For Seven Generations:

Visioning for a Toronto Aboriginal Birth Centre

REPORT FROM COMMUNITY VISIONING MEETING

Prepared by:
Janet Smylie, Sara Wolfe, and Laura Senese for Seventh Generation Midwives Toronto (SGMT)

Well Living House

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Acknowledgements

As Indigenous people and allies we will start by acknowledging the land where the gathering was held. The greater Toronto area represents traditional territory for the Mississauga, Anishnawbe, and Iroquoian peoples and was historically a meeting place where families, communities, and nations came together.

We would also like to acknowledge all of our relations – our kin who helped make us who we are, supported us in the work of this gathering and who will carry on for us in future generations.

We dedicate this report to Indigenous people living in Toronto, in particular the future generations.

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Finally and importantly, we would like to thank all of the Indigenous community members who attended and shared.

Executive Summary

This report summarizes the process and outcomes of a three-day gathering focused on exploring priorities and developing strategies for an Aboriginal birth centre in the Greater Toronto Area (GTA). The *For Seven Generations: Visioning for a Toronto Aboriginal Birth Centre*[1] gathering was held June 5-7, 2012 at the Native Canadian Centre of Toronto, Ontario. This gathering aimed to create an opportunity for members of the Aboriginal community in the GTA and relevant Aboriginal reproductive health stakeholders to inform the strategic development of an Aboriginal birth centre in Toronto. It was hosted through a partnership between *Sara Wolfe* of the Seventh Generation Midwives Toronto (SGMT) *and Dr. Janet Smylie* of the Aboriginal Health research program at St. Michael's Hospital's Centre for Research on Inner City Health (CRICH).

In planning the meeting, it became clear that just as birth is a ceremony, so too was this meeting - we would be birthing a birth centre. As a result, the gathering was undertaken in accordance with the laws and customs for ceremony as we understand them. We began with a Sunrise Ceremony and kept the Sacred Fire we started burning for the entire gathering. Elder *Jan Longboat* began the meeting with a traditional opening. Elders *Katsi Cook*, a traditional Aboriginal midwife from Akwasasne, and *Maria Campbell*, a Cree-Métis writer and storyteller, provided opening addresses and reflections throughout the gathering. We concluded the gathering with a community feast that we sponsored as a part of the Native Canadian Centre of Toronto's Thursday night Community Drum Social.

We sought the input, ideas and reflections of community members and relevant stakeholders in various ways throughout the three-day gathering. The first day focused on community birth story sharing circles, which generated a number of powerful themes. Links between kinship and the birth process were prominent in community members' stories about the power of a birth to shape families and communities. It was evident that colonization has disrupted the cultural processes of birth in our communities and continues to have negative implications for us. Many community members shared stories that highlighted the powerful potential of birth in healing families and communities. These stories also spoke to the ways in which reclaiming Indigenous cultural practices surrounding birth contributes importantly to decolonization, and in particular, to the central role of midwives in this reclamation. Finally, the sharing circles revealed that the community's vision for a Toronto Aboriginal Birth Centre (TABC) centered on an expectation of physical, cultural, social and spiritual inclusivity. The birth centre was envisioned as a midwife-led community initiative that would support Indigenous community building in Toronto and support the resurgence of Indigenous cultures in Toronto through leadership in Indigenous birthing.

The second day of the meeting included a pregnancy and birth data collection workshop in the morning and a presentation and feedback session focused on the draft strategic plan for the TABC in the afternoon. The workshop began with presentations by *Maria Campbell, Janet Smylie* and *Billie Allan*. A number

1*We use the term 'Aboriginal' and 'Indigenous' interchangeably in this report to be inclusive of all people who self-identify as Aboriginal, First Nations, Indian, Indigenous, Inuit and/or Métis in Canada as well as global Indigenous peoples.

of key themes emerged from these presentations. These included:

- Indigenous knowledge is sacred and must be both shared and received with care and respect
- Women have important traditional roles as knowledge keepers
- Data collection is an important tool for well-being
- Disparities in the collection of health information are linked to the perpetuation of negative stereotypes and generalizations about the health of Aboriginal peoples

We broke off into smaller groups to discuss a few issues in greater depth: our aims in collecting and sharing knowledge about birth experiences; the kinds of information we need to collect to support these goals; and perspectives about SGMT as the guardian for this health information on behalf of the community. On the whole, the community feedback was supportive of SGMT in collectively governing, protecting, and ensuring that our health information is used in a good way; there was recognition that there is an important need to ensure that they remain accountable to the community.

Sara Wolfe presented the draft strategic plan for the TABC in the afternoon of the second day. She explained the theoretical framework for TABC, which aimed to build an Indigenous space where women, families and communities can access culturally safe birthing care. The proposed TABC would consist of four main interconnected components: Cultural Based Program, Clinical Care, Education, and Research and Development. Following her presentation, there was an open discussion with frontline workers from various relevant GTA agencies. The discussion and feedback centered on:

- Indigenous care and identity (e.g. who the TABC would be *for*)
- Relationships with the broader community (e.g. building connections with community and other supports/services)
- Access (e.g. making sure centre is physically, socially, culturally inclusive)

The third day saw the bringing together of leadership stakeholders from local and provincial organizations with an interest in Aboriginal reproductive and maternal/child health, to provide feedback on the TABC strategic plan. The session was chaired by *Sylvia Maracle* and began with a former client of SGMT sharing her very powerful story about the transformative power of birth and the importance of the culturally secure care that she received at SGMT. *Sara Wolfe* presented the draft strategic plan for the TABC. Among the rich discussion that followed, a few important themes emerged:

- The importance of focusing on the many marks of strength among Aboriginal communities, rather than defaulting to deficit based thinking/planning, including respect for Indigenous knowledge
- Issues surrounding accessibility and inclusiveness of the proposed TABC
- The ways in which the language of risk impacts inclusivity
- The importance of Aboriginal/non-Aboriginal coalitions that truly acknowledge and address structural inequities
- Issues surrounding the ownership of evaluation processes including recognition that community based Indigenous evaluation methodologies must be used in evaluating a TABC

Throughout the gathering, community members worked on a collective art project led by Métis artist *Christi Belcourt*. The beautiful mural, which was a reflection on what spiritual world we want to bring our children into, was presented on the third day, following the stakeholder meeting. Filming was also done throughout the gathering and has been assembled in a short documentary entitled "For Seven Generations: Visioning for a Toronto Aboriginal Birth Centre".

Overview of Objectives

The intent of this planning meeting was to create an opportunity for members of the Toronto Aboriginal community and relevant Aboriginal reproductive health stakeholders to inform the strategic development of an Aboriginal birth centre in the Greater Toronto Area (GTA). The meeting evolved out of a partnership between a Seventh Generation Midwives Toronto (SGMT) and the Aboriginal Health research program at St. Michael's Hospital's Centre for Research on Inner City Health (CRICH).

Together with the support of community members, a team of Aboriginal reproductive health researchers and knowledge users from the following partner organizations, came together to ask for input from members of the Toronto Aboriginal community and relevant Aboriginal reproductive health stakeholders about priorities, needs, aspirations and opportunities for the Toronto Aboriginal Birth Centre (TABC). This input has been essential to the ongoing development of the strategic implementation plan for the TABC. The community priority setting meeting complements the ongoing Canadian Institutes for Health Research (CIHR)-funded systematic review of published and oral knowledge regarding Aboriginal birthing and reproductive care that is being led by midwife Sara Wolfe (SGMT) and Dr. Janet Smylie (CRICH), by ensuring that the scholarly findings of the systematic review are balanced with input from Aboriginal community and reproductive health care stakeholders.

By holding a three day gathering of Elders, knowledge keepers, Aboriginal community members and maternal-child and reproductive health front line workers, as well as a diverse mix of local, regional, provincial and national stakeholders (health workers, health managers, health policy makers, and community knowledge keepers), the research team was able to gather broad community level input and recommendations regarding the strategic planning of an Aboriginal birth centre for the GTA.

The meeting took place June 5th, 6th and 7th, 2012. The outputs from the meeting include this meeting report; a community generated mural art project; a short documentary using film footage of the meeting focused on the meeting process; and input on the strategic plan that incorporates community and key stakeholder feedback and recommendations shared at the meeting. Copies of the meeting report will be publicly available at or through major Toronto Aboriginal organizational and service venues. The community-generated mural will be displayed at various organizations on a rotating basis.

The specific meeting objectives included:

1. To gather more specific strategic implementation feedback and recommendations from core Aboriginal community health and social service organizations in the GTA by holding a nested half day GTA Aboriginal organizational strategic planning session.
2. To determine the needs and priorities of the Toronto Aboriginal community regarding the collection, storage, and application of health information (health information systems) to support maternal-child and reproductive health services by raising and discussing this issue specifically at both the community focus groups and Aboriginal organizational meeting.
3. To bring together additional local, regional, provincial, and national stakeholders in order to

strategically update and consult with them regarding the birth centre community consultation and strategic planning process.

4. To document the meetings and raise public awareness of the TABC planning process by producing and disseminating a meeting report and putting the Toronto Aboriginal birth search mural on display at various Aboriginal organizations throughout the city.
5. To integrate Toronto Aboriginal community priorities, feedback and recommendations from all meetings into the TABC strategic plan.
6. To share, document, and celebrate urban First Nations, Inuit, and Métis traditions and culture regarding birth and reproductive health care.

The community gathering was planned by a committed group, including the team of researchers and knowledge users, several of whom are Aboriginal midwives or other health care practitioners. This group has a strong sense of the needs and priorities for urban Aboriginal maternal-child health in Toronto. We have been told by our teachers and understand that *birth is a ceremony*. Regardless of all of the other things that happen at a birth, the transition of that baby coming through the door of the spirit world and into the physical world is considered a ceremony for that mother and child, and for her family and community.

As the time of the meeting approached, it became clear that the gathering, in and of itself, was a ceremony; we were birthing a birth centre. Immediately, ceremonial protocols were implemented and the gathering was treated in accordance with the laws and customs for ceremony as we understand them. These approaches are noted throughout the report.

This collaborative research meeting was funded by a Canadian Institutes for Health Research (CIHR) Meetings, Planning and Dissemination grant.

Figure 1: *(Left to right) Jan Longboat, Maria Campbell, Katsi Cook*

Meeting Agenda - Day 1

DAY 1 – June 5, 2012 **Birth Stories** ~ *Open invitation to Aboriginal community members and allies*	
5:30	**Sunrise Ceremony and Sacred Fire – James Carpenter**
8:00 – 9:00	**Registration**
9:00 – 9:45 9:45 – 10:30	**Welcome and Prayer** Review agenda **Opening Keynote– Iroquois traditional midwife, Katsi Cook** The significance of our birth stories
10:30 – 11:00	**BREAK**
11:00 – 11:45	**Storytelling – Cree-Métis Elder, writer and storyteller, Maria Campbell** Helping us tell our birth stories
11:45 – 12:00	**Reflections – City Councillor and Co-Chair of Aboriginal Affairs Committee, Mike Layton**
12:00 – 1:00	**LUNCH**
1:00 – 3:00	**Community Sharing Circles – Birth Stories** Small groups to share our birth stories and visions for a birth centre
3:00 – 3:30	**BREAK**
3:30 – 4:15 4:15 – 4:30 4:30 – 5:00	**Community Sharing Circles – Birth Stories (continued)** Small groups meet back together to share What are the biggest priorities for an Aboriginal birth centre in Toronto? **Intro to Community Birth Art Project – Christi Belcourt** 'Birthing a birth centre' art mosaic **Reflections and Wrap-up**

Meeting Agenda - Day 2

DAY 2 – June 6, 2012 **Community Birth Art Project and Perinatal Health Information Systems Panel Discussion ~** *Open invitation to Aboriginal community members and allies* **Frontline Stakeholders Working Group ~** *Invitation to frontline stakeholders*		
9:00 – 9:15	**Welcome and Opening Reflections**	
9:15 – 10:15	**Collecting and Sharing Knowledge About Birth Experiences as a Tool for Wellbeing: Community Workshop** w/ Maria Campbell, Billie Allan, Janet Smylie "What makes young Indigenous families well and how do we know?"	**Community Birth Art Project** Christi Belcourt (max. 20 participants)
10:15 – 10:45	**BREAK**	
10:45 – 12:00	**Collecting and Sharing Knowledge About Birth Experiences as a Tool for Wellbeing: Community Workshop** (continued) ~Community Feedback/Input	**Community Birth Art Project** (continued)
12:00 – 1:00	**LUNCH**	
1:00 – 3:00	**Frontline Workers Meeting** Discussion on needs and priorities for a 'Toronto Aboriginal Birth Centre' Feedback on TABC draft strategic plan	**Community Birth Art Project** (continued)
3:00 – 3:30	**Reflections and Wrap-up**	

Meeting Agenda - Day 3

DAY 3 – June 7, 2012 **Leadership Stakeholder Meeting** ~ *Invitation to leadership stakeholders* **Closing Keynote & Reflection, Community Feast** ~ *Open invitation to everyone*	
9:00 – 1:00	**Research Team Meeting** Pulling together the feedback and revising draft plan for leadership stakeholder meeting
1:00 – 2:45	**Leadership Stakeholder Meeting** Meeting opening – Maria Campbell Midwifery client story and perspective Presentations on stories and community/frontline feedback from DAYS 1 and 2 Part 1 – Discussion and feedback on draft Strategic Plan
2:45 – 3:15	**BREAK**
3:15 – 4:30	**Leadership Stakeholder Meeting – Continued** Part 2 – Discussion and feedback on draft Strategic Plan Art mural project presentation
4:30 – 5:15	**Closing Keynote & Reflections – Maria Campbell**
5:15 – 5:30	**Traditional Closing – Sylvia Maracle**
6:30 –	**Community Feast and NCCT Drum Social**

Figure 2: *(Left to right) Jan Longboat, Sara Wolfe, Janet Smylie, Cheryllee Bourgeois, Bernice Downey, Katsi Cook, in discussion, with Wampum Belt.*

Day 1 – Sharing Our Birth Stories

1.1 OVERVIEW OF DAY 1 – JUNE 5, 2012

The gathering began with a sunrise ceremony at 5:30 a.m. outside the meeting venue, the Native Canadian Centre of Toronto (NCCT). A local knowledge keeper, *James Carpenter*, led a pipe ceremony as the sun came up and spoke of the importance of acknowledging creation every day. A sacred fire was lit at the sunrise ceremony and the fire burned for the entire three days (day and night) of the gathering. Tobacco and cedar were available for community members to put into the fire throughout the gathering.

Elder *Jan Longboat* began the meeting with a traditional opening. She stated this was a historic event and noted that on this day, June 6th, 2012, there was a full moon and Venus was traveling across the sun in an event that will not occur again for one hundred years. Focusing on the significance of sharing our birth stories, Elders *Katsi Cook*, a traditional Aboriginal midwife from Akwasasne, and *Maria Campbell*, a Cree-Métis writer and storyteller, provided opening addresses. Maria Campbell was the dedicated Elder for the event, guiding us throughout the three-day gathering. Reflections on the morning's talks and advice on how to ensure that local municipal government hears the community were provided by *Mike Layton*, Toronto City Councillor and Co-Chair of the city's Aboriginal Affairs Committee.

After breaking for lunch, we formed two birth story community sharing circles. Led by *Katsi Cook* and *Billie Allan*, these circles provided community members with an open space to share their stories about birth. We asked the groups to reflect on what their stories tell us about culture and tradition; kinships and relationships; geography; and healing and resilience. We came back together in one circle to share what we had discussed and to articulate together our community vision for an Aboriginal Birth Centre in Toronto.

There were approximately fifty attendees on Day 1. This included project leaders *Sara Wolfe* and *Janet Smylie*, the gathering's facilitator *Audrey Huntley* and organizing team members *Ellen Blais, Chloe Nepinak, Conrad Prince, Hannah Schreck, Rebecca Schreck, Genevieve Blais* and *Laura Senese*. A group of student volunteers from Ryerson Aboriginal Student Services (R.A.S.S.), a film crew from Maaiingan Productions, several midwives from Seventh Generation Midwives Toronto (SGMT), staff from the Centre for Research on Inner City Health (CRICH), and a team of sacred fire keepers from Na Me Res participated in and supported the events. In addition, approximately 30 Aboriginal community members and allies participated in the day's events. Participants were mostly women.

1.2 KEY TEACHINGS FROM OUR ELDERS

Throughout the events of the first day, numerous powerful teachings were shared by our Elders and knowledge keepers. They are summarized below as distinct entities in an effort to allow the reader to engage with the teachings on their own terms. In instances when different Elders shared similar or related teachings, their names are included after the teaching.

- ***Sunrise ceremony*** – importance of acknowledging creation, every day. Sunrise ceremony teachings – a long time ago the Eagle travelled in all four directions to save humans, who had forgotten to acknowledge creation. Finally Eagle spotted some grandparents teaching their grandchildren the sunrise ceremony. Sunrise is one of the first ceremonies that children are taught and everybody can learn it.

Jan Longboat:

- ***History in the making*** – Full moon and Venus (representing women) travelling with us.
- ***Dish with one spoon wampum*** – agreement that when people travelled to a territory, everyone from all nations would be fed and taken care of.
- ***Women's council beads*** – laid out when women are meeting. They are made of wampum, from the ocean. There are links between water and woman; birthing connection to water.
- ***Importance of song in birthing*** "laying down our song" – Songs that celebrate creation, birthing songs – beautiful baby that comes from the stars (*Jan Longboat, Katsi Cook, Maria Campbell, Christi Belcourt*).

Katsi Cook:

- ***Influence of cosmology*** – June 5, 2012, the opening day of the Gathering, is consistent with the 13 *Imosh* on the Maya calendar round, a sacred count of the medicine of time. According to the Maya cosmological vision, the *Imosh* is a day to receive cosmic messages. It includes a duality of creation, high male intelligence, male and female energy that is balanced in the left and right arms and is easily imbalanced. Indigenous cosmology includes our Creation Stories; our original Birth Stories in which birth, dream and ceremony are interwoven.
- ***If you heal the mother you heal the baby*** – Woman is the First Environment - it is in this most critical window of lifecycle development within the mother's mind, body, and spirit -the child's first environment, first experience, first relationship - that the embodied wealth of First Nations is determined.
- ***Teaching young people about birthing through the first birth story*** – Sky woman falling from the sky to Turtle Island tells us about our relations with the universe and all things. There is a feeling of being part of something since this first birth story instructs us about our responsibilities within Indigenous ecosystems and provides us with the foundations of social development and cultural regeneration. This story belongs to Aboriginal midwifery, women's circles and unique ecosystems of Mother Earth. Sky woman exemplifies compassion, courage, and the shaping of human bodies by the cosmos. This is a life cycle teaching for women from puberty to Elderhood. Birds bring Sky woman to rest on the turtle's back which draws connections to the egg leaving the ovary and traveling to the fallopian tube and recapitulates Sky Woman's fall drawing a germinal connection to Sky woman, to our DNA, and the leadership of women including through Clan families.

- ***Importance of location and local context*** to Indigenous peoples and our belief and knowledge systems – It's not possible to grow maple trees in the desert. Our stories, beliefs, languages and knowledge are linked to specific locations and events that occur in these locations. Our bodies and landscapes are connected.

- ***Indigenous midwifery knowledge encompasses the full environment of woman's bodies*** – Not limited to physical but also includes dreams, relationships, ecology. Understanding how trauma/ environment work inside our bodies and affect our genes; girls are born with all of the cells for the next generation while men keep producing them.

- ***Link between ceremonial practices and the birthing space – Protocols of Peace and Condolence*** - When people came to our village we met them at the edge of the village, set their minds right, said words to comfort them, assuage their grief – we calmed their spirit at the edge of the woods and made sure it was safe for them to enter our village.

- ***Our people "die" at birth because birth is no longer done as was intended by nature*** – For example, giving drugs, being passed from nurse to nurse, being misplaced. This causes our babies to "die." There is a lack of respect for pain during birth. The health of children across their lifecycle depends upon the distinct advantages of natural childbirth (NSVD), breastfeeding and organic foods that support immune function, as in the "Completed Self" (Dietert, 2013).

- ***Birth story demonstrates the power of tradition and ceremony –*** Our ability to rediscover, re-engage, re-enter sacred ceremonial practice of birth. Rebirth of mothers during birth of their children – "I could hear and see everything my baby saw and I felt a great peace as I knew my baby was ok. And when he was born, I was born. In my birth I found a new meaning to life. I won't go one more day without speaking my language or let a history book we did not write define who I am or who we are as a people. It is we, the real people, who can deliver who we are within ourselves" *(Birth story related by Katsi Cook).*

- ***Pain during birth as something to be honoured and respected*** – This is the only time that pain is associated with joy. It awakens birthing mother to her personal power, often expressed as "Digging deep within".

- ***Life long, multi-generational, across family and community impacts of Indigenous midwifery and birthing care*** – Community midwives carry the knowledge, stories of how the birth experiences influences the mother, infant-child, family over time – this is sacred private knowledge.

- ***The knowledge is in the practice.***

- ***Our languages are full of ecological context.***

Maria Campbell:

- ***In our birth stories we carry the stories of our people.***
- ***Midwives as role models and the glue that held communities together*** – Strong and gentle, wise and soft-spoken; laughing and singing. They meant security for children. Many interconnected community roles – they had medicines to treat sick children, counseled people who were fighting, taught of culture through storytelling, attended to death as well as birth, prepared bodies after death.
- ***Importance of women and women's kin systems to communities*** – Métis communities were often sister communities (i.e. communities comprised of sisters and their families). This was overlooked by European researchers/systems.
- We may have been poor in money and material but we were ***rich in language, community.***
- ***Midwives as the heart and centre of this community*** – In particular when we are looking for pieces of things that were lost – our culture and our way of life.
- ***Teaching children about sex as something special and beautiful*** – Teachings about babies and birthing. These are linked to processes and teachings about gardening. For example, waiting for the first electrical storm before planting – after this 'shake up', planting the seed while the earth is wet. Maria realized later that these gardening teachings were about sex too after her first sexual encounter. Sex is not shameful.
- ***Word bundles*** – we can learn our languages one word at a time – each word has a bundle that can be unpacked. For example 'Cheechum', which means honoured one. This word connects babies and Elders and honours their connection to the spirit world. "One of the things in there is honoured one but also means other things such as holding your hand – I'm taking hers, she is taking mine – we are teaching, sharing, learning" *t*eaching of reciprocity.
- ***Be so glad when baby starts talking*** – "it's not baby talk**, it's the language of the spirit world** – and we are privileged to hear that language. We know as we get older, we will come back to that place – and babies can teach you that language again"
- ***Role as first great-grandchild was to spend time with the old ladies*** – "giving me to those ladies was making sure we saved our languages, teaching"
- ***Midwives as advocates for our children and our communities*** – intervening in the community when this was required. "Midwives work for the nation. They have authority as they birth everyone"
- ***We all carry a piece of the puzzle*** – if we come together, we can piece back the puzzle that was scattered by colonization. "There is no such thing as no culture, story, language – it's not lost – it's out there and everyone has a piece of it…when we put the pieces together at first the puzzle does not make sense, but eventually it will, we will rebuild it together"
- "Even **learning one word of your language a day or a month** – pretty soon you will have a great big bundle – stuff it under the bed and go learn another word – and soon you will be sitting on a bed of dreams"

- **"A new cycle is starting – it will be a hard one but in the end, a powerful one.** The current cycle started in the 1960's – we were lucky with grants but it caused fights – what will save us in the end is coming together and putting our stories together. It's like we will start a new kind of healing"
- ***Role of the first child and helper during birthing*** – keep kids busy, tidy, prepare tea, cook.
- ***Sinew ropes used in birthing*** – "Any bedroom had round metal things for putting ropes made of sinew for the birthing"
- ***Washing babies in sage water***
- ***Warming up bear grease that the baby would be washed in*** – "The bear is the most powerful medicine person of all as the fat is full of most of the medicine found in the land"
- ***Preparing the placenta*** – It's important to place the placenta in the ground because is ensures that we can "find our way home". "No matter where we went in the world, our spirits would come back to place" – like a spring or invisible cord. "So keep your placenta and place it somewhere important to you – does not necessarily have to be home – but pick a place that feels like home to you. Bring your child there as well – and talk about the story that as long as this is there you will never be lost."
- ***"You don't have to be here, you have choices"*** – For Maria the placenta and the story behind it were key to her recovery from addictions. It helped her come back home and brought her back to a place where there were Elders who taught her this and believed in this.
- ***Time for women to create change – men will be strong enough to nurture this change.*** In the past, the reclaiming came from men across Canada who were Elders – they always spoke about the importance of women. Men have had their time.
- ***"Storytelling is the medicine we need now*** – What will help us through are the stories that we will say to each other. Even if you feel you have no story or culture, you do have a piece of it. Don't believe that your story is not important – it does not matter what kind of story it is. We need it – it's a little medicine that comes out"
- ***Telling your story is going to hurt*** – but crying is good for us. Babies teach us this all the time, because it's not good to hold this in.
- ***"Even what is bad can be a powerful teacher and guide*** that we can use because it is medicine that is going to heal us and heal each other. If you think you have a negative story, there is a flipside to that, just as we have nighttime and daytime and each is equally important to us"
- "When midwifery was no longer allowed, when breastfeeding was not allowed and was replaced by carnation milk and there was no more laying out of people who had died. It was done by funeral homes and when people died in hospitals instead of at home – something else also broke in the community and there was a loss that happened"

- ***Old women also knew about birth control*** – "My great grandmother said that in olden times women didn't have lots of kids – we never had more that we could grab in a battle – more than we could protect. The only time we had lots was after an epidemic -– otherwise we never had more than you could look after"

- ***Our community can be here in downtown Toronto*** – "In urban centres we come from all over but create unity. **A birthing centre can really hold this together**. In the urban centres is where we could have some kind of self-determination"

We would like to acknowledge the powerful teachings that our Elders and knowledge keepers shared with us. These teachings provided a strong backbone for the gathering, which shaped and enriched the whole process.

1.3 THEMES FROM BIRTH STORY SHARING CIRCLES

As the Elders' teachings make clear, birth stories are layered and complex; they are full of symbols and structures that contain important teachings. The telling of birth stories is a powerful means of owning and reclaiming birth as Indigenous peoples. A number of themes emerged when we came together as a community to share our birth stories and they are summarized below.

Kinship and the Birth Process

Our sharing circles acknowledged that the birthing process is a ceremony that honours and re-enforces our connections to each other, to the environment, and to Creator. It is essential to respect and honour the birth process as a ceremony.

Many community members reflected on the transformative capacity of the birth process. Birth was discussed as a means of reconsolidating kin ties – of reestablishing and reinforcing vital family and community relationships. The role of extended families in supporting women through the birthing process was clear. Many community members shared birth stories in which the excitement and fear around birth was shared among family members. For example, one grandmother explained how when her first grandchild was born, she

> "was as joyous as when I had my own daughter. After the baby was born… I had to call my ex-husband but I was so upset I had no one to share it with. I had no one to tell, running around saying it's a girl, it's a girl! I was so thrilled. Most wonderful thing I've ever experienced".

The potential for a birth to impact entire families was also highlighted in the sharing circles. One participant explained that her mother had had a traumatic birthing experience, which contrasted with her own very supportive, midwife-led birth experience. She expressed that she was "glad I was able to give that to my mom. And I helped heal her. She found trust in women and our bodies. She says now I'm her hero… She still tells her story the same, but she implements mine into hers".

It was clear from the stories shared that the birth experience has tremendous power that can act as catalyst for change and reconnection with culture. A birth story, relayed by *Katsi Cook,* expressed how giving birth to her son helped one woman find her way back to her culture:

"…when he was born, I was born!...In my birth I found a new meaning to life. I'm not going to go one more day not speaking my language. I'm not going to go one more day letting a history book that we didn't write define who I am, and who we are as a People. I'm not going to live my life that way anymore because I now know we can do this"

Birth Interrupted

Though the links between the kinship relationships and positive birthing experiences were clear from our circles, the stories shared by community members also spoke to the ways that colonization disrupts these cultural processes. Historical and ongoing colonial abuses have disrupted kinship systems and the transmission of Indigenous knowledge and practices through kin lines. The stories shared in our circles highlighted how these how colonial abuses are manifested in the birth process.

One significant way in which women expressed these experiences was through the multigenerational impacts of sexual abuses in their families, resulting in feelings of shame; gaps in their knowledge surrounding birth and reproduction; and the encroachment of past trauma on subsequent birth experiences.

Another important experience of colonial abuse was found in community members' interactions with western biomedical reproductive health care. A number of community members described the care they had received from doctors in hospitals as cold, gruff and isolating. They also spoke about the disregard they felt in biomedical settings and the lack of support they felt they were receiving from the health care practitioners. For example, one woman noted that the "doctors were pretty disinterested and didn't care. My grandma caught me…she was the one paying attention…the regular doctor was gone" Another woman explained that she felt very disconnected, ill-informed and unsupported in the care she had received at a hospital:

" I didn't know anything that was happening. Back in that day they shaved you and gave you an enema. There was no control over anything. I was in hospital for 2 days and they induced me. Then I had an epidural, I had no knowledge of anything, felt alone at that time. It was pretty traumatic and was during a snowstorm."

Indigenous knowledge and traditions have been dislocated and broken up through the imposition of western knowledge systems in ways that undermine Indigenous reproductive and birthing knowledge and practices.

Birth as Healing and Reclaiming

In addition to highlighting how colonization has 'interrupted' birth, the stories shared by community members also suggest how these forces are resisted by Indigenous communities through the reclamation of Indigenous birthing practices and traditions. Through the culturally secure and inclusive care that they provide, midwives are central to this reclamation.

In describing the support they had received from midwives at SGMT, sharing circle participants showed how they drew strength from this care. They noted the importance of working with women who already had an understanding of where they are coming from. For example, not needing to explain to their care providers about histories of sexual abuse or about high levels of mobility and the ways that these realities will impact the support that they'll need throughout the birth process, was key.

Women also spoke about how important it was to receive midwifery care centered around Indigenous cultures and traditions. For example, one woman noted, "how healing it was not to explain my culture in order to receive care and not feel shame and embarrassment but feel supported for what I wanted in my pregnancy" The notion that participants drew strength from the culturally secure support they received from midwives at SGMT came up often. One woman explained how the care she received at SGMT allowed both her and her husband to connect with their culture:

> "For my husband, who is Cree, it was very healing for him. To welcome his baby girl and to feel extremely comfortable… he felt a lot of disconnection in his past, so for him as a Cree man who's very traditional, it was a really powerful experience."

From the strong grounding provided by the midwives, women shared how they were able to deal safely with issues that came up for them in their pregnancies, such as sexual abuses, issues with their own birth or parenting experiences. One woman explained that "it was very healing for me to be able to be surrounded by women who could offer such love, care and support. How I felt connected to my body or my role as a woman, they helped me with that and I have so much gratitude for that" Others spoke of the ways in which receiving culturally secure care at SGMT had given them the sense of acceptance and support to make their own decisions about their pregnancies and birth options. Some also explained how this care had empowered them to demand this type of care in other care settings:

> "It was like the opposite of every health care experience that I've had. I did not have a perception of health care as kind, or somewhere I could be myself, my whole self…So having my baby with Seventh Generation [SGMT] was having a different experience of receiving care. I should be entitled to that same care wherever I go, whether it is a mammogram, checkup, etc.; that respect you would want to receive in care from a midwife."

The impacts of such care were not restricted to the women having the baby – the birth stories expressed the power of a positive birth experience to impact not just individuals, but also their families and communities. The sharing circles highlighted the ways in which a positive birth experience has the potential to initiate significant, life-long change, which is carried on into future generations. One woman explained that

> "having these incredible midwives who grounded me and my family, being able to create our own space… the experience of giving birth in this way has empowered me for the rest of my life in a way that nothing else could."

It became clear throughout the sharing circles that the work of midwives who provide Indigenous centered care is central to ongoing processes of Indigenous reclamation and is thus very powerfully contributing to decolonization.

Cultural Security/Safety

The vision for a Toronto Aboriginal Birth Centre (TABC) expressed by the community focused on an expectation of physical, cultural, social and spiritual inclusivity. Consistent with the care that is currently provided by SGMT, community members made it clear that setting a tone of complete inclusivity

and acceptance right from the outset was a priority. That is, the feeling that everyone should be welcome at this centre, regardless of their cultural identity and the degree to which they are currently connected with their culture, their sexual and gender identities, their age or their socioeconomic status, was apparent. Urban Indigenous communities are increasingly mixed and we need spaces that welcome this diversity in a supportive way so that we can embrace our cultures and traditions. Community members described the birth centre as "a place where we can be enveloped, held in all of our complications" and where they can expect to be met where they are, on their own terms. This means engaging with everyone who wants to be there in a non-judgmental way and allowing them to make decisions about their birth with positive support.

An important part of fostering this type of space was also linked to the physical environment. Community members explained that it would be important that the TABC be centrally located and accessible by public transportation. Ensuring that the TABC supports the cultural integrity of traditional practices by providing spaces to connect with the natural environment was also clearly expressed. Having a place to bury your placenta, or offer tobacco, for example, were important concerns. It was critical that the physical space of the centre be big enough to accommodate all of the cultural teachings and events (e.g. Elders teachings) that community members wanted to have available there. The space should also be able to comfortably accommodate the families of women who had their babies there.

Birth Centre as Community

It became clear throughout the sharing circles that what we were talking about was in fact much bigger than a birth centre. In keeping with the role of midwives traditionally in Indigenous societies, what we were discussing was a midwife-led community initiative that would support Indigenous community building in Toronto. We were talking about the birth centre as an inclusive space where women and men, from all four directions could come together to celebrate and support birth and reproductive health in traditional, culturally appropriate ways. This would happen through offering diverse reproductive support (e.g. everything that comes with birth, from grief, loss counseling, to family planning, coming of age ceremonies, sexual health, and support in aging/elderly) and through fostering connections with other culturally secure supports that exist in the city. The centre would acknowledge and celebrate the diversity of the Indigenous community in the GTA. It would also provide supports for the whole family, not just the pregnant mother. It would be a place where community connections could be built and supported. The TABC would thus support the resurgence of Indigenous cultures in Toronto through leadership in Indigenous birthing.

Day 2 – Indigenous Knowledge Sharing and Birth Centre Strategic Plan

2.1 OVERVIEW OF DAY 2 – JUNE 6, 2012

Maria Campbell opened the second day of the gathering and invited *Christi Belcourt* to sing a healing song. We went around the room and introduced ourselves; there were 34 community members and allies

in attendance, including 8 frontline workers. *Janet Smylie, Billie Allan,* and *Maria Campbell* led a community workshop focused on health information systems entitled *Collecting and Sharing Knowledge about Birth Experiences as a Tool for Wellbeing*. Following presentations by the speakers, we broke off into three smaller groups to discuss our community priorities for health information data collection. We then came back together as a larger group to share our findings and discuss further. After a break for lunch, *Sara Wolfe* presented a working draft of SGMT's strategic plan and proposal for a Toronto Aboriginal Birth Centre. Her presentation was followed by a discussion that allowed us to gain feedback and input from frontline community workers about the proposal.

Throughout the entire day, a small group of community members worked on an art project led by Métis artist *Christi Belcourt*. Participants shifted freely between participation in the art project and the presentations that occurred throughout the day. In determining what to paint on their canvases, Christi invited participants to share their vision for the birth centre and to reflect on what spiritual world we want to bring our children into. The community mural is made up of five rows of unique paintings on the following themes (from bottom to top): earth, animals/insects/birds, medicines, water and the universe. She guided participants through their paintings and helped them to create really beautiful work. In describing the project, Christi noted that she wants "people who see it to feel what everyone put into it, their love and care" The community mural is on display at SGMT and will rotate throughout Aboriginal organizations in the GTA, hopefully finding its eventual home in the proposed TABC.

2.2 PREGNANCY AND BIRTH DATA COLLECTION WORKSHOP

Janet Smylie (JS), Billie Allan (BA) and *Maria Campbell (MC)* each spoke about their understandings of knowledge keeping/data collection. Some of the main points made by the speakers are summarized below:

- Indigenous knowledge is sacred; the spirit with which we share it impacts the way it will be used. We have a responsibility when we share Indigenous knowledge to have a sense of how it will be carried on, and to ensure that this will be done in a good way (*BA*). In giving our knowledge, we are demonstrating the trust and care that we have for the recipient (*MC*).

- Women have traditionally been the keepers of knowledge and have been leaders in making decisions about what to do with it; it was women who kept the stories, which contain the laws and the knowledge. Storytelling is an important form of knowledge sharing (*BA* and *MC*).

- Collecting and sharing of knowledge about birth experiences can be a tool for the wellbeing of the community – "If you want to know about the health of the infant you need to know about the health of the grandparent" (*JS*).

- There is an Indigenous basis for data collection prior to colonization – this was essential in order for people to survive. For example, the Cree word for measurement translates to 'counting with a purpose', which was the way that quantitative and empiricist tools were used to the benefit of the community. Indigenous words for knowledge are connected to words for action (*JS*).

- There are current disparities in the collection of health information; an unacceptable gap exists between the data for Aboriginal peoples and for the general Canadian population. For example, although 80% of

Aboriginal people in Ontario reside in urban centres, most data collection focuses only on reserve-based populations (*JS*).

- It is not good that we do not have solid public health data to showcase the positive impacts of our work. For example, Toronto has a high caesarean section rate, but SGMT does not; the lack of public health data for Indigenous peoples obscures the fact that Indigenous midwives are actually in a position to be leaders and role-models in their field (*JS*).

- Part of the problem with Aboriginal health data is that it is very focused on the negative; we seem to need to start with how bad the health outcomes are for Aboriginal peoples in order to get the attention of funding agencies. We should start focusing more on the strength in our communities; this does not mean that we ignore the pain and the trauma, but instead make an effort to show that this is not inherent to us. People need to know that it is difficult for Aboriginal people to heal from trauma when we are living in a society that largely ignores the impacts of colonization or tells you to get over it – "collective healing requires everyone acknowledging that something has happened" (*BA*).

- It is important that we 'own the measuring stick' in terms of data collection. It must be up to Aboriginal peoples to define the way we gather knowledge and how we define success. We need to develop coalitions in order to do this (*JS*).

We broke off into three groups led by *Maria Campbell, Katsi Cook* and *Billie Allan* to discuss the following questions:

1. What are our aims in collecting and sharing knowledge about our birth experience?
2. What kind of information do we need to support these goals?
3. What do we think about SGMT taking the responsibility on behalf of the community to collectively govern, protect, and ensure our group health information is used in a good way?

The questions generated a lot of rich discussion. The responses were complex and often brought up further questions. Collective responses from the group discussion are summarized below.

1. Our aims in collecting and sharing knowledge about our birth experience:

- Restoring the sanctity of birth; we are born with our practices and we need to restore these roles and the ceremony of birth.

- Knowing and re-affirming what makes us healthy.

- Improving our practices and services. Understanding what is working and what is not. This will include moving towards services that are supportive and helpful and away from services that shame or make women feel they are at risk when they seek birth care. Through better supporting women and their families in making well-informed choices around birth, we will ultimately, improve birth experiences and outcomes.

- Healing – telling our stories and being able to manage our knowledge in and of itself, is a form of healing.

- The existing ways that data is collected are flawed and incomplete; this causes fear and distrust around data collection. It also takes data out of context so we do not see the whole story. We can manage and direct our own data collection using an Indigenous framework. This will ensure that it will be used more effectively.

- Having the numbers will also help us better support arguments for change.

- Centering our women's knowledge – women's health should be defined by women's stories. Women need to govern and take care of our knowledge. We also need to create space to include the stories and experiences of men in the context of birth.

- Including the diversity of our nations, identities and life experiences in the systems we develop to collect and share this knowledge.

2. The kind of information we need to support these goals:

- Identify Aboriginal people in a way that allows people to self-identify and is not limited to First Nations, Inuit and Métis identities.

- Data collection and storytelling can be one and the same if done in an appropriate way. We need to develop systems that allow us to do this. It will be important that they demonstrate health in the big picture over a long period of time (e.g. linkage of birth information over multiple births – ripple effects of 'difficult birth' to next birth experiences – over lifespan, across kin lines, family stories) because currently, our data collection methods only capture a small part of the story and we are missing out on a bunch of other data that is just as important.

3. Perspectives on SGMT taking the responsibility on behalf of the community for this health information:

- Concerns about the added expectations on the midwives – how will they be able to do this in addition to all of their other responsibilities? How can we, as a community, support them in this role – how can we help our helpers? Keeping specific files and using matrices might be help support midwives in collectively governing and protecting health information; they are already doing much of this work in their roles as midwives in their communities.

- Fear – within the context of high involvement of child protection agencies historically and currently. We need to be mindful of mainstream policies that still influence the situation for pregnant women and their families and how this makes women reluctant to share their information. It would be dangerous not to address this issue as this information has been used to disrupt families. We will need ways of expressing that it is a safe space to share information and to be mindful of negative connotations of words like 'health information' or 'social worker'. This is a great chance to model for policy makers.

- There is a need to acknowledge the privacy of birth stories, and that this extends to the lifecycle of individual baby. These stories need to be carried by midwives over time.

- Accountability – if SGMT is the health data custodian, we need to ensure that they are accountable to the community to make sure they are doing this in a good way. Developing a community council to fill this role would be a good idea. If we root knowledge gathering and dissemination in an Indigenous framework and we work in an Indigenous way, then accountability and what knowledge we need to gather become clear. It's all in the practice…

- The question assumes that Indigenous methods are being applied in the prenatal care, but what about Indigenous interpretation? Are midwives prepared to do Indigenous methods and interpretation in their schooling; this is something we need to think about in terms of preparing the next generation of midwives. Western medical hegemony, 'mind control', has made it so that midwives have had to prove that we are 'just as good'. Aboriginal people have had to prove we are 'just as human'. There are multiple things that prevent us from truly being who we are, for example, using pharmaceuticals from drug companies instead of our medicines and ceremonies. Mainstream knowledge resource systems support western medical hegemony; a baby born with a caul (the amniotic sac over the head) – results in seer in the community – midwife support and encourage proper development of that baby over time.

- Sharing of Indigenous knowledge and practice across space and nation.

On the whole, the community feedback was supportive of SGMT in collectively governing, protecting, and ensuring that our health information is used in a good way, but there was recognition that nobody knows, or can do, it all. We will need a multidisciplinary team, including doulas, ceremonialist, Elders; it takes a team to raise a baby. We will also need to ensure that accountability to the community is maintained.

Figure 3: *Billie Allan and Baby Ayatisowin.*

2.3 TORONTO ABORIGINAL BIRTH CENTRE STRATEGIC PLAN AND PROPOSAL

Sara Wolfe presented SGMT's strategic plan and proposal for a Toronto Aboriginal Birth Centre. The presentation outlined the collaboration between SGMT, CRICH and Toronto Aboriginal Midwifery Initiative (TAMI) on this project and acknowledged the contributions of *Nan Brooks*, from Women's College Hospital in helping to develop the proposal.

The theoretical framework that guided the proposal is presented in *Figure 4*. Birth is at the centre because Aboriginal midwives see birth as the best opportunity to impact the ways in which we will achieve optimal health for our communities. A new life represents the potential for our future. We will be healthier through healing all our generations going forward. It is not meant solely to represent the physical and specific time of the birth, but all the support, preparation, learning and interconnectedness surrounding birth and the birth year. Healing the birthing process allows a mother, a family and the community to engage and connect to her baby so profoundly that hope for the future generations and a sense of responsibility to the sacredness of that child's life is found. Surrounding the idea that *birth is the strategy*, we see the various activities that interconnect to meet the woman and infant's needs. The activities that surround birth are:

1. Midwifery – The practice of midwifery (in the sense of being the one who aided birth, usually along with many other roles they would have held) was traditionally acknowledged as a very important role to be held in the community.

2. Education – Community midwives would always have been conscious of who was going to carry on the knowledge and traditions, and an apprentice would have been chosen early on in her life and taught the ways, medicines, songs, ceremonies, etc.

3. Research – We need to know where we are coming from, where we are going, what we want and what we want to know, be a place to preserve some of the traditional practices and put back into practice, inspire innovative approaches to addressing our needs and priorities and evaluate them in a way that is relevant and respectful.

4. Indigenous Knowledge or Culture – By integrating cultural knowledge and traditional practices into midwifery, we are engaging families at a time when they are most motivated to heal, and in a way that allows a sense of pride and identity to build as Indigenous people. Using an Indigenous worldview approach to respectfully and responsively relate to Aboriginal women and families in a way that is natural and intuitive.

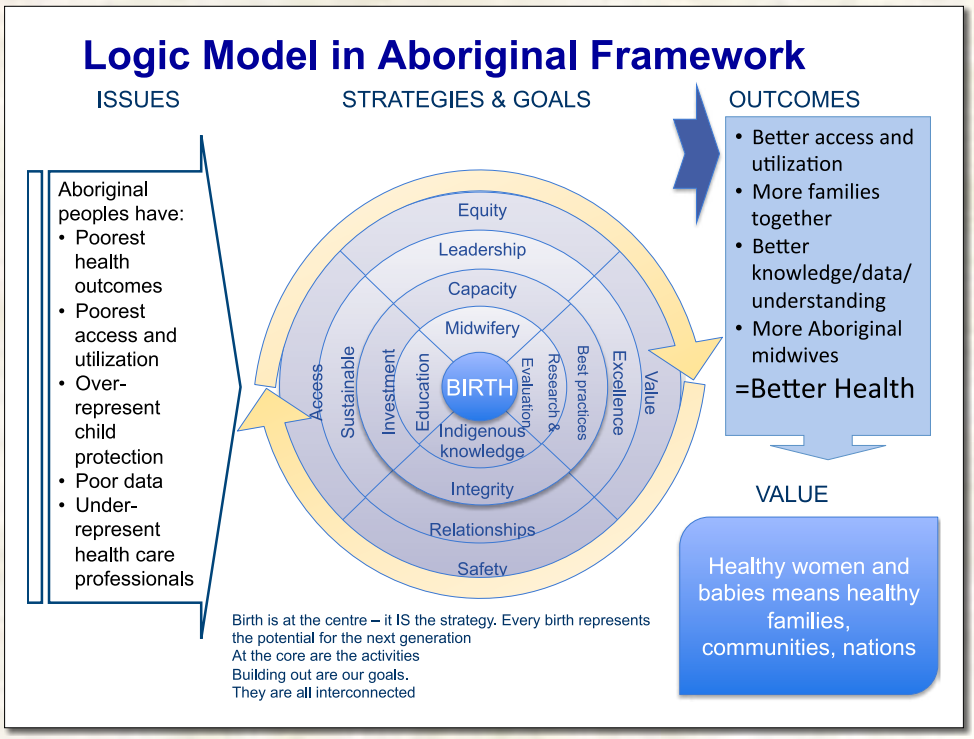

Figure 4: Theoretical Framework for TABC.

The second, third and fourth concentric layers show how the key activities overlap and build on each other to reach the goal of creating a safe, equitable, accessible service that is valued and used by the community. This will break down the barriers to achieve better health for Aboriginal women, infants, families, communities and nations. The theory is still evolving and being refined.

This theoretical framework provides the basis for the early development of a vision, purpose, model of care and specific goals for the Toronto Aboriginal Birth Centre (TABC):

Vision
To build an Indigenous space where women, families and communities can access culturally safe birthing care.

Purpose
The purpose of the TABC is to work toward achieving optimal health and wellness for the whole community through culturally centred care, education and research that support the practice of Aboriginal midwifery in its fullest scope, both culturally and professionally.

Model of Care
Aboriginal delivery framework:
- Holistic approach
- Responsive and respectful services
- Children are sacred gifts

Aboriginal midwife's role defined by the community she serves:

- Full participation, integration and collaboration in the health care system
- Support for normal birth and appropriate use of technology
- Better coordination and use of community based services (Medical, Social services)
- Appropriate use of hospital based services
- Capacity building at all levels (Service, Education and Research)
- Support families and communities

Goals

- ✓ To provide a clinically and culturally safe space that increases access to midwifery and out of hospital birth
- ✓ Support capacity building activities at all levels of academia with a special focus on support for Aboriginal learners
- ✓ To provide cultural competency knowledge and skills to the next generation of midwives and other health care professionals
- ✓ To develop a strong evaluation framework with community relevant outcome indicators
- ✓ Uphold the highest standards of care, ethics and accountability
- ✓ Improve health, increase the number of midwives, understand what we do and improve the lives of women, infants, families, communities and nations

The proposed TABC would be made up of four main components: Cultural Based Program, Clinical Care, Education, Research and Evaluation (See *Figure 5*).

Figure 5: *Components of TABC.*

An important element of the this structure is the Research and Evaluation piece, which draws on the partnership between *Sara Wolfe* and *Janet Smylie*, who have been working on urban Aboriginal midwifery and education research for a number of years. The possibility of collaborating further with SGMT to develop a community-based evaluation system to measure outcomes at the proposed TABC, was brought up.

We then had an interesting discussion and received valuable feedback from frontline workers. Some of the important points that emerged from this discussion are summarized below.

- *Youths and Risk*– we focus on youths because Aboriginal women tend to have children younger than the general Canadian population. This is not necessarily out of the ordinary or a sign of risk. Risk is a relative term; we are all at risk because of our histories.

- *Identity* – SGMT provides Aboriginal focused care. Initially, SMGT wanted to provide care exclusively for Aboriginal mothers, but funding for a population specific practice was not available. SGMT found afterward that providing Aboriginal focused care for women who identify as Aboriginal or non-Aboriginal is an important strength of SGMT's practice and has made them much more inclusive.

  > "We've been able to take care of a much broader group of families that identify as part of an Aboriginal community, or identify with having Aboriginal ancestry." (*Sara Wolfe – SW*)

- *Indigenous care* – what makes it Indigenous if non-Aboriginal people regularly access these services?

  > "Midwifery in general is holistic. It's really indigenizing the delivery of it for everyone – not just Aboriginal clients, for all clients. Everyone is getting that same fundamental framework and philosophy. That same respectful care." (*SW*)

  > "We're successful at creating space in our practice – feeling comfortable exploring how their identity affects their health and their interaction with health care. We could name a few things, for example, put pictures on our wall, have sage, but quite honestly it's just basically about we, as midwives and as a practice, acknowledge that your identity and experience affects your health care and we create a place where that can be expressed." (*Cheryllee Bourgeois – CB*)

- *Relationships with broader community* – SGMT is really good at working with other frontline workers to support clients.

  > "A big part of our work is the relationships we can build with the broader community services and seeing ourselves as part of the bigger picture instead of someone providing primary care, and 'oh here's a number for some other person' – no we build the relationships with those other resources." (*CB*)

  But there is a need to get the word out about midwifery and develop further connections with other service providers to help dispel some of the misinformation about midwifery that is out there. There's also interest in fostering more connections with sexual health service providers – it's bigger than birth.

- *Geographic access* – will the TABC be able to support women living outside of the GTA? The expectation is that the TABC would be able to work with women from outside of the GTA, as SGMT currently does. The issue for midwives is not catchment area, but the number of clients they can support.

- *Housing support* – there is an expressed need to support women who struggle to find housing with a place to stay with their baby after their birth.

Day 3 – Leadership Stakeholder Meeting

3.1 OVERVIEW OF DAY 3 – JUNE 7, 2012

A meeting of leadership stakeholders from local and provincial organizations took place on the final day of the meeting. The session was chaired by *Sylvia Maracle*, Executive Director of the Ontario Federation of Indian Friendship Centres (OFIFC). In attendance were 34 leadership stakeholders and seven research support/organizing team members. *Maria Campbell* provided a closing keynote address following the stakeholder meeting. *Christi Belcourt* presented the community art mural that community members had worked on throughout the gathering. Our gathering concluded with a community feast that we sponsored as a part of the Native Canadian Centre of Toronto's Thursday night Drum Social.

3.2 LEADERSHIP STAKEHOLDER MEETING MINUTES

In attendance:
Deb Adams (Registrar – College of Midwives Ontario)
Vanessa Ambtman (Toronto Central LIHN)
Juana Berinstein (Policy Director – Association of Ontario Midwives)
Ellen Blais (Midwife & prenatal & infant worker, Native Child and Family Services of Toronto)
Native Child and Family Services)
Genevieve Blais (student volunteer)
Cheryllee Bourgeois (SGMT)
Nan Brookes (Women's College Hospital)
Nadya Burton (Ryerson University, Midwifery Education Program)
Maria Campbell (Elder)
Katsi Cook (Elder & Midwife)
Colleen Crosbie (Midwife)
Jennifer Dockery (Women's College Hospital)
Bernice Downey (CRICH, Nurse)
Larry Frost (Executive Director – Native Canadian Centre Toronto)
Jane Harrison (Health Director – Anishnawbe Health)
Vivian Holmberg (BORN Ontario)
Audrey Huntley (gathering facilitator)
Wanda Kimewon (Jean Tweed Centre)
Jules Koostachin (Elizabeth Fry Institute Toronto)
Sara Luey (former client at SGMT)
Sylvia Maracle (OFIFC)
Monica McKay (Ryerson Aboriginal Student Services)
Heather McPherson (Women's College Hospital)
Chloe Nepinak (meeting organizer – CRICH)

Sandra Parker (Provincial Council for Maternal and Child Health)
Catherine Pawis (Toronto District School Board)
Cathy Punnett (Manager – Native Child and Family Services)
Rachel Rapaport Beck (College of Midwives Ontario)
Angela Robertson (Women's College Hospital)
Judy Rogers (Ryerson University, Midwifery Education Program)
Frances Sanders (Executive Direct, Nishnawe Homes)
Rebecca Schreck (student volunteer)
Laura Senese (meeting organizer – CRICH)
Mary Sharpe (Ryerson University, Midwifery Education Program)
Sharon Smoke (Six Nations Birthing Centre)
Janet Smylie (CRICH)
Liz Sutherland (Knowledge Translation Specialist, Echo: Imp Women's Health in Ontario)
Rebeka Tabobondung (Maaiingan Productions)
Vicki Van Wagner (Ryerson University, Midwifery Education Program)
Jo Watson (Sunnybrook Health Sciences Centre)
Krysta Williams (Native Youth Sexual Health Network)
Sara Wolfe (SGMT)
Billie Allan (PhD candidate, University of Toronto)

Introductions and Presentations

- *Katsi Cook* opened the session by sharing a birthing song called the 'Morning Star Song', in the Lakota language. She passed around tobacco for all in the group to touch then placed it in the sacred fire that had been burning throughout the gathering:

  > "I'm going to pass this tobacco around I was given in order to greet you to this place and time. I'm asking you to touch it and pass it along so all our hearts, minds and prayers can be put together and piled up, to say thank you to life itself. While we do this, I'd like you to not pay attention to me, as I'm here to ask you to put your best mind forward, to use your intellect in service of the heart, and to follow the thought of the morning is standing all over the earth, the morning is standing for a new day of birth, look at it and hold this moment close."

- *Sylvia Maracle* invited all in attendance to introduce themselves to the group and reviewed the meeting agenda. *Sara Wolfe* introduced *Ellen Blais*, an Aboriginal midwife and infant specialist at Native Child and Family Services (NCFS), and *Sara Luey*, a former client at SGMT who had been invited to share her birth story with the group. *Ellen* explained that her role at NCFS is to preserve the sacredness of birth in an urban Aboriginal context. She noted that "the pain with cultural genocide and historical trauma we have endured and colonization and assimilation…I see the trauma reflected back to me in the eyes of every woman I work with". She introduced *Sara Luey* and explained that she had referred *Sara* to SGMT. Ellen was graciously filling in for Sara Luey's midwife who was scheduled to be there but was attending to another birth.

- *Sara Luey* began by telling the group that she had struggled with addictions for 18 years. She had had four

children with OBGYNs, and they had all been lost to her and apprehended by child protection agencies as a result of her addictions. When she became pregnant with her fifth child, *Ellen* was placed in her path and directed her towards SGMT. *Sara* described the incredible support she received from the midwives at SGMT as an important turning point in her life. She explained that this had enabled her to connect with her culture and community, and thus to make the changes necessary in her life to keep her child.

> "the minute he was born and placed on my tummy, I felt in love and I knew at that moment he wasn't going anywhere. But everything changed for me. If SGMT wasn't there for me, I don't know where my son would be today or where I would be today. The community opening up their arms to me, made a huge change for me. All my life I've felt like doors have been shut in my face. I felt like I came to this doorway and there was a little crack in the doorway, and I was peering in. When they [SGMT] saw me peering in, they opened the door wide open for me and brought me in. I'm still here today and part of my community now. Because it wasn't always like that, I was adopted and lost my culture."

- *Sara Luey* finished by saying "if I felt this from that experience, how many other women could feel that as well? To have that spot here [an Aboriginal birth centre] would be great." The sharing of this very powerful and transformative birth story seemed to set the tone for the rest of the meeting.

- *Sara Wolfe* presented SGMT's strategic plan and proposal for the TABC.

Discussion

Sylvia Maracle led a discussion and questions following *Sara Wolfe*'s presentation. Four questions were posed to guide the discussion:

1. What relationships can you envision you or your organization having with SGMT or a Birth Centre?
2. How can we work together?
3. What do we need to do in order to work well together?
4. Other feedback?

- *Sylvia* invited individuals to speak about these questions and asked specifically if they would be willing to offer support from their organizations for an Aboriginal birth centre in Toronto. A number of attendees voiced their congratulations on the well-developed and thoughtful proposal presented by *Sara Wolfe*. Support was pledged by several organizations throughout the meeting and the need for collaboration between Aboriginal and non-Aboriginal organizations was stressed.

- It was noted that there were very few men in the room – *Larry Frost* (NCCT) being the only man present. He was thanked and congratulated on his courage in being there. The increasing presence of strong voices of Aboriginal women in our communities was noted.

- The importance of acknowledging and engaging youths in these types of meetings was brought forward. *Krysta Williams* (NYSHN) noted that youth make up a majority of the Aboriginal population, but are

seldom included in such talks; she expressed thanks at being invited to attend. She explained that youth are connected with our communities and traditions, but also with contemporary realities.

- Representatives from Ryerson University noted great progress had been made at the university over the past few years in creating space for Aboriginal students. In particular, the work of *Cheryllee Bourgeois*, partner at SGMT and lecturer at Ryerson, in developing Aboriginal content for the midwifery program and making this program more accessible to Aboriginal students, was acknowledged. Ryerson aims to integrate Aboriginal content into curricula throughout all programs at the university.

- Questions were raised as to whether the proposed birth centre would be open to underserved and vulnerable groups broadly (e.g. those who are incarcerated, refugees, uninsured), or would be restricted to those who identify as Aboriginal. It was expressed that a birth centre that welcomed a diversity of clients would be more likely to receive funding and would make it more possible for some organizations represented at the meeting to support the proposal. Representatives from SGMT explained that they are very effective at serving a diverse population in their current practice, including services for persons who have a history of incarceration, for refugees, and for the uninsured. They explained that they provide Aboriginal focused midwifery care, rather than care only for Aboriginal peoples. Maintaining this inclusiveness is central to the strategic plan for the proposed birth centre.

- The discussion around inclusivity at the proposed birth centre raised questions regarding respecting Indigenous knowledge and practices. Indigenous knowledge has been underestimated and has not received appropriate respect and recognition in mainstream society. In order for the Indigenous spaces that are being created in institutions to be genuine and effective, they must be grounded in community; community is not an afterthought. These institutions must be a bridge for Indigenous knowledge, but must also recognize how this knowledge is distinct from western knowledge. This will require respecting practices that often do not align directly with entrenched western practices.

- The need to bridge regulated vs. Aboriginal midwifery was discussed. It was noted that a truly Indigenous approach to birthing recognizes that the role of midwives is defined by the community, not by legislation. The need to create space for midwives working under the provincial exemption from legislation regulations at the birth centre, was brought up. There was some support in the room for 'choice of birth place', which may indicate a willingness to engage in discussions about bridging links between legislated midwives and those working under the provincial exemption.

- Some questions were raised around the language of 'risk' that is often used when discussing birth centres. This is particularly true from an evaluation and outcomes perspective – e.g. how would you support high-risk pregnancies? It was explained that risk is a relative and constructed term. Risk is a biomedical factor that is imposed on Aboriginal peoples; simply self-identifying as Aboriginal is considered a risk factor in some biomedical models. It was noted that rather than reflecting something inherent about Aboriginal peoples that would make us 'high risk', this is actually a reflection of colonization and racism. It was suggested that it is perhaps more appropriate to use the term 'medically complex'.

- It was expressed that we need support from allies who are willing to work in *coalition* with Aboriginal organizations. It was recognized (by some organizations represented at the meeting) that partnerships and

collaborations between Aboriginal and non-Aboriginal groups have not historically worked out equitably. There has been a long track record of Aboriginal peoples being 'left with nothing', even when intentions were good and the aim was to divide resources up equitably.

- The importance of acknowledging existing power dynamics and structural barriers at the outset when developing effective coalitions was raised. We need a clearer understanding of these barriers. Using the language of self-determination (not self-government) when developing (or using existing) protocols that will govern coalitions is essential; the terms must be clear at the outset in order to ensure that these relationships are fairly developed.

- It was also expressed that in addition to being thoughtful in terms of entering into coalitions with non-Aboriginal groups, it is also important to concern ourselves with 'rebuilding our own house'. Rather than focusing solely on colonial legacies, it is important to recognize that despite historical and ongoing colonial forces, Aboriginal peoples are still here and maintain strong identities. This is a huge mark of strength that should be used to propel us forward more positively.

- These issues also came up in discussions surrounding the evaluation of outcomes and quality assurance at the proposed birth centre. BORN Ontario may be responsible for conducting evaluations at the birth centres that are funded by the province. The College of Midwives of Ontario will be responsible for developing and implementing quality assurance guidelines. If a true commitment to Indigenous knowledge and practices is made in developing an Aboriginal birth centre in Toronto, it will be necessary for community based Indigenous evaluation methodologies to be used. There was agreement from BORN that evaluation methods for the birth centre would be developed in consultation with Aboriginal communities. There was confirmation from the College of Midwives of Ontario that they were aware that consultation means more than attending a meeting such as the one in question, which is more a discussion of ideas than a full community consultation. There was an expressed need for the evaluation methods to be based in Indigenous knowledge and practices, and also to speak effectively to policy-makers.

- The present government interest in funding birth centres was put into historical context over the past 20 years. It was noted that while important to acknowledge the recent work that has been done to generate this political interest, it is also key to recognize that Aboriginal communities have been actively pursuing and contributing to developing the political will to fund birth centres for much longer. The development of the birth centre at Six Nations in 1995 was given as an example.

As a conclusion to the lively discussion that we had, *Sylvia Maracle* provided a brief summary and a final call to action:

- Aboriginal people have had enormous numbers of things that have removed us from our identities; we need some space and we need to be able to do things in our own way. We've talked about physical, ethical and cultural space today, so it may appear we are talking about different things; you may not always be able to understand our teachings.

- I understand what it feels like to walk into a room full of passion and to feel like an outsider. We appreciate the work that many of you are doing and that you're going to get back to us about support

from your organizations. We understand that some of you are not in a position to be overt about your support here.

- Power, privilege and sharing of resources is a long-road; we're asking you to think about the power, privilege and authority that you possess, about where it comes from and about how you can support us through it. There needs to be an understanding that there must be a shift.

- We've presented our vision here today. We understand that there will be multiple proposals put forward. How do we take what we have shared here today and move this forward? Beyond writing letters of support, how can we form coalitions? Certain things need to happen, people need to support or get out of the way.

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