Aboriginal Doulas for Aboriginal Women:

An Action Plan for Bringing Traditional Birthing Support Practices Back into the Hands of Women

FINAL REPORT
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Submitted to the:
Aboriginal Doula Advisory Committee

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Executive Summary

Background

Improving maternal health services for Aboriginal women and bringing birthing "closer to home and back into the hands of women" was identified as one of 29 priorities in the *Transformative Change Accord First Nation's Health Plan* (Nov 2006).

Following a series of consultations, the introduction/integration of doulas into the maternity services offered to Aboriginal women (First Nations, Métis and Inuit) was identified as a way of contributing to this objective.

In 2008/09, a pilot project was initiated to support doula training for Aboriginal women. A culturally relevant curriculum was developed and a four-day doula workshop was offered at each of two "pilot" sites, one in Hazelton and one in Kamloops (February 2009). Twenty-six Aboriginal women participated in the workshop. An evaluation was completed at the end of the workshop and concluded that the pilot project had achieved its objectives.

This paper supports the planning for the next phase of doula introduction/integration in BC. It summarizes the learnings from the 2008/09 pilot project, it describes successful models of introducing/integrating doulas into maternity care in a variety of settings, and it consolidates the learnings into a sustainable model for BC Aboriginal women with recommendations for next steps.

Learnings from the 2008/09 Pilot Project

The Aboriginal specific curriculum was well received. Participants gained much knowledge about pre/intra/post partum care which was useful in their personal lives and, for many, in their work lives. Participants felt more able to act as advocates for women around the minimal use of interventions (e.g., epidurals, cesarean sections). The knowledge they gained during the workshop took the "scare" and "mystery" out of the birth experience. They were able to use this knowledge to translate women's desires to health care providers.

Doulas and health directors alike valued the concept of doula "certification." While a few of the doulas that completed the 2008/09 doula workshop had completed some of the certification requirements, none had completed all of the requirements. Barriers included being unsure of what was required, difficulty getting the paperwork organized, the logistics of finding 3 pregnant women for which to provide doula services to achieve certification and hesitancy in asking doctors/midwives and nurses to complete the required evaluations.

The most significant barriers to working as a doula were funding, getting time off to attend births (especially for those in non-maternal/child related positions), lack of awareness in the community about doulas and, in some communities, small numbers of pregnant women.

Successful Doula Models of Introducing/Integrating Doulas into Maternity Care

Doulas programs reviewed as part of the environmental scan differed as to whether they were community or hospital-based and whether they were publicly or privately (self-pay) funded. Examples of each are provided in the report.

Common elements of most of the programs included:

- Programs focused on a specific population, often a specific culture and/or underserved group.
- Start-up funding was provided through a one-time grant. Ongoing funding was provided via the health care system (e.g., hospitals, health units, etc).
- A Coordinator was designated as program lead and responsible for hiring/selecting doulas, organizing the training and setting up a system to match doulas and women. Matches were done at 7 months pregnant.
- Doulas were not usually affiliated with the health service in which the doula program resided; they were usually externally contacted. Some found that using doulas from within the health service created operational issues when the doulas were called to a birth.
- Doulas had completed some type of formal training, most commonly a DONA-approved 16 hour workshop; some programs required certification and some did not.
- Doula programs at large, tertiary hospitals had a doula on-call 24/7 to allow coverage for women transferred to the hospital on an unplanned basis.
- Doulas usually accepted care for between 1 and 6 women per month, depending on their life/work schedule. On average, doulas supported 10 – 20 births per year.
- Doulas may or may not receive payment for their services. If payment was received, it was usually for a "course of care" (rather than an hourly wage).
- Where outcomes had been measured, they were consistent with the literature (fewer cesarean sections, less pain medications and greater levels of satisfaction).

Sustainable Model for Doula Services in BC

The long-term vision is to *develop a provincial* network of certified Aboriginal doulas to support Aboriginal women before, during and immediately after childbirth.
Aboriginal = First Nations, Métis and Inuit women.

The goals for a doula service for Aboriginal women in BC are: to improve the birth experience and birth outcomes for Aboriginal women; to re-introduce traditional Aboriginal support practices into the childbirth experience; to improve maternity care systems and access within geographic areas; and to increase the number of Aboriginal women with formal doula training.

While the specifics of how doula services will be implemented will vary across geographic areas/communities, the report identifies operating parameters that are recommended as common to all services. These parameters cover setting up doula services (structures, support and planning),

provision of the services (criteria to provide services, eligibility to receive services and the establishment of a doula network), reimbursement for doula services and doula training.

Next Steps

Developing a province-wide network of doulas to support Aboriginal women will require significant effort, time and resources. For these reasons, it is suggested that the implementation be phased-in over several years. The recommendations, including funding, in this report will enable: (a) the development of an infrastructure to support a gradual roll-out of the doula service as time and resources in local geographic areas/communities permit; and (b) the establishment of a demonstration project in one geographic area for testing the operating parameters of the doula model, the logistics of setting up the service, service uptake, funding requirements and payment mechanisms.

Recommendations:

1. Establish an Aboriginal Doula Implementation Advisory Committee (reporting to the Tripartite Leads responsible for perinatal health) to oversee the roll-out of the Aboriginal Doula Initiative across BC.

2. Recruit a Provincial Doula Coordinator to support the roll-out of the Aboriginal Doula Initiative and the Provincial Doula Network. Consider locating the Coordinator position within Perinatal Services BC.

3. Under the leadership of the Provincial Doula Coordinator, develop a plan to educate multiple stakeholders across the province about (a) the role and benefits of doulas supporting Aboriginal women during birth; and (b) collaborative actions needed to establish doula services in a geographic area/community.

4. Confirm the proposed model of service delivery, including the course of care definition, the appropriate training and support for certification and remuneration for each course of care (proposed operating parameters are identified in section 4.3.4 of the report).

5. Add the content on breastfeeding and childbirth education that is required for certification to the Perinatal Services BC-coordinated Aboriginal Doula Workshop (this will increase the length of the workshop from 4 to 5 days but will lessen the post-workshop certification requirements).

6. Work with the local Health Directors to support the certification process for those doulas that completed the February 2009 Aboriginal Doula Course in Hazelton and Kamloops to achieve certification, if desired.

7. Encourage regional HAs and community partners to include the provision of doula services as a priority in their respective Aboriginal Health Plans.

8. Explore funding opportunities to create an infrastructure to support the provincial roll-out of doula services for Aboriginal women in BC. Estimated funding required is $135 in years 1 and 2 and $165,000 in year 3 and beyond. Funding requirements include:
    - Provincial Doula Coordinator (0.5 FTE in year 1, 0.6 FTE in year 2 and 0.75 FTE in year 3 & beyond (salary + expenses)
    - Follow-up of doulas that completed the February 2009 Aboriginal Doula Workshop offered in Hazelton and Kamloops to achieve certification (year 1 only).
    - Curriculum review and update to incorporate breastfeeding, childbirth education and other culturally relevant doula support (year 1 only).
    - Doula network: tele/videoconferences; starting in year 3, hosting an annual doula conference (speakers, venue, food)
    - Doula workshops: 6 per year (food, DONA Approved Trainer fees and expenses)
    - Indigenous cultural competency training (tuition for 10 participants in year 1, 15 in year 2 and 20 in year 3 and beyond.

9. Explore funding opportunities to support a demonstration project in the Thompson-Cariboo-Shuswap (TCS) Health Service Delivery Area (HSDA) to test and evaluate the operating parameters of the doula model, the logistics of setting up the service, service uptake, funding requirements and payment mechanisms. Estimated funding required is $150,000 per year and includes:
    - Doula Liaison role (honorarium)
    - Community planning meetings (food)
    - Doula workshop: 1 per year (food, participant expenses, DONA Approved Trainer fees and expenses)
    - Doula fees: 125 births in year 1, 250 births in year 2 and onwards (25% of total births to Aboriginal women in the TCS HSDA) @ $350 per course of care).
    - Indigenous cultural competency training (tuition for 10 participants)
    - Project evaluation

10. Encourage regional HAs and community partners to work together in the submission of proposals to various granting agencies for the establishment of doula services in their respective HA/communities. Examples of expenses that will require include:
    - Annual doula conference (participants salaries and expenses)
    - Doula training workshops (venue, participant salaries and expenses)
    - Indigenous cultural competency training (participant salaries)
    - Doula service provision:
        - Liaison role (salary and expenses)
        - Community planning meetings (venue and food)
        - Doulas (fees and expenses)

11. Offer the BC Aboriginal Doula Workshop to communities that have developed a sustainable plan to establish doula services in their respective HA/communities (plan must include the identification of funding sources).

12. Work out arrangements for non-Aboriginal certified doulas that are interested in being part of the provincial network of doulas to take PHSAs on-line Indigenous Cultural Competency course.

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1.0 Background

March 2005: The Province of BC and the First Nations Leadership Council (BC Assembly of First Nations, First Nations Summit and Union of BC Indian Chiefs) agreed to enter into *The New Relationship* guided by principles of trust, recognition and respect for Aboriginal rights and title.

November 2005: The Province of British Columbia, the First Nations Leadership Council, and the Government of Canada signed the *Transformative Change Accord*. The Accord recognizes the need to strengthen relationships on a government-to-government basis, and affirms the parties' commitment to achieve three goals, one of which is to close the gap between First Nations and other British Columbians in the area of education, health, housing and economic opportunities over the next 10 years.

March 2006: The Province of BC and the Métis Nation British Columbia signed the *Métis Nation Relationship Accord*. The Accord focuses on closing the social and economic gap for Métis people in B.C.

November 2006: The Province of British Columbia and the First Nations Leadership Council signed the *Transformative Change Accord: First Nations Health Plan*. The plan included 29 priorities for action, including action #21 which states:

> *A Maternity Access Project will be implemented to improve maternal health services for Aboriginal women and bring birth "closer to home and back into the hands of women."*

2008: The Tripartite Management Team (TMT) of the First Nations Health Advisory Committee designated the BC Perinatal Heath Program (BCPHP) and the Aboriginal Perinatal Health Executive responsibility for providing the leadership, direction and oversight in implementing action #21. Strategy development is to be done in consultation with the Aboriginal Perinatal Health Committee (reports to the Aboriginal Perinatal Health Executive) and with Aboriginal women through the Aboriginal Maternal and Child Health Committee of the First Nations Health Council. See Appendices 1 and 2 for terms of reference for the Aboriginal Perinatal Health Executive and the Aboriginal Perinatal Health Committee.

One of the strategies identified to improve maternal health services for Aboriginal women and to bring birth "closer to home and back into the hands of women" was the introduction/integration of doulas into the maternity care offered to Aboriginal women.

2008/09: A pilot project was initiated to support doula training for Aboriginal women. A culturally relevant curriculum was developed. In February 2009, a four-day doula workshop was offered at each of two "pilot" sites, one in Hazelton and one in Kamloops. Twenty-six Aboriginal women

participated in the workshop. An evaluation was completed at the end of the workshop and concluded that the pilot project had achieved its objectives and was highly successful (Indigo Sweetwater, March 31, 2009).

2.0 Project Purpose

The purpose of this project is to plan for the next phase of introducing/integrating doulas into the maternity care offered to Aboriginal women (First Nations, Métis and Inuit). This will be accomplished through a review of the learnings from the 2008/09 pilot project in BC, an environment scan of successful models of introducing/integrating doulas into maternity care, and a consolidation of these learnings into a sustainable model for BC Aboriginal women with recommendations for next steps.

The project deliverables included:

1. An evaluation of the experiences (during and after training) of the women trained as doulas during the 2008/09 BC pilot project.

2. An environmental scan of successful models of introducing/integrating doulas into maternity care within different health care systems.

3. Development of a sustainable model for introducing/integrating doulas into existing health programs to support Aboriginal women in BC.

4. Creation of a phased-in implementation plan.

3.0 Project Structure

The Aboriginal Perinatal Health Executive Committee provided oversight and leadership for the project. A working group, the Aboriginal Doula Advisory Committee, was struck to provide advice on the process for completing the project, the model for integrating doulas into existing health programs to support Aboriginal women and the final report. See Appendices 3 and 4 for the terms of reference and a list of the members of the Aboriginal Doula Advisory Committee.

Information was collected in a variety of ways to inform the project. Mechanisms included focus groups, telephone interviews, e-mail, list-serves and meetings. See Appendix 5 for a list of individuals/groups interviewed/contacted through the course of the project for their feedback/input.

4.0 Project Findings

4.1 Aboriginal Women Trained as Doulas: An Evaluation One Year Later

4.1.1 Doula Workshop (February 2009)

In 2008/09, the BC Perinatal Health Program (BCPHP) coordinated the development of a 4-day culturally relevant doula workshop for Aboriginal women which targeted the specific needs of pregnant Aboriginal women. The DONA Birth Manual was utilized as a guide for the development of the curriculum to ensure the content aligned with the international DONA® certification standards. The curriculum was intended to train birth doulas (focus on the pregnancy and birth), although some post-partum content was included.

The doula workshop was offered as a pilot project at 2 sites in February 2009: Kamloops (Q'wemtsin Health Society) and Hazelton (Gitxsan Health Society). See Table 1 for details.

Table 1: Doula Workshops Offered in February 2009

	Kamloops (Q'wemtsin Health Society)	**Hazelton (Gitxsan Health Society)**
Dates of training	February 16 – 19, 2009 (4 days, 0900-1600 hours)	February 23 – 26, 2009
# of applicants	25	18
# selected for training	17 (68% of those that applied)	15 (83% of those that applied)
# who attended the training	17 (100% of those selected)	9 (60% of those selected)
Participant characteristics	Age range: 21 – 56 Education: grade 10 – masters level (including 4 undergraduate nurses)	Age range: 27 - 48 Education: grade 10 – undergraduate degree
Communities of residence for doulas	Whispering Pines Bonaparte Lil'wat Fort Nelson Chilcotin Bridge River Redstone and Alkali Lake Skeetchestn Neskonlith	Gitxsan villages (Gitwangak, Gitsegukla, Gitanmaax, Glen Vowell, Kispiox) and two provincial municipalities (Hazelton, New Hazelton).

Source: Sweetwater, Indigo, Final Evaluation: Aboriginal Birth Doula Project, March 31, 2009

An evaluation of the workshop was completed and concluded that the pilot project had achieved its objectives and was well received (Sweetwater, March 31, 2009).

4.1.2 One Year after the Doula Workshop (March 2010)

4.1.2.1 Methodology

Doula workshop participants and their health directors[1] were invited to participate in one of three focus groups held in March 2010. The purpose of the focus group was to seek feedback on the workshop from participants one year later, to learn whether doulas had been able to use the knowledge gained and to obtain suggestions for introducing/integrating doula support into maternity care for Aboriginal women.

Focus groups were held in Kamloops on March 1, 2010 and in Hazelton on March 2, 2010. About 30% of doulas that attended one of the two doula workshops held in February 2009 and 30% of their respective health directors participated in a focus group.

Doulas and their respective health directors that did not participate in one of the focus groups were invited via e-mail to participate in a one-on-one telephone interview. 3 doulas and 2 health directors/managers responded and were interviewed. Thus, in total, follow-up was completed for 42% of doulas that attended the workshop and 50% of their health directors. See Table 2.

Table 2: Follow-up of Doulas and Health Directors

		Kamloops (Q'wemtsin Health Society)	**Hazelton (Gitxsan Health Society)**	**Total**
# who attended the workshop	Doulas	17	9	26
# invited to participate in focus groups (Mar 1 & 2, 2010)	Doulas	15 (unable to contact 2)	9	24 (unable to contact 2)
	Health directors	6	4	10
# that participated in focus groups (Mar 1 & 2, 2010)	Doulas	4/17 (24%)	4/9 (45%)	8/26 (31%)
	Health directors	2/6 (33%)	1/4 (25%)	3/10 (30%)
# that did not participate in focus groups but invited for 1 on 1 interviews	Doulas	9	5	14
	Health directors	4	3	7
# 1 on 1 interviews	Doulas	2	1	3
	Health directors	2	0	2
Total in focus group/ interviewed	Doulas	6/17	5/9	11/26 (42%)
	Health directors	4/6	1/4	5/10 (50%)

[1] Health directors refer to health directors, managers and coordinators throughout this report.

4.1.2.2 Focus Group/Interview Feedback

Follow up questions about the doula workshop:

- Focus group participants felt they gained much knowledge about pre/intra/post partum care by attending the doula workshop. They reported the knowledge was useful in their personal lives (e.g., reflecting on their own pregnancy/labour experience; coaching pregnant family members and friends) and, for many, in their work lives (particularly for those that worked in roles with pregnant women and young babies). All reported that they would recommend the workshop to others. Comments made by health directors were consistent with those of the workshop participants.
- Focus group participants had attended at least one birth (in addition to their own experience giving birth) prior to attending the doula workshop. Since the workshop, participants had attended between zero and three births. Those that had attended births since the workshop felt the knowledge they gained at the workshop provided them with more confidence and more skills to support the mother during the birth experience.
- Several commented that they felt more able to act as advocates for women, particularly around the minimal use of interventions (e.g., epidurals, cesarean sections). The knowledge they gained during the workshop took the "scare" and "mystery" out of the birth experience. They were able to use this knowledge to translate women's desires to health care providers.
- Several commented that they appreciated having the opportunity to spend time with other Aboriginal women. They noted that the similarity in interests and beliefs was refreshing.
- Written materials provided for the workshop had been used by some since the workshop, but not by others. Information about nutrition and massage was used the most often.
- Suggestions made for future workshops included more content on breastfeeding, post-partum depression and grief and loss. They also suggested having an elder/traditional midwife present throughout the workshop to share their experiences would be helpful.

Doulas working in Aboriginal communities:

- The doula role (without certification) has been in place for many generations in aboriginal communities as aunties, mothers, families and friends.
- The "formal" introduction of doulas to support maternity care for Aboriginal women was seen very positively by focus group participants and health directors. Benefits included doulas being able to provide support to women that would otherwise be alone and/or not supported, bridging the "cultural divide" between women and their health care providers, advocating for care that minimizes interventions and educating health care providers about cultural competency.
- Doulas and health directors alike valued the concept of doula "certification." They felt that it provided a common standard, increased the confidence of prospective women to utilize doula services and enhanced the credibility of the "doulas" working in hospital labour/delivery settings. Health directors also felt that certification would reduce issues of liability.
- Many of the doulas that participated in the focus groups or interviews were interested in being certified and working as a doula. A "best guess" would be that about half were interested and, with support, would pursue certification and work as a doula. The other half appeared less directed in this pursuit.
- Barriers identified by doulas and health directors to ***completing the certification process***:

- Unsure of what was needed to become certified.
- Difficulty getting organized to complete the certification (e.g., paperwork, readings, etc).
- Hesitant to ask doctors/midwives and nurses to complete the required evaluation following a birth (worried they are too busy and/or were shy about asking for such "favours").
- Logistics of finding 3 pregnant women to provide doula services:
  - Small numbers of pregnant women in the community.
  - Participants did not like to "advertise" themselves as doulas until they are certified.
  - Busy schedules (families, work, etc), making the doula not available when the woman goes into labour.
  - Women don't feel a doula is needed (have lots of family/friend's support).
- Even when arrangements were in place for a doula to attend a birth, circumstances often precluded this from occurring: mother did not call the doula prior to going to hospital, delivery was very fast and doula did not arrive in time, baby was delivered by cesarean section or the delivery was at a hospital out of town.
- Feeling "alone" and without a mentor to ask questions and/or discuss difficult birth experiences.
- Costs of certification, mostly related to the expenses to attend births (travel, accommodation, child care). Participants said they were willing to provide their services for free but could not afford the expenses to attend births.

- Barriers were identified by doulas and health directors to ***working as doulas***:
  - Funding doula services was the most significant issue, particularly funding doulas working off-reserve or those working on reserve in non maternal/child health roles. Potential program synergies were noted with the Canadian Prenatal Nutrition Program (CPNP; core-funded; universal; on and off reserve), Maternal and Child Health (MCH; not core-funded; not universal; on-reserve), Aboriginal Headstart (some core funded and some not; not universal; on and off reserve), Brighter Futures Program (core funded; universal; on-reserve) and Fetal Alcohol Spectrum Disorder (FASD) Program (not universal; not core-funded; on-reserve). Community Heath Representatives (CHRs) were also discussed but the health directors felt their capacity was fully utilized.
  - Difficult for some doulas to get time off to work as a doula (especially if their job is not maternal/child related).
  - Limited demand for doulas as there is little awareness amongst women in the community and health care providers about the existence and role of doulas (often mixed up with midwives).
  - Small numbers of pregnant women in some communities.
  - Limited numbers of doulas in a community makes 24/7 coverage is difficult, as is coverage for women that are transferred out of their home community. Need a "buddy system" to ensure a doula is available for mothers at the time of labour/birth and a process to connect with another doula if a mother is transferred to another community (in remote communities, women often have to go to an urban centre one month before their estimated date of delivery).
  - Some felt uncomfortable running a doula service as a "business" (said it "felt weird").

- Barriers were identified by doulas and health directors to ***women accepting doulas***:
  - Relationships between families can be problematic if the women/family and doula are too close (feels awkward) or if there is intergenerational tension between the women/family and the doula/family (some families will never ask other families for help).
  - Some women/families are not willing to utilize doulas from other communities/ territories.
  - Building trust is difficult. Some see the doula in her past life, not in her present life (fear the way she used to be rather than knowing her now).
  - Some women/families are not in healing and are living in the past; resent accepting help from those that have recovered/healed.
  - Some women/families are reluctant to ask for "help" (may be related to sexual abuse and/or intergenerational trauma and conflicts).

Doula ongoing education and support:

- Participants commented on the importance of ongoing education for doulas. Most felt that the best format was face-to-face and suggested an annual doula conference. Such a conference would allow for clinical updates and would provide networking opportunities.
- In addition to doula specific education, doulas felt it would be useful for them to attend maternity related conferences, workshops, hospital inservices, etc.
- Participants identified the need for ongoing support in their role as doulas. Suggestions included the development of a provincial doula network, establishment of a provincial doula "coaching" role and formalizing a doula or doula/midwife mentoring program.

Ways that doulas can help "bring birth back into the hands of women" (Action #21 in the Health Plan):

- Doulas can help to bring birth "back into the hands of women" by:
  - Supporting women/families in preparing for the birth experience and the early days of parenting.
  - Encouraging women/families to seek out prenatal care early in their pregnancy.
  - Advocating on their client's behalf for a natural childbirth (where appropriate) and ensure care is provided in a culturally sensitive manner.
  - Utilizing comfort techniques and encouraging positions that promote progress during labour and encourage a natural childbirth.
  - Translating "medical" terminology and hospital processes to women/families.
  - Maintaining a sense of "calm" in a chaotic labour/delivery environment.
  - Informally influence the culture in the labour/delivery room through role modeling, questioning and educating.
  - Helping to nurture and protect a women's memory of birth.
  - Promoting early breastfeeding and bonding.

4.2 Environmental Scan of Successful Models of Introducing/Integrating Doulas into Maternity Care

4.2.1 Doulas in BC

Doulas in BC may be certified or not certified. If certified, they may be certified through a variety of certification bodies such as DONA® International, Childbirth and Postpartum Professional Association (CAPPA), International Childbirth Education Association (ICEA), Birth Works, Childbirth International (CI) and the Organization of Labor Assistants for Birth Options & Resources (formerly ALACE). Information about the organizations and certification requirements is provided in Appendix 6. DONA® is by far the most common certification in BC (and has the largest worldwide membership).

There are estimated to be 83 *certified* birth doulas in BC (76 DONA® certified, 6 CAPPA certified and 1 CI certified). While there is no way of estimating the number of *non-certified* birth doulas, the total DONA birth doula membership may be a reasonable proxy. The total DONA birth doula membership in BC is 316 (as of March 18, 2010), suggesting that for every certified DONA doula there are 3 non-certified DONA doulas. There is no way of estimating how many of the 83 *certified* or 316 total birth doulas are Aboriginal, although anecdotally the number is reported to be very low.

The certified birth doulas offer services in both small and large communities in BC. Some offer services in more than one community (i.e., their own community plus a neighbouring community or two). See Table 3 for a breakdown by health authority (a detailed breakdown of certified doulas by community is available in Appendix 7).

Table 3: Certified Doulas (DONA®, CAPP and CI Certified)

Health Authority	# Birth Doulas
IHA	28
FHA	48
VCH	33
VIHA	22
NHA	4
Total	**135**

Note: The count is higher than the number of certified doulas because some doulas list their services in more than one community.

There is no way to track the number of women that are supported by birth doulas in BC. Anecdotally the numbers are estimated to be small, although the numbers are thought to be on the increase.

4.2.2 Models of Doula Services

Doula services can be categorized as to whether they are community or hospital-based and whether the doula services are paid (may be publicly or privately funded) or volunteer.

Table 4: Models of Providing Doula Services

	Paid Doulas		Volunteer Doulas
	Publicly funded	**Privately funded**	
Community-based			
Hospital-based			

In Canada and in many other countries (including the United States, United Kingdom, Australia and New Zealand), the majority of doulas are community-based and are hired and paid for through private, fee-for-service arrangements with clients. This is currently the predominant model in BC. Because the services are privately paid, underserved (marginalized and/or "at risk") populations do not have the funds to access doula services. This means that women who have the most to gain from receiving doula services have the least access to them.

Generally speaking, doulas practicing in BC have some level of doula training and experience. Certification with an international certification body is becoming more and more the standard, particularly in programs where doulas are publicly funded. Volunteer doula programs often rely on a shorter (usually one day) program and provide mentoring opportunities with experienced doulas.

In the past few years, other models have started to emerge in BC and elsewhere which focus on underserved women. These models utilize publicly funded or volunteer doulas. Some of these programs serve Aboriginal women. All of the programs are based in a single community or hospital; none have taken a regional approach as is envisioned in BC. Table 5 shows examples of these programs, with a description of each in Appendix 8.

Table 5: Examples of Doula Programs

	Paid Doulas		Volunteer Doulas
	Publicly funded	**Privately funded**[2]	
Community-based	1. South Community Birth Program (Vancouver) 2. Tillicum Haus Native Friendship Centre (Nanaimo) 3. Cowichan Tribes, Ts'ewulhtun Health Centre (Duncan) 4. Seabird Island Health Centre (Upper Fraser Valley) 5. Healthy Babies, Healthy Families Program (Smithers)	Multiple doulas are available for private pay clients (see DONA® website)	7. Single Parent Centre (Halifax) 8. Canadian Mothercraft of Ottawa
Hospital-	6. U of Minnesota Medical	Some labour/delivery	9. BC Women's Fir Square

[2] Usually a fee-for-service arrangement between the doula and client.

	Paid Doulas		
	Publicly funded	**Privately funded[2]**	**Volunteer Doulas**
based	Centre	rooms have lists of doulas that can be called if a women request. Privately paid.	(Vancouver) 10. Birth Center, University of San Diego Medical Center (Hillcrest, San Diego)

Common elements of most of the doula programs included:

- Programs focused on a specific population, often a specific culture and/or underserved group.
- Start-up funding for the program was provided through a one-time grant. Ongoing funding was provided via the health care system (e.g., hospitals, health units, etc).
- Coordinator was designated as program lead and was responsible for hiring/selecting doulas, organizing the training and setting up a system to match the doulas and women requesting doulas.
- Program uptake was slow at first as it takes time to get the word out and to build up trust for the program in the community (often 1 – 2 years).
- Doulas were not usually affiliated with the health service in which the doula program resides; they were externally contacted. Some found that using doulas from within the health service created operational issues when the doulas were called to a birth.
- Doulas had completed some type of formal training, most commonly a DONA-approved 16 hour workshop; some programs required certification and some did not.
- A buddy/mentor system for new doulas to attend births with experienced (often certified) doulas prior to attending births on their own.
- Coordinator matched doulas and women or, in some cases, programs provided women with lists of doulas and women did their own matches. Match was done at 7 months pregnant.
- Doulas were on-call 24/7 for their assigned women. This required considerable flexibility in their work/life schedule. Doulas arranged their own back-up doula coverage if unable to attend a birth.
- Doula programs at large, tertiary hospitals had a doula on-call 24/7. This allowed for women who were transferred to the hospital on an unplanned basis to have a doula if desired.
- Doulas were usually able accept between 1 and 6 women per month, depending on their life/work schedule. On average a doula supported 10 – 20 births per year.
- Doulas may or may not receive payment for their services. If payment was received, it was usually for a "course of care" (rather than an hourly wage). If payment was not provided, training was provided free of charge and expenses required to attend the birth (e.g., the doula's childcare and parking) were reimbursed.
- "Course of care" usually included 1 to 3 visits prior to the birth, attendance at the birth and 1 to 3 visits after the birth.
- Where outcomes had been measured, they were consistent with the literature (fewer cesarean sections, less pain medications and greater levels of satisfaction).

4.3 A Sustainable Model of Doula Services for BC Aboriginal Women

4.3.1 Long-term Vision

The long-term vision is to develop a *provincial* network of certified Aboriginal doulas to support Aboriginal women before, during and immediately after childbirth.

Aboriginal = First Nations, Métis and Inuit women.

4.3.2 Rationale

Although there has been no research about doula care specific to Aboriginal women, there have been numerous studies to show that continuous emotional and social support to women during childbirth has positive impacts on not only labour and delivery, but also on breastfeeding rates and attachment (NAHO). Continuous emotional and social support describes the role of a doula.

A systematic review conducted by the Cochrane Collaboration (16 trials, 11 countries, over 13,000 women) concluded that continuous labour support enhanced normal labour processes and women's feelings of control and competence, and thus reduced the need for obstetrical intervention. Women who received continuous labour support were more likely to give birth "spontaneously", i.e. give birth with neither caesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours. In general, labour support appeared to be more effective when it was provided by women who were not part of the hospital staff. It also appeared to be more effective when commenced early in labour. No adverse effects were identified (Cochrane Collaboration, 2009).

Hospitals typically spend 60% more to care for women who have caesarean section births than for women who have vaginal deliveries ($2,800 for a vaginal delivery vs $4,600 for a cesarean section) (CIHI, Giving Birth in Canada, the Costs, 2006). Every cesarean section that the social and emotional support of a doula prevents saves the health care system $1,800. This compares to $300 to $600 for the cost of a doula.

Aboriginal women's experiences of pregnancy and labour often differ from non-Aboriginals. Birth outcomes are often influenced by inadequate living conditions and lack of health care choices.

> *…lack of access to health care and transportation; shortages of food; the lack of appropriate and affordable housing; the absence of culture-based prenatal outreach and support programs for Aboriginal women; and the mandatory evacuation of birthing mothers to distant hospitals, regardless of their medical risk…(as well as) fathers, siblings, grandparents and extended family were excluded from the birthing process, and traditional rituals to name and welcome newborns were delayed or abandoned, (along) with vital contributions of Aboriginal midwives to health promotion and family bonding lost as well* (Royal Commission on Aboriginal Peoples (RCAP, 1996).

The introduction of doulas into the present day maternity care team has the potential to reduce some of these disparities and to have positive physical, emotional, and economic outcomes.

4.3.3 Goals

The goal of developing a provincial network of doulas to support Aboriginal women is to:

1. Improve the birth experience and birth outcomes for Aboriginal women;
2. Re-introduce traditional Aboriginal support practices into the childbirth experience;
3. Improve maternity care systems and access within geographic areas; and
4. Increase the number of Aboriginal women with formal doula training.

4.3.4 Operating Parameters

While the specifics of how doula services will be implemented will vary across geographic areas/communities, the next section lists the operating parameters recommended to be common to all services.

Planning for doula services

1. A Provincial Doula Coordinator will be available to support HA staff and local health care providers in planning and setting up local doula services for Aboriginal women.

2. Each geographic area/community will identify a Doula Liaison. The Liaison will be responsible for the maintenance of the doula program for that geographic area/community and perform duties such as:
   - educating the community about doulas;
   - liaising with the hospitals & community providers;
   - setting up a process to match doulas and eligible women;
   - setting up a process to provide a "back-up" service for doulas unable to attend a birth and/or to transfer care of a woman to a doula in another community if required;
   - setting up a process to pay doulas for their services;
   - following up issues as they arise; and
   - supporting doulas on an ongoing basis.

3. The Doula Liaison will reside within an existing organizational structure(s), preferably one that has an Aboriginal focus (e.g., on-reserve HUB/Health Centre or off-reserve Canadian Prenatal Nutrition Program/Pregnancy Outreach Program).

4. Planning for doula services in a geographic area/community will involve the local hospital(s), regional referral hospital(s), public health nursing, physicians, midwives, on-reserve community engagement HUBS/health services, off-reserve health services and interested doulas.

5. Doula services in a geographic area/community will be integrated with other primary maternity care services.

6. Where women give birth outside their local community, efforts will be made to connect the woman to a doula in the community in which the birth is expected to occur.

7. Each geographic area/community will identify the specifics of the service model for the geographic area/community. The primary difference will be how doula services are accessed and the mechanism for payment of the doulas.

Access to & Payment of Doulas is Through Established Programs	*Access to & Payment of Doulas is Managed Centrally*
• Doula Liaison maintains a list of certified doulas in the local community and community(ies) in which women are referred for specialized services. • Funding for doula services is allocated to designated programs (may be off-reserve &/or on-reserve) for a specified # of women each year. • Women who wish to have a doula attend one of the designated programs. • Program contacts the doula and confirms the services. • The doula provides the services and bills the program.	• Doula Liaison maintains a list of certified doulas in the local community and community(ies) in which women are referred for specialized services. • Program or care provider identifies an Aboriginal woman interested in having a doula (Aboriginal women may also self-identify). • Program or care provider contacts the Doula Liaison to approve the funding for a doula. • Program or care provider contacts the doula and confirms the services. • The doula provides the services and bills the Doula Liaison's organization.

Doula services

8. All women living on reserve and all Aboriginal women (self-identified) living off-reserve will be eligible to receive doula services (pending the availability of a doula in a geographic area/community).

9. Doulas will be community-based. In communities that receive high numbers of *unplanned* transfers of Aboriginal women (e.g., Lower Mainland), a 24/7 on-call doula service is recommended.

Doulas

10. To the extent possible, doulas of Aboriginal origin will be available for Aboriginal women. Where not possible, doulas of non-Aboriginal origin that have completed an Indigenous cultural competency course will be available.

11. Doulas will support on and off-reserve women.

12. Doulas will be reimbursed on a "course of care" basis (clients will not be charged).
    - A course of care will include 2 pre-birth visits, support during the labour and birth, and 1 post-birth visit. This may need to be adjusted to match available funds.
    - Partial "courses of care" will be reimbursed on a pro-rated basis (e.g., transfers out of a community).
13. Doulas must be certified to receive reimbursement.

Doula training and ongoing support

14. The BC Aboriginal Doula Workshop will be offered in interested communities at a nominal fee.

15. The Provincial Doula Coordinator will select the candidates for the workshop in collaboration with the Doula Liaison for the geographic area/community.
    - Strategies will be developed to provide potential candidates with a realistic expectation of the doula role and demands on their time (e.g., orientation session; on-line video or "buddy" with an experienced doula).
    - Selected candidates must have enough flexibility in their job or life to be able to be on-call and available to attend births at short notice.
    - Selected candidates must state an intent to achieve certification.

16. The Provincial Doula Coordinator will work with the Doula Liaison, community health care providers and individual doulas to develop a plan and to support doulas to achieve the births (and evaluations) required for certification.

17. The Provincial Doula Coordinator will establish a Provincial Doula Network and organize an annual doula conference.

4.3.5 Recommendations

Developing a province-wide network of doulas to support Aboriginal women will require significant effort, time and resources. For these reasons, it is suggested that the implementation be phased-in over several years. The recommendations and funding request that follow will enable: (a) the development of an infrastructure to support a gradual roll-out of the doula service as time and resources in local geographic areas/communities allow; and (b) the establishment of a demonstration project in one geographic area for testing the operating parameters of the doula model, the logistics of setting up the service, service uptake, funding requirements and payment mechanisms.

The Thompson-Cariboo-Shuswap (TCS) Health Service Delivery Area (HSDA) is proposed as the geographic area for the demonstration project. This area is proposed because (a) it would be a continuation of a project already initiated in February 2009 when 17 women attended the doula workshop (it is estimated that up to 50% are interested in achieving certification); (b) TCS is 2nd out of 10 HSDAs in the number of births to Aboriginal women; and (c) TCS has Aboriginal women living on and off-reserve and in urban, rural and remote areas; and (d) TCS has a mix of regional and local hospitals. Testing of the "roll-out" logistics in the TCS will enable continuous quality improvement and will facilitate the expansion to other geographic areas as geographic areas/communities are "ready" and funding becomes available.

See Appendix 9 for a map of health service delivery areas (HSDAs) and Appendix 10 for an estimate of the number of births to Aboriginal women by HSDA.

Recommendations:

1. Establish an Aboriginal Doula Implementation Advisory Committee (reporting to the Tripartite Leads responsible for perinatal health) to oversee the roll-out of the Aboriginal Doula Initiative across BC.

2. Recruit a Provincial Doula Coordinator to support the roll-out of the Aboriginal Doula Initiative and the Provincial Doula Network. Consider locating the Coordinator position within Perinatal Services BC.

3. Under the leadership of the Provincial Doula Coordinator, develop a plan to educate multiple stakeholders across the province about (a) the role and benefits of doulas supporting Aboriginal women during birth; and (b) collaborative actions needed to establish doula services in a geographic area/community.

4. Confirm the proposed model of service delivery, including the course of care definition, the appropriate training and support for certification and remuneration for each course of care (proposed operating parameters are identified in section 4.3.4 of the report).

5. Add the content on breastfeeding and childbirth education that is required for certification to the Perinatal Services BC-coordinated Aboriginal Doula Workshop (this will increase the length of the workshop from 4 to 5 days but will lessen the post-workshop certification requirements).

6. Work with the local Health Directors to support the certification process for those doulas that completed the February 2009 Aboriginal Doula Course in Hazelton and Kamloops to achieve certification, if desired.

7. Encourage regional HAs and community partners to include the provision of doula services as a priority in their respective Aboriginal Health Plans.

8. Explore funding opportunities to create an infrastructure to support the provincial roll-out of doula services for Aboriginal women in BC. Estimated funding required is $135 in years 1 and 2 and $165,000 in year 3 and beyond. Funding requirements include:
   - Provincial Doula Coordinator (0.5 FTE in year 1, 0.6 FTE in year 2 and 0.75 FTE in year 3 & beyond (salary + expenses)
   - Follow-up of doulas that completed the February 2009 Aboriginal Doula Workshop offered in Hazelton and Kamloops to achieve certification (year 1 only).
   - Curriculum review and update to incorporate breastfeeding, childbirth education and other culturally relevant doula support (year 1 only).
   - Doula network: tele/videoconferences; starting in year 3, hosting an annual doula conference (speakers, venue, food)
   - Doula workshops: 6 per year (food, DONA Approved Trainer fees and expenses)
   - Indigenous cultural competency training (tuition for 10 participants in year 1, 15 in year 2 and 20 in year 3 and beyond.

9. Explore funding opportunities to support a demonstration project in the Thompson-Cariboo-Shuswap (TCS) Health Service Delivery Area (HSDA) to test and evaluate the operating parameters of the doula model, the logistics of setting up the service, service uptake, funding requirements and payment mechanisms. Estimated funding required is $150,000 per year and includes:
    - Doula Liaison role (honorarium)
    - Community planning meetings (food)
    - Doula workshop: 1 per year (food, participant expenses, DONA Approved Trainer fees and expenses)
    - Doula fees: 125 births in year 1, 250 births in year 2 and onwards (25% of total births to Aboriginal women in the TCS HSDA) @ $350 per course of care).
    - Indigenous cultural competency training (tuition for 10 participants)
    - Project evaluation

10. Encourage regional HAs and community partners to work together in the submission of proposals to various granting agencies for the establishment of doula services in their respective HA/communities. Examples of expenses that will require include:
    - Annual doula conference (participants salaries and expenses)
    - Doula training workshops (venue, participant salaries and expenses)
    - Indigenous cultural competency training (participant salaries)
    - Doula service provision:
        - Liaison role (salary and expenses)
        - Community planning meetings (venue and food)
        - Doulas (fees and expenses)

11. Offer the BC Aboriginal Doula Workshop to communities that have developed a sustainable plan to establish doula services in their respective HA/communities (plan must include the identification of funding sources).

12. Work out arrangements for non-Aboriginal certified doulas that are interested in being part of the provincial network of doulas to take PHSAs on-line Indigenous Cultural Competency course.

5.0 Summary

In 2008/09, a pilot project was initiated to support doula training for Aboriginal women. A culturally relevant curriculum was developed and a four-day doula workshop was offered at each of two "pilot" sites, one in Hazelton and one in Kamloops (February 2009). Twenty-six Aboriginal women participated in the workshop. An evaluation was completed at the end of the workshop and concluded that the pilot project had achieved its objectives.

A one-year post-workshop evaluation identified that none of the workshop participants had completed the requirements for doula certification and none were actively working as doulas in their communities. Several "system" related barriers were identified including the logistics of finding 3 pregnant women for which to provide doula services to achieve certification, funding to pay doulas for their services, getting time off for doulas to attend births (especially for those in non-maternal/child related positions), lack of awareness in the community about doulas and, in some communities, small numbers of pregnant women.

This paper makes recommendations for reducing some of these barriers and supports planning for the next phase of doula introduction/integration in BC. It summarizes the learnings from the 2008/09 pilot project, it describes successful models of introducing/integrating doulas into maternity care in a variety of settings, and it consolidates the learnings into a sustainable model for BC Aboriginal women with recommendations for next steps.

Introduction/integration of doulas into the maternity services offered to Aboriginal women will help to improve maternal health services and bring birthing "back into the hands of Aboriginal women." This supports of action #21 in the *Transformative Change Accord: First Nation's Health Plan* (Nov 2006).

Appendix 1:

Aboriginal Perinatal Health Executive - Terms of Reference

BRITISH COLUMBIA PERINATAL HEALTH PROGRAM

ABORIGINAL PERINATAL HEALTH EXECUTIVE
TERMS OF REFERENCE

NOVEMBER 2009

1. **Purpose:**

   To provide leadership, direction and oversight in order to implement Action #21 of the Transformative Change Accord (TCA) First Nations Health Plan to improve the perinatal health outcomes for Aboriginal women and their infants in British Columbia.

2. **Mandate:**

   The Tripartite Management Team (TMT) has designated the BC Perinatal Health Program (BCPHP) and this Tripartite Executive to be responsible for the implementation of Action #21 "A Maternity Access Project will be implemented to improve maternal health services for Aboriginal women and bring birth 'closer to home and back into the hands of women' (The Transformative Change Accord: First Nations Health Plan (BC) 2005 ;).

3. **Responsibilities:**

   3.1 Provide leadership, planning and direction setting to improve and facilitate coordination of provincial strategies in order to improve access for Aboriginal women to quality and culturally appropriate Aboriginal perinatal services (prenatal, intrapartum and postpartum)

   3.2 Develop an action plan using identified and prioritized quality improvement initiatives, current trends and /or emergent health issues for Aboriginal Women.

   3.3 Ensure Aboriginal women across BC are engaged in providing input into planning, implementing, and evaluating the provincial strategies in partnership with the FNHC through their Aboriginal Maternal and Child Health Committee, Aboriginal Perinatal Health Committee and any other venues.

   3.4 Provide expert implementation advice to the tripartite partners and other stakeholders in their work to improve access to and culturally appropriate quality outcomes for Aboriginal women and infants.

4. **Accountability:**

   4.1 Tripartite Process – the Executive is accountable to the Tripartite Management Team.

   4.2 Individual members- are accountable to their organization.

5. Deliverables:

5.1 Develop annual detailed action plan, create, and support project teams to achieve designated projects under the action plan. Ensure the action plan, project charters and all evaluations include full consultation with the Aboriginal Perinatal Health Committee and with Aboriginal women through the Aboriginal Maternal Child Health Committee of the First Nations Health Council.

5.2 Planning, negotiating and setting, monitoring, adjusting, and reporting budget to the Tripartite Management Team. It is not a shared budget as each organization is accountable to their own budget; the Executive provides a mechanism to bring those components together for a shared vision on identified projects.

5.3 Support Aboriginal Perinatal Health Committee and review TOR on an annual basis.

5.4 Report progress annually and as required to the Committee, PHSA and the Tripartite Management Team

5.5 Facilitate / recommend / advocate best practice guidelines, policy and planning, and ensuring culturally appropriate practices where appropriate.

5.6 Provide guidance to the tripartite partners regarding broader provincial issues.

5.7 Collaborating and networking with key stakeholders to establish a network with key stakeholders and link with relevant regional, provincial, and national initiatives.

6. Reporting:

6.1 Formal TMT Level

6.2 Organizational

6.3 Informal through community

6.4. Community level – gathering wisdom

7. Membership: the membership reflects the tripartite agreement

7.1 BC Perinatal Health Program

7.2 Aboriginal Perinatal Nurse Consultant, BCPHP- staff support, no vote

7.3 Women's Healthy Living Secretariat- one member with a shared vote with 7.1

7.4 First Nations Health Council- one member with one vote

7.5 First Nations and Inuit Health-one member with one vote

8. Members responsibilities:

8.1 Respect the principles of the Tripartite agreement, especially reciprocal accountability.

8.2 Set mutually agreed upon timelines and meet those or provide explanation for need for extension

8.3 Consult with colleagues in member organizations prior to and following meetings to ensure full participation of your organization of the tripartite relationship.

8.4 Raise areas of concern and participate fully in their resolution.

9. Chair:

9.1 The chair is the Provincial Director, BCPHP. Provincial Director can delegate the chair to others should the need arise.

9.2 The chair is responsible for managing the agenda, the meetings and the distribution of minutes to the Executive.

9.3 Refer areas of concern that the committee cannot resolve to the TMT for joint dialogue and resolution.

10. Meetings:

10.1 Meetings will be held a minimum of every two months.

10.2 Meetings require the attendance of tripartite members and/or their delegates.

10.3 Members may assign a delegate from their organization ensuring the delegate is fully briefed. Executive membership is to be informed of delegacy prior to the meeting.

10.4 Decisions are made through consensus. If consensus cannot be reached with those present (in person or online), a vote will take place and the majority vote will rule.

10.5 All action items are to be brought forward at subsequent meetings. It is the responsibility of the Executive to keep a bring-forward list. It is the responsibility of the Chair to ensure follow-up take place for all action items.

11. Documentation:

11.1 The maintenance of minutes, agenda, and other documentation related to the Executive is the responsibility of the Chair.

12. Project Teams:

12.1 Each project in the Action Plan will have a project charter as per the tripartite management team's tools.

12.2 The leads for each project will be determined based on deliverables.

12.3 Each project membership will include experts and tripartite representation.

13. Planning Cycle:

October	Executive will use a budgeting planning cycle to achieve deliverables.
January	Draft action plan and budget for next fiscal year
March	Action plan and budget confirmed
April	Submit year end project reports for past fiscal year
April	Strike new project teams as required by action plan
April	Continue with ongoing projects
September	Mid-year review and evaluation

Appendix 2: Aboriginal Perinatal Health Committee – Terms of Reference

British Columbia Perinatal Health Program

Aboriginal Perinatal Health Committee
Terms of Reference draft 8
February 2010

1. PURPOSE:

1.1 Under the direction of the Aboriginal Perinatal Health Executive (APHE), the Aboriginal Perinatal Health Committee will provide implementation, coordination, communication and evaluation support in order to implement Action #21 of the Transformative Change Accord First Nations Health Plan to improve the perinatal health outcomes for Aboriginal women and their infants in British Columbia.

2. Mandate:

The Committee advises, delivers on priorities and reports to the APHE in support of Action 21.

3. Responsibilities:

3.1 Supports the leadership of the APHE by supporting implementation of provincial strategies through this committee and / or associated working groups.

3.2 Provides expert advice and guidance to the APHE on the development of the action plan.

3.3 Identifies quality improvement initiatives, current trends and/or emergent health issues which require strategic action and communicates information to APHE in a timely manner.

3.4 Engages Aboriginal women across BC to ensure their voice is included in planning, implementing, and evaluating provincial strategies.

3.5 Provides expert advice and guidance to the APHE, Tripartite partners and other stakeholders to improve access to, quality and culturally appropriate programs/initiatives for aboriginal women and infants.

4. **Accountability:**

4.1 The members are accountable to the APHE, their organization and / or professional college under the Tripartite process.

5. **Deliverables:**

Implement the action plan which includes the following:

5.1 Supports the implementation of the action plan by working with partners and stakeholders.

5.2 Provides current information to the APHE on action plan progress, current trends and emergent health issues, and opportunities for furthering action plan success.

5.3 Co-ordinates with the other reference groups, e.g. Women's Health Research Institute, Centre of Excellence, BCPHP Guidelines committee to the BCPHP in developing, implementing and monitoring strategies.

5.4 Promotes timely and effective communication of key BC perinatal health initiatives to APHE and stakeholders, including specific Aboriginal action initiatives.

5.5 Facilitates strategic communication and networking with key stakeholders and link with relevant regional, provincial, and national /international initiatives.

5.6 Participates in the evaluation of the action plan including assisting other stakeholders to actively participate.

5.7 Provides a forum for the discussion of Aboriginal perinatal health.

6. Membership:

Refer to chart.

7. **Members responsibilities:**

7.1 Respect the principles of the tripartite agreement, especially reciprocal accountability.

7.2 Set mutually agreed upon timelines and meet those or provide explanation for need for extension.

7.3 Consult with colleagues prior to and following meetings to ensure full participation of your organization of tripartite relationship.

7.4 Provide communication links with each member organization/agency.

7.5 Assist in selection of members for working groups. Selection will be based on availability and ability to participate in all meetings of the decision making body.

8. **Chair:**

8.1 The chair is the Aboriginal Perinatal Health Nurse Consultant

8.2 The chair is responsible for managing the agenda, meetings and distribution of minutes, inclusive of the Executive.

9. Meetings:

9.1 Meetings will be held quarterly or at the call of the chair.

9.2 Members may assign a delegate from their organization provided the committee agrees and the delegate is fully briefed.

9.3 It is the responsibility of the Chair to keep a bring-forward list and ensure follow-up for action items.

9.4 Project Charters for working groups will be developed.

9.5 Meetings will require the attendance of a quorum.

10. Documentation:

The maintenance of minutes, agenda, and other documentation related to the council is the responsibility of the Chair.

Membership - Aboriginal Perinatal Health Committee

BC Perinatal Health Program	Executive Sponsor – BC Perinatal Health Program (Perinatal Services BC)
	Perinatal Nurse Consultant
	Perinatal Data Registry
Aboriginal Representatives • Includes four (4) members	• First Nation
	• Inuit
	• Métis
	• Urban
Health Authority Representatives	Fraser Health • Aboriginal Health • Perinatal Health Lead
	Provincial Health Services Authority • Aboriginal Health • Perinatal Health Lead
	Vancouver Coastal • Aboriginal Health • Perinatal Health Lead • Director, Aboriginal Health
	Northern Health • Aboriginal Health • Perinatal Health Lead
	Interior Health • Aboriginal Health • Perinatal Health Lead
	Vancouver Island Health • Aboriginal Health • Perinatal Health Lead
Provincial Representatives	First Nations Health Council – VP Health Planning
	Métis Nation BC – Director Health
	BC Association of Aboriginal Friendship Centres – Health Director
	Director, Women's and Children's Health Ministry of Healthy Living and Sport Women's Secretariat
Federal	First Nations Inuit Health - Manager, Children and Youth Unit
	Public Health Agency of Canada - Program Consultant, Child and Youth

Appoint any other members as deemed appropriate.

Appendix 3: Aboriginal Doula Advisory Committee

BRITISH COLUMBIA PERINATAL HEALTH PROGRAM

ABORIGINAL DOULA ADVISORY GROUP
TERMS OF REFERENCE
JANUARY 25 2010

DRAFT 4

1. PURPOSE

Under the direction of the Chair of the Aboriginal Perinatal Health Committee, the Aboriginal Doula Advisory Group will provide expert advice to support the review and evaluation of the Aboriginal Doula pilot project and the development of a sustainable framework/model to successfully support continued Aboriginal Doula training in BC.

2. RESPONSIBILITIES

2.1. Provide expert advice to the Chair and the Contractor(s) hired to support the project.
2.2. Provide representation from local community and/or region that will assist in informing the Chair and Contractor in developing the sustainable framework or model for future Aboriginal Doula training in BC.
2.3. Identify current trends and/or emergent issues which will influence the planning and implementation of an Aboriginal doula training program.
2.4. Ensure Aboriginal women in BC are engaged in providing input.

3. ACCOUNTABILITY

3.1. The members are accountable to the Chair and the Contractor hired to support this project.

4. DELIVERABLES

Work with Tripartite partners, the Chair and the Contractor(s) hired to implement the project charter and expected deliverables:

4.1. Assist in informing the plan to undertake an environmental scan of doulas/midwives in BC First Nation communities.
4.2. Provide feedback and input in the development and implementation of the evaluation to determine the experiences of previously trained Aboriginal doulas.
4.3. Participate in analyzing the information from the environmental scan and evaluation to help inform the development of a sustainable model or framework of inclusive of Cultural Competency Aboriginal Doula training in BC.
4.4. Provide guidance to assist with the revision of existing Aboriginal Doula curriculum used in the pilot project.

4.5. Assist in informing the development of the final report on the work that will be submitted to the Aboriginal Perinatal Health Executive that outlines the deliverables have been met including recommendations for future actions required.
4.6. Provide advice and guidance, to ensure success of the Aboriginal Doula training program and recommendations for prioritizing future training sites.

5. MEMBER RESPONSIBILITIES

5.1. Respect the principles of the tripartite agreement, especially reciprocal accountability.
5.2. provide advice and guidance on cultural competency
5.3. Work within the agreed upon timelines.
5.4. Consult with colleagues prior to and following meetings to ensure full participation of your organization or community.

6. CHAIR

6.1. The chair is the Aboriginal Perinatal Health Nurse Consultant.
6.2. The chair is responsible for managing agendas, meetings and distribution of minutes.

7. MEETINGS

7.1. This Advisory group has responsibility to support work occurring between January 20, 2010 to March 31, 2010.
7.2. One to two face to face meetings will be held as well as teleconference meetings to support the deliverables.
7.3. It is the responsibility of the Chair to keep a bring-forward list and ensure follow-up for action items.

8. DOCUMENTATION

8.1. The maintenance of minutes, agenda, and other documentation related to the Advisory Group is the responsibility of the Chair.

Appendix 4: Doula Advisory Committee Members

Name	Job Title	Organization
Azeita Harding	Manager, Maternity, Victoria General Hospital	Vancouver Island Health Authority
Barbara Selwood	Perinatal Nurse Consultant	BC Perinatal Health Program
Candace Robotham	Early Childhood Program Manager	Seabird Island First Nation
Christine Atkins	Director of Health	BC Association of Friendship Centres
Christine Burgess	Manager, Children and Youth Unit	Public Health Agency of Canada
Diana Day	Leader, Aboriginal Community Development	Vancouver Coastal Health
Georgia Hunt	General Practitioner	Sheway
Jalana Grant	Doula Trainer	Langley
Jeanette Tough	GAIA, Family Counselor	Aboriginal Family Services, Dawson Creek
Leslie Cochrane	Community Health Nurse Maternal Child Health Coordinator	Ts'ewulhtun Health Centre, Duncan
Leslie Varley	Director, PHSA Aboriginal Program	PHSA
Liana Zimmer	Program Consultant, Child and Youth	Public Health Agency of Canada
Lorie Hrycuik	Director, Women and Children's Health	Ministry of Healthy Living and Sport
Lucie Poisson	Aboriginal Health Program Advisor	Interior Health
Lucy Barney (Chair)	Perinatal Nurse Consultant	BC Perinatal Health Program
Patti Nicks	Perinatal Educator, Central and North Island	Vancouver Island Health Authority
Penny Stewart	Manager, Children & Youth Unit	HC, First Nations & Inuit Health
Rosie Butler	Manager, Maternity, Royal Inland Hospital	Interior Health Authority
Trish Osterberg	Aboriginal Health Human Resources Initiative Coordinator	First Nations Health Council

Appendix 5: Interviews/Contacts

List serves:

- Aboriginal Nurses Association of Canada (via Doris Fox) – sent March 16, 2010
- US Indian Health Services, Centering Pregnancy mailing list – sent March 9, 2010

Interviews (telephone/1:1)

- Anna Maria Gorsuch, Perinatal Social Worker, BC Women's
- Bobbie Adkins, Registered Midwife, Smithers
- Christine Atkins, Director of Health, BC Association of Friendship Centres
- Chris Koop, Promising Babies Program Coordinator, Port McNeill/Port Hardy
- Diana Day, Leader, Aboriginal Community Development, VCH
- Gillian Sippert, Program Manager, Birth & Parent Companion Program, Mothercraft Ottawa
- Hilary Marentette, Coordinator, Single Parent Centre, Volunteer Doula Program, Halifax
- Indigo Sweetwater, Coordinator, BCPHP Aboriginal Doula Program
- Jackie Wells & Carrie, Port Alberni Friendship Centre
- Jalana Grant, Doula Trainer, Langley, BC
- Jane Hughes, Program Manager, Healthy Families Program Manager, Courtenay, BC
- Jeanette Tough, Aboriginal Family Services, Dawson Creek
- Jen Cody, Tillicum Haus Friendship Centre, Nanaimo
- Julana Grant, Doula Trainer & Doula Coordinator, South Community Birth Program
- Kathie Lindstrom, Douglas College Doula Instructor
- Kenny Der, BCPHP (perinatal database registry)
- Leah Mantic, Metis doula
- Leslie Cochrane, Maternal Child Health Coordinator, Ts'ewulhtun Health Centre, Duncan, BC
- Leslie Varley, Director, PHSA Aboriginal Program
- Liana Zimmer, Program Consultant, Child & Youth, Public Health Agency of Canada
- Lisa Walberg, RN, Seabird Island Health Centre
- Lorie Hrycuik, Director, Women and Children's Health, Ministry of Healthy Living and Sport
- Lucie Poisson, Aboriginal Health Program Advisor/Patient Navigator, Kootenay
- Lucy Barney, Perinatal Nurse Consultant, BC Perinatal Health Program
- Marilyn Ota, VP, First Nations Health Council
- Melanie Basso, CNS, BC Women's
- Michelle Prouty, Pregnancy & Breastfeeding Outreach, Skidegate Health Centre, BC
- Nicole L'Orsa (doula), Pregnancy Outreach Program, Smithers, BC.
- Pam Morrison, Canadian Prenatal Nutrition Program
- Patti Nicks, Perinatal Educator, Vancouver Island HA
- Penny Stewart, Manager, Children & Youth Unit, First Nations & Inuit Health
- Sherie Deveney, DONA Trainer
- Tanya Davoren, Metis Nation of BC
- Trish Osterberg, Aboriginal Health Human Resources Initiative Coordinator, First Nations Health Council

Appendix 6: Certification Requirements

Doulas of North America (DONA)	CAPPA Canada (Childbirth & PP Prof Assn)	ICEA (International Childbirth Education Association)	Birth Works	Childbirth International	Organ'n of Labor Assistants for Birth Options & Resources (formerly ALACE)
Not-for-profit	Private	Not-for-profit	Not-for-profit	N/A	N/A
Membership: $41.50 US per year	Membership: $45.00 Can per year	Membership: $75.00 Can per year	Membership: $60 US per year	Not available	Not available
Certification package: $28 US Certification application: $48 US Recertification: N/A	Certification package: $34 Can Certification processing fee: $75 Can Recertification: N/A	Certification: $100 US	Certification package: $175 US Recertification: N/A	Certification: $430 (includes course)	Certification: $425 (includes course)
Read 5 books Attend 2 day workshop Complete basic knowledge self-assessment tool Attend childbirth education series of 12 hrs minimum Attend local breastfeeding class Attend 3 births (with 3 evaluations per birth & birth record sheets) Write essay (500-1000 words) Provide 2 character references 4 years to complete certification 8,000 members (largest in the world); estimate 250 certified in Canada, 80 in BC.	Read 5 books Complete pre-workshop study guide Attend 2 day workshop (can be done by distance DVD) Pass test (open book) Attend childbirth education class Attend local breastfeeding class Attend 3 births (with 3 evaluations per birth) 131 certified in Canada, 6 in BC.	Read 8 books Attend 18 hr workshop (ICEA or equivalent) Complete 6 ICEA alternate contact hr program tests Attend childbirth education series Attend 3 births (with 3 evaluations per birth) One year to complete certification 3 certified in Canada; none in BC	Submit profile of a Doula Complete Doula Journal Workbook Attend 3-day Workshop & complete reading and written exercises Attend 2 births and obtain 2 evaluations for each birth None certified in Canada	Read 3 books Self-study module with on-line evaluations for each module (no workshop required) 2 written assignments Complete childbirth survey of childbirth classes in community Attend 2 births and write summary (no evaluations required) 14 certified in Canada, 1 in BC	Read 10 books Attend 2-day workshop Successful completion of written exam Audit a series of Childbirth Preparation Classes Written summaries of 6 births (3 can be prior to workshop); written evaluations from 3 people 7 certified in Canada, 0 in BC

Appendix 7: Certified Doulas in BC

(DONA®, CAPP and CI Certified)

HA	City/Town	# Birth Doulas
IHA	Blind Bay	1
	Cranbrook	1
	Creston	1
	Invermere	2
	Kamloops	1
	Kelowna	5
	Lumby	1
	Nelson	2
	Oliver	1
	Penticton	3
	Redstone	1
	Salmon Arm	3
	Summerland	1
	Vernon	2
	Westbank	2
	Williams Lake	1
	IHA Total	28
FHA	Abbotsford	5
	Burnaby	8
	Chilliwack	3
	Coquitlam	4
	Delta	2
	Langley	5
	Maple Ridge	1
	Mission	1
	New Westminster	1
	Port Coquitlam	1
	Port Moody	1
	Surrey	14
	White Rock	2
	FHA Total	48

HA	City/Town	# Birth Doulas
VCH	North Shore	1
	North Vancouver	2
	Richmond	1
	Roberts Creek	1
	Squamish	1
	Vancouver	25
	West Vancouver	1
	Whistler	1
	VCH Total	33
VIHA	Comox	4
	Courtenay	4
	Ladysmith	2
	Nanaimo	3
	Parksville	1
	Tofino	1
	Victoria	7
	VIHA Total	22
NHA	Prince George	3
	Quesnel	1
	NHA Total	4
Grand Total		135

Note: The count is higher than the number of certified doulas because some doulas list their services in more than one community.

Appendix 8: Environment Scan of Doula Programs

Paid Doula Programs

1. **South Community Birth Program (Vancouver)**
   The South Community Birth Program, established in October 2003, offers publicly funded doula services as part of the services they provide to low-risk pregnant women accessing their program. Doulas were included as part of the health care team at the outset, along with family physicians, midwives and community health nurses. Doulas undertake DONA doula training and then mentor with experienced doulas until they are competent and comfortable to work on their own as the primary doula (usually takes about 3 births).

   Once able to work on their own, doulas are matched (by the Doula Coordinator) to clients who wish to have doulas (which is almost all clients). Doulas meet their clients once during the pregnancy (around 37 weeks), are present during the labour and birth and visit the client once at home after the birth. Doulas often go to their client's homes during early labour, helping them to decide on the best time to go to the hospital. Once assigned a client, doulas are on call for the client 24/7. Doulas make own arrangements if unable to take call or respond to a call (e.g., on vacation, child sick). Doulas are paid an honorarium to provide a "course of care" (if they are being mentored, the mentor receives the payment).

   Some doulas accept 1 client per month (if work FT elsewhere) and some accept up to 5 or 6 clients per month (many also work as childbirth educators and/or post partum doulas). The 30 doulas at the South Community Birth Program support about 300 births per year. About 50% are DONA certified. The doula program was initially funded through the federal government Primary Care Transition Funds but funding for ongoing operations is provided by BC Women's and through donations.

2. **Tillicum Haus Native Friendship Centre (Nanaimo)**
   The Building Better Babies Program (host agency is the Tillicum Haus Native Friendship Centre) contracts with 4 community-based doulas to provide doula support to pregnant women in their program. Women learn about the concept of a doula in prenatal classes at which one of the doulas comes to speak. Women are offered the option of a doula and are given a choice of the four on contract to the program. Once a doula and women are matched, the doula is on call for the woman 24/7. The doula conducts 3 prenatal visits, attends the labour and delivery and conducts 3 postpartum visits. She is paid for the "course of care." Doulas are available to women who reside in Nanaimo and who come to Nanaimo to give birth (often come for a month before the birth). The program is funded through a 3 year VIHA Aboriginal Health Initiative Program (AHIP) grant and is currently in its final year of its funding.

About 60% of clients in the Building Better Babies Program are Aboriginal, with the rest being low income and/or having other challenges. Some are teen mothers. Women self-identify as needing support.

None of the doulas work in other capacities in the Building Better Babies Program or the Tillicum Haus. All work as doulas in the community and also accept private pay clients (one works full-time in another role in the community so is less available for doula work). All are DONA certified.

Doulas support approximately 2 births per month (about 25 births per year). They work out their own back-up coverage if not available.

Outcomes are tracked and have been very positive with lower intervention rates for doula supported clients than for non-doula support clients. Cesarean section rate in year 1 was 7-8% (vs 15% for those in the program that did not have a doula) and was 0% (0 out of 19) in year 2. Rates are higher in year 3 but have not yet been calculated. Regional cesarean section rates are about 30%.

3. **Cowichan Tribes, Ts'ewulhtun Health Centre (Duncan)**
Doula services at the Ts'ewulhtun Health Centre are offered through the Centering Pregnancy Program. The program is co-facilitated by a Registered Nurse and Registered Midwife (RM). There are 4 RMs in Duncan, each of whom rotates their participation.

Doula services are provided by two maternal/child health workers who have taken a DONA® approved workshop (through Mothering Touch) and are currently working to get their certification.

The program is still very new and the numbers of pregnant women accessing the service are low (goal is for 4 women and partners per group). The community has 125 births per year in the community (about 50% are births to Aboriginal women). The Centering Pregnancy Program was funded through a one-time grant from Health Canada.

4. **Healthy Babies, Healthy Families Program (Smithers)**
The Healthy Babies, Healthy Families Program (Pregnancy Outreach Program; 25% - 40% of clients are Aboriginal) recently received a one-time local grant (from a forestry council) to support the costs of a part-time Doula Coordinator, training, mentoring program and certification.

Twelve doulas were offered and attended a 2 day DONA approved birth doula workshop (included 2 experienced doulas). Funding is also available to cover workshop participants to attend a birth with an experienced doula (the experienced doula is paid but the trainee is not). The trainee is an observer and may assist if requested by the doula (trainees cannot count this birth toward certification but it does provide some experience).

The program currently provides a list of doulas willing to provide doula services to mothers (some are certified and some are not). Some on the list charge minimally and some provide services by donation. The list is provided to women attending the Healthy Babies, Healthy Families program.

5. **Seabird Island Health Centre (Upper Fraser Valley)**
   Two home visitors in the mat/child health program and 1 worker in the Aboriginal Infant Development Program took a DONA approved birth doula workshop about a year ago. If a mother wishes to have doula support at her birth, these workers may attend and bank the time. None of the workers are certified yet. Uptake in the Centering Pregnancy Program is low. There are 60 births per year in the community and most have family support.

6. **Doula Program for Somali Women, University of Minnesota Medical Centre**
   A hospital-based doula program for Somali women with volunteer Somali doulas was established in 2002 at the University of Minnesota Medical Centre and is still in operation. Six DONA certified doulas support a total of about 50 - 75 women per year (although the number of newly immigrated Somali women has been declining in recent years as the immigration rules have been tightened).

   Doulas are scheduled in 24 hour blocks of time and assist with any births that occur in that timeframe. They are paid by the hospital at a rate similar to a nursing assistant. They also receive on-call pay. There is a back-up doula scheduled (but not paid on-call pay) in case there are more births than one doula can manage.

   Outcomes have been positive in terms of lower cesarean section rates, positive patient feedback and nurses feeling more confident in caring for Somali women.

   Initial funding for the program was provided through a grant from a local foundation. Since the grant expired, the hospital has funded the program.

Volunteer Doula Programs

7. **Single Parent Centre (Halifax, Nova Scotia)**
   The volunteer doula program at the Single Parent Centre in Halifax started in 1996. The program is a partnership between the Single Parent Centre and the IWK Hospital (maternity hospital), both of which are in Halifax. The Single Parent Centre offers prenatal classes, parenting programs and counselling. The clients are mostly mothers with special needs (e.g., mental health issues, physical disabilities, low-income, substance using, history or current family violence, teens and/or immigrants).

   The program has 60 doulas which range in age from 16 to 60 (many are students). Doula applicants are interviewed/screened by the Program Coordinator (works out of the Single Parent Centre). The doula training is provided free of charge and includes 3 hours of training per week x 30 weeks plus one 12 hour shift on the labour/delivery unit in the

IWK. Volunteers must be on the hospital volunteer roster (includes a criminal record check).

The Program Coordinator matches mothers with doulas 2 months prior to their due date. Doulas usually make 2 to 6 visits prior to the birth, provide support during the birth and make visits for 4 to 6 weeks post partum. Most doulas support 2 to 6 births per year (depending on their availability). Most are not certified, although many go on to take massage therapy, hypnotherapy, etc. All births are done at IWK Hospital (25% of women come from outside Halifax).

Doulas are not paid for their time, although they are provided child care reimbursement for the time at births (but not for home visits). Program funding comes from the Capital Health Region and IWK Hospital (total of $25,000 per year).

8. Canadian Mothercraft of Ottawa-Carleton (CMOC)

The CMOC established the *Birth and Parent Companion Program (BPCP)* in 1991. Birth Companion volunteers provide one-on-one support to expectant moms who are "underserved" (40% young single moms and 60% new immigrants and/or women with other special needs). There is no charge for the service. Volunteer training is 7 weeks (40 hours in total). Every client is matched with a trained and experienced volunteer who provides emotional support, advocacy, and information to her match during pregnancy, throughout her entire labour and childbirth, and during the postpartum period. The volunteers are on call 24/7 and stay with their clients through the entire births. Birth companion volunteers spend on average 30 hours with each client. Program has 50 active doulas in the program (100 on the list), with each supporting between 3 and 10 births per year. Train 40 new volunteers per year. Program provides labour support to about 160 women per year. Volumes are increasing up to 25% per year. Canadian Mothercraft of Ottawa-Carleton is run by 2 part-time coordinators (4 d/wk each). Coordinator interviews all new mothers and matches mothers and volunteer doulas.

The *Mothercraft Birth Support* initiative provides doula services to low and middle income families who otherwise would be unable to afford the services of a doula. Doula services are offered on a sliding fee scale basis (usually around $300). Of the $300, $150 is paid to the volunteer and $150 is kept to subsidize the Birth Companion Program.

9. BC Women's Fir Square (Vancouver)

Doula services are provided to women on Fir Square at BC Women's by medical, nursing and midwifery students who have been provided DONA approved doula training. A call for applications is sent out annually and 18 people are selected (they receive three times as many applicants as they are able to accept). Women that are admitted to Fir Square prenatally and wish to have a doula are assigned a "team" (a team consists of a medical, nursing and midwifery student). The "team" supports the woman prenatally, during the labour/birth and after the birth while the woman is in hospital. The "team" works out amongst themselves who will provide what support and when. Each "team" supports 3 – 4 women per year. The Program coordinator is provided a small stipend, as are speakers for weekly inservices. The "team" works as volunteers. The program was

initially funded through a Collaborative Maternal Newborn Health Grant and it has been operational for 4 years.

10. Birth Center, University of San Diego Medical Center (Hillcrest, San Diego)

Hearts & Hands volunteers attend an 8-hour introductory doula course (offered once a month). Upon completion, they work with experienced mentor doulas until they are ready to work on their own. Volunteers are asked for a commitment of two on-call "shifts" a month. Volunteers need to have a flexible schedule and the ability to work very long hours from time to time. Volunteers sign up for 12-hour morning and evening shifts, during which they are available to be called to the hospital when a mother requests a doula. When a doula is called upon, she stays with the mother throughout her labour and delivery. She does not leave when her "shift" ends. The average time a doula stays at a birth is 10-12 hours.

Doulas are offered to all women delivering at the UCSD Medical Centre. Also have a "referral program" where women are referred to doulas during pregnancy but these are available on a more limited basis. Interested volunteer doulas can also receive training to work with specific populations of women (e.g., pregnant inmates or women who are HIV+). Hearts & Hands is the only program of its kind in San Diego Country and one of the largest in the US. Program has 40 doulas (2005). Program is funded by the UCSD Medical Centre and through donations.

Other Doula Initiatives Underway in BC

11. Port Alberni Friendship Centre

The Early Childhood Development (ECD) worker has connected with one of the certified DONA doulas in Port Alberni. There are 8 doulas that have completed the doula workshop and are looking for birth experiences in order to get certified. A doula meeting is scheduled soon and the doulas will develop a list of those looking for birth experiences with contact numbers. The ECD worker will provide clients who are in high need of labour support (e.g., single mothers) with the list. The doulas will provide services free-of-charge in order to get experience.

12. Healthy Babies Prenatal Nutrition Program (POPS; Courtenay)

Mothers in Healthy Babies program who are most in need (e.g., single mothers, risk of apprehension of baby, etc) are offered a list of doulas which includes 6 who have agreed to offer their services free-of-charge for mothers unable to pay. Of these 6 doulas, 2-3 work in the Pregnancy Outreach Program.

The Healthy Babies Program has submitted a proposal to a funding agency to provide funding for doula services. If funded, the doula function would be incorporated into the role of the outreach workers.

13. Pregnancy and Breastfeeding Outreach (Skidegate, BC)

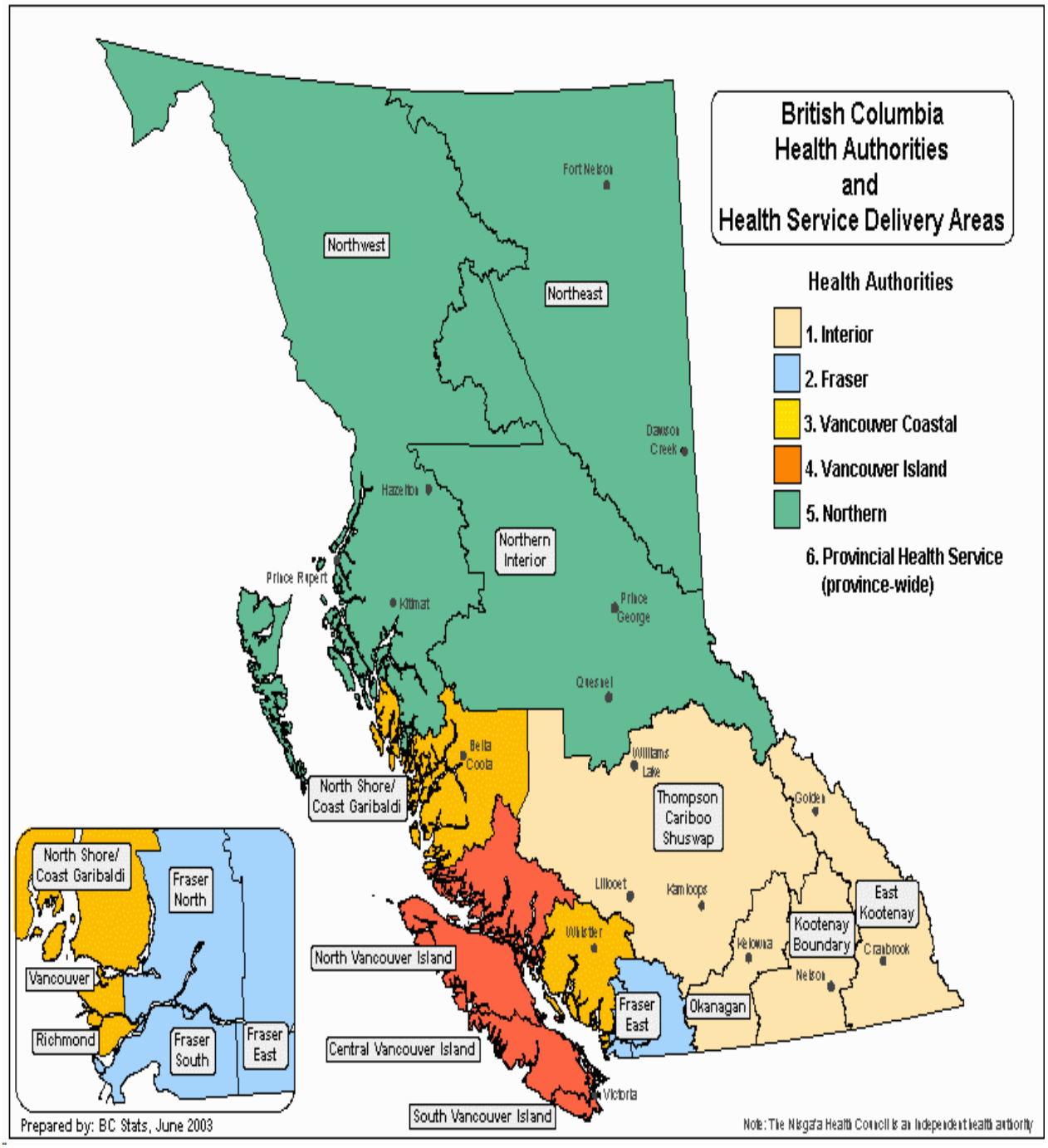
42 women participated in doula training in 2005 (combination of Aboriginal and non-Aboriginal women). Many of these women (and others) work as "volunteer" doulas to

support women during childbirth and the postpartum period. Low-risk births are done near Skidegate (in Queen Charlotte City) and high risk births go to Prince Rupert or Vancouver. 70 – 80 births per year. “Doula program” is really “formal” title for work that has been done for years by women in Skidegate.

14. North Vancouver Island (Mount Waddington) – in proposal stage

A proposal has been submitted to the Tripartite Perinatal Committee to establish a birth support program to serve 4 Aboriginal communities on North Vancouver Island. The proposal is to set up an integrated, multidisciplinary model of primary maternity care for low risk, Aboriginal women using the Centering Pregnancy model. The program team would include 3 contracted (or salaried) community-based doulas along with family physicians, midwives, community health nurses and allied health providers. Collaborative partnerships would be established with obstetricians, midwives and other providers in Comox and Campbell River.

Appendix 9: Map of Health Service Delivery Areas (HSDAs) of BC



Appendix 10: Birth Estimates by HSDA

Unfortunately the only published *birth-related* data that is available is live births to Status Indian women between 1992 and 2002 (11 year period). Source: Regional Analysis of Health Statistics for Status Indians in BC, 1992 – 2002. This data does not include births to Non-Status Indian, Metis or Inuit women and does not distinguish between births to Status Indian women living on and off reserve.

2006 census data provides the number of people living on-reserve (Aboriginal and non-Aboriginal), numbers of Status Indians living on and off-reserve and the numbers of self-identified Metis and Inuit (thought to be under-reported). % calculations for non-Status and Metis/Inuit are based on 2006 census estimates (which likely overstates the births as the birth rates for all populations were assumed to be the same).

The numbers of births per year to Aboriginal women in the chart below were estimated using the average live births per year to Status Indian women between 1992 and 2002 and pro-rating these figures to the population proportions of First Nations, Metis and Inuit in the census data. **These figures are very gross and provided for "order of magnitude" purposes only.**

		Status Indian				Non-Status Indian				Metis/Inuit				Total		
		Live Births				Live Births				Live Births				Live Births		
Health Service Delivery Area		On Reserve (44%)	Off Reserve (56%)	Total		On Reserve (2.6%)	Off Reserve (97.4%)	Total (77% x Status)		On Reserve (Negligible)	Off Reserve (97.4%)	Total (32% x Status+Non-Status)		On Reserve	Off Reserve	Total
11/12	E Koot/Koot Bdary	27	34	60		1	45	47		0	34	34		28	113	141
13	Okanagan	73	93	166		3	124	128		0	94	94		76	311	388
14	Th-Cariboo-Shu	153	194	347		7	260	267		0	196	196		160	651	810
21	Fraser East	93	119	212		4	159	163		0	120	120		98	398	495
22	Fraser North	73	93	167		3	125	129		0	95	95		77	313	390
23	Fraser South	82	105	187		4	140	144		0	106	106		86	351	437
31	Richmond	10	12	22		0	16	17		0	12	12		10	41	51
32	Vancouver	107	136	243		5	183	187		0	138	138		112	457	569
33	NS/C Garibaldi	85	108	193		4	145	149		0	110	110		89	363	452
41	So Van Is	76	96	172		3	129	132		0	97	97		79	322	401
42	Central Van Is	150	191	341		7	256	263		0	193	193		157	641	798
43	N Van Is	69	88	157		3	118	121		0	89	89		72	295	367
51	Northwest	193	245	438		9	329	338		0	248	248		202	823	1,024
52	Northern Interior	129	164	293		6	220	226		0	166	166		135	550	685
53	Northeast	54	69	122		2	92	94		0	69	69		56	230	286
BC Total		**1,374**	**1,748**	**3,122**		**63**	**2,341**	**2,404**		**0**	**1,768**	**1,768**		**1,436**	**5,858**	**7,294**
CPNP - on reserve, 2006/07														970		
CPNP - off reserve, pregnant, all women, 2008/09															2,794	
CPNP - off reserve, pregnant, Aboriginal women (30% of total), 2008/09															838	

Appendix 11: Provincial Doula Coordinator Role

Examples of Duties:

- Support HA staff and local health care providers in planning and setting up doula services for Aboriginal women in local communities.
- Coordinate the offering of the BC Aboriginal Doula Workshops in relevant communities.
- In collaboration with a designate(s) from the HA and/or local health care provider, select candidates for the workshop.
- Facilitating the doula workshop in local communities.
- Work with individual doulas and community representatives to develop a plan and support doulas to achieve the births (and evaluations) required for certification.
- Work with Doula Liaisons across the province to maintain a provincial list, by community, of certified birth doulas (Aboriginal and non-Aboriginal) interested in supporting Aboriginal women.
- Develop a provincial network of birth doulas that support Aboriginal women.
- Organize an annual birth doula conference and other continuing education/support opportunities.

Appendix 12:

Steps for Setting up a Doula Service for Aboriginal Women

Activities		Lead	Note
Planning for doula services			
1	Identify the targeted geographic area/community for the doula service.	Prov Doula Coord/ Leaders from geographic area	Consider: • Community readiness • Availability of a lead person/organization • Sufficient numbers of women interested in working as doulas and a critical mass of births in the geographic area/community
2	Identify a person as the Doula Liaison for the targeted geographic area/community.	Prov Doula Coord/ Leaders from geographic area	Consider: • On-reserve HUB/Health Centre Health Director or Mat/Child Coordinator • Off-reserve: Canadian Prenatal Nutrition Program (CPNP)/Pregnancy Outreach Program Coordinators (POP)
3	Estimate demand for the doula service.	Prov Doula Coord/ Doula Liaison	• # Aboriginal women giving birth per year in the geographic area/community and % likely to request a doula. • See Appendix 10 for estimated numbers of births by health service delivery area.
4	Estimate the supply of doulas required.	Prov Doula Coord/ Doula Liaison	Assume 1 doula can support 10 births.
5	Facilitate a meeting of *key contacts*: • Confirm model of providing doula services (centralized or through designated organizations). • Confirm roles. • Identify mechanism to support doulas to get births required for certification.	Prov Doula Coord/ Doula Liaison	Include: • Local & regional hospital(s) (Aboriginal portfolio & labour/delivery areas) • Public/community health nursing (on & off-reserve) • Physicians & midwives • HUB/On-reserve health services • Off-reserve health services
Recruit & train Aboriginal doulas			
6	Put out a call for Aboriginal women interested in working as doulas.	Prov Doula Coord/ Doula Liaison	
7	Facilitate information meeting/webinar/teleconference for women interested in working as doulas.	Prov Doula Coord/ Doula Liaison	
8	Screen applications, interview candidates, check references and select participants for workshop.	Prov Doula Coord/ Doula Liaison	
9	Line up birth experiences for doulas post-workshop.	Prov Doula Coord/ Doula Liaison	
10	Offer the BC Aboriginal Doula Workshop.	Prov Doula Coord	
11	Confirm plans for individual doulas to get certified.	Prov Doula Coord/ Doula Liaison	

Activities		Lead	Note
12	Coach individual doulas to get certified.	Prov Doula Coord	
Recruit non-Aboriginal doulas interested in being part of the network to support Aboriginal women			
13	Put out a call for certified doulas interested in joining the network.	Prov Doula Coord/ Doula Liaison	
14	Facilitate information meeting/webinar/telecon for certified doulas interested in joining the network.	Prov Doula Coord/ Doula Liaison	
15	Support doulas to complete the PHSAs on-line Indigenous Cultural Competency course.	Prov Doula Coord	• On-line, instructor-facilitated training. • 8 hours of learning over a 4-week period.
Service implementation			
16	Develop list of certified doulas (Aboriginal and non-Aboriginal doulas).	Prov Doula Coord/ Doula Liaison	
17	Set up payment mechanisms (for programs and doulas).	Doula Liaison	
Create HSDA/community awareness of doula service			
18	Create print materials describing the role of doulas & the benefits, eligibility and how to access	Prov Doula Coord/ Doula Liaison	
19	Facilitate a meeting of local providers to discuss to role of doulas & the benefits, eligibility and how to access.	Prov Doula Coord/ Doula Liaison	Include same groups as identified in step 5 (key contacts).
20	Places notices in local newspapers, Aboriginal newsletters, hospital newsletters, etc re the doula service.	Prov Doula Coord/ Doula Liaison	
Ongoing support for doulas			
21	Organize regular meetings/teleconference for doulas.	Prov Doula Coord/ Doula Liaison	
22	Involve doulas in local educational initiatives.	Doula Liaison	
23	Offer annual provincial doula conference.	Prov Doula Coord	
24	Support attendance at annual doula conference.	Doula Liaison	

Appendix 13: Infrastructure Budget Requirements

The budget estimated below refers to recommendation #9 (Explore funding opportunities to create an infrastructure to support the provincial roll-out of doula services for Aboriginal women in BC). The estimate needs to be updated when specific information re salaries, expenses and other costs are known.

Nature of Expense			**Yr 1**	**Yr 2**	**Yr 3**	**Total**	**Assumptions**
Provincial doula coordinator		Salary	$42,000	$50,400	$63,000	$155,400	0.5 FTE in yr 1, 0.6 FTE in yr 2 and 0.75 FTE in yr 3 (& ongoing); $70,000 per year + 20% benefits
		Travel	$5,000	$7,000	$10,000	$22,000	5 trips in yr 1, 7 trips in yr 2 & 10 trips in yr 3 (& ongoing); $1,000/trip
		Office expenses	$5,000	$7,500	$10,000	$22,500	Development of print material, etc
		Sub-total	$52,000	$64,900	$83,000	$199,900	
Doula network	Tele/videoconferences		$2,000	$2,000	$2,000	$6,000	4 tele/video conferences/yr; $500 per call
	Provincial doula conference	Speakers	$0	$0	$2,000	$6,000	Honoraria for speakers
		Venue + food	$0	$0	$3,000	$3,000	Participants Yr 3: 50; $30/person/d
		Participant salary	$0	$0	$0	$0	Will be self or employer funded
		Participant expenses	$0	$0	$0	$0	Will be self or employer funded
	Sub-total		$2,000	$2,000	$7,000	$11,000	
Doula training requests	Doula workshops	Venue	$0	$0	$0	$0	Will use community space; no cost
		Food	$18,000	$18,000	$18,000	$54,000	6 x 5 d workshop/yr; $30/person/d; 20 participants/workshop
		DONA Approved Trainer Fees	$18,000	$18,000	$18,000	$54,000	6 x 5 day workshops/yr; $600/d
		DONA Approved Trainer Expenses	$12,000	$12,000	$12,000	$36,000	6 x 5 day workshops/yr; $2,000 per workshop (travel, accommodation, meals, other expenses)
		Participant salary	$0	$0	$0	$0	Will be self or employer funded
		Participant expenses	$0	$0	$0	$0	Will be self or employer funded
		Support for doulas trained in 2009 to become certified	$10,000	$0	$0	$10,000	$500/person: 2-day brstfeeding/childbirth educ'n course in Kamloops & Hazelton; 10 participants/workshop; participant food/travel; trainer fees/travel/expenses; Follow-up support by Provincial Doula Coord
		Add content to curriculum (BF/Childbirth educ'n)	$7,000	$0	$0	$7,500	100 hrs x $50/hr + $2,000 travel/expenses
	Indigenous cultural competency training	Salary	$0	$0	$0	$0	Will be self or employer funded
		Expenses	$5,000	$7,500	$10,000	$22,500	10 participants in yr 1, 15 in yr 2 and 20 in yr 3 (& ongoing); $500 per participant (tuition)
	Sub-total		$70,000	$55,500	$58,000	$183,500	
Contingency (10%)			$11,000	$12,600	$17,000	$40,600	
Total			**$135,000**	**$135,000**	**$165,000**	**$435,000**	

Appendix 14: TCS Doula Demonstration Project Funding Requirements

The budget requirements estimated below relates to recommendation #10 (explore funding opportunities to support a demonstration project in the Thompson-Cariboo-Shuswap (TCS) Health Service Delivery Area (HSDA) to test and evaluate the operating parameters of the doula model, the logistics of setting up the service, service uptake, funding requirements and payment mechanisms). The estimate will need to be updated when specific information re salaries, expenses and other costs are known.

Nature of Expense			**Yr 1**	**Yr 2**	**Yr 3**	**Total**	**Assumptions**
Thompson-Cariboo-Shuswap	Doula Liaison	Honorarium	$10,000	$10,000	$10,000	$30,000	Admin time & office expenses
	Community planning meetings	Venue	$0	$0	$0	$0	Will use community space; no cost
		Food	$1,200	$1,200	$1,200	$3,600	$300/meeting x 4 meetings per year
	Workshop	Venue	$0	$0	$0	$0	Will use community space; no cost
		Food	$3,000	$3,000	$3,000	$9,000	1 x 5d workshop/yr; $30/person/d; 20 participants/workshop
		Participant salary	$0	$0	$0	$0	Will be self or employer funded
		Participant expenses	$10,000	$10,000	$10,000	$30,000	1 x 5d workshop/yr; $500/participant (travel, accommodation, meals, other expenses); 20 participants/workshop
		DONA Approved Trainer Fees	$3,000	$3,000	$3,000	$9,000	1 x 5 day workshop/yr; $600/d
		DONA Approved Trainer Expenses	$2,000	$2,000	$2,000	$6,000	1 x 5 day workshop/yr; $2,000 per workshop (travel, accommodation, meals, other expenses)
	Advertisement		$0	$0	$0	$0	Will use existing community mechanisms
	Doulas	Fees	$43,750	$87,500	$87,500	$218,750	Year 1: 125 births; Year 2 & onwards: 250 births @ $350/birth
		Expenses	$0	$0	$0	$0	Incorporated into the doula fee.
	Cultural competency training	Salary	$0	$0	$0	$0	Will be self or employer funded
		Expenses	$5,000	$5,000	$5,000	$15,000	$500/participant x 10 participants/yr (tuition)
	Evaluation		$5,000	$5,000	$13,000	$23,000	Yr 1 & 2: collection of data; Yr 3: write report
Contingency			$52,050	$8,300	$300	$60,650	
Total			**$135,000**	**$135,000**	**$135,000**	**$405,000**	

Assumptions:

1. Doula supported births in the Thompson-Cariboo-Shuswap area will total 250 per year (25% of total births to Aboriginal women).
2. Anticipate requiring 25 trained doulas to support 250 births per year.
3. 5/17 (30%) doulas that completed the doula training in Feb 2010 will complete their certification.
4. 50% of doulas that participate in future doula workshops will complete their certification.