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## 10. Indigenous Birth in Canada

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### Reconciliation and Reproductive Justice in the Settler State

ERIKA FINESTONE AND CYNTHIA STIRBYS

Over twenty years ago, the 1996 Final Report of the Royal Commission of Aboriginal Peoples (RCAP) stated, “there is a growing convergence between Aboriginal and non-Aboriginal perspectives on what make people healthy. Indeed, some Aboriginal communities are on the leading edge of innovations in this area. This suggested improved collaboration might be mutually beneficial” (RCAP 10). Two decades have passed and though collaborative efforts between Indigenous and non-Indigenous stakeholders exist, an imbalance of power in favour of Western ontologies still punctuates many of these relationships. With the collaborative writing of this chapter we the authors—one Saulteaux-Cree<sup>1</sup> scholar and the other a settler scholar<sup>2</sup>—attempt to identify where and how new relational convergences can foster mutually beneficial changes in our communities. We are connected and propelled by our shared desire to advance Indigenous reproductive justice in Canada as one necessary component of a broader decolonizing and reconciliatory project in the settler state.

We come together as women,<sup>3</sup> both at our core seeking further freedom of choice, freedom of being, and freedom of thought in a colonial context oppressive to *all woman* (albeit in different ways and with different consequences).<sup>4</sup> We hope that by critically engaging with the history of childbirth in Canada, we can better understand the particular ways in which Indigenous birth has been challenged by patriarchal policies and practices. At the same time, we hope to open space for dialogue and further inquiry into the ways in which we, as women of varying backgrounds, both

settler and Indigenous, have been at once privileged *and* oppressed throughout this history of birth and into the present. By framing the chapter in this way, we aim to experiment with the creation of an “ethical space of engagement”<sup>5</sup> wherein Indigenous and non-Indigenous women can begin to imagine new possibilities for a less violent system within which all women can safely bring new life onto these lands.

## INTRODUCTION

This chapter emerges from its intellectual gestation at a point in time when Indigenous women around the globe are tirelessly seeking reproductive justice by standing up for the right to practice their own birth and childcare ceremonies. Reproductive justice can be defined as “the right to have children, not have children, and parent the children we have in safe and healthy environments—[and] is based on the human right to make personal decisions about one’s life, and the obligation of government and society to ensure that the conditions are suitable for implementing one’s decisions” (qtd. in Hoover et al. 1645). This movement toward reproductive justice exists on multiple sociopolitical levels; it is at once a struggle to reclaim Indigenous birth practices and sovereignty over the family; a demand for customary rights and emerging forms of matriarchy; and a movement toward self-determination and community resurgence. The reclamation of Indigenous birth is *not* a struggle for recognition by the Canadian state. It is *not* a struggle for cultural preservation to salvage a disappearing tradition. A movement toward Indigenous birth does not occur in opposition to the settler state and its desires or values; it stands alone and involves the resurgence of ceremonies and practices that, at their core, assert the futurity of Indigenous peoples by honouring the very first environments—the mother’s womb (Cook 79).

This chapter begins by giving a brief history of some of the key challenges to Indigenous pregnancy and birth in the settler colonial context in the lands commonly known as “Canada.” We then move on to some of the contemporary challenges faced by Indigenous communities when it comes to maintaining Indigenous birth practices in settler colonies. Specifically, we highlight some

of the work being brought to life by Indigenous scholars and community advocates, many of whom are investing their time and energy into advancing Indigenous reproductive justice in Canada. In the following pages, we aim to interrogate the layers of meaning, conflict, and opportunity associated with the joining of the terms “Indigenous” and “birth” into ideology and praxis. We will ask the following: what makes Indigenous birthing practices distinct from other birth methods? How does Indigenous birth stand alone as a decolonial project, and how does it become part of the broader politics of pregnancy, birth, motherhood, and childrearing in settler states? These questions, and others, will be incubated in the sections below.

#### HISTORICAL CHALLENGES TO INDIGENOUS BIRTH MODELS AND INDIGENOUS MIDWIFERY

The RCAP Report offers several recommendations aiming to “re-store justice to the relationship between Aboriginal and non-Aboriginal people in Canada” (1). The report asserts that policies put in place by the Canadian government to “heal” Indigenous Peoples are often well intentioned but “wrong for the job” (1). Specifically, the RCAP Report highlights that Indigenous Peoples’ health is based on “the connectedness of human systems,” the environment in which healthcare is administered, and “personal responsibility” over health, which Indigenous Peoples determine is “as important as professional expertise” (5-6).<sup>6</sup>

Good intentions alone have not alleviated the health discrepancies between Indigenous communities and the rest of Canada. In fact, the recommendations RCAP intended to put into practice still hold relevance now as they resurface in the 2015 Final Report of the Truth and Reconciliation Commission of Canada (TRC). The report stresses that “Indigenous peoples have the right to be actively involved in developing, determining, and administering health programs that affect them” (207), and also “have the right to traditional medicines and to maintain their traditional health practices” (207). The TRC calls upon “those who can affect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of

Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients” (210).

When it comes to reproductive rights, one of the central challenges in honouring the TRC’s commitment is the fact that birth practices do not fall comfortably within the realm of “healing practices”; pregnant Indigenous women do not require a cure or “treatment” for symptoms. Indigenous women will give birth, will give life, and will bring forth a new member of the community. This is a process of gifting, not of removal. A gift necessarily requires a receiver, whether a community member, a midwife, a friend, or even the labouring woman herself. The gift of birth should not (in most cases) require a healer or medical practitioner, only a supporter. This explanation may seem redundant, but pregnant women have been pathologized and birth medicalized to such an extent in Euroamerican societies that this reconceptualization of birth, not as a procedure but as a sacred gifting process, is a necessary rearticulation.

Midwives are crucial receivers in Indigenous birth, and active agents of the Indigenous reproductive justice movement. Paramount to many Indigenous birthing practices, the role of the midwife is to provide education in maternal, family, and community health (NAHO, “Midwifery” 4-5). Traditionally and contemporarily, an Indigenous midwife coaches women on lifestyle changes in addition to creating programming pertaining to diet, home life, substance-use challenges, and emotional and spiritual wellbeing. As such, Indigenous midwives provide a holistic support system to pregnant women throughout the childbearing cycle (Midwives of Sudbury).

Women’s traditional practice as healers and midwives was a respected vocation wherein women primarily supported women during childbirth, not just for the benefit of the birthing mother, but to provide female caregivers the opportunity to apprentice with more experienced midwives (NAHO, “Midwifery” 5; Anderson 48). From this apprenticeship, younger women learned about the “*people’s medicine*” from the older midwives (Ehrenreich and English 22, emphasis in original). Overall, birth was a time for women to honour and celebrate the “prodigious power” they held as life givers (Corea 303).

Challenges to maintain Indigenous birth practices began soon after settlers arrived with new ideas of health and the female body. In the early twentieth century, philanthropic foundations, such as the Carnegie and Rockefeller Institutes, gave financial backing to create a medical profession excluding women; thus, the new sciences and technology were only allowed for use by male physicians who propagated their superiority over not only midwives but “the mystique of women [pregnancy]” (Stirbys “Without” 3). The eventual decline of the midwife’s role began with the patriarchal notion that women did not have the intellect to practice medicine (NAHO, “Midwifery”). Medicine was for male practitioners only, who eventually transformed obstetrics into a “lucrative business” (Ehrenreich and English 20). With the newly established medical profession, male physicians campaigned against midwifery and claimed it was unsafe because midwives lacked formal medical training (20). Ironically, midwives taught medical students about pregnancy and birth at McGill University in Canada until the late 1880s (NAHO, “Midwifery”). Nonetheless, discrediting midwives had “more to do with business, politics and economics than developing new and innovative ways to reliably secure the safety of mothers and children” (Stirbys, “Without” 3).

Changing attitudes toward midwifery continue to affect Indigenous women’s access to birth plans rooted in their communities’ customs and practices. Although midwifery was once “the customary, respected practice even among the colonists,” with the creation of the medical profession physicians began almost unanimously promoting biomedical-birthing interventions over midwifery (NAHO, “Midwifery” 7). At this time, physicians were relegating Indigenous knowledge of childbirth to the past, as something not quite on par with the scientific and technological advances of the medical profession; they framed Indigenous birth methods as ‘risky’ by comparison. According to many Indigenous peoples, this formula for biomedical risk has contributed to the design of government policies and legislation that “undermine their collective sense of identity” and chips away at their “right to be self-governing, self-determining peoples” (Canada, RCAP 23). Overall, Indigenous birthmothers in Canada have “come under increasing surveillance and ideological control” since colonization

(Fordyce and Maraesa 1), and their reproductive freedoms continue to be threatened under these conditions today.

### CONTEMPORARY CHALLENGES TO INDIGENOUS BIRTH MODELS

Indigenous women seeking customary birth methods in their communities may face many challenges. Primary amongst them is the dominant ideology that giving birth in community with the help of a midwife alone puts them at risk of “reproductive danger” (Fordyce and Maraesa 1). This fear mongering around reproductive risk has fuelled the development of medical policies, public health campaigns, and development initiatives that claim to mediate these risks (Fordyce and Maraesa 1). For instance, in the early 1970s, the federal government began implementing the policy of “evacuation” requiring that all pregnant women residing in “isolated and under populated northern areas of Canada travel to urban hospitals in the south, several weeks before their expected due date” (Bourgeault et al. 3).

Although this practice was framed as a way of “mediating risk,” it has been reported that forced evacuations have resulted in the “breakup of families, the loss of community knowledge about birth, and health problems [for] women who must sit for weeks in southern cities waiting to go into labour, with strange food, little exercise and no family support” (Daviss 445). This process has been most traumatically felt in Inuit communities, where there was once a “near obliteration of their childbirth practices” (Stirbys, “Without” 16). For the Inuit this has become a “focus of political, community, and personal outrage” (16).

Tr’ondëk Hwëch’in scholar Rachel Olson argues a link exists between the advancement of colonization and practices designed to control the bodies of Indigenous women (Olson 178):

I see that taking the job of midwives and moving birth into the hospital is something that is akin to colonization.... Most non-native people, and even some native people, would see this as just something about modern life. But I am not convinced and I don’t think I will ever be convinced,



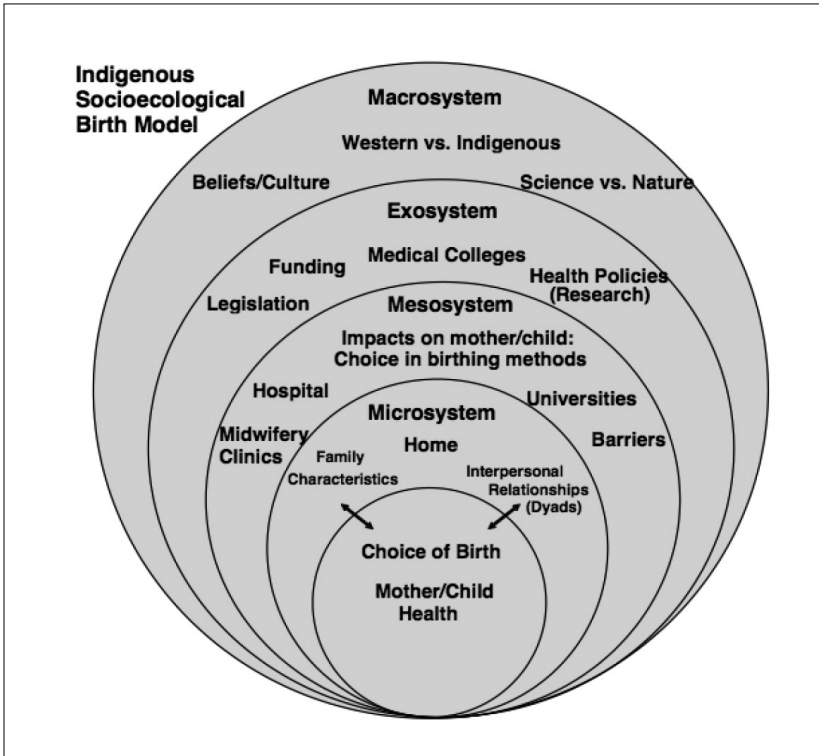
that we needed to have modern life that much...Just like taking our land, they took our bodies. And they used women's bodies. And we can look at that through history, that this was the way people conquered...conquered the land, conquered the people...[I]t wasn't always negative, but I think in the case of birth it did become negative, because we [midwives] were made useless. (178)

Policies removing birthmothers from their communities as a means of mediating risk are a classic example of the self-congratulatory efforts of the settler state to save Indigenous peoples from their own so-called risky practices (Ross; Di Tomasso and de Finney). These impositions into traditional birth practices have wide-ranging and long-term effects. Giving birth outside of one's community could mean the loss of crucial opportunities for mother-child bonding, a missed opportunity for intergenerational knowledge exchanges surrounding birth, and the inability to perform ritualistic postpartum practices involving the mother, newborn, the extended family, and the land (Schwarz; Andersen; Simpson). Of particular concern, many stories tell of Indigenous women (often those who have open child welfare cases) being forced into the hospital setting to give birth only to have their newborn apprehended by a child protection agent and placed in care immediately thereafter.<sup>7</sup>

Such instances remind us that another set of risk factors linger long after a so-called safe hospital birth: the psychological and emotional risks associated with a loss of freedom over one's body; the risk of losing one's child to the system; the risk of cultural erasure and identity loss for mother and child. In the next section, we explore the multitudinous effects of an extractive approach to childbirth vis-à-vis a discussion of Urie Bronfenbrenner's adapted socioecological model.

### THE INDIGENOUS SOCIOECOLOGICAL BIRTH MODEL

The TRC and RCAP reports clearly outline that Indigenous communities have the right to access and practice their customs and/or traditions. Despite the political and constitutional recognition of



Indigenous customs, the state continues to intrude upon Indigenous women's sovereignty over the birth process. This signals a possible disjuncture between the politics of recognizing Indigenous customs and understandings of the practical forms these customs take in contemporary contexts (Coulthard; Povinelli). In this section, we will discuss some of the nuances of Indigenous birth customs that, at times, markedly challenge dominant Euroamerican birth models.

To illustrate these differences, Dr. Stirbys adapted Bronfenbrenner's socioecological model<sup>8</sup> (Bronfenbrenner and Crouter; Bronfenbrenner) through an Indigenous reproductive justice lens (Hoover et al.; SisterSong; Gurr; Weibe) now named the "Indigenous Socioecological Birth Model." Using the model, the benefits of a Western biomedical approach to birth can be measured next to Indigenous birth values<sup>9</sup> by calling attention to contextual issues such as the birthmother's family and community and the external and internal forces affecting them: social, spiritual, cultural, environmental, political, and beyond. We hope this model

can be used as a tool to assist in the development of appropriate protocols and practices that honour, as opposed to undermine, Indigenous women's experience of pregnancy, birth, and motherhood in settler states.

The Indigenous Socioecological Birth Model consists of four concentric circles encompassing the different variables affecting the choices and health of an expectant mother and child: the "microsystem," "mesosystem," "exosystem," and "macrosystem." The four levels of the model are also individually and collectively impacted by a temporal dimension called the "chronosystem" (not pictured in model).

The macrosystem represents the cultural, geopolitical, and economic context constructing different belief systems. This level allows one to reflect on the different approaches to childbirth resulting from diverse worldviews and cultural practices. Whereas a dominant Western worldview sees medical intervention and technology as a common component of childbirth, the Indigenous worldview promotes choice, whereby the woman controls where and how she will birth—whether that be with the assistance of a midwife, a doctor, or otherwise.

The exosystem acknowledges the societal context in which a decision maker is situated, but specifically refers to the factors an individual cannot directly control. It highlights the societal structures impacting the scope of possibilities available to the decision maker, such as the availability of and funding for community services and agencies devoted to childbirth, or the policies and/or laws related to birth. The exosystem often determines the extent to which a woman can access different birth options. The availability of diverse birth options or practices varies greatly between Indigenous communities, especially when communities are more remote (i.e., further from a metropolitan centre) and/or socioeconomically strained. In other cases, discrepancies between Indigenous traditions and provincial laws and/or policies surrounding birth affect women's access to alternative options, such as midwifery and homebirths. When considering Indigenous reproductive justice, it is important to remember that "the ability of a woman to determine her reproductive destiny is in many cases directly tied to conditions in her community" (qtd.

in Hoover et al. 1646). These issues and their outcomes will be discussed further in the coming sections.

The innermost circle is the microsystem, which makes up the immediate social context of Indigenous expectant mothers, including interpersonal relationships, and/or the activities and roles she and her primary supporters take on. These relationships, or 'primary dyads,' consist of two people emotionally significant to each other (Bronfenbrenner). Included in the Indigenous Socioecological Birth Model's microsystem are the mother-child dyad; the mother-father dyad; the midwife-mother dyad; and the mother-other-members-of-the-extended-family dyad, which can include aunts, grandmother, friends, and children. In an Indigenous birth model, relationship building with the extended kin (both biological and relational) is central to creating a safe space for the expectant mother. As such, the midwife (or any chosen birth-supporter) considers the needs of both the mother and the family when developing an individualized birth plan.

Falling between the exosystem and microsystem is the mesosystem, which accounts for the connections between multiple microsystems (Bronfenbrenner). This level considers the potential outcomes of bridging two microsystems, and the effect this can have on the birth plan, and/or the health of mother and baby. For instance, imagine a midwife-mother dyad (one microsystem) has a meeting with an important member-of-the-extended-family, such as the maternal grandmother (another microsystem). This bridging of two microsystems has the potential to be a positive experience for all participants. Perhaps the grandmother gets along well with the midwife and becomes an active member of their birth support network; this reinforces the mother's birth choices and escalates her chances of having a minimally stressful, healthy birth. Alternatively, perhaps the grandmother does not approve of the midwife and, as such, disrupts the midwife-mother dyad; she calls her birth plan into question and creates stress negatively affecting mom and baby. This example speaks to the importance of good communication, consent, and cooperation between microsystems during the birth cycle in order to advance mother and child health.

The temporal dimension known as the chronosystem considers the historical factors or political climate that may have impacted

the birthmother or the members of their support network. The chronosystem surrounds all levels of the socioecological model from micro to macro, symbolizing that historical context has a profound effect on all levels of the system. Contextualizing the chronosystem through an Indigenous lens requires a shift away from Western notions of personhood and corporeality. Whereas Western thought sees land and body as distinct (hierarchically positioning humans above nature), many Indigenous societies believe the memories and substance of lived experience are held in the land itself; in this sense, the land has a spirit inextricable from the bodies of Indigenous peoples occupying it. This relationship between land and body crosses generational boundaries in a spiritual flow of time. The history and memory of birth is therefore felt in the fibres of the land on which the mother performs this act, which nurtures the body and spirit of her surrounding community and all the living things within it. Birth is a ceremony binding Indigenous life to the land.

Because of the connective force between an Indigenous birthmother and land, any policies or practices disrupting this connection are extremely problematic, and can leave a lasting mark on the chronosystem of which the mother, child, and community are a part. For this reason, the systematic dislocation of Indigenous life givers from their traditional territories<sup>10</sup> (or whichever community they call home) represents a direct assault on Indigenous spirits, bodies, lands, and relations. Any fissure in the sacred relationship between birth, memory, and land affects all levels of the socioecological model and, by extension, the long-term health of Indigenous families and communities.

In sum, the Indigenous Socioecological Birth Model illustrates the importance of considering all factors—social, historical, political, economic, relational, geographic, and spiritual—affecting a birthmother's decision-making process or the degree to which she can access different birth options. With these multileveled considerations in mind, it becomes easier to comprehend how challenges that may seem quite minor in any one level of the model can have a trickle-down effect and become sizable barriers to Indigenous reproductive justice. The model also shows the redundancy of policy changes seeking to break down one barrier to Indigenous birth through a Band-Aid approach while failing to address its

root causes. In the following section, we explore how the current power relations at work in the Canadian settler state affect the different levels of the Indigenous Socioecological Birth Model.

### INDIGENOUS BIRTH AND RECOGNITION POLITICS IN CANADA

Acknowledging the interdependence of the levels in the Indigenous Socioecological Birth Model, we must question policies claiming to recognize Indigenous self-determination over birth, while upholding systems creating barriers within or between its levels. As Elizabeth Povinelli importantly points out, the “cunning” of state recognition in settler colonies is that although the state seemingly acknowledges Indigenous ways of life, it tactfully skirts around the issue of “the potential radical alterity of Indigenous beliefs, practices, and social organization” (163). Indigenous birth customs are often only recognized insofar as they do not disturb medicalized standards for proper birth practices as per the dominant Canadian nation state’s macrosystem. In place of policies recognizing the nuances of Indigenous birth customs, the state more often uplifts customary practices deemed acceptable within their existing standards for “Good and Right practices” (163).

Take for instance the “Aboriginal Birthing Strategy” (ABS)—an initiative of the Society of Obstetricians and Gynaecologists (SOGC)—created with the goal of generating “action to improve the health of Aboriginal children, to address health inequities and create a framework for comprehensive, collaborative partnerships” (NAHO “Celebrating Birth” 26). The ABS highlights, among other goals, the importance of developing “culturally sensitive practices” and “listening to women’s voices” (27). These are, without a doubt, two important focus areas when it comes to improving Indigenous women’s contemporary experience of pregnancy and birth. However, other areas of the document are still arguably written in the language of biomedicine, with an emphasis on mediating the perceived risks of childbirth through “standardized curriculums” for midwives (27). Framing the goals of the ABS in this way continues to emphasize the importance of professionalization as a “safety measure”, which, ironically, was exactly the discourse that historically undermined the credibility of midwives.

Not surprisingly, Indigenous customary practices officially recognized by the Canadian government are often the least transgressive and the most tokenistic, yet they are often touted as examples of Canada's admirable adherence to the value of multiculturalism. When it comes to Indigenous customary birth practices, these efforts to gain state recognition may inadvertently trivialize Indigenous traditions. For instance, prior to colonial contact when,

midwives lived a distance away from where the delivery was to take place, it was often necessary for her to move in with the expectant mother. Living with the mother fostered an extended model of care.... By moving in with the families or being in close proximity, the midwives were able to help with prenatal and postnatal care as well as infant care. (Anderson 48)

Today, the First Nations Inuit Health Branch (FNIHB), an arm of Health Canada, proposed to work with Aboriginal Peoples, provinces, and territories as part of an initiative to return safe birthing closer to communities (FNIHB). Although the FNIHB's strategy represents an attempt to bridge Canadian and Indigenous health priorities, their goals do not holistically address the issue of proximity, intimacy, and long-term care between Indigenous birthmothers and birth supporters. For many Indigenous Peoples, the goal is not to bring birthing *closer* to but actually *back* to their communities, which follows the chronosystem's emphasis on birth, land, and memory. Therefore, a closer examination of the values underpinning traditional birth models may be necessary to inform new policies and programs that can better meet the needs of Indigenous birthmothers and their communities.

In another act of recognition that misses the mark, though the federal government has now recognized midwifery as, at minimum, a tolerated form of birth-assistance in Canada, this courtesy has not yet been extended to Indigenous midwives (Stirbys, "Explaining," "Without"). By extension, there is little (and in some provinces no) government funding for Indigenous midwifery clinics, and in all but three provinces, there is no provincial legislation under which Indigenous midwifery falls<sup>11</sup>; consequentially, there are relatively

few Indigenous midwifery clinics in Canada.<sup>12</sup> Existing Aboriginal midwifery clinics mostly offer a hybridized version of Indigenous practices “complemented” by so-called “*modern* forms of medical care” (Skye 32, emphasis added). Although these Indigenous midwifery centres may be safe spaces for a number of Indigenous mothers, the tendency to position Indigenous birth practices as antiquated in relation to modern midwifery styles remains problematic. As well, because of their limited number, these clinics do not currently represent a holistic or even viable solution to the risk of evacuated birth.

The general attitude that outside intervention is a common-sense response to Indigenous birthmothers’ current challenges foregoes more long-term investment in, and capacity building for the development of community-led, culturally relevant birth options. This issue is salient in underserved and remote communities, but it also applies to a growing number of urban Indigenous peoples requiring birth supports as well. The tendency of settler governments to extract from rather than invest in Indigenous communities is easily visible in policies such as evacuated birth, but it does not stand alone; it can be categorized alongside a whole host of other Canadian social policies that (though at times well-intentioned) simply bandage up structural issues instead of treating root problems. A more critical and specific assessment of the different barriers (financial, emotional, familial, and geographic) preventing Indigenous birthmothers from accessing safe birth options will be necessary if we are to approach this issue in a trauma-informed, long-term, and anticolonial way.

Moving forward, we must think critically not only about the alliances built to advocate for Indigenous birthmothers but the operative language used to describe the changes being sought. The labelling of Indigenous birthmothers as risky, or calling their birth practices premodern, reflects a blaming logic that first victimizes and then seeks to save Indigenous bodies, often under the guise of reconciliation. Breaking down barriers to Indigenous women’s access to their own birth practices requires assessing where colonial traces linger in current health policies and making them visible for what they often are: instances of obstetric violence<sup>13</sup> diminishing Indigenous women’s reproductive freedoms. Indigenous scholars



and activists play a hugely important role in naming and critiquing instances where reconciliation and recognition politics overshadow the decolonizing of birth in Canada. These actors are responding with powerful alternatives—some of which will be explored below.

### INDIGENOUS RESISTANCE TO THE ERASURE OF INDIGENOUS BIRTH

In *Defamiliarizing the Aboriginal: Cultural Practices and Decolonization in Canada*, Julia Emberley argues that colonial policies were originally put in place to “regulate the bodies of Indigenous women by controlling their sexual, reproductive, and kinship relations” (47). The reproductive body was and remains a crucial component of colonial and neocolonial governance. Advocates for Indigenous peoples’ reproductive justice are, therefore, not only resisting the state’s encroachment on the domain of birth, but also the larger colonial project of Indigenous erasure. This section showcases some scholarship that challenges the state’s attempts to further control and confine Indigenous families by theorizing about and modeling contemporary approaches to Indigenous birth in settler states.

Michi Saagiig Nishnaabeg scholar Leanne Simpson contends a resurgence of Indigenous pregnancy, birth, and childrearing creates a foundation for sustained Indigenous nationhood. Simpson asks us to picture the Indigenous family as the “teaching ground” (L. Simpson 106) for the building of positive relationships between peoples and nations. These teachings are actualized, in part, through the “everyday acts” of mother and child (L. Simpson; Corntassel et al., forthcoming). For instance, the relationship between breastfeeding and treaty making may not be immediately obvious. Simpson, however, sees the act of breastfeeding as providing the very first teaching of reciprocity between two peoples, which sets the stage for relationships between nations (106). She argues the following: “Nursing is ultimately about a relationship. Treaties are ultimately about a relationship. One is a relationship based on sharing between a mother and child and the other based on sharing between two sovereign nations” (107). By magnifying breastfeeding as a practice through which anti-imperialist relationships are

built, Simpson illustrates the importance of the mother-child dyad being honoured as a model for healthy nation-building spiraling outward from the microsystem.<sup>14</sup>

Indigenous women across Turtle Island are coming together to signal the importance of women's bodies as the "first environments" for community growth. Cree lawyer, judge, and legislative advocate for children's rights Marie Ellen Turpel-Lafond argues that "It is women who give birth both in the physical and in the spiritual sense to the social, political, and cultural life of the community" (qtd. in Emberley 55). From this point of view, fertility and motherhood are not taken-for-granted aspects of a gendered life course but are inextricably linked to an Indigenous nation-building project reliant on the activities of women. Leanne Simpson adds: "By reclaiming pregnancy and birth, we are not only physically decolonizing ourselves but we are also providing a decolonized pathway into this world. It is our responsibility to the next generation" (28). As such, Indigenous birth secures the futurity of Indigenous communities and is, therefore, an inherently decolonial practice. By extension, we must remain critical of colonial policies couched in the language of recognition that deliberately or inadvertently "undermine [Indigenous women's] sacred responsibilities as life-givers" (Couchie and Nabigon 41-43; Patel and Al-Jazairi 55).

Evacuated birth and other extractive policies further the colonial enterprise by erasing Indigenous presences from their land. In the language of the socioecological model, these processes disrupt the chronosystem where the memory of birth is spiritually and physically invested in land and community. Resisting this form of erasure, Cherokee scholar Jeff Corntassel describes his own experience renewing a birth ceremony in a settler-colonial context. He writes,

After [my daughter] was born, the nurses saved the birth cord and placenta for me in the refrigerator. I froze it for several months while thinking of a plan for how to return it to Cherokee territory ... I wanted to motivate her to go home and feel what it's like to walk among our ancestors... to breathe in and connect with the land so deeply that you can't imagine your life without it. When my daughter was

older, I showed her where it was buried in Oklahoma, and she remembers. Through a process of renewal (retelling and regenerating this story and actions that go with it), she embodies her relational responsibilities. This is where people, place and practices converge. (Corntassel et al. np.)

Corntassel offers, by way of conclusion, “When talking about everyday, we have these new stories to share on new ways we re-engaged with our traditions.” By recounting this “living history” (np) of a postpartum land-based ceremony, Corntassel is activating Indigenous resurgence. Such stories, lived, told, and embodied in place, represent an investment in the futurity of Indigenous Peoples on lands where their presence is often erased. Building on Audra Simpson’s reminder that “colonialism is not a finished product,”<sup>15</sup> we must remember that despite ongoing colonial violence and the disruption of community-based birth practices, Indigenous families continue to grow; birthmothers and other caregivers continue to invest their love, values, and teachings into a new generation of Indigenous kin. Therefore, our intention as allies in Indigenous reproductive justice can be to hold up that love, growth, and care as a means of pushing back against the violence of settler colonial policies, to “reawaken our women to the power that is inherent in that transformative process that birth should be” (Cook 80).

That said, it is important to understand that in the process of decolonizing birth, one is not dealing with a homogenous subject (“The Indigenous Mother”) but incredibly diverse Indigenous women from various sociocultural and geopolitical backgrounds. As such, Indigenous women may choose to forego customary practices even if they do have access to them for any number of reasons, and they should not be shamed for that decision. It is the ability to decide how they will give birth, where they will give birth, and who will be present during the birthing process that is crucial. Overall, Indigenous women must be free to choose. The act of Indigenous birth is, at its core, an act of radical love<sup>16</sup>—an affirmation of Indigenous family resilience, of Indigenous peoples’ continued presence on these lands, and of Indigenous peoples’ strength and futurity. Thus, in an effort to deconstruct the artificial

boundaries between politics and the body, we move forward with an acknowledgement of the real decolonial possibilities that flourish when Indigenous women are given the opportunity to decide the best path forward for their unborn children.

## CONCLUSION

This chapter has aimed to tell a story about Indigenous birth in Canada, and more broadly, Indigenous birth in a settler state. Indigenous storytelling sometimes has a circular quality (Cruikshank). Accordingly, we have told a story that will not conclude with a falling action but rather with a rising one. Today, we find ourselves in a historical and political moment in which community mobilization for Indigenous reproductive justice is quite literally on the rise; many communities are coming together to signal the importance of bringing customary birth practices back to their territories and regaining agency over life giving as a whole.

Though motivated by these forms of resurgence, we must continue thinking critically about the nature of that rising action, the ways in which those actions are taking place, with whom, and with what potential socioeconomic and political consequences. Both the RCAP and TRC, for example, make recommendations about Indigenous health. The TRC's "calls to action" ask that we advance the wellbeing of Indigenous communities in Canada through a process of reconciliation. The TRC's focus on reconciliation inextricably ties the project of Indigenous wellbeing to the reparation of Indigenous-settler relations. Here, we have to be cautious that the emphasis on reconciliation does not inadvertently bury assertions of Indigenous sovereignty beneath the contradictory goal of settler innocence (i.e., alleviating "white guilt") as per a nationalist agenda (Tuck and Yang; Sium et al.); this misguided formula for reconciliation forgoes the project of actually "unsettling" settler colonialism (Snelgrove et al.) which would, contrarily, require settler institutions to step aside while Indigenous peoples build and sustain their families and nations on their own terms.

That said if the Canadian government facilitated the resurgence of Indigenous birth practices instead of pushing back against them,

this could represent one step toward repairing Indigenous-settler relationships. Reconciliation is often framed as a reparative process between settlers and Indigenous peoples that manifests in the strengthening of a single nation—Canada; this is a violent misconception that continues to erase Indigenous nationhood. Reconciliation should instead represent a process of building a nation-to-nation relationship between Indigenous Nations and Canada. A first step in this process requires the Canadian nation state’s demonstration of respect for the very first environment, the mother’s womb.

It is worthwhile to note that Indigenous midwives originally showed this respect for settler birthmothers in the early days of European settlement. For instance, Cree and Métis educator Kim Anderson offers that one of her Elder’s stories tells of Indigenous midwives coming to the aid of settler women and assisting in the birth of “[not only] Indian babies, [but] Métis babies and French babies” alike (49). These excavated stories resurface a historical moment when Indigenous women offered settler life givers support in a time of need. Notably, Indigenous midwives did not seek to reform the birthing practices of these foreign women; rather, they drew upon their own traditional knowledge to ensure the safe arrival of settler children onto their land.

If we imagine an Indigenous paradigm of reciprocity presiding over the politics of birth in settler states, we might ask: how can settlers begin the work of reciprocating the kindness of Indigenous midwives that provided this invaluable contribution to their own families’ origin stories in Canada? How can we hold space for Indigenous Peoples to be self-determining when it comes to birth? Tackling these kinds of questions may offer new ways of approaching our activism and engagement. By critically analyzing the relationship between reconciliation, decolonization, and birth, we can begin to explore a necessary reframing of Indigenous reproductive justice in Canada: one that combines recognition and repatriation from the settler state with an ongoing lateral flow of respectful knowledge exchanges between nations about life-giving. To achieve reproductive justice, we can learn from those early stories of Indigenous midwives and settler birthmothers who set the tone for a nation-to-nation relationship—one

that did not seek to reform but to *support* each other's ways of knowing, being, and birthing.

#### ENDNOTES

<sup>1</sup>Dr. Cynthia Stirbys is Saulteaux-Cree from the Cowessess First Nation. Her master's research focused on reclaiming Aboriginal midwifery practices, and she continues examining how to optimize Indigenous women's wellness in Canada.

<sup>2</sup>Erika Finestone is a settler of Polish and Romanian descent and Jewish ancestry. Her family settled on the unceded territory of the Kanien'keha:ka in what is now commonly known as Montreal, and she is now a grateful visitor on the traditional territory of the WS'ANEC' (Saanich), Lkwungen (Songhees), Wyomilth (Esquimalt) peoples of the Coast Salish Nation. She is a doctoral candidate in the department of anthropology at University of Toronto, and is currently conducting research with the urban Indigenous community in Victoria, BC, on the topic of family resilience, kinship, and nationhood.

<sup>3</sup>For the purpose of this chapter, we have decided to use the word "woman" to describe female-bodied life givers because of the chapter's specific focus on pregnancy, birth, and motherhood. However, we are aware that this choice of language may be exclusionary to other female-identified folks who do not either have the capacity or desire to give birth. We acknowledge this choice and remain open to critical feedback about how we could frame the content of this chapter in a way that more appropriately acknowledges and honours the LGBTQIPA community. It is worthwhile to note that our focus on women and birthmothers does not connote an underestimation of the crucial role other caregivers (many of whom may not be female identified) play in the life of a child.

<sup>4</sup>In her book *Becoming An Ally: Breaking the Cycle of Oppression in People*, Anne Bishop gives instruction on how to critique one's own privilege and identify how it has played into other people's oppression. She describes how to use this form of reflection as a means of understanding how to be a good ally in combating those oppressive structures with the people it has disenfranchised. On her website [www.becominganally.ca](http://www.becominganally.ca), she describes "being an ally" in

the following way: “Allies are people who recognize the unearned privilege they receive from society’s patterns of injustice and take responsibility for changing these patterns.” Our chapter borrows from this idea of allying to tease out the ways in which women of different levels of privilege can begin productive conversations and organizing around how to reform the system so that all women can more easily access reproductive justice.

<sup>5</sup>Dr. Willie Ermine coined the phrase the “ethical space of engagement” in his 2007 paper by that same title. He describes it in the following way: “The ‘ethical space’ is formed when two societies, with disparate worldviews, are poised to engage each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue between human communities. The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous legal issues and particularly to the fragile intersection of Indigenous law and Canadian legal systems” (1).

<sup>6</sup>RCAP recommended that all governments should base their Indigenous health policies on the following principles: holism, that is, attention to the whole person in their total environment; equity, that is, equitable access to the means of achieving health and rough equality of outcomes in health status; control by Aboriginal peoples of the lifestyle choices, institutional services and environmental conditions that support health; diversity, that is, accommodation of the cultures and histories of Aboriginal peoples that make them distinctive within Canadian society and that distinguish them from one another (5-6).

<sup>7</sup>There has recently been increasing reports of newborns immediately removed from “precarious” mothers at birth, often straight out of the hospital. Some of these women have open files with Children’s Aid Society or the Ministry of Child and Family Development, or have been incarcerated. In one particular case at the Maple Ridge Prison where it was legally decided that inmates were allowed to “keep their babies while incarcerated,” two babies born to Indigenous mothers were apprehended by the Ministry of Children and Family Development “and separated from their mothers within

hours of their birth” (Corbett). Although these women were taking part in a prison-based “prenatal education” program and “parenting programs” through a “mother-child unit” (Corbett), this training was disregarded. It was noted by Dr. Ruth Elwood Martin in personal correspondence with the prison administration that “these babies have irrevocably lost the opportunity to breastfeed and establish vital maternal-infant bonding, which research has demonstrated benefits infant development and adulthood health, and reduces recidivism for their mothers” (Corbett).

<sup>8</sup>Dr. Stirbys originally adapted the Bronfenbrenner socioecological model shown here for the purpose of her master’s research on the reclamation of Aboriginal midwifery practices in 2006 (Stirbys, “Without”).

<sup>9</sup>In our use of broad designations like “Western” versus “Indigenous,” we mean to fulfill a specific goal of this chapter which is to begin a discussion of what makes Indigenous birth unique, especially in a settler context where dominant ideas around birth seem to disrupt Indigenous ontologies of kinship broadly and birth specifically. However, by doing so, we recognize the risk of reinforcing artificial dualities like the “West/Rest” divide that is, at times, used to further an imperialist agenda rather than disrupt it. For a more complete discussion of this topic see Chapter One of Michel-Rolph Trouillot’s *Global Transformation: Anthropology and the Modern World*.

<sup>10</sup>This mention of the dislocation of Indigenous women from traditional territories is deliberately broad, referring to the many systematic and structural ways in which Indigenous women have been removed from their lands since European contact. Women have been dislocated in multiple violent ways: some have lost status through enfranchisement, or lost status and been forced off reserves as per Bill C-31. Some women were removed into Indian Hospitals (see Laurie Meijer Drees’s book or Karen Tote’s *An Act of Genocide*) land during residential schools. Today, many Indigenous girls are apprehended from their lands through the child welfare system. Many women are criminalized and institutionalized in federal prisons. There are countless ways in which Indigenous women are forcefully dislocated from land, and the subsequent limitations this places on Indigenous women’s ability



to access culturally safe Indigenous birth methods should not be underestimated.

<sup>11</sup>Midwives work without any appropriate legislation in the Northwest Territories, Nunavut, Yukon, Prince Edward Island, New Brunswick, and Nova Scotia. Only three provinces have specific midwifery legislation: Quebec, Ontario, and Manitoba (NAHO, “Midwifery”).

<sup>12</sup>A list of the twelve existing Indigenous birth clinics in Canada can be found on the National Aboriginal Council of Midwives (NACM) website at the following address: <http://aboriginalmidwives.ca/aboriginal-midwifery/practices-in-Canada>. It is worthwhile to note that in the case of British Columbia, although there are no stand-alone Aboriginal midwifery clinics, a Committee on Aboriginal Midwifery exists under the umbrella of the College of Midwives of BC.

<sup>13</sup>The term “obstetric violence” has been recently employed by scholars across disciplines to describe the violence experienced by women during the birth cycle, which could include one or all of the following: physical violence (for instance, a woman being drugged and restrained in order for a doctor to perform a Caesarean section without her consent); psychological violence (as in, if a woman is coerced into birth plans they are uncomfortable with); or emotional violence (for example, being shamed by medical practitioners and called “bad mothers” due to suspicions of continued substance-use during pregnancy, leaving their newborn at risk of apprehension by the ministry). For a more thorough description of some of the potential cases of obstetric violence experienced by women see Dixon’s article “Obstetrics in a Time of Violence”; Berry’s *Unsafe Motherhood*, or D’Greggario’s “Obstetric Violence.”

<sup>14</sup>In the book *Molded in the Image of Changing Woman: Navajo Views on the Human Body and Personhood*, Maureen Trudelle Schwarz focuses specifically on the profound spiritual importance invested in human substance (hair, saliva, fluids, blood, milk, etc.) and how these substances create and maintain a sense of Navajo personhood. It has helped our understanding of Leanne Simpson’s explanation of the importance of transferring breast milk from the mother’s body to the newborn’s body. She explains the Maussian theory of “synecdoche” to describe this process: “the principle of

synecdoche holds that people, objects, and other entities that have contact may influence each other through the transfer of some of all of their properties. The part stands for the whole” (5).

<sup>15</sup>Dr. Audra Simpson powerfully spoke these words in her January 2015 colloquium presentation at the University of Toronto.

<sup>16</sup>The idea of “radical love” has been explored by many different authors, but most likely has its roots in queer-feminist theory and critical theology.

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