Aboriginal Midwifery: A Model for Change

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ABSTRACT
This paper will discuss indigenous knowledge and epistemologies of health and well-being as essential practices to improving the health status of Aboriginal communities. These methods will be illustrated through the practice of Aboriginal midwifery and birthing practices currently being revitalized in Aboriginal communities. Indigenous knowledge of health, well-being, medicine, and healing practices have historically sustained the health and well-being of Aboriginal communities for centuries pre-contact. However, these traditional epistemologies of health and healing have been eroded through centuries of colonial oppression and the imposition of western scientific methodologies and legislation. Through decades of acculturation, much of the traditional knowledge of health, medicine and healing has been lost. However, a recent resurgence of traditional Aboriginal midwifery has occurred in an effort to retain, revive and restore the indigenous knowledge of Aboriginal communities. The revival of traditional Aboriginal midwifery has resulted in the development of Aboriginal birthing centres that blend traditional knowledge, medicine and healing practices with contemporary medical services, to provide culturally significant maternal care services for Aboriginal women and families. Currently, there are Aboriginal birthing centres and services in, Nunavut, Quebec and Ontario. The high quality of community-based maternal care, access to culturally significant health services - utilizing traditional medicine and employing traditionally trained Aboriginal midwives has shown improved outcomes, impacting community healing, cultural revival, and community capacity building. The traditional methodologies employed by Aboriginal birthing centres will be detailed to exemplify the significance of indigenous knowledge and epistemologies of health in providing improved health care services to Aboriginal communities.

KEYWORDS
Indigenous knowledge, healing, Aboriginal philosophies of health, traditional Aboriginal midwifery

INTRODUCTION
Indigenous people in Canada experience some of the worst social, economic and environmental circumstances in the Nation (Canadian Population Health Initiative, 2004). For example, rates of diabetes are three times higher in First Nations and Inuit populations, and rates of cardiovascular disease, hypertension, obesity, and arthritis/rheumatism are all higher than Canadian rates (First Nations and Inuit Regional Health Survey, 1999; Kinnon, 2002). Sexually transmitted infections, particularly HIV/AIDS, is a growing concern with Aboriginal people representing 15 per cent of new cases of HIV/AIDS (Health Canada, 2000a). Also of concern is the maternal and child health of Aboriginal populations. It is reported that Aboriginal women experience perinatal and still birth rates that are twice the national average and 2.5 times greater in Inuit communities (Royal Commission on...
Aboriginal Peoples [RCAP], 1996). The First Nations and Inuit Regional Health Survey has found that Aboriginal infant mortality rates are roughly 3.5 times the national rates (Assembly of First Nations, 1999), and levels of Fetal Alcohol Syndrome and Fetal Alcohol Effects are considered to be “alarmingly high” in many First Nations communities (National Aboriginal Health Organization, [NAHO], 2004, p.12). Further disturbing is the suicide rate among First Nations and Inuit youth and young adults. Health Canada reports that suicide and self-injury are the leading cause of death among First Nations youth, accounting for 38 per cent of all causes of death among Aboriginal people (Health Canada, 2003). As a result of these grave health circumstances, First Nations women and men’s life expectancy is decreased by five and seven years less than the general Canadian population respectively (MacIntosh, 2005). While among the Inuit, life expectancy is 14 years less for women and six years less for men (MacIntosh, 2005).

On almost all measures of health and social well-being, the statistics are startling. Indigenous Peoples across the country fare much worse than our non-Indigenous counterparts (Durie, 2004). This state of health has been described by many as simply unacceptable and is considered by many as a “national disgrace” (Romanow, 2002; Native Women’s Association of Canada, 2007, p.3).

Recent census data from Statistics Canada (2008), reports that in 2006, Aboriginal populations surpassed the 1 million mark with a national population of 1,172,179. As a result, Aboriginal people account for 3.8 per cent of the Canadian population and have a growth rate of 45 per cent compared with only 8 per cent of the non-Aboriginal population (Canadian Population Health Initiative, 2004; Statistics Canada, 2008). With half of the Aboriginal population under the age of 24 (Statistics Canada, 2008) the young and growing population of Aboriginal Canadians, combined with the illustrated health disparities, creates an urgent need to address Aboriginal health care concerns.

A recent attempt to address the serious health concerns of Aboriginal populations has called for the integration and utilization of Traditional Indigenous Knowledge. Health Canada, public health officials and many Aboriginal organizations have begun to acknowledge the pivotal role that culture loss has played in shaping the health conditions of Aboriginal Peoples and have recognized the possible benefits of indigenous knowledge, language and spirituality in health services for Aboriginal people (Health Canada, 2003; Van Wagner, 2007; Kinnon, 2002). It has also been recognized that the current bio-medical model, upon which the Canadian health care system is based, is ineffective for servicing the unique health care needs of Aboriginal people (NAHO, 2008; RCAP, 1996). An approach which attempts to address indigenous knowledge and philosophies of health can be exemplified in the practice of traditional Aboriginal midwifery (Ross Leitenberger, 1998). The contemporary practice of Traditional Aboriginal midwifery is based in traditional knowledge, medicine and practices of maternal and child health and complements this practice with modern medicine.

This paper will discuss indigenous knowledge and philosophies of health and well-being as essential foundations for restructuring health care service models in First Nations communities to address the health concerns of Canada’s Aboriginal population. The history, significance, and legitimacy of indigenous knowledge and practices will be established followed by a description of current traditional Aboriginal midwifery services in Canada that exemplify models of health care service rooted in indigenous pedagogy. The complications and politics of utilizing indigenous knowledge and philosophies of health will be discussed.

Indigenous Philosophies of Health

Indigenous knowledge systems have historically operated to sustain the health and well-being of Indigenous Peoples worldwide for centuries pre-dating modern medical care (Waldram, Herring & Young, 2000). However, indigenous knowledge systems have been shattered to various degrees through centuries of colonial domination. Speck (1987) argues that through colonial oppression, Aboriginal knowledge of social, physical, spiritual and mental health were deemed inferior and subordinate to western knowledge systems (NAHO, 2008). It has been further argued that the cultural destruction and loss of indigenous knowledge systems experienced by Indigenous populations has produced severe consequences, creating the destitute social, environmental, and health conditions facing Aboriginal Peoples (RCAP, 1996; Durie, 2004). The National Aboriginal Health Organization reports that in a 2002 opinion poll, 57 per cent of Métis and 63 per cent of First Nations respondents identified loss of culture and land as significant factors contributing to poor health (NAHO, 2008). Accordingly, culture and ethnicity have more recently begun to be considered as key determinants of health as recognized by Health Canada, Aboriginal advocates and Aboriginal organizations such as the National Aboriginal Health Organization (NAHO, 2008).

An Aboriginal model of health has been generalized for the purposes of this paper; however, it is acknowledged
that much diversity about conceptions of health and well-being exists among Aboriginal populations (Kinnon, 2002). Still it is known that many Aboriginal people share similar core values, beliefs, practices, attitudes, behaviours, and worldviews (Aboriginal Health, 1992; Royal Commission on Aboriginal Peoples, 1996; Letendre, 2002). A traditional Aboriginal model of health is thought to be inherently based in the concepts of balance and holism (Eschiti, 2004; RCAP, 1996). Through a traditional Aboriginal way of life, medicine and spirituality are consistently interwoven and everything is seen as interconnected: mind, body, spirit, and emotions; all of which are viewed as essential to achieve optimal health (RCAP, 1996; Cook, 2007). Eschiti (2004) describes a holistic model as a way of viewing everything as working together to form a whole, instead of considering things as fragments or parts and suggests holism is believed to have significant implications for ideas about wellness, illness and disease. Classic concepts in Aboriginal models of health and healing propose that elements of life are interdependent and by extension well-being flows from balance and accord among the elements of personal and collective life giving equal significance to the mental, physical, spiritual, and emotional aspects of the individual (RCAP, 1996; Battiste & Henderson, 2000). It is believed that if a person is to be healthy they must be in balance not only within themselves, but within their social environment as well.

The described Aboriginal approach to health and well-being is similar to health promotion and population health approaches that have been advocated both nationally and internationally in public health (NAHO, 2008; McIntosh, 2005; RCAP, 1996). When the Royal Commission on Aboriginal Peoples (RCAP, 1996) explored Aboriginal philosophies of health, researchers were amazed by the parallels of traditional Aboriginal models of health to the leading edge work on the social determinants of health and well-being. Through these insights researchers began to believe that there is a promising meeting point of these two systems that poses potential for improving the health and well-being of Aboriginal people and non-Aboriginals (RCAP, 1996; Durie, 2004).

**Indigenous Knowledge and Science**

Modern science presents itself as a superior knowledge system, and throughout history has positioned other systems as irrational, superstitions, and more recently has labelled Indigenous knowledge and medicine as “alternative.” Indigenous knowledge is often discredited on the premise of scientific evaluation methodology, which discredits anything that cannot be supported by empirical evidence (Durie, 2004). However, Battiste and Henderson (2000) describe indigenous ecological knowledge as a valid science in and of itself:

> The traditional ecological knowledge of Indigenous people is scientific, in the sense that it is empirical, experimental, and systematic. It differs in two important respects from western science, however; traditional ecological knowledge is highly localized and it is social. Its focus is on the web of relationships between humans, animals, plants, natural forces, spirits, and land forms in particular locality as opposed to the discovery of universal laws (p. 44).

Indigenous Peoples have begun to contest the superior position of science and begun to promote the benefits of indigenous knowledge (Durie, 2004; NAHO, 2008). Similarly, governmental and indigenous organizations across the country are increasingly recognizing the potential benefits to applying indigenous knowledge to public health and health programming in Aboriginal communities (NAHO, 2008). How to best utilize Indigenous knowledge in contemporary practice is however, a contentious debate. Martin-Hill (2003) discusses the contemporary use of traditional Aboriginal medicine in her research with Elders/healers, and points out that the most consistent request by Elders/healers was for those in policy or academia to restore the “respect and honour of Indigenous knowledge and medicines” (p. 25). The Elders/healers further warn that a healthy respect for indigenous knowledge and traditional medicine by leaders, health care providers and decision makers is essential (Martin-Hill, 2003). The Elders/healers proclaim that it is not enough for traditional medicine and knowledge to simply be tolerated and humoured but that it needs to be acknowledged and accepted for its historical as well as contemporary legitimacy (Martin-Hill, 2003).

What this article advocates is not a fusion of modern science and indigenous knowledge but systems that acknowledge both knowledge systems for their strengths, and utilize those qualities to best meet the holistic health care needs of Aboriginal Peoples. It is proposed that
constructions of health care for Aboriginal Peoples should be based on indigenous knowledge systems of those being served. Aboriginal communities each have unique needs and those needs need to be addressed in the fundamental structure of health care service models.

**Traditional Aboriginal Midwifery**

A successful approach which encompasses modern medicine into a culturally-based indigenous knowledge framework of health care service for Aboriginal Peoples can be illustrated in the modern practice of traditional Aboriginal midwifery. Traditional Aboriginal midwifery is based in traditional knowledge, medicine and practices of maternal and child health, and complements this practice with modern medicine to deliver culturally significant health care services for Aboriginal families. Aboriginal midwifery incorporates all elements of the mother and child; spiritual, mental, physical, and emotional health through ceremony, use of traditional herbal medicine and counselling to address the totality of needs of mother and child (Ross Leitenberger, 1998). Traditional midwife Katsi Cook (2007) comments that in learning Aboriginal midwifery, her focus was on “integrating indigenous knowledge with the biomedical skills necessary to be a safe practitioner” (p.12).

Historically in Aboriginal cultures, pregnancy and childbirth were regarded as sacred events that were part of the natural life cycle governed by the Creator (Carroll & Benoit, 2004; Ross Leitenberger, 1998). The birth of a child signified new life and the powerful balance between the spiritual and physical worlds (Carroll & Benoit, 2004). A woman’s ability to give life and raise children, therefore, placed her in a highly esteemed, sacred, authoritative and respected role within Aboriginal cultures (NAHO, 2004; Carroll & Benoit, 2004). Fiske (1992) reports that, “reproductive roles were central to women’s claims to social prominence” (p. 201), and the women who were successful in raising children and providing care became influential as family spokespersons. Likewise, the profession of a traditional midwife was a respected role within Aboriginal communities and was considered an art that was passed down through familial generations of women (NAHO, 2004; Carroll & Benoit, 2004). Fiske (1992) also describe the traditional midwifery as a process that systematically excluded issues of race, gender, class, and culture. Oakley and Houd (1990) also describe the medicalization of childbirth as a process that systematically excluded issues of race, gender, class, and culture. Oakley and Houd (1990) conclude that the medicalization of the birthing process served to redefine pregnancy as an illness and the practice of midwifery as incompetent. The medicalization of birthing institutionalized the birthing process and removed birth from Aboriginal communities and placed it in often distant hospitals. As a result many Aboriginal women are still evacuated from their communities to give birth in hospitals (NAHO, 2004).

Recently, traditional Aboriginal midwifery is increasingly becoming popularized and revived through the political lobbying of Aboriginal women and organizations, as well as by the move toward community controlled and community based health care models (Van Wagner, 2004; Carroll & Benoit, 2004). Aboriginal women have initiated the restoration of more traditional models of health and ways of life, and many Aboriginal women in communities across Canada have attempted to reclaim their position within their communities as “givers of life” through the practice of Aboriginal midwifery (Carroll & Benoit, 2001, p.1). The traditional cultural, spiritual, physical, and emotional significance of birthing practices necessitate the revitalization of traditional Aboriginal midwifery and birthing practices as essential methods to improving the health and well-being of Aboriginal women, children and communities (Ross Leitenberger, 1998).
Traditional forms of midwifery included pre-natal, ante-natal and post-natal care which included frequent monitoring and counselling by an Elder or traditional midwife, an appropriate diet, traditional medicines and physical fitness regimens (Jasen, 1997). It is suggested that Aboriginal midwives were herbalists, gynaecologists, obstetricians, and nutritionists all rolled into one (Ross Leitenberger, 1998). Midwives were reported to be able to reduce the intensity and pain of labour, and save the lives of women and infants (Native Women’s Association of Canada, 2007). In traditional Aboriginal cultures, pregnancy and childbirth is regarded as a sacred period in a woman’s life, with several customs and practices to be adhered to throughout. There are many instructions on what foods to eat and how to conduct oneself during this sacred time (Ross Leitenberger, 1998). For example, women of the Carrier Nation of British Columbia reported that foods such as raspberries are restricted as they are thought to cause “raspberry birthmarks,” red blotches on the skin of babies (Ross Leitenberger, 1998, p. 79). Similarly, customs such as avoiding negative actions, sights and sounds as they can pass through the pregnant women to the unborn child are recommended (Ross Leitenberger, 1998). Further, traditional practices were also used to prevent complications such as breech births, and to alleviate labour pains and prevent haemorrhaging (Ross Leitenberger, 1998). It is important to note that although these cultural customs differ from one Aboriginal community to another, there are many similarities between Nations (Ross Leitenberger, 1998). In examination of historical literature, evidence suggests that although Aboriginal midwives were thought to be limited in capacity for solving obstetrical emergencies, mortality and morbidity for mother and baby were in all probability lower in the pre-colonial era (Doblyns, 1983).

**Traditional Medicine**

Central to the practice of traditional midwifery is the use of herbal medicines to prepare the mind, body and spirit for childbirth, as well as calm the woman to manage the delivery (Jasen, 1997). Carroll & Benoit (2004) report that knowledge of traditional medicine and herbs were critical to preventing potential complications of pregnancy and labour. Herbal medicines were used in traditional birthing practices throughout the pre-natal and post-partum period for mother, and medicines were also prepared for mom and baby after birth (Ross Leitenberger, 1998). Further, Ross Leitenberger (1998) reports that traditional medicines could also be prepared for special situations, such as inducing labour and for assisting women who were not able to become pregnant.

Cook (2007) comments that the knowledge and use of these traditional medicines is categorized as “Complementary and Alternative Medicine, but is simply, but no less significantly, the cultural knowledge we have had to depend on to maintain our health and well-being” as Indigenous Mohawk people. Cook (2007) further explains that the resilience and survival of Aboriginal people is based in our traditional medicines and practices. Katsi Cook, a traditionally and medically trained midwife and activist suggests that the traditional knowledge of sacred medicines has become removed from Aboriginal societies to the extent that people are unfamiliar with the medicines and are unaware how to use them (Cook, 2007). Cook describes how mothers no longer know the difference between a sick baby and a baby that can be cared for at home, by which there are several medicines that can cure a number of minor baby conditions (Cook, 2007).

The loss of indigenous knowledge and medicine in Aboriginal cultures has been described by many leaders and Elders as the root of many contemporary health and well-being issues, faced by Aboriginal Peoples. For example, Elders describe that we did not experience health issues such as post-partum depression, indicating that there were medicines to help renew and heal a woman after giving birth, and to bring her “spirits back up” (Interview, June, 2008). However, it is believed that because we may have lost this knowledge of medicine and do not use traditional birthing medicines, many of our women experience post-partum depression, mental health concerns, and subsequent alcohol and drug abuse. It is expressed that our knowledge of ceremony and medicine can have great benefits to improving health and well-being among Aboriginal populations.

**Modern Practice of Aboriginal Midwifery**

Although the knowledge and practice of traditional Aboriginal midwifery survives throughout various remote and urban locations in Canada, there are currently only three established Aboriginal birthing centers in Canada. The Inuulitisivik Health Center in Puvirnituq, Quebec was the first centre to open in 1986, followed by the Rankin Inlet Center in Nunavut in 1995, and the Tsi Non:we Ionnakeratsha Ona:grahsta: Six Nations Maternal and Child Centre in Ohsweken, Ontario in 1996 (Carroll & Benoit, 2004). Each centre provides maternal care services based in traditional Aboriginal health and birthing practices complimented by modern forms of medical care in unique manners specific to their respective community (Carroll & Benoit, 2004). Through these centres, Aboriginal women...
are able to plan their birth, choosing to deliver in the centre or at home, as well as have access to traditional Aboriginal herbal medicines for pregnancy, and are able to incorporate traditional ceremonies and rituals into their service.

The Inuulitsivik birthing centre in northern Quebec is an Inuit midwifery project that trains Inuit midwives and provides maternal care and delivery services to surrounding communities (Carroll & Benoit, 2004; NAHO, 2004). The women at the Inuulitsivik Centre are able to communicate with the staff in Inuktitut and birth as they choose incorporating cultural practices (Carroll & Benoit, 2004). The Inuulitsivik Centre is one of the most renowned Aboriginal birthing centres in Canada and is also one of the oldest (Carroll & Benoit, 2004). However, since 1990, the centre has been considered a pilot project to determine the feasibility of traditional Inuit midwives as legitimate professionals (Carroll & Benoit, 2004). In 1999, the Quebec government legitimized midwifery as a profession, however this victory has not influenced Aboriginal midwives, since there are clauses in the act that pertain to Aboriginal “traditional” midwives, stating that the midwives from Inuulitsivik are prohibited from practicing outside the Nunavik territories, and the communities are required to consult with the Ministry of Health for arrangements of the practice of “traditional” midwives (Carroll & Benoit, 2004).

The Rankin Inlet Birth Centre, in Nunavut provides birthing and midwifery services to women residing in the central Arctic region (Carroll & Benoit, 2004). The centre began as a Keewatin Regional Health pilot project for low risk pregnancies in 1993, staffed by certified nurse-midwives, prior to which, women had to be evacuated from the community to give birth in southern hospitals (Carroll & Benoit, 2004). In 1995, the centre became an established program staffs three midwives, two Inuit maternity workers and a clerk-interpreter (NAHO, 2004). Unique to this program is a multidisciplinary committee that determines whether a client can deliver within the centre or must fly south to deliver at a hospital (NAHO, 2004). Although the program provides culturally appropriate services to the Inuit communities that have in the past had to receive maternity care in a language and community foreign to them, it is operating without a legislative framework on midwifery as there is currently no legislation in Nunavut (NAHO, 2004; Carroll & Benoit, 2004). Furthermore, because there are no Aboriginal midwifery training programs, the availability of midwives in the north is limited and staff shortages are a recurring issue (NAHO, 2004).

The Tsi Nonwe Iommakeratsha (which means, “the place they will be born” in Mohawk) Onagrahsta: (which means, “a birthing place” in Cayuga) Six Nations Maternal and Child Centre is located on the Six Nations of the Grand River Reserve in southern Ontario, and opened in 1996 through funding from the Aboriginal Healing and Wellness Strategy (NAHO, 2004; Carroll & Benoit, 2004). The Six Nations Maternal and Child Centre offers a range of maternal care services to complement their personal beliefs and customs through a balance of traditional and contemporary services; for example, women are given the choice to give birth in their home or in the centre (NAHO, 2004). The centre has also developed an Aboriginal midwifery training program to train midwives in traditional Aboriginal midwifery (NAHO, 2004; Carroll & Benoit, 2004). The centre has done an excellent job in educating the community and providing traditional services through the use of traditional medicines and Elders participating in workshops and community ceremonies (Carroll & Benoit, 2004).

The described Aboriginal birthing centres are examples of great achievements in the area of traditional Aboriginal health and healing services for Aboriginal populations. The described Aboriginal birthing centres have been able to bring maternal health care to their communities, and bring the birthing process back to women and to the community. Aboriginal birthing services exemplify how traditional Aboriginal knowledge and medicine can be bridged with contemporary practices to better meet the medical, cultural and spiritual needs of Aboriginal women.

Further, limited research evaluating traditional Aboriginal midwifery practices has been positive. Through community interviews and a literature review of Aboriginal birthing services, specifically in Inuit communities, Couchie and Sanderson (2007) report that Aboriginal maternity centres can safely manage low-risk births. The researchers further conclude that training Aboriginal midwives to work in the community was shown to improve the prenatal care and birth experiences of Aboriginal women as well as improves overall community health and healing (Couchie & Sanderson, 2007; Archibald & Grey, 2000).

Nevertheless, there is much more to be done. There are only three Aboriginal birthing centres in Canada which means thousands of Aboriginal communities in Canada are without access to culturally significant, Aboriginal midwifery and birthing services. Furthermore, Ontario is the only province to provide legal exemption to Aboriginal midwives and only a few provinces, such as Quebec and Nunavut, publicly fund midwifery care (Carroll & Benoit, 2004).
**The Politics**

Inherently problematic in the provision of health care services to First Nations and Inuit communities are historical and legal issues of jurisdiction. MacIntosh (2005) concluded that in regards to Aboriginal health, the Canadian health care system is fundamentally inadequate as it reflects historical and legal divisions of power and responsibility. The provision of health care for Aboriginal Peoples is described as a “complex myriad of mechanisms and jurisdictionally separated agencies, provisional departments and federal ministries” with little coordination (MacIntosh, 2005). The complexity is further complicated by issues of status, eligibility, place of residence (on-reserve and off-reserve), and provincial residence which consequently produces gaps in service (MacIntosh, 2005).

It is noted that in recent years, Aboriginal populations have been given greater responsibility for their health care but still do not have the power to make fundamental changes with the provision of health care services. Speck (1987) exemplifies the predominant governmental ideology on the provision of health care for Aboriginal populations with a quote from Robert H. McClelland, Minister of Health for British Columbia, 1979, which states:

> There is no question native Indians should have the right to determine their health care needs and how they can be met most appropriately. But….native peoples should make these decisions within the established democratic process of this country and within the context of one comprehensive health care system (as cited in Speck, 1987, p. 147).

This quote illustrates the problematic paradigm of which the current Canadian health care system operates for Aboriginal populations. In this system, community controlled health care is an illusion. Although the Canadian government has given most Aboriginal communities responsibility for a great deal of the delivery of their health care, the delivery must be within the context of western constructs of the medical system, which poses immense limitations for providing culturally significant services based on traditional Aboriginal philosophies of health. What is needed is the power to develop health care service models that are based on the unique community needs and based in Aboriginal conceptions of health and healing. It is not sufficient to simply be “culturally appropriate,” these efforts merely represent window dressing for western ideologies and constructions of health to be represented as Aboriginal specific through hiring Aboriginal secretaries or using Aboriginal art in clinics. These efforts do not address the fundamental structural problems inherent within the health care system for addressing the distinctive needs of Aboriginal populations. The National Aboriginal Health Organization states:

> The respect for, and use of, indigenous knowledge and practices in the development and implementation of public health programs can only hope to succeed if the holders of that knowledge are allowed to define the how, when, where, who, what and why of its utilization in the best service of Aboriginal Peoples (NAHO, 2008, p.17).

However, the current situation of health care for Aboriginal populations has been described as the optimal phase to facilitate change in the structure and delivery of health care services for Aboriginal Peoples (NAHO, 2008).

**CONCLUSION**

Evidenced by the described social, environmental and health circumstances of Indigenous Peoples, it is extremely clear that the current health care system is ineffective for serving Canada’s Indigenous Peoples (RCAP, 1996; NAHO, 2004). Yet at present, little has been done to modify the current health care services for Aboriginal peoples and what has been accomplished is fragmented and done on an “ad hoc basis” (NAHO, 2008, p.8). For example, despite the support and success of modern practices of traditional Aboriginal midwifery, there are only three base centres in Canada which leaves thousands of reserves without community based, traditional Aboriginal maternal and birthing services. Attention, resources, the acknowledgement of indigenous knowledge and medicine are required to facilitate the development of culturally significant health care services for Aboriginal Peoples. Contemporary Aboriginal midwifery provides a framework for the development of culturally significant health care services as Aboriginal midwifery illustrates a health care model based within indigenous knowledge, philosophy and medicine, complemented with modern medicine that has proved successful in addressing health care needs and gaps within Aboriginal communities. The Aboriginal midwifery model demonstrates the integrity and contemporary utility of indigenous knowledge and philosophies of health. Further, Aboriginal midwifery illustrates a promising model for the application of indigenous knowledge to other sectors of the health care system servicing Aboriginal Peoples. Durie (2004) points out that although we tend to appreciate indigenous knowledge for its historical significance and “traditional.
qualities,” by doing so we tend to overlook the present value of such philosophies which have potential to be applied in Canadian health services, in parallel with other knowledge systems (p. 1139).

However, fundamental to the successful utilization of indigenous knowledge and medicine in the broader context of Canada’s health care system is the acknowledgement and respect of indigenous knowledge and medicine as an equally valuable health care service for Aboriginal Peoples. Mohawk scholar Marlene Brant Castellano (1982) states:

Substantive Indian participation in all phases will require a radical revision of the structural relationships, which have prevailed in a colonial environment. Both Indians and government personnel will need to engage in a re-education process to facilitate. The absorption of new knowledge about other’s ways, attitudinal change and the development of organizational structures to translate the promise of consultation into the reality of social change (p.127).

If the health policy in Canada is going to address the Aboriginal health crisis, that attempt requires a fundamental restructuring of the health system to encompass the appropriate respect and dignity of indigenous knowledge and medicine. In doing so, Aboriginal communities would be better able to develop, implement and define how best that knowledge is implemented (NAHO, 2008).

REFERENCES


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