

In Context: Understanding Maternity Care in Canada



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In Context: Understanding Maternity Care in Canada

If it takes a village to raise a child, it certainly takes one to bring a child into this world. New and expectant mothers receive care from many people throughout the perinatal period, and the networks and relationships that support them can play a major role in ensuring the health and well-being of new mothers and their newborns.

Childbirth is a milestone, an exciting time when the family grows and a new generation begins. It's also a period of significant child development – a time of great vulnerability but also of great opportunity to benefit from healthy nurturing.

The experience of pregnancy, childbirth and postnatal care continues to evolve through the generations. Rates of maternal mortality (women dying as a result of pregnancy and childbirth), maternal morbidity (women developing complications as a result of childbirth) and infant mortality all saw significant declines throughout the 20th century following medical advances and improvements in maternal care, nutrition and general living standards.

In the 1800s to the mid-1900s, maternity care in Canada typically took place in the local community and birth occurred in the home, with families and midwives routinely providing care to new and expectant mothers. However, with the development of medicare throughout the 20th century, births and maternity care gradually moved into hospitals and medical clinics, with care being delivered primarily by medical professionals such as doctors and obstetricians – a trend sometimes referred to as the “medicalization of childbirth.”⁵

By the early 1980s, the vast majority of births occurred in regional hospitals, where family physicians or obstetricians were present and assisted by obstetrical nurses. Partners and other family members became largely left out of the childbirth process, often relegated to waiting rooms. Following birth, babies were placed in nurseries, separated from their mothers – a situation that was sometimes traumatic for mothers and their newborns.

Hospitals eventually started allowing the *rooming in* of mother and baby to facilitate mother–infant attachment and support breastfeeding for the health and well-being of both. During the rooming-in period, nurses would provide new mothers with information for the recovery period, such as instruction about breastfeeding and postnatal care. Throughout this transition in postnatal care practices, the length of time women spent in hospital after having a baby decreased significantly, from an average of nearly five days in 1984–1985 to 1–2 days after vaginal delivery today.^{6, 7}

Today, partners are more involved in the birthing process and the perinatal period generally than in the past. Most are present for births, taking on a greater role in these first moments of their children's lives and in the child rearing in the years that follow. It is more common for couples today to conceptualize childbirth as a *shared experience*, and many people use language that reflects this trend (“We’re expecting,” etc.).



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Childbirth is a milestone, an exciting time when the family grows and a new generation begins. It's also a period of significant child development – a time of great vulnerability but also of great opportunity to benefit from healthy nurturing.

MATERNAL AND INFANT MORTALITY IN CANADA

Maternal mortality dropped from 508 deaths per 100,000 live births in 1931 to 7 per 100,000 in 2015.^{1, 2}

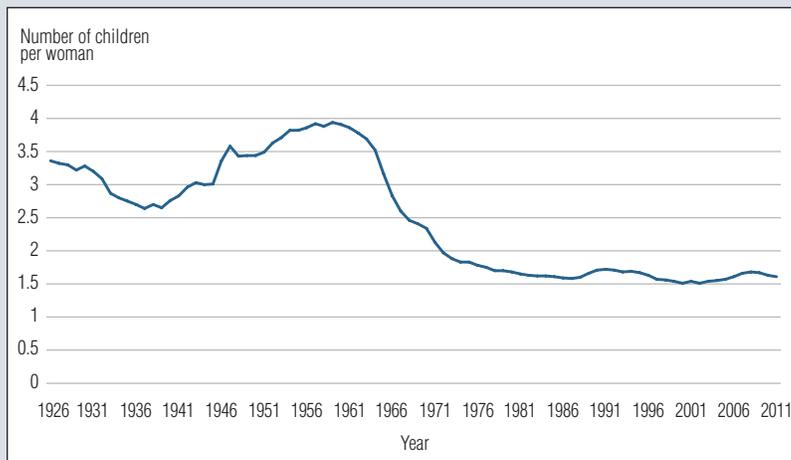
Infant mortality rates fell from an average of 76 deaths per 1,000 live births in 1931–1935 to 4.9 per 1,000 in 2013.^{3, 4}

TRENDS IN MODERN CHILDBIRTH IN CANADA

Experiences of childbirth and motherhood in Canada have evolved greatly across generations, fuelled by a variety of social, economic, cultural and environmental trends.

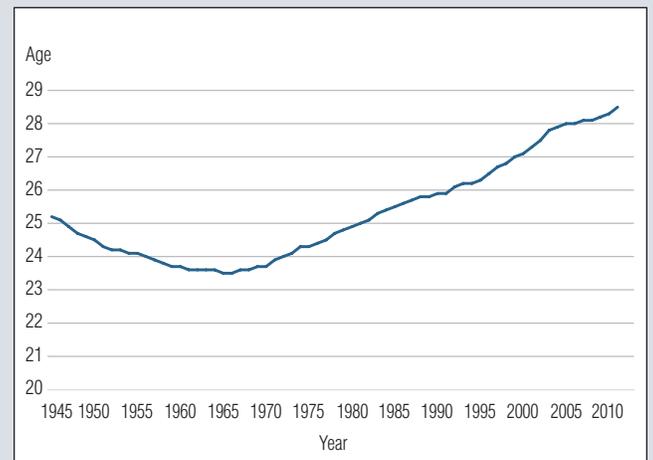
- There have been **more than 327,000 births in Canada every year** since 1971, ranging from a low of 327,107 in 2000–2001 to a high of 403,280 in 1989–1990.⁸
- Mothers in Canada are having fewer children on average than in the past – a continuation of a long-term trend. According to Statistics Canada, the **fertility rate** in 2013 was 1.59 children per woman,⁹ down from 1.72 in 1991 and far lower than the rate of 3.94 recorded in 1959 during the baby boom years (see Chart A).¹⁰
- The average fertility rate across Canada masks **regional variation**. In 2013, rates varied from a low of 1.41 children per woman in British Columbia to a high of 3.04 in Nunavut.^{11, 12}
- Mothers are also older than in the past, many of whom are pursuing post-secondary education and establishing careers before having children. The **average age of first-time mothers** was 28.5 in 2011, up from 26.2 in 1994 and well above the 1959 average of 23.7 years (see Chart B).¹³
- Coinciding with this trend, the fertility rate of **women aged 35 to 39** increased every year between 2000 and 2013 (from 33.9 to 53.6 live births for every 1,000 women, respectively).¹⁴
- The **number of mothers aged 40 and older** experiencing their **first live birth** has increased significantly over the past several decades, from 1,283 in 1994 to 3,648 in 2013.¹⁵
- There has also been a steady increase in the prevalence of **multiple births** in Canada over the past several decades, climbing from 2.1% of all births in 1991 to 3.3% in 2013.¹⁶

Chart A: Total Fertility Rate (Number of Children per Woman), Canada, 1926–2011



Source: Statistics Canada

Chart B: Average Age of First-Time Mothers, Canada, 1945–2011



Source: Statistics Canada

What is maternity care?

Maternity/perinatal care (hereafter referred to as *maternity care*) is an umbrella term encompassing a continuum of care provided to the mother and child before, during and after birth. This includes prenatal/antenatal care (care **during pregnancy**), intranatal care (care **during labour and delivery**) and postnatal/postpartum care (care for the mother and newborn **following birth**). Since both mothers and infants undergo major changes throughout the perinatal period, maternity care entails a diverse range of health monitoring and care.



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Prenatal/antenatal care (hereafter referred to as *prenatal care*) monitors and supports the health and well-being of mothers and the developing fetus *prior* to birth. Fetal health is monitored through screening and diagnostics, such as ultrasounds and blood tests. Health providers also closely track the mother's health during this period; expectant mothers are provided with information about pregnancy, fetal development, physical comfort, testing, planning for delivery and preparing for parenthood.

Most women (87%) say they were supported by a partner, family or friends throughout the prenatal period.

According to the 2009 *Canadian Maternity Experiences Survey*, most women (87%) say they were supported by a partner, family or friends throughout the prenatal period.¹⁷ This support, as well as the care provided by health practitioners, can be particularly important during this time when many (57%) women report most days as being stressful. During pregnancy, maternal stress can have an impact on the well-being of the baby, leading to premature birth and/or low birth weight.

Nearly all expectant mothers (95%) report that they started prenatal care in their first trimester. Certain groups were more likely than others to report that they did *not* start prenatal care in the first trimester, however, such as women aged 15–19 years, those with less than high school education or those who live in low-income households. One of the main reasons cited for not starting care early in the pregnancy was lack of access to a doctor or health care provider.¹⁸

Intranatal/intrapartum care (hereafter referred to as *intranatal care*) refers to the care and assistance provided to mothers *during* labour and childbirth. This involves facilitating the delivery itself in a safe and hygienic manner as well as monitoring the health of mother and child throughout the delivery process. This care is most often provided in hospitals, with mothers receiving care from a variety of health practitioners including obstetricians/gynecologists (reported as the main health care provider during labour and birth by 70% of surveyed mothers), family doctors (15%), nurses or nurse practitioners (5%) or midwives (4%).¹⁹

Whether provided by a spouse, partner, friend, family member, midwife or doula (or some combination thereof), *emotional support* during this time is important. Research shows that women who receive continuous social support are more likely to have a shorter labour (i.e. fewer hours) and a vaginal birth, are more likely to report feeling happy with their labour and birth experience and are less likely to use pain medication.²⁰

Postnatal/postpartum care (hereafter referred to as *postnatal care*²¹) supports mothers and newborns *following* childbirth, and involves health monitoring and routine assessments to identify any deviation from expected recovery following birth, and to intervene, if necessary.²²

Research shows that women who receive continuous social support are more likely to have a shorter labour and a vaginal birth, and are more likely to report feeling happy with their labour and birth experience.

The postnatal period accounts for the first six weeks of a child's life – a “critical phase” in which examinations and care from health practitioners play an important role in ensuring the well-being of the mother and child, according to the World Health Organization (WHO).



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In their 2013 postnatal care guidelines, WHO outlines best practices including postnatal care in the first 24 hours to all mothers and babies (regardless of where the birth occurs), ensuring that healthy women and their newborns stay at a health facility for at least 24 hours and are not discharged early, and have at least four postnatal checkups in the first 6 weeks following childbirth.²³

According to the *Maternity Experiences Survey*, more than 7 in 10 women (73%) rated their health as “excellent” or “very good” by 5 to 14 months postpartum. However, more than 4 in 10 women in Canada (43%) said they experienced a “great deal” of

problems with at least one postpartum health issue during the first three months following childbirth, such as breast pain (16% of women), pain in the vaginal area or in the area of the caesarean incision (15%) and back pain (12%).²⁴

Postnatal support can be important in mitigating postpartum depression, which is reported by 10%–15% of mothers in developed countries. Research has shown that maternal stress during pregnancy, the availability of social support and a prior diagnosis of depression are all significantly associated with developing postpartum depression.²⁵ Studies have also shown that emotional support from partners and other family members throughout the perinatal period can reduce the likelihood for postpartum depression and emotional distress for mothers and newborns.^{26, 27}

Postnatal care services vary across regions and communities in Canada. These can include informational supports, home visits from a public health nurse or a lay home visitor, or telephone-based support from a public health nurse or midwife.

Privately delivered postnatal services have become more prevalent over the past several decades, with postpartum doulas advertising high-intensity supports such as newborn care, breast- and bottle-feeding support, child-minding services, meal preparation, household chores and more. However, these private services often involve out-of-pocket costs that can limit accessibility for some families.²⁸

GRANDPARENTS' EVOLVING ROLE IN MATERNITY CARE

Historically (and to this day), grandparents have been a source of care for new and expectant mothers in many families across Canada. Those who provide care do so in diverse ways, such as providing informational and emotional support, nurturance, transportation and more.

Intergenerational cohabitation is increasing, as a growing number of grandparents are living with younger generations. In 2011, nearly 600,000 grandparents (8%) lived in the same household as their grandchildren, with this rate being higher among Indigenous²⁹ (11%) and recently immigrated³⁰ grandparents (21%).³¹ In these homes, grandparents have all the greater capacity to provide maternity care to new and expectant mothers in younger generations.

While many grandparents provide care, they also must manage other responsibilities in their lives, such as paid employment, which can limit or prevent them from caring for new and expectant mothers and their newborns. Three in 10 grandparents in Canada participate in the paid labour market,³² and the labour market participation rate of seniors has more than doubled since 2000 (growing from 6.0% in 2000 to 13.7% in 2016).³³

As life expectancy increases and Canada's population continues to age, opportunities for intergenerational relationships will continue to grow in the coming years, which can facilitate family care of *all* kinds – including grandparents providing maternity care to women in younger generations.

Who provides maternity care?

In addition to the care and support provided by family members and friends, modern maternity care is delivered by a range of health practitioners including family physicians, obstetricians/gynecologists, nurses, nurse practitioners, midwives and birth doulas – all of whom make unique contributions in the continuum of care.

Family physicians provide care to most new mothers throughout the perinatal period and can be involved in all stages of maternity and infant care, though not all provide the full range of care.³⁴ Fewer physicians across Canada are providing maternity care than in previous decades: the share of family physicians in Canada delivering babies declined from 20% in 1997 to 10.5% in 2010.³⁵ Today, a growing number of care tasks and responsibilities are being delivered by other medical practitioners, such as obstetricians and midwives.³⁶

Most family physicians who report being involved in maternity and newborn care provide “shared care,” offering prenatal care to a certain point (often between 24 and 32 weeks), after which they transfer care to another provider (e.g. obstetricians, midwives or another family physician who delivers babies). Some attend deliveries, but rates vary widely between provinces and the availability of other health providers.³⁷

Obstetricians and gynecologists (OB/GYNs) are providing a growing amount of intranatal care in Canada – though not all do so, and rates vary across the provinces. With specialized knowledge and expertise in pregnancy, childbirth and female sexual and reproductive health care (including surgical training, such as caesarian sections), many also serve as consultants to other physicians and are involved in high-risk pregnancies.

Nurses constitute the largest group of maternity care providers in Canada.³⁸ They can be involved throughout the entire perinatal period, providing a range of care services including childbirth education, pre-birth home care services to women in high-risk situations,³⁹ assistance during childbirth and sometimes follow-up care to new mothers. Following childbirth, nurses often provide information to new mothers while preparing them for discharge, educating them about topics such as breastfeeding, bathing, jaundice, safe sleep, postpartum mental health, nutrition and more.⁴⁰

Nurse practitioners (NPs) are registered nurses who play a wide variety of roles in health care. They sometimes serve as primary care providers for low-risk pregnancies, performing a variety of tasks such as physical examinations, screening and diagnostic tests, and postnatal care. When providing or facilitating maternity care, NPs often work in interdisciplinary teams with other health professionals such as physicians and midwives. In hospital settings, they also work in labour and delivery units, postpartum units, neonatal intensive care units and outpatient clinics.⁴¹ Due to the breadth of their training and expertise, NPs play important roles in rural and remote communities, where many provide a full range of health care services.⁴²

Midwives provide primary care to expectant and new mothers throughout the entire perinatal period, and are playing a growing role in modern maternity care in Canada. They provide a range of care services, including ordering and receiving tests, accompanying women at home or in birthing centres, admitting women for hospital births, as well as assisting with breastfeeding, the early days of parenting and monitoring postpartum healing.⁴³ Midwives work collaboratively, consulting with, or referring to, other medical professionals when appropriate.

Due to the breadth of their training and expertise, nurse practitioners play important roles in rural and remote communities, where many provide a full range of health care services.

The role of midwives has evolved over the past several decades, with a growing number assisting in all settings where care may be needed – at home, in the community and in hospitals, clinics or health units.⁴⁴ There has been increasing emphasis on specialization and training, as midwives have become recognized by and incorporated into most (but not all) provincial/territorial health care systems across the country.⁴⁵



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INDIGENOUS MIDWIFERY IN CANADA

In recent decades, there has been a resurgence in traditional Indigenous midwifery in Canada, with a growing number of Indigenous women employing traditional knowledge, medicine and practices with Western medical practices for new mothers and their newborn babies.

Historically, midwives have been essential providers of maternity care in Indigenous communities, with these roles being served by grandmothers and other women in the mother's lives.⁴⁶ These midwives provided prenatal, intranatal and postnatal care to new and expectant mothers, which included monitoring and counselling by Elders and traditional midwives to ensure appropriate diet, traditional medicines and exercise.

Across generations, a legacy of colonial influence and assimilation policies, coupled with the "medicalization" of childbirth in Canada, diminished the role of traditional midwives in Indigenous communities.^{47, 48} As a result, many Indigenous women living in northern regions travelled great distances to hospitals outside their homes and communities – a process that was reported to have spiritual and cultural impacts on individuals, families and communities.⁴⁹

Decades of lobbying from Indigenous women and organizations, as well as a broader move toward community-based health care models in Canada generally, have fuelled the revitalization and popularization of Indigenous midwifery in recent years.⁵⁰

Some of these practices are being delivered through midwifery-led birthing centres such as those in Nunavik (Quebec), Cambridge Bay (Nunavut), Six Nations (Ontario), Toronto (Ontario) and the Fort Smith Health and Social Services Midwifery Program in the Northwest Territories.⁵¹

According to the National Aboriginal Council of Midwives, Indigenous midwives play an important role in providing culturally safe and relevant care in diverse settings (urban, rural and remote), reducing the number of routine evacuations from remote communities, keeping families together during the childbirth process, improving the health outcomes for parent and baby, and facilitating self-determination in health care.



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Doulas provide *non-clinical/medical* support, working with new mothers and their families as well as health care practitioners such as physicians, midwives and nurses. Doulas are not regulated; they focus largely on emotional and informational support, and they do not provide direct health care or deliver babies.⁵²

There are different types of doulas for different stages in the childbirth process. *Antepartum doulas* provide emotional, physical and informational support during the prenatal period. This can include informing new mothers and their families about support groups, techniques for enhancing physical comfort and helping with home care tasks such as errands and

meal preparation. *Birth doulas* support new mothers and their partners during labour and delivery, including emotional and informational assistance and supporting physical comfort. *Postpartum doulas* support new mothers after the baby is born, providing information about topics such as infant feeding and soothing techniques, and sometimes helping with light housework and childcare.⁵³

Perinatologists provide care in the event of high-risk pregnancies (e.g. pregnancy in the context of chronic maternal health conditions, multiple births or genetic diagnoses). They are trained as OB/GYNs and then receive specialized education to facilitate complicated pregnancies. OB/GYNs refer patients to perinatologists when needed, but continue to work collaboratively to support maternal health.⁵⁴

Unique experiences: childbirth in rural and remote areas in Canada

Maternity care in rural and remote areas (including Canada's northern regions) faces unique challenges due to distances from medical facilities and specialized equipment, less peer support for care providers, as well as a limited number of physicians available for on-call services, and fewer caesarean section and anaesthesia capabilities/services compared with urban centres.⁵⁵

Rural maternity care is most often provided by teams of family physicians, nurses and midwives – in fact, in some communities, they're the *only* health practitioners providing maternity care.⁵⁶ Rural family physicians are far more likely to provide obstetrical care than their urban counterparts, though over the past several decades, many rural communities have seen a reduction in the number of family physicians providing maternity care and closures of maternity wards.⁵⁷

Due to the limited availability of maternity care providers and services in rural and remote regions, many expectant mothers travel to urban centres to give birth. According to a 2013 report from the Canadian Institute for Health Information, more than two-thirds of rural women in Canada (67%) report that they gave birth in urban hospitals, 17% of whom travelled more than two hours to deliver their babies.⁵⁸ Rates are far higher in the North: two-thirds of surveyed mothers in Nunavut and half of those in the Northwest Territories report that they gave birth away from their home community.⁵⁹

This has an impact on the well-being of many Indigenous women living in northern regions, many of whom have had to fly to hospitals far from their homes, land, languages and communities to receive maternity care at tertiary or secondary care hospitals (see *Indigenous Midwifery in Canada* textbox). When surveyed, the majority of mothers reported that leaving home to have their babies was a stressful experience and that it had a negative impact on their families.⁶⁰ In April 2016, the federal government announced that it would provide financial compensation to allow someone to travel with Indigenous women who need to leave their communities to give birth.⁶¹

The number of community hospitals offering obstetrical care in northern regions has fallen since the 1980s. However, a number of birthing centres have opened to fill this care gap, such as in Puvirnituk (Nunavik), Rankin Inlet (Nunavut) and in Inukjuak (Quebec). These facilities have helped women with low-risk pregnancies remain in their communities; however, those with complications or requiring a caesarian birth often still have to travel to give birth.



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Two-thirds of surveyed mothers in Nunavut and half of those in the Northwest Territories report that they gave birth away from their home community.

| Midwifery-Assisted Births per Province and Territory, 2015–2016 | |
|---|---|
| British Columbia | Midwifery has been regulated since 1998. In 2015–2016, midwives assisted 21% of births in the province. ⁶² |
| Alberta | Midwifery has been regulated since 1998. In 2015–2016, midwives assisted 4.9% of births in the province. |
| Saskatchewan | Midwifery has been regulated since 2008. In 2015–2016, midwives assisted 2.9% of births in the province. |
| Manitoba | Midwifery has been regulated since 2000. In 2015–2016, midwives assisted 6.4% of births in the province. |
| Ontario | Midwifery has been regulated since 1994. In 2015–2016, midwives assisted 15.2% of births in the province. |
| Quebec | Midwifery has been regulated since 1999. In 2015–2016, midwives assisted 3.9% of births in the province. |
| New Brunswick | Midwifery has been regulated since 2016. Data is not yet available on how many births were assisted by midwives in 2015–2016. |
| Nova Scotia | Midwifery has been regulated since 2009. In 2015–2016, midwives assisted 2.8% of births in the province. |
| Prince Edward Island | Midwifery is not currently regulated or funded in PEI and there are no practicing midwives in the province. In 2014, an application for regulation was submitted by the Prince Edward Island Midwives Association. |
| Newfoundland and Labrador | Midwifery has been regulated since 2016. Data is not yet available on how many births were assisted by midwives in 2015–2016. |
| Yukon | Midwifery is not currently regulated or funded in the Yukon. A motion was put forward to form a midwifery working group led by Yukon’s Health and Social Services, which began its work in June 2015. |
| Northwest Territories | Midwifery has been regulated since 2005. In 2015–2016, midwives assisted 12.7% of births in the territory. |
| Nunavut | Midwifery has been regulated since 2011. In 2015–2016, midwives assisted 15.4% of births in the territory. |

Source: [Canadian Association of Midwives](#), 2017.

Unique experiences: new and expectant mothers new to Canada

Canada is home to many immigrant families, which have represented a growing share of the total population. In 1961, 16% of people in Canada reported that they were born outside the country – a rate that increased to 21% by 2011.⁶³

Immigration has an impact on the maternity experiences, such as when women decide to have children. Research shows that immigrants have relatively fewer births in the two-year period before migration, which is often followed by a “rebound” in fertility afterward.⁶⁴ According to researchers Goldstein and Goldstein, “Fertility preferences of movers may more closely resemble those of the destination country than those of the source country even before they arrive.”



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Studies have explored a number of reasons why fertility can be affected by the immigration experience, including temporary separation of spouses during the migration process,⁶⁵ a conscious decision to delay childbearing until access to supports such as child allowances is ensured⁶⁶ and economic disruption during migration and in the early period (while parents are securing paid employment).⁶⁷

Recent immigrants⁶⁸ are significantly more likely than their Canadian-born counterparts to live in multi-generational households (those with three or more generations living under one roof); 21% of immigrants aged 45 and older who arrived in Canada between 2006 and 2011 reported that they live in shared homes, compared with 3% of the Canadian-born population.⁶⁹ As such, new and expectant mothers in multi-generational homes may benefit from having more family members nearby to provide care and support.

With regard to accessing maternity care services, research has shown that many immigrant women generally have the opportunity to receive the necessary maternity care services, but rates of satisfaction with maternity care vary greatly across Canada. Some report having faced barriers to *accessing* and utilizing maternity care services, including (but not limited to) a lack of information about or awareness of the services (sometimes the result of language barriers), insufficient support to access the services (i.e. navigation of the health care system) and discordant expectations between immigrant women and service providers.⁷⁰ In some areas, doulas provide valuable emotional, informational and navigation support to immigrant women during the perinatal period.

Social support (e.g. from family, friends and community members) has been identified by immigrant parents as a key factor in accessing maternity care. This circle of support can play an important role in connecting new and expectant mothers from outside Canada with maternity care, and can work with health care and service providers to ensure these women receive “culturally congruent and culturally safe” maternity care.⁷¹

PERINATAL EXPERIENCES OF WOMEN WITH PHYSICAL DISABILITIES (JANE'S STORY)⁷²

There are many misconceptions about women with physical disabilities, including the idea that they cannot or should not become mothers. [Research](#) has found that women with physical disabilities experience a range of attitudinal, informational, physical and financial barriers to motherhood. While most women face a variety of social and emotional pressures to *have* children, research has found that many women with physical disabilities are often pressured *not* to have children – an experience that has sometimes been called “training against motherhood.”

In one qualitative Canadian [study](#) of mothers with physical disabilities, Jane, a married and employed mother of two with a spinal cord injury, shared some of her perinatal experiences. While her experience was positive overall, largely thanks to her strong advocacy skills and a great team of health care providers, she still experienced a number of negative social interactions commonly experienced by physically disabled women in the perinatal period.

Sometimes these interactions were overtly discriminatory and negative, such as the time a stranger on the sidewalk told Jane she “shouldn’t be allowed to have children.” Other negative interactions, however, were more subtle. Like many women with physical disabilities, Jane found that many people didn’t see pregnancy as a possibility for her or even recognize her as being pregnant, as they might have with other women. People would sometimes react surprised or astonished to her pregnancy and status as a mother while in public spaces. Jane recalled occasionally experiencing differential treatment, such as the time she was asked in a grocery store whether she had her daughter “naturally” (Jane noted that it’s unlikely a mother without a disability would have been asked the same question).

For some mothers with physical disabilities, becoming a parent takes focus away from their disability and places it on other aspects of their lives, such as the attachment between parent and child as well as the child’s imagination and creativity. As Jane puts it, “Becoming a mom is probably the best thing that I did because it totally lessened ... my focus or other people’s focus on my disability. My parents ask way less about my own health; they ask more about the kids.”

Jane talked about how her physical inability to do certain activities with her young son has led to opportunities to bond and play with him in other ways: “[My son] knows that I do all the creative stuff with him, so I do all the artwork ... he kind of sees [my husband and I] as having those different [roles] ... I love doing imaginative things and I think that’s important for his growing and learning ... so for me what’s really boosted my confidence in parenting is that I have that ability or that gift to do that with him and the daycare has commented that he’s such a really imaginative kid.”

The experiences of women with physical disabilities during the perinatal period provide learning opportunities for all families and their children. Listening to and documenting the stories and experiences of women like Jane will be integral to understanding diverse experiences of pregnancy and childbirth in Canada.

Maternity care: supporting Canada’s growing families

Pregnancy and childbirth are major life events, not only for new mothers, but also for their families, friends and communities. While there have been many changes in family experiences over the generations regarding pregnancy, childbirth and the postnatal period, there have also been some constant threads: the value and importance of quality care, the diversity of experiences across Canada, and the joy and excitement that can accompany this memorable and life-changing milestone. ♥

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- ¹¹ Statistics Canada, *CANSIM Table 102-4505*.
- ¹² It is important to note that due to Nunavut's relatively small population, fertility levels may show larger annual variations. In reporting Nunavut's fertility rate in the [February 2017 census data release](#), Statistics Canada calculated the average for the 2011-2013 period (2.9 children per woman), which reduced the impact of large annual variations.
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