adjustments, among others.²⁰

Parent-infant attachment can be significantly facilitated by events at the time of birth and in the following months. Physical contact with the mother (and other parent) as soon as the baby is born, preferably uninterrupted and skin-to-skin, for the first hour or more after birth, is optimal for all births, both vaginal and caesarean. Ideally, routine maternity and newborn care procedures are delayed to allow for parent-infant time together. If a procedure is medically necessary, they can be done while the newborn remains skin-to-skin if it is medically safe to do so. Thereafter, rooming-in 24/7, care by parents and baby-led (demand or cue-based) feeding is preferred to enhance parent-infant attachment. Family-centred care supports early mother-infant contact and successful breastfeeding as the early mother-infant dyad experience profoundly affects infant and child development and the health of the family.²¹⁻²⁷

In Canada, 86% of mothers who had vaginal births report holding their babies within 5 minutes of birth, but only 29% of mothers who gave birth by caesarean birth report holding their newborns within the same time. However, only 39% of women who had vaginal births and 8% of those who had caesarean births held their babies skin-to-skin at this time. While 71% of women report 24-hour rooming-in after vaginal birth, only 47% of mothers who gave birth by caesarean birth do so. Half of all mothers (50%) report baby-led breastfeeding.¹⁹

The WHO and the United Nations Children's Fund's (UNICEF) emphasize the importance of skin-to-skin, mother-infant contact at birth to facilitate breastfeeding. The Baby-Friendly Hospital Initiative (BFHI), including its *Ten Steps to Successful Breastfeeding*, was initiated by WHO and UNICEF to protect, promote and support breastfeeding.²⁸ Consistent with the WHO and UNICEF, Health Canada and other Canadian professional bodies (including the Public Health Agency of Canada, the Canadian Paediatric Society, the Breastfeeding Committee for Canada, and Dietitians of Canada), recognize breastfeeding as *the normal and unequalled method of feeding infants* and recommend breastfeeding exclusively for the

first 6 months, and sustained for up to 2 years or longer with appropriate complementary feeding. Breastfeeding is important for the nutrition, immunologic protection, growth, and development of infants and toddlers.²⁹ Both mothers and infants benefit from breastfeeding.³⁰

In Canada, the BFHI is called the Baby-Friendly Initiative (BFI), and it describes a continuum of care for hospitals and community health services in 10 evidence-based steps designed to optimally support breastfeeding and maternal-child health for all mothers and babies.³¹⁻³³ Breastfeeding is being re-established as the cultural norm in Canada. An encouraging rate of 90% was reported both for women who intended to initiate, and who actually initiated, breastfeeding. Significant challenges still exist, however, regarding exclusivity and duration rates. A little over half (52%) of Canadian women reported exclusively breastfeeding their infants at 3 months of age and only 14% at 6 months. Within 1 week of birth, 21% of breastfeeding mothers added other liquids to their baby's diet and 25% by 14 days

of birth. Breastfeeding rates also varied widely with maternal age and across Canada, with rates higher among older mothers and higher in western Canada compared with eastern Canada.¹⁹

“ The development of parent-infant attachment begins long before birth and continues long afterwards.

Early infant-parent attachment has long-lasting effects on the psychological development of infants and their future relationships including parenting, ability to deal with stresses and self-perceptions. Programs and services for families that focus on encouraging evidence-based attachment practices during pregnancy and birth and through the early years are encouraged.³⁴



PRINCIPLE 4

FAMILY-CENTRED MATERNAL AND NEWBORN CARE APPLIES TO ALL CARE ENVIRONMENTS

Family-centred care applies equally in low-risk and in higher-risk environments, including care of sick or preterm newborns and of mothers who require intensive or specialized care.

Family-centred care for postpartum mothers and their healthy newborns has been encouraged for some decades in Canada and is well established across the country. For example, 95% of hospitals have policies that support rooming-in for at least 19 to 24 hours a day.³¹ Recent NICU initiatives encourage a newborn/family-centred care model

that includes *kangaroo care*, which advocates skin-to-skin contact, as well as programs that cluster newborn interventions and minimize environmental disturbances.³⁵ One such example is the Newborn Individualized Developmental Care and Assessment Program (NIDCAP).³⁶

Extensive skin-to-skin care of babies in the NICU has a positive effect on earlier discharge, improved breastfeeding initiation and duration, and on morbidity including fewer severe infections or sepsis, fewer cases of hypothermia, and fewer severe illnesses at the 6-month follow-up.³⁷⁻³⁹ Nevertheless, although 79% of hospitals in Canada have policies that encourage mothers to hold their NICU infants skin-to-skin (sometimes with restrictions based on infant health), only 37% of hospitals report that almost all NICU babies are held this way.³¹

“ **Family-centred care applies not only to NICUs but to all the environments and centres where mothers and babies receive care.** ”

Ninety-six percent of Canadian maternity hospitals encourage breastfeeding of babies in NICUs. However, in practice only 52% of hospitals report that almost all babies in their NICUs are breastfed. A further 37% of hospitals report that more than half their infants are breastfed once their suckling and swallowing reflexes are coordinated.³¹

Parental rooming-in for 24 hours a day and significant care of the baby in the NICU by parents has been shown to improve infant growth, facilitate earlier discharge, support breastfeeding and encourage maternal confidence and competence. Although this approach is advocated by the Family-Centred/Humane Perinatal Care Initiative, it is still not extensively implemented in Canada.^{40,41} The *Canadian Hospitals Maternity Policies and Practices Survey (CHMPPS)* revealed that only 8% (11/134) of hospitals surveyed reported that 24/7 rooming-in is possible throughout the baby's NICU hospital stay.³¹ Further initiatives supporting 24/7 rooming-in of either or both parents with a newborn who requires special care are encouraged, in line with family-centred care principles.

In addition, single-room family care is emerging as a potential model for the design of new NICU units. Reported benefits include reduced environmental noise, increased parental involvement, improved breastfeeding outcomes, reduced infections, shorter length of stay and increased staff satisfaction. Single-room family care is a good fit with the theoretical underpinnings and philosophy of family-centred care.⁴²⁻⁴⁶ However, both the provision of single-room care and the philosophy of a family-centred approach are needed to promote optimal outcomes.

Family-centred care applies not only to NICUs but to all the environments and centres where mothers and babies receive care. This includes special or intensive care of mothers from the prenatal period through to readmission postpartum for both mothers and babies following discharge. Optimal care in these situations includes caring for mother and baby together. For example, mothers with severe depression who require hospital admission and observation are ideally cared for together with their newborns, with appropriate safety concerns addressed.

“ **Extensive skin-to-skin care of babies in the NICU has a positive effect on earlier discharge, improved breastfeeding initiation and duration, and on morbidity...** ”

Family-centred care in higher-level care settings creates new challenges. These include difficulties for families living in rural and remote areas, and for those with other home or community commitments as well as parental leave limitations. Systems will need to adapt in order to provide family-centred care in situations that do not traditionally allow for this.



PRINCIPLE 5

FAMILY-CENTRED MATERNAL AND NEWBORN CARE IS INFORMED BY RESEARCH EVIDENCE

These national guidelines are based on the best available evidence. HCPs are encouraged to base their practice decisions on current evidence and to facilitate the process of integrating new evidence into practice.

Optimal care during pregnancy and birth uses the fewest possible interventions, and decisions for intervening are based on the best available evidence. Quantitative and qualitative research methods provide this evidence, though no single methodology is able to answer every type of research question. Existing evidence strongly argues, however, that when a choice is possible, the more natural and less invasive option is preferable.¹¹

Both the *MES* and the *CHMPPS* revealed wide-ranging rates of intervention usage in labour and birth across Canada's 13 provinces and territories.^{19,31} Rates of caesarean births, epidurals, continuous electronic fetal monitoring, supine position for delivery, episiotomies and perineal stitching, among others, differ considerably.⁴⁷ Similarly, a recent examination of regional variations in caesarean birth rates among women in the English National Health Service trusts revealed that maternal characteristics and clinical risk factors account for little of the variability.⁴⁸ These wide variations suggest that use of interventions is not always based on evidence or on medical need. Rather, it may be influenced by a variety of other factors, including the types of HCPs most commonly found in different regions, hospital size, availability of resources, maternal access to care, rural or urban residency, long-established ways of providing care, local cultural

variations, medico-legal concerns, availability of technology, and maternal demographic variables. How maternity care is organized or reimbursed, how and where providers are trained and prevailing attitudes toward pregnant women and their families may also influence practice.

The application of evidence-based practice is relevant to all families, regardless of socioeconomic status. The *MES* findings raised concern that women living in households at or below the low-income cut-off experience different rates of interventions in labour and birth, compared to women in higher-income groups. They were more likely to be shaved, given enemas, have their abdomens pushed on during birth and lie in a supine position for birth, all of which are unproven (if not potentially harmful) practices.¹⁹

Best available evidence applies not only to labour and birth but also to preconception, prenatal and postpartum care. At the same time, several aspects of prenatal care remain under debate, including the optimal number of prenatal visits, the value of routine first trimester ultrasounds when menstrual period dates are known, the routine weighing of women at each prenatal visit, the recommended weight gain advised for women at various body mass index levels, and routine iron supplementation in pregnancy.

Implementation of the BFI within Canadian hospitals serves as a benchmark example of the often-slow process of translating evidence-based knowledge into practice. Launched by WHO and UNICEF over 20 years ago (as the BFHI), the initiative was expanded in Canada to include baby-friendly community health services in

addition to maternity centres. However, despite the strong evidence from randomized controlled trials of its benefits and the endorsement from our professional bodies of breastfeeding according to WHO/UNICEF global standards, very few Canadian maternity hospitals are currently designated as *baby friendly*.^{28,31,33,49,50}



PRINCIPLE 6

FAMILY-CENTRED MATERNAL AND NEWBORN CARE REQUIRES A HOLISTIC APPROACH

Family-centred maternal and newborn care addresses biological, social, psychological, cultural and spiritual well-being.

FCMNC is in keeping with the internationally accepted WHO definition that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”^{51, p1}

For the sake of practicality, these guidelines follow the convention of viewing maternal and newborn care in discrete clinical segments covering preconception (including interconception), pregnancy, birth, and the 6-week postpartum period. The guidelines also recognize the importance of exclusive breastfeeding for the first 6 months of life and then sustaining it for up to 2 years or longer.

However, this kind of practical segmentation should not minimize the importance of considering and applying FCMNC, in practice, as an interrelated and interdependent continuum of care. Indeed, an even more holistic approach to FCMNC would see this continuum extend throughout the reproductive years.

SOCIAL ISSUES

Providing effective care for families moving into parenthood involves addressing social determinants of health. The most effective interventions occur at the population health level, by responding to such issues as food insecurity, affordable housing and a living wage. This requires the creation of stronger social safety nets for families and healthy public policy and environments supportive of healthy lifestyles. Less effective but still important are interventions at the individual level, for example, interventions addressing lifestyle choices.⁵²

Society can contribute to the parents’ state of confidence, excitement and happiness during pregnancy and, in particular, after birth. Although extended families often provide considerable assistance, our increasingly mobile nature means that many families can no longer exclusively rely on such traditional support systems. Most communities offer numerous

local networks that provide women and their families with information and social support as well as extensive opportunities to share with and learn from other women or families with similar experiences. These facilities can be immensely helpful and supportive to those embarking on parenthood.

PSYCHOLOGICAL NEEDS

Preparation for pregnancy, birth and parenthood: Psychological preparation for the transition to parenthood is an integral component of family-centred care. Concerns about pregnancy, labour, birth, the postpartum period and parenting can arise at any time. Families rely on a number of resources to help them resolve these issues—HCPs, family and friends, the Internet and media, books, prenatal preparation classes and multiparas' previous pregnancy experiences.

“ **Women should have continuous support throughout labour and birth as this corresponds with clinically meaningful benefits.** ”

Thirty percent of Canadian maternity hospitals provide prenatal classes for families, and courses are also offered through community health services, by individual HCPs and, increasingly, online.³¹ However, only two-thirds of all primiparous women (66%) attended prenatal education classes.¹⁹ Both the training/education of prenatal educators and curricula of preparation programs suffer from a lack of standardization, allowing gaps to develop. For example, information on preparing for unexpected outcomes (including caesarean births) is often lacking despite the fact that 26% of women in Canada experience surgical delivery.^{31,53} Monitoring of the outcomes and effectiveness of courses and programs is hampered by their wide variability.

The role of fathers: Although fathers are increasingly encouraged to be involved in pregnancy, birth and parenthood, guidance is limited regarding their roles or their adjustment to them. In 2007, about one-quarter (27%) of Canadian fathers took parental leave and the same number were stay-at-home parents in 2008.⁵⁴

The few studies that have examined the role of fathers suggest that paternal involvement during pregnancy may have important implications for maternal prenatal health behaviours and the health of the fetus and newborn, including a positive influence on attending prenatal care, abstinence from alcohol and smoking, and reduction in low birth-weight and small-for-gestational-age infants.⁵⁵ Involving fathers also contributes to more beneficial infant-feeding practices.⁵⁶ However, research has shown that men have needs of their own that require support during the transition to parenthood—such as addressing feelings of fear, frustration and exclusion—and that these are not always fully considered.⁵⁷ Additional research into what fathers are experiencing is needed.

Support in labour and birth: Encouraging companionship for women from family members or other supportive people during labour has been one of the most significant psychological contributions to the experience of birth for families in recent decades. The *MES* revealed that most Canadian women were accompanied by their husband or partner during labour (95%) or birth (92%) while about one-third (36%) were supported by a companion other than their partner.¹⁹

Meta-analyses of studies in this area conclude that all women should have continuous support throughout labour and birth as this corresponds with clinically meaningful benefits, including increased frequency of spontaneous vaginal birth; shorter labours; and less likelihood of intrapartum analgesia, caesarean birth, instrumental vaginal birth, regional analgesia, low 5-minute Apgar score or reported dissatisfaction.⁵⁸

Stress and depression during preconception, prenatal and postpartum:

Psychological concerns or stresses do arise during a family's transition to parenthood, even when the pregnancy and birth are normal and healthy. The *MES* examined the amount of stress experienced by women in the year before giving birth. About one-fifth (17%) reported experiencing 3 or more stressful life events in this period, and almost 13% reported that most days were very stressful in the 12 months before their baby was born. The majority (87%) of women did, however, have support available to them all or most of the time during their pregnancy, which helped them to cope with such stresses.¹⁹ For many, adjusting to the events experienced during pregnancy, birth and new parenthood is stressful. Discussions held soon after birth that encourage women and their families to review their birth experiences and the challenges they faced in the days immediately following birth, may contribute to their adjusting more easily to breastfeeding and parenthood.⁵⁹ Additional problems can include emotional distress, such as the postpartum blues that occur in up to 80% of women, depression that emerges in approximately 10% to 20% of new mothers, or more severely and rarely, psychosis (in fewer than 1% of women).^{19,60} Coming to terms with prenatal and perinatal loss due to miscarriage, stillbirth and infant death, a preterm birth or the birth of a baby with special needs is also difficult. There is a link between the hospitalization of an infant and the development of depression or anxiety in parents.^{61,62} Families whose infants are hospitalized should have access to mental health support.

Women and families who have pre-existing psychological or psychiatric concerns, including severe depression or addiction to alcohol, drugs or other substances, can face serious difficulties. Physical or sexual abuse before, during or after pregnancy also potentially makes transitioning to parenthood more difficult.⁶³ The *MES* found that 11% of women report physical or sexual abuse in the 2 years prior to the survey, with younger, less well-educated and lower-income women

reporting abuse more often than older, better-educated and higher income women.¹⁹ Caring for families facing any of these challenges is central to ensuring the emotional health of mother and newborn. Extended family and friendship support can play an important role in this regard as well.

There is no specific category of HCP in Canada dedicated to assisting parents (and their caregivers) with such psychological adjustments.⁴⁰ In the absence of perinatal health psychologists, for example, these concerns become the responsibility of any or all professionals (or family members/friends) caring for women and their families during the transition to parenthood. Women with more debilitating problems require referral to specialist care providers, such as a psychologist or psychiatrist.

Infant mental health: Infant mental health promotion aims to ensure a sense of security and self-esteem and the ability to form satisfying relationships, to engage successfully with the world and to learn and develop throughout life. Supporting families during the preconception, pregnancy, birth and early postpartum months is central to promoting infant mental health. Parental stress and mental health pathologies during the perinatal period can adversely affect the parent-infant relationship, leading to concerns about infants' mental health development.⁶⁴ Infant mental health initiatives have been introduced internationally and are encouraged in Canada.

SPIRITUAL NEEDS

The spiritual beliefs and practices of diverse cultural groups need to be considered in both normal pregnancies and those with adverse outcomes. While clinical care remains paramount, respect of an individual's spiritual traditions is also important. Such practices might involve support from spiritual leaders, wearing or maintaining contact with a symbol of spiritual importance, or observing traditional rituals.



PRINCIPLE 7

FAMILY-CENTRED MATERNAL AND NEWBORN CARE INVOLVES COLLABORATION AMONG CARE PROVIDERS

Successful application of family-centred maternal and newborn care requires collaborative contributions among a wide range of care providers including (but not limited to) midwives, family doctors, obstetricians, neonatologists, pediatricians, nurses, nurse practitioners, anesthetists, childbirth and parenting educators, doulas, breastfeeding advisors, social scientists and community supports.

Care during pregnancy and birth is often seen as the domain of nurses (including nurse practitioners), midwives, family physicians, and obstetricians. This concept has been expanded to include those who care for the psychological, social, and cultural needs of women. Members of the team caring for women may include psychologists, social workers, doulas, breastfeeding advisors, and community health/health promotion workers. Ideally, all of these professionals contribute and collaborate to provide family-centred care, based on the needs and preferences of the woman and her family.

According to the *CHMPPS*, 72% of births in Canada were attended by obstetricians, 25% by family physicians, and 3% by midwives.³¹ Although the application of interprofessional maternity care could help to close gaps in health human resources, a recent survey of more than 1700 Ontario midwives, family physicians and obstetricians revealed multiple barriers to collaboration, including divergent philosophies of care as well as liability and insurance issues. Factors that encourage collaboration included improvements to on-call arrangements and obstetrical back-up.⁶⁵ However, current practices often keep these professional groups apart, including educational settings and the

preponderance of single-discipline professional bodies and conferences. Alternate models that encourage interprofessional interactions in teaching programs, journals and publications, as well as within professional associations and conferences, could provide additional momentum to strengthening successful integration of care services. A number of Canadian universities are beginning to explore interprofessional educational courses with some success.^{66,67}

Hospitals address the complexities of interprofessional care in different ways, including the application of education and quality assurance programs that have the potential to improve interprofessional communication and maternal-newborn outcomes. The *CHMPPS* revealed that 67% of hospitals regularly schedule interprofessional meetings that may include mortality and morbidity rounds and collective discussion of the operations and functions around labour and birth. Of the hospitals surveyed, 75% indicated they have an established system for resolving issues between nurses, midwives, obstetricians and family doctors when they work as a team.³¹ While these figures represent the major categories of maternity HCPs in Canada, they do not account for the full array of professionals who contribute to maternity and newborn care.

The growing contribution to health care by lay health workers is increasingly being recognized. A Cochrane Review examining maternal-child health and the management of infectious diseases concluded that the involvement of lay health workers provided promising benefits in promoting immunization uptake and breastfeeding and reducing child morbidity and mortality when compared to standard care. As such, integrating the activities of professional and lay health workers could further strengthen maternal and newborn care.⁶⁸ The integration of public health and hospital or related maternity health care services is equally important. Particular benefits accrue from home visits.^{66,67,69}

The interface between conventional and alternative/complementary/natural therapies is an emerging issue. The rapidly growing adoption of these alternatives in everyday life has filtered through to maternity care as well. A recent literature review identified the need for greater respect and cooperation between conventional

and alternative practitioners, as well as for improving communication between all maternity care providers and their patients regarding the use of alternative/complementary medicine.⁷⁰

In principle, it is best to choose an HPC with the optimum skills for the level of care required. Ideally, normal pregnancies and births are left in the hands of primary care providers (midwives or family physicians) whereas the development of complications calls for the intervention of specialists. The types of HCPs and maternity care centres available, geographical limitations, available transport options in case of need, as well as a woman's personal and family preferences, will naturally influence these choices. Whatever caregiver option the woman and her family choose, interprofessional collaboration is necessary for optimal maternal and newborn safety, particularly when care is transferred to or shared with alternate professional group members.



PRINCIPLE 8

CULTURALLY-APPROPRIATE CARE IS IMPORTANT IN A MULTICULTURAL SOCIETY

Family-centred maternal and newborn care respects cultural differences between individuals, families and communities, all while following the essential principles of care.

One in five Canadians is foreign-born—the highest proportion in 75 years.⁷¹ *Cultural safety*, a concept that is increasingly being highlighted within the Canadian health care system, encourages HCPs who work with families from different cultural backgrounds to communicate respectfully and without stereotyping.^{72,73} HCPs who integrate a cultural safety perspective into their practice develop a critical understanding of culture and how this relates to maternal-child

health.⁷⁴⁻⁷⁷ *Cultural competence* focuses on the skills, knowledge and attitudes of practitioners. Cultural safety goes one step further by promoting partnership in a person's care. The key to practising cultural safety is self-reflection and building trust and respect.⁷⁶ Furthermore, cultural safety involves being aware of the power disparities in health care delivery, i.e., that providers have *power* over patients.⁷⁵

Traditional practices should be considered with sensitivity and tolerance and should be encouraged unless they are evaluated as harmful. Condemning or discouraging such practices simply because they are *different* is inappropriate. Although practices may not directly contribute to biological health, they might be important factors for psychological well-being. Even when cultural practices are regarded as harmful, sensitivity and understanding is needed when providing care to women who practise them. Research suggests that this is not always the approach taken. A Canadian study of women with previous female genital cutting who were giving birth revealed that 88% of the 432 women interviewed reported hurtful, embarrassing or offensive comments made to them. Over 50% had caesarean births although fewer than 1% wanted them.⁷⁷ Even when cultural differences are valued and respected in society, ignorance and prejudice may play a disconcertingly large role. It is important to prepare HCPs so that they can offer culturally safe care. This involves training in the humanities or psycho-social cultural issues.

Given the multicultural nature of Canadian society, it is important that health care services and educational programs recognize and respond to individual cultural factors while attending to the health needs and expectations that apply to all. While it may be unrealistic that providers become familiar with every characteristic of each of the more than 100 cultural groups that make up the Canadian mosaic, it is reasonable to expect that many of the more common distinctive cultural differences can be learned and addressed.⁷⁸ It is equally important to raise awareness about the similarities between cultures in particular, the universal need for respect, dignity, sensitivity, and understanding.⁷⁹

A significant proportion of women who give birth in Canada (14% in 2011) speak a language other than English or French most often at home.⁷¹ Some are unable to communicate with HCPs in a common language. Solutions to this challenge include using printed or audio/visual translated materials, or having family, professional interpreters or cultural brokers serve as an

intermediary. Translated materials are limited to a predetermined set of information, while interpreters or translators are limited by a lack of trust in their ability, linguistic or otherwise, to precisely convey the information.⁸⁰ Although partners and children in an immigrant family are often the first to acquire the local language, having them interpret in the case of maternity care is often inappropriate.

The *CHMPPS* revealed that 21% of hospitals had developed written guidelines for providing patients with culturally-appropriate care. More than half (53%) of the surveyed hospitals indicated that none of their staff had received in-service education programs on cultural sensitivity. The most commonly provided services for women with cultural and /or linguistic needs were language interpretation services (71%), support for customs and rituals (70%), special dietary provisions (59%), and translation of written materials (44%).³¹

“ HCPs who integrate a cultural safety perspective into their practice develop a critical understanding of culture and how this relates to maternal-child health.

Recent migrants often have particularly distinctive health and perinatal health concerns. Many migrant groups are at greater than average risk for inadequate prenatal care, gestational diabetes, pre-eclampsia, low birth-weight, emergency caesarean birth, and stillbirth. The reasons for these and other differences remain unclear, although health services delivery is believed to play an important role independent of biomedical explanations.^{78,81-84} Eligibility for health care coverage for refugee and migrant women will depend on their immigration class, status, and current federal and provincial/territorial laws and regulations.

Other perinatal health care challenges faced by recent refugee or migrant women may include:⁸⁵⁻⁸⁸

- Increased likelihood of recent exposure to violence;
- Separation from husbands, children, or other family members;
- Perceptions of the role of partners in decisions about their care that may conflict with that of the health care system;
- Difficulty adjusting to the climate;
- Transportation challenges;
- Difficulty scheduling appointments;

- Lack of available childcare;
- Not fully understanding the rationale for referrals to different care providers;
- Barriers to communication;
- Lack of familiarity with care systems;
- Perceptions of discrimination, or unkind and disrespectful (culturally unsafe) care.

Like all women, immigrant and refugee women seek safe, high-quality, respectful, compassionate, attentive, and individualized care, with optimal information and support.



PRINCIPLE 9

INDIGENOUS PEOPLES HAVE DISTINCTIVE NEEDS DURING PREGNANCY AND BIRTH

Because of their distinct cultures, as well as their particular historical experiences and frequently remote geographical locations, Indigenous Peoples in Canada have particular care needs in the preconception period, during pregnancy, at birth and postpartum.

More than one million Canadians—over 3% of the population—identify themselves as Indigenous. Between 1996 and 2006, the Indigenous population grew by 45%, nearly 6 times faster than the 8% increase in the non-Indigenous population.⁸⁹

INDIGENOUS COMMUNITIES

Socioeconomic marginalization, along with the poor health status of many Indigenous women, has been well researched and documented. Indigenous Peoples continue to be affected by the history of residential schools and forced colonization. The lasting effects of this include mistrust of western medical and educational systems as well as a cycle of violence in many Indigenous communities.

The health and well-being of many Indigenous women have been undermined by racism, sexism, poverty, unemployment and culturally inappropriate or inaccessible health services.⁹⁰ When working with Indigenous women and their families and communities, HCPs must take these barriers into account and prioritize information sharing, partnership and collaboration. Providers also need to understand the historical context in order to promote and communicate effective strategies for cultural safety within their own organizations.^{73,76,91,92}

HEALTH DISPARITIES

Overall, the health disparities between Indigenous Peoples and other Canadians are widespread and largely influenced by socioeconomic factors, including vast differences in income, education and occupational opportunities, environmental factors as well as frequent geographical isolation and limited access to health care services.⁷³

In 2001, the estimated average life expectancy for the total Canadian population was 77 years for men and 82 years for women. However the estimated average life expectancy was 70 years for Indigenous men and 77 years for Indigenous women.⁷⁶ HCPs need to appreciate these health determinants and consider what strategies can be implemented in partnership with the community in order to address the health disparities identified by the community.^{75,76,93}

INDIGENOUS WOMEN'S PREGNANCY AND BIRTHING EXPERIENCES

The psychological, physical and sexual abuse experienced by children in residential schools, together with the breakdown of traditional family life resulting from the policies of forced assimilation, have left their mark on many Indigenous families and disrupted traditional pregnancy and birth-related events.⁹⁴ However, a growing pride and respect for Indigenous culture and traditions have resurfaced recently, and this has influenced childbearing issues.⁹³ Among Inuit in Canada, as with other Indigenous populations living in the territories, replacement of traditional birthing practices with a biomedical model that requires evacuation to southern metropolitan hospitals has increased tension in the communities.⁹⁵ The proportion of women giving birth far from their homes is high. As many as 40% of women in the Northwest Territories, 23% in Yukon and 38% in Nunavut travelled more than 100 kilometers to give birth.¹⁹ Evacuation for childbirth has deleterious psychological, social and cultural effects, and support for traditional communal birthing combined with biomedical techniques and technology is considerable.⁹⁵ Establishment

of a culturally-appropriate doula program and in-hospital visits by First Nations elders were more desirable approaches to these women than access to tele-visitation with family members.⁹⁶

Hospital-based maternity care programs for Indigenous women in remote communities need to achieve a balance of clinical and cultural safety.⁹⁶ Outcomes are better with less travel to outside communities, but where travel is necessary, social, emotional and financial supports need to be considered.^{97,98} For women at low risk of complications, returning birthing to the community, with appropriate training and protocols in place, is supported and encouraged.⁹⁸

Community birthing centres that integrate traditional techniques with biomedical support have recently been established in Nunavik and Nunavut.⁹⁵ For example, Inuulitsivik midwifery service and education program is an internationally recognized approach to returning childbirth to the remote Hudson Bay-coast communities of Nunavik. The service is seen as a model of community-based education of Indigenous midwives, integrating both traditional and modern approaches to care and education. It is integrally linked to community development, cultural revival and healing from the effects of colonization. It involves effective teamwork between midwives, physicians and nurses working in the remote villages and at the regional and tertiary referral centres. Evaluative research has shown improved outcomes for this approach.⁹⁹

The *Report of the Royal Commission on Aboriginal [Indigenous] People* stated that Indigenous “women who are pregnant need culture-based prenatal outreach and support programs, designed to address their particular situation and vulnerabilities.”^{100, p 122} In addition, Indigenous women often have little or no prenatal care, putting them at a higher risk.⁹² A culturally safe model of delivering prenatal care that is family-centred and designed to empower the expectant mother, her family and the community includes addressing barriers

such as lack of transportation and childcare, fear of being judged for lifestyle choices, and fear of the health care system due to historical legacies. A holistic care model for the mother, the father and the family that coincides with the teachings of the *Medicine Wheel* implements mental, emotional, spiritual and physical wellness through health assessment, education, and support, and strengthens relationships between

the mother and her HCP.^{74,93} “Services that are provided on a continuum of care involving community agencies, health professionals, social workers, life support counselors and [Indigenous] community elders” strengthen culturally-based care.^{75, p 40} Childbearing practices that include respect for and appreciation of these long-established cultures should be actively encouraged and welcomed.



PRINCIPLE 10

CARE AS CLOSE TO HOME AS POSSIBLE IS IDEAL

Ideally, every woman and newborn in Canada would have access to family-centred maternal and newborn care as close to home as possible, with seamless transition to specialized care when appropriate.

Based on total area, Canada is the second largest country in the world, with populations found in both rural areas and urban centres.¹⁰¹ As a result, about one-quarter of all Canadian women report travelling to another city, town or community to give birth.¹⁹ The availability of local maternity care services and the mother’s obstetric and medical health and preferences may influence whether she travels far from home to give birth. Travel to distant centres may result in negative outcomes both in terms of clinical morbidity and travel hazards.^{102,103} Such travel may have an emotional impact as well as increase costs both for families and for the health care system.¹⁰²⁻¹⁰⁶ In contrast, care close to home may offer more culturally and psychologically appropriate options. In addition, such care can be clinically safe, even in centres without caesarean birth facilities, provided that safety systems (including transport) are available.¹⁰⁷

A range of professional services may be required to optimize care in rural communities including public health, acute care, community and mental health programs; laboratory and diagnostic imaging services; breastfeeding, neonatal and child health programs; and transport, among others. Effective rural care requires innovative interprofessional models that provide high-quality, collaborative, integrated, woman- and family-centred, culturally sensitive and respectful care.⁹⁷ It is widely accepted that a well-organized network of high-risk perinatal services, situated so that they are not too far from where women live, can contribute to better outcomes.¹⁰² Services need to be planned within a strategy that crosses professions, ministries and funding envelopes.

Training midwives, nurses and physicians in collaborative practice is essential for care in rural and remote communities. The type of HCP is not as important as the skills they possess, as

well as their access to advanced training such as surgery and anesthesia. Training generalist HCPs is crucial for effective care in rural and remote settings.⁹⁷ Challenges facing those in rural practice

include call frequency, financial incentives, holidays, continuing professional education, and expense coverage, among others. Strategies for overcoming such obstacles are required.



PRINCIPLE 11

INDIVIDUALIZED MATERNAL AND NEWBORN CARE IS RECOMMENDED

Family-centred maternal and newborn care involves choices. While clinical guidelines provide the best available evidence on which to base practice decisions, the wide geographic, cultural, social and psychological characteristics of women giving birth in Canada, as well as their personal and family preferences, require that HCPs individualize maternal and newborn care.

Individualized care advocates that “each childbearing woman and her family should be treated as if they are extraordinary.”^{108, p43} While professional guidelines and the best available evidence can indicate what approach to care is generally best, the particular needs and preferences of each individual woman and her family may call for the application of alternative practices.

“ Individualized care advocates that “each childbearing woman and her family should be treated as if they are extraordinary.”

Although the term *family-centred* serves as the primary focus of these guidelines, priorities *within* the family must also be distinguished, especially when the needs or expectations of one member conflict with those of another. These guidelines take the perspective that the

needs and expectations of the mother take priority with respect to her care and, once the baby is born, the needs of the newborn take priority with regard to his/her care.

Potential conflicts between the woman’s needs and those of her caregivers or of the maternity centre or service where she receives care also need to be considered. The pregnant woman’s or new mother’s wishes take priority for family-centred care, recognizing that the health of the mother and of her baby remain the primary consideration. Giving priority to the mother’s needs and expectations may give rise to issues of crucial importance in questions of life or death, but also applies to non-life threatening situations. For example, addressing a mother’s needs or wishes versus a provider’s convenience might include such preferences as maintaining an upright position for vaginal birth, avoiding having legs placed in stirrups, encouraging immediate skin-to-skin contact with the baby at birth, or making maternal postpartum assessments when these interfere least with mother-baby contact.^{109,110}

While the above list is far from comprehensive, it highlights the underlying value of prioritizing the mother’s needs over those of caregivers or maternity centres when both mother and baby are well or following a *standard* process of care. In emergencies, the hierarchy of needs may

change to allow for the safest provision of care for the mother and newborn. While individualized care has been valued for a long time, exactly what this means—and how this value is implemented—is worthy of renewed attention.¹⁹



PRINCIPLE 12

TO MAKE INFORMED CHOICES, WOMEN AND THEIR FAMILIES REQUIRE KNOWLEDGE ABOUT THEIR CARE

Sharing information is the mutual responsibility of HCPs, health care organizations, women and families.

Optimal decision making by women and their families should always be based on accurate, up-to-date, and unbiased information and evidence. Allowing for *informed choice* has long been a tenet of Canadian health care philosophy.¹¹¹ The process of obtaining informed choice should follow the rules of ethical practice: care choices should be offered to the patient in an objective manner based on best available evidence. Decision making should be devoid of any coercion by the HCP.

“ **Optimal decision making by women and their families should always be based on accurate, up-to-date, and unbiased information and evidence.** ”

Despite its obvious merits, this concept can be challenging to implement. Sometimes, information provided by an HCP about care

choices may be influenced by that professional’s personal approaches, practices, beliefs or biases, as well as by the care options that are most readily available. For example, HCPs may not advise mothers about the risks of not breastfeeding for fear of causing guilt among those who choose to formula feed. While there is little hesitation to warn against the risks of consuming alcohol or of smoking during pregnancy, breastfeeding does not always receive the same level of advocacy, despite its global acknowledgement as the optimal infant-feeding method, imparting multiple infant and maternal health benefits.

Despite the availability of evidence-based guidelines from professional bodies regarding best practices in maternity care interventions, data suggests that these are being inconsistently applied in clinical situations across Canada.^{47,112} Furthermore, it has long been acknowledged that professional practice is often slow to evolve with the most up-to-date evidence, sometimes taking years, if not decades, to catch up. This delay is reflected in the slow adoption rate of the BFI within Canadian maternity hospitals.¹¹³

Implementing professional knowledge into practice is clearly subject to delays that may influence the information on which families base their decisions about care.

Reliable sources of information about pregnancy, birth and parenthood ensure that families are well prepared for their role as new parents. In responses to the *MES*, current sources of information rated as most useful by Canadian women included HCPs (32%), books (22%) and a previous pregnancy (17%). Among women

attending prenatal education classes, 19% rated these as their most useful source of information. Almost one-third (31%) of teenagers (aged 15 to 19 years) reported family and friends as their most useful information source. Note that while only 8% of women rated the Internet as their most valuable source of pregnancy-related information, reliance on this resource is likely on a steady increase.¹⁹ The relative quality and reliability of information gleaned from these various sources, however, is as yet unknown.



PRINCIPLE 13

WOMEN AND THEIR FAMILIES PLAY AN INTEGRAL ROLE IN DECISION MAKING

Family-centred maternal and newborn care means that women are the primary decision makers about their own care and that parents are the primary decision makers for the care of their newborn.

Health related decisions made by a woman or by parents are based on many factors, professional recommendations being only one of them. Others include advice from family and friends, health literacy and knowledge, and personal/spiritual/religious beliefs. Almost three-quarters (73%) of Canadian mothers reported being very satisfied with their level of personal involvement in decision making about their care. Younger women (aged 15 to 19 years), however, are less likely to rate this aspect of their care so positively.¹⁹

Encouraging women to play a central decision-making role in their own care is embedded within a larger concept reflecting trust in women as collaborative health care partners. One indicator of such trust has emerged with the adoption of maternal-held health care records. This practice has the added potential benefits of increased

sense of control and satisfaction for women during pregnancy, and increased availability of antenatal records during hospital attendance. Trials indicate that women who held their antenatal records would prefer to do so again in a subsequent pregnancy.¹¹⁴ A family-centred model of care is, by its very nature, supportive of such practices.

“ Encouraging women to play a central decision-making role in their own care is embedded within a larger concept reflecting trust in women as collaborative health care partners.

Involvement in decision making incorporates the concept that a woman and her family have a right to refuse consent for care. In most situations, this right is respected.¹¹⁵ At times, however, a conflict in treatment decisions between the rights of the mother, the baby, the partner or the family may even require legal judgment. Conflicts may also occur between a woman's decision or request for a particular form of care and her HCP's own professional, philosophical or religious commitment. Possible options for mediating such conflicts include facilitating the process of obtaining a second opinion, seeking the guidance of a health care facility ethics professional, or proposing a referral to another provider.

Women's decisions about maternal and newborn care are not limited to their own pregnancy, labour and birthing experiences. Their voices need to be heard by maternity care services, including organizations and the professionals who work within them. However, according to the *CHMPPS*, only 23% (62/266) of in-hospital maternal-newborn committees included community groups and only 10% (27/266) included consumers.³¹ Although numerous professional organizations (such as the SOGC and the Canadian Paediatric Society) and mother/family-generated organizations (such as Multiple Birth Canada) represent specific interests and issues of women and their families during their transition to parenthood, there is currently no overarching national consumer advocacy organization in Canada. This makes the appointment of representative women and their families to committees (including the one overseeing the revision of these guidelines) challenging. Increasingly, some maternity and

newborn centres are including women and parent advocates in their decision-making processes (for example, by drawing on representatives of family advisory groups such as the Canadian Family Advisory Network). Until an association emerges that would be better positioned to recommend representatives, a viable alternative is to include women from local communities who are willing to serve on such committees.

“ Women’s decisions about maternal and newborn care are not limited to their own pregnancy, labour and birthing experiences. Their voices need to be heard by maternity care services, including organizations and the professionals who work within them.

Similarly, there is no overarching national organization in Canada that represents all the various professional components of perinatal care, such as those that exist in the US (The National Perinatal Association), Britain (The British Association of Perinatal Medicine) and South Africa (The Association for Childbirth and Parenthood). The absence of a national multidisciplinary perinatal organization creates challenges when seeking expert involvement and collaboration in projects (such as these guidelines) and consensus on improvements to perinatal care.



PRINCIPLE 14

THE ATTITUDES AND LANGUAGE OF HEALTH CARE PROVIDERS HAVE AN IMPACT ON A FAMILY'S EXPERIENCE OF MATERNAL AND NEWBORN CARE

Because words can reflect attitudes of respect and disrespect, inclusion and exclusion, and acceptance or judgment, an HCP's choice of language can either ease or impede communication.

A special roundtable discussion in the journal *Birth* reflects the increasing importance granted to the language surrounding pregnancy and birth. This series of papers raises a number of issues around the *medicalization* of the terminology of pregnancy, birth and practice, for example, referring to breastfeeding as *lactation*.¹¹⁶ Language can also be used to reflect and maintain power differentials in the childbirth setting (“I am *just* going to examine you”), to demean women and

their bodies (“What is she?” to mean how far the woman's cervix is dilated) or mindlessly and meaninglessly (“The section in room 22”).¹¹⁷ Language may be used imprecisely, such as *failure to progress* (when this might mean failure to wait).¹¹⁸ The excessive use of acronyms, including those that stand for different terms (for example, IUD may be an intrauterine device or an intrauterine death) also plagues the language of birth.¹¹⁹



PRINCIPLE 15

FAMILY-CENTRED MATERNAL AND NEWBORN CARE RESPECTS REPRODUCTIVE RIGHTS

Family-centred maternal and newborn care respects the human and reproductive rights of women and those of their partners, newborns and families.

In recent decades, the rights of those transitioning to parenthood have been under increased focus. The International Conference on Population and Development (ICPD), held in Cairo in 1994, pushed towards an understanding of sexual and

reproductive health as a collection of human rights. The ICPD defined reproductive health as: “... a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating

to the reproductive system and to its functions and processes.”^{120, p1} Accordingly, reproductive health implies that people are able to enjoy a satisfying and safe sex life and have the freedom to decide if, when and how often to reproduce.¹²⁰ In addition, the SOGC has outlined 10 sexual and reproductive rights for women and their families.¹²¹

Since the 1990s, the United Nations health agencies have spearheaded an almost-universally accepted movement towards multicultural, multidisciplinary, and internationally applicable concepts of appropriate obstetric and neonatal care. Initiatives supporting women’s and children’s rights (including reproductive rights) have been captured in the form of United Nations declarations/conventions. Among these, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, and the Declaration on the Elimination of Violence against Women provide models or goals to which every nation should aspire.¹²²⁻¹²⁴ In essence, these declarations (and their subsequent and ongoing refinements) reflect a policy of people-centred development based on the following key principles:¹²²⁻¹²⁴

- Everyone should be able to enjoy all human rights and fundamental freedoms. Achieving social equality and justice is a priority objective of the global community, in particular for girls and women, Indigenous Peoples, and other vulnerable groups;
- Empowering people and eradicating poverty, especially through access to information, resources, and democratic institutions, are essential to unleashing human potential and securing peace and development for all;
- Women’s rights are human rights. National development cannot be achieved without the full and equal participation of women in public and private decision making, and their access to equal opportunities in all aspects of social and economic activity;

- Men sharing and participating in all aspects of family and household responsibilities, including child rearing and child support, sexual and reproductive behaviour and family planning practice, must be encouraged to enable men and women to develop partnerships based on equality and mutual respect;
- Children have inalienable rights of person, identity, family and well-being with statutory state obligations to protect those rights and to support their access to education, welfare, justice and health;
- Health and education for all are core factors of development that must be addressed as a part of interrelated efforts to eradicate poverty.

These principles form the basis of numerous international initiatives that are designed to safeguard sexual and reproductive rights, and to ensure conformity with ethical and human rights and standards. The outcomes of these initiatives are monitored through ongoing reporting and research. Canada supports all of the declarations/conventions cited above, and they form an integral component of our country’s philosophy regarding women and their families during the transition to parenthood and beyond.

“ **Increasing use of interventions in childbirth has contributed to women no longer believing in their ability to give birth without technology.** ”

OTHER RIGHTS-BASED ISSUES

A number of additional *rights-based* issues are emerging as moral, legal or professional responsibilities that are relevant to an FCMNC approach.

The importance of women being actively involved in their birth processes: As many professional associations and groups have noted, the increasing use of interventions in childbirth has contributed to women no longer believing in their ability to give birth without technology. Consequently, the right of a woman to experience normal vaginal childbearing without unnecessary or inappropriate technological intervention is an emerging principle.^{4,11,40,41}

Having access to evidence-based care: The SOGC’s tenth sexual and reproductive right specifies the obligation of HCPs to ensure that people have access to the best available evidence-based care and are able to fully exercise this right.¹²¹

The right to privacy, dignity and confidentiality: The right to privacy is also central to reproductive health care. The WHO European Regional Office included the importance of respecting “the privacy, dignity and confidentiality of women” into their 10 *Principles of Perinatal Care*.^{125, p203} While this

is important at all times, it is even more so when caring for women who have been subjected to violence. Respecting such *privacy, dignity and confidentiality* is also central to the concerns of various cultural groups where physical exposure—including during routine prenatal examinations, labour and birth or postpartum—is contrary to cultural norms.¹²⁶

The right to safety: Patient safety represents an area of growing concern, both globally and across all disciplines of health care. The concept most commonly focuses on the minimization of medication and clinical care errors, but should apply equally to the promotion of procedures and practices that optimize health (for example, those that support and promote women having a normal birth and following optimal infant-feeding practices). Not following such recommendations may result in unnecessary morbidity—if not mortality—in both mothers and their offspring and therefore constitutes a matter of patient safety.¹²⁷



PRINCIPLE 16

FAMILY-CENTRED MATERNAL AND NEWBORN CARE FUNCTIONS WITHIN A SYSTEM THAT REQUIRES ONGOING EVALUATION

Family-centred maternal and newborn care requires planning. An efficient, reliable, timely and standardized system of national, provincial and territorial data collection, plus local evaluations of services, is necessary to effectively monitor and evaluate policy implementation, clinical outcomes and patient satisfaction.

The Public Health Agency of Canada established the Canadian Perinatal Surveillance System (CPSS) in 1999 to collect, analyze and report on perinatal data nationally. However, national perinatal databases are subject to limitations, such as obtaining data in a timely fashion from all provinces/territories, and variances in

indicator assessment methods among Indigenous populations. Alternatives to the national registry include real-time provincial/territorial databases that allow for collection of perinatal data as births occur. Local or regional retrospective perinatal databases have also emerged across the country.¹²⁸

“ ...analyses are crucial towards effectively understanding the personal and clinical needs of higher-risk segments of the population.

While collecting national data remains challenging, its dissemination and utilization can also be problematic. In particular, privacy concerns may constrain the analysis of subgroups of databases (for example, mothers requiring specialized or intensive care or NICU admissions), although such analyses are crucial towards effectively understanding the personal and clinical needs of higher-risk segments of the population. A balance needs to be achieved between privacy considerations and the effective provision of maternal and newborn care services.

“ A balance needs to be achieved between privacy considerations and the effective provision of maternal and newborn care services.

In addition to monitoring clinical care across the country, these databases can contribute to a better understanding of how women and their families perceive their maternity experiences. The *MES* has taken a first step in this direction by interviewing mothers.¹⁹ According to the *CHMPPS*, 78% of hospitals report regularly

contacting women about their satisfaction with the care they received while giving birth, although this proportion varies across provinces.³¹ *Satisfaction*, however, can be difficult to objectively assess and is considered only a partial step towards evaluating cognitive and emotional contentedness. Many contributing factors can influence a particular satisfaction rating including: a positive or negative birth outcome; congruence between expectations and reality regarding the process of pregnancy, labour and birth; the number and nature of medical interventions used in labour, birth and postpartum care; the type of HCP and the continuity of care provided; place of birth; degree of support during pregnancy, labour, birth and postpartum from the partner and other family members; previous birth experiences; and expectations based on care offered in other countries, among others. Such surveys can reveal telling information—for example, just over half of Canadian women (54%) reported they were *very positive* and a further (26%) *somewhat positive* about their overall experience of labour and birth.¹⁹

While national or provincial/territorial data collection is important, it remains incumbent on individual maternity care services to institute and maintain their own system of client and provider care ratings, in order to monitor and evaluate their policies and practices. Regularly-updated evaluations provide valuable findings that can be applied to program improvement. Outcomes need to be measured and assessed; these might include adverse events, level of satisfaction with care, process indicators such as the number of caesarean births, and (perhaps most importantly) the family-centredness of care. Ideally, health services accreditation processes would also address similar areas of performance measurement.



PRINCIPLE 17

FAMILY-CENTRED MATERNAL AND NEWBORN CARE BEST PRACTICES FROM GLOBAL SETTINGS MAY OFFER VALUABLE OPTIONS FOR CANADIAN CONSIDERATION

While the Canadian health care system in general, and our endorsement of universal access to equitable care in particular, have long provided a model for emulation around the globe, there is value in exploring how innovative aspects of care created or implemented in other countries could be applied in Canada.

While Canada is in a position to model and assist other countries with aspects of their perinatal care programs and practices, we can also benefit from exploring innovative developments originating in other jurisdictions. Examples include: ^{40,41,129-133}

- Some Scandinavian countries have instituted *patient hotels*—comfortable hotel accommodation for new parents and their newborns from the day after birth, adjacent to and connected with the maternity hospital, providing for daily midwifery care and 24-hour access to health care staff as needed;
- The Republic of Moldova is committed to training and including perinatal health psychologists in every maternity centre in the country;
- Estonia has pioneered the Family-Centred/Humane Perinatal Care Initiative, where mothers are able to stay with their newborns 24 hours a day in the NICU and assist in their care;
- The University of Witwatersrand in South Africa introduced integrated psychological-obstetric teaching for all medical students several decades ago;

- A number of centres, such as the Evergreen Hospital Medical Center in Kirkland, Washington, have incorporated the FCMNC philosophy into the very design of their facility, providing single-room care (including in the level II and III special care nurseries). Nurses have been cross-trained to care for families during labour, birth, and postpartum in order to enhance continuity of care;
- The French National Authority for Health has developed national guidelines covering prenatal care of pregnant women and the importance of identifying those in vulnerable situations. These guidelines advocate for an earlier start to preparation for birth and parenthood, and a broader approach to parent support and to improving the skills of women and their partners.

When developing guidelines, protocols, and policy statements, or planning the design of new facilities, it is worth considering how such alternative approaches might be of benefit. Studies comparing Canadian perinatal health care with that of other countries are useful tools for evaluating our own systems. ^{16,40,81,134}

CONCLUSION

The guiding principles outlined in this chapter set the overall philosophy and serve as a foundation for advancing the implementation of FCMNC in Canada. Where family-centred initiatives are already underway, the principles also offer a broad direction on how these might be enhanced to improve care and outcomes.

These updated principles and the following guideline chapters that flow from them reflect the important progress that has been made since

Family-Centred Maternity and Newborn Care: National Guidelines was last updated in 2000. They also underline the continued evolution and progress that is required now and into the future.

What remains a constant is the need for HCPs and families to work together in collaboration and partnership to ensure that preconception, pregnancy, birth, and postpartum experiences, care and outcomes in Canada continue to improve.

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