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Indigenous Birth as Ceremony and a Human Right

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Abstract

Birthing can be an empowering experience for women. Within many Indigenous cultures around the world, birth is a ceremony to celebrate new life, acknowledging the passing from the spiritual world into the physical world. While initiatives to "indigenize" health care have been made, this paper argues that the United Nations Declaration on the Rights of Indigenous Peoples and the United Nations Sustainable Development Goals contain frameworks for Indigenous rights that include the right to incorporate Indigenous childbirth ceremonies into clinical practice. Examining the importance of birthplace, this paper details a current movement in Manitoba, Canada, to "bring birth home," which recognizes that the determinants of health experienced in the early stages of a child's development can have health implications for an individual's future.

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Introduction

Women and children play a crucial role in society, so investing in improvements to their overall health and wellness is "not only the right thing to do, but it also builds stable, peaceful and productive societies."[1] Birthing can be an empowering experience for women, but it can come with risks, including maternal and infant mortality. Mainstream medicine has attempted to reduce these risks by encouraging hospital births and introducing interventions such as inductions, optional caesarean sections, and various analgesics. While we must recognize that there is a place for necessary medical interventions, there are many cases in which such interventions have negative impacts. The concept of obstetric violence was introduced in 2007 as

> *the appropriation of women's bodies and reproductive processes by health personnel that is expressed through dehumanizing treatment, the abuse of medicalization, and the pathologization of natural processes, resulting in a loss of women's autonomy and ability to decide freely about their bodies and sexuality, negatively affecting their quality of life.*[2]

Within many Indigenous cultures, birth is a ceremony to introduce new life into this world, acknowledging the passing from the spiritual world into the physical world, and Western medical interventions may not always be appropriate. As Amber Skye observes, the devaluing of Indigenous medical practices is one form of ongoing colonialization.[3]

While initiatives to "indigenize" health care have been made, this paper argues that the human rights frameworks contained in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Sustainable Development Goals (SDGs) allow for the incorporation of Indigenous childbirth ceremonies into clinical practice. Examining the importance of birthplace, this paper details a current movement in Manitoba, Canada, to "bring birth home" and the life course epidemiology that recognizes that the determinants of health experienced in the early stages of a child's development can have significant health implications for an individual's future.[4]

United Nations Declaration on the Rights of Indigenous Peoples

UNDRIP is considered "the most comprehensive international instrument on the human rights of Indigenous peoples, including a wide range of political, economic, social, cultural, spiritual, and environmental rights," and was adopted by the United Nations (UN) General Assembly in 2007, with the majority of states voting in favor, excluding Australia, Canada, New Zealand, and the United States.[5] Notably, these four countries have large Indigenous populations. In 2010, Canada issued a statement of support endorsing the principles of UNDRIP; however, because of concerns about the declaration being "overly broad, unclear and capable of a wide variety of interpretations," Canada maintained its formal vote against adopting the declaration.[6]

A declaration is not legally binding, nor does it present any new rights; in the case of UNDRIP, it only affirms the inherent collective and individual rights of Indigenous peoples around the world. The creation of UNDRIP was largely in response to criticism that universal approaches to human rights had failed to adequately include Indigenous peoples.[7] Although some have argued that human rights frameworks are simply another colonial concept, Canada's statement of support for the declaration was important for showing a willingness and commitment to transform Canada's relationship with First Nations, Inuit, and Métis peoples.[8] It was not until 2016 that Canada removed its objector status and announced that it would fully support, without qualification, the implementation of the declaration.[9]

UNDRIP recognizes the "dual reality of many Indigenous people who live in two worlds. In one world, they hold fast to their cultural traditions, beliefs, and values. The other world is that of a colonizing nation, and it is where many Indigenous peoples go for … health care."[10] Article 24 of UNDRIP is essential to understanding these health rights. It states:

> *24.1 Indigenous peoples have the right to their traditional medicines and to maintain their health*

> *practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
>
> *24.2 Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*[11]

This provision is especially important for Indigenous peoples in Canada, whose historical experience with health care access in the country involves traumatization, experimental procedures, and segregation.[12] Prior to the mid-20th century, pregnant Indigenous women gave birth in their communities, supported by family members, friends, Knowledge Keepers, traditional midwives, and birth workers.[13] Often, the role of a midwife was viewed as a calling; it was a very spiritual and powerful position.[14] The midwife continued supporting the family following the birth by living in the home for a period of time to tend to the infant and mother and to assist with the new mother's work.[15]

Despite article 24's call to protect the health rights of Indigenous peoples, there continue to be distinct risk factors that may affect Indigenous women's experience with pregnancy and childbirth. These include reduced access to standard prenatal care; inaccurate estimation of gestational age and subsequent complications of post-term pregnancies; preexisting medical conditions; young maternal age; marital status; malnutrition; and low educational attainment.[16] While some may argue that the moving of Indigenous births from the home to the hospital in the 1920s by the Department of Indian Affairs supports Indigenous access to health services, this shift has led to a Western-based overmedicalization of Indigenous childbirth that often focuses solely on the physical component of well-being to the detriment of the emotional, mental, and spiritual components that are crucial to Indigenous health.[17] The World Health Organization has confirmed that childbirth is becoming overmedicalized, particularly in low-risk pregnancies, including through the overuse of caesarean section.[18] Under this medicalization of childbirth, physicians are promoted as superior birth attendants, having been trained in Western science and technology.[19] As Colleen Varcoe and colleagues state, the dominance of biomedicine results in the imposition of medically based maternity technologies, with Indigenous women being told that "their time honored midwifery and birthing practices [are] unsafe and that they must turn to the advances of western medical practice for 'modern' maternity care."[20] The impact of this message, and how it is operationalized, is significant for the physical and mental health of Indigenous women and families, and Indigenous women still face less desirable birth outcomes compared to other groups in Canada.[21]

The disparities in maternal health for Indigenous women in Canada that are intertwined with colonization and the resulting deep inequalities in socioeconomic status and health outcomes are exacerbated by violations of article 24. Across Canada, infant mortality rates are more than twice as high for each Indigenous group (First Nation, Métis, and Inuit) compared with the non-Indigenous population.[22] For First Nations women living on reserves, more than half of the women (56.6%) must travel between 50 and 350 kilometers to give birth.[23] Further, in urban areas, the preterm birth rate is higher among First Nations infants compared to all other Manitoban infants living in the lowest- and highest-income areas.[24] Sudden infant death syndrome is the leading cause of death for First Nations and Inuit children, whose rates are more than seven times higher than that of the non-Indigenous population.[25] In the province of Manitoba, which has one of the highest Indigenous populations in Canada, "infant mortality rates for First Nations (FN) people range from 2.1 – 2.9 times higher than the rate for other Manitobans."[26] These statistics demonstrate that distinct needs are likely remaining unaddressed for the Canadian Indigenous population. One explanation for the disparity, offered by Robert Allec, is culture, but the author fails to identify exactly what aspects of culture might explain the difference.[27] Other explanations have been put forward in documents such as the United Nations factsheet "Indigenous Women's

Maternal Health and Maternal Mortality," arguing that Indigenous women have an increased risk for maternal mortality compared to "other women"; however, these studies do not examine Canada specifically.[28]

Internationally and irrespective of ethnicity, women's experiences during childbirth within medical institutions are often distressing due to discrimination and overmedicalization. In 2010, a report by Diana Bowser and Kathleen Hill, which gathered stories from women in 18 countries, including Canada, revealed that many women felt disrespected and abused during institutional childbirth; their study revealed "subtle humiliation of women, discrimination against certain subgroups of women, overt humiliation, abandonment of care and physical and verbal abuse."[29] Medical interventions have made childbirth a negative, and potentially damaging, experience. In Canada, there has been an increase in the use of induction, vacuum extraction, and caesarean section, in addition to the risk of injury from operative vaginal deliveries where vacuums or forceps are used.[30] Injuries range from minor cuts to more serious issues that might affect the woman's long-term quality of life, including bladder and bowel control, sexual dysfunction, and perineal pain.[31] According to one ethnographic study of hospital birth in a Canadian setting, "Whilst women are treated kindly and attention is paid to them in this hospital, there is very little respect for the birth process and the physiological nature of this event."[32] These issues, combined with the historically fraught relationship that Indigenous peoples have with medical institutions, leads many Indigenous women to seek non-facility alternatives for the birthing process.

Indigenous birth ceremony as compliance with article 24

A recent movement in clinical care seeks to offer family-centered maternity and newborn care (FCMNC) that recognizes that "Indigenous peoples have distinctive needs during pregnancy and birth."[33] FCMNC was originally created to address the physical, emotional, psychosocial, and spiritual needs of women, their newborns, and their families.[34] FCMNC recommends integrating cultural safety into prenatal care for Indigenous women and details some of the barriers to prenatal care, such as physical distance from care, lack of child care for other children, and fear or distrust of the health care system.[35] In its recommendation that hospitals and birthing centers develop protocols and policies to "support traditional birthing customs and cultural practices," the Public Health Agency of Canada could be seen as attempting to implement UNDRIP's article 24(1), though it does not make this explicit connection.[36] An understanding of birthing as ceremony—one that includes distinct customs, rituals, and traditions for Indigenous women—must be achieved as countries move to fully adopt and implement UNDRIP.[37] UNDRIP recognizes the inherent right of Indigenous peoples to practice and revitalize their cultural traditions and customs, and it can be argued that the loss of community birth is a cultural loss.[39] The loss of culture can also be categorized both as "distal (e.g. historic, political, social and economic contexts)" and as an "intermediate (e.g. community infrastructure, resources, systems and capacities)" social determinant of health.[40]

Traditionally, pregnant Indigenous women had an important role in "carrying the spirit," and the community came together to honor the spirit by "invest[ing] in the well-being of the mother."[41] The pregnant mother is viewed as a conduit between the spiritual world and the physical world, thereby making prenatal care a community endeavor.[42] Therefore, a woman's pregnancy and birth were the responsibility of the entire community rather than an individual family event. The community was expected to support the mother not only in antenatal care but also in emotional and spiritual support. Furthermore, cultural practices around birth, including ceremonies for welcoming and celebrating the new life and the sharing of traditional knowledge and teachings, helped establish strong community roots for the mother and newborn by encouraging healthy lifestyles and a sense of belonging for the family.[43] The child would have a clear sense of their identity and place within the

community, which, according to the Society of Obstetricians and Gynaecologists of Canada, "helps them to become resilient and responsible members of that community."[44]

Ceremonies in birth can also be in the form of stories that show a connection to the land. Rachel Olson details "the water ceremony" and the connection to birthplace and landscapes.[45] Pregnancy is understood as carrying "sacred water," metaphorically referring to the amniotic fluid surrounding and protecting the baby but also connecting to the important role of the water breaking in labor. Anishinaabekwe (Anishinaabe women) are considered the caretakers of water, which is one of their most important roles in society.[46] Midwife and activist Katsi Cook echoes this significance, stating:

> *In the Mohawk language, one word for midwife is iewirokwas. This word describes that "she's pulling the baby out of the Earth," out of the water, or a dark wet place. It is full of ecological context. We know from our traditional teachings that the waters of the earth and the waters of our bodies are the same water.*[47]

Anishinaabekwe traditionally were encouraged to maintain a "good frame of mind," since emotions would influence the baby.[48] In First Nations communities in northwestern Ontario, women began learning obstetrical care and cultural practices, such as "careful attention to the sacred handling of the placenta and umbilical cord; and [the] careful wrapping of the newborn in fur" by observation in their teenage years.[49]

As Canada works to protect the inherent rights of Indigenous peoples across the country by fully implementing UNDRIP, it must also recognize the cultural significance of birth and ceremonies that are crucial for protecting the maternal health and birthing rights of Indigenous women.[50]

Sustainable Development Goals

On September 25, 2015, the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development Goals, titled "Transforming Our World: The 2030 Agenda for Sustainable Development," which came into effect on January 1, 2016.[51] This document, which "provides a global blueprint for dignity, peace and prosperity for people and the planet," consists of 17 goals and 169 corresponding targets.[52] The SDGs were a response to the Millennium Development Goals (MDGs), which were perceived as embracing a top-down approach and which failed to involve Indigenous peoples in identifying the health issues that most affect their well-being.[53] Both iterations of the Development Goals prioritize health care for mothers and children in the global arena: Goals 4 and 5 of the MDGs aimed to reduce child mortality and improve maternal health, while Goal 3 of the SDGs seeks to "ensure healthy lives and promote well-being for all at all ages" and sets specific targets for a reduction in maternal and child mortality.[54] These goals can be reached only by implementing a rights-based and culturally sensitive approach that respects traditional health practices and supports Indigenous peoples' own methods of providing services.[55]

Pregnancy and childbirth pose risks for mothers, with 830 women dying each day from preventable causes related to pregnancy and childbirth around the world.[56] Although Canada boasts one of the world's lowest maternal mortality rates, better access to health services in rural and remote communities, as well as improved funding and culturally safe health care services, are among the keys to improving the health disparities, including maternal mortality ratios, between Indigenous and non-Indigenous women.[57] Further, as stated in the previous section, there are striking disparities between Indigenous and non-Indigenous birth outcomes, including infant mortality rates. Some studies indicate that "on-reserve First Nations, off-reserve status Indians, and Inuit have rates of infant mortality ranging from 1.4 to 4 times that of non-Indigenous infants."[58]

In Canada, programs to "promote well-being for all at all ages" include the Strengthening Families Maternal Child Health Program, the Canadian Prenatal Nutrition Program, and the Aboriginal Head Start Program, but many Indigenous communities operate without these supports. In fact, only 14 of 63 First Nation communities in Mani-

toba offer the Strengthening Families Maternal Child Health Program.[59] Though Canada has a long history of being a leader in the global arena with respect to maternal, newborn, and child health and has committed to focus on prevention and early intervention, health disparities for Indigenous women continue to exist. Determining who is responsible and accountable for providing health care services in Canada to First Nations and Inuit is often difficult and compromised by competing financial demands.[60] Each provincial and territorial government is required to provide health care under the Canada Health Act; however, Canada also has a constitutional responsibility to provide health care to First Nations ("Indian") and Inuit peoples.[61]

Moreover, as some have argued, there is a direct correlation between the lack of supports for Indigenous maternal health and the overrepresentation of Indigenous children in government care and government-appointed foster families who are often non-Indigenous.[62] Marni D. Brownell and colleagues analyzed data from the Manitoba Child and Family Services, Department of Justice, and Population Health Registry to explore the relationship between having a history of Child and Family Services involvement during childhood (0–17 years) and being charged with a crime as a youth (12–17 years).[63] They found a substantial overlap between the child welfare and youth justice systems, with overrepresentation of Indigenous youth in both systems.[64]

Implementing these UN human rights declarations and goals to address health disparities between Indigenous and non-Indigenous peoples in Canada is important, and reclaiming Indigenous birth practices is a palpable way in which to implement these rights.

Reclaiming Indigenous birth practices in Manitoba

Though adverse birth outcomes are more likely for Indigenous (compared to non-Indigenous) women in Canada, they are even more prominent for First Nations and Inuit women who live in rural or isolated communities.[65] The shortage of maternal health personnel can prevent women from accessing the same level of maternity care as Indigenous women living in urban areas.[66] Lack of access to health care and systemic conditions can lead women to feel mistreated during childbirth.[67] This lack of local health care support for First Nations and Inuit women has been used to justify the First Nations and Inuit Health Branch of Health Canada's maternal medical evacuation policy, according to which pregnant Indigenous women are routinely evacuated from rural or isolated communities to urban centers at 36 weeks' gestation.[68] This policy separates women from their support networks and places them in unfamiliar environments as they prepare for labor and delivery.[69] Being alone and unsupported creates unnecessary stress and can create negative health consequences for both the woman and baby, such as anxiety, preterm birth, and low or high birth weights. This policy prioritizes Western biomedicine in obstetrical management of pregnancy and is inconsistently applied because it lacks clear documentation and details.[70]

One tangible way to address these issues is through the use of Indigenous doulas, birth attendants, and midwives. Indigenous birth workers, both traditionally and in the modern context, provide support for women during active labor and throughout the birthing process. The resurgence of trainings for Indigenous women to act as helpers in birthwork or to provide full-spectrum doula care can be viewed as a significant step toward compliance with UNDRIP and the SDGs. The role of an older female relative is documented as a key component of pregnancy and childbirth, and critical cultural practices are essential to establishing and revitalizing the strong cultural connection and spiritual path for Indigenous children.[73] Doulas extend their role of emotional support companion to advocate for various social supports following the birth. Although doulas do not help with the delivery of a baby, they do support women with antenatal care. Midwives and traditional birth attendants (sometimes referred to as community-based midwives) overlap with doulas in many respects, as they are individuals hired to support women during the birthing process. The

amount of formal training may be the most obvious difference.[71] Support for women during active labor and birth has been proven to reduce the use of medications and interventions, and the right to appropriate and respectful care during pregnancy and birthing is imperative to ensure positive long-term impacts for mothers and children.[72]

This type of birth support is proposed by two Manitoba-based research projects. The first is the Winnipeg Boldness Project, a research and evaluation center that uses social innovation research as an incubator to develop ideas to improve outcomes for people in the Point Douglas inner-city community in Winnipeg. The Winnipeg Boldness Project initiated the first urban Indigenous doula short-term pilot program in Winnipeg, in which 12 Indigenous women were trained as birth helpers to support pregnant Indigenous women and families over a one-year period in order to understand the gaps in support for urban-based pregnant Indigenous women.

The second Manitoba-based research project is titled "Indigenous Doulas as a Culturally Based Health Intervention to Improve Health and Birth Outcomes for First Nations Women in Remote Communities Who Travel for Birth" (hereafter referred to as the Northern Manitoba Indigenous Doulas Project). This project is a partnership between Wiijii'idiwag Ikwewag (formerly known as the Manitoba Indigenous Doula Initiative), the First Nations Health and Social Secretariat of Manitoba, and the University of Winnipeg that involves three northern First Nations communities. It pairs expectant First Nations women with local and urban Indigenous doulas and examines how Indigenous doulas can support First Nations women who are forced to travel for birth in Manitoba. While the project is currently collecting data on the experiences of Indigenous women who give birth with and without doulas, preliminary findings have emerged that concern the Indigenous doulas themselves. These findings demonstrate that Indigenous birth workers require multiple provisions to enable their support of mothers, including a stable service delivery model with concrete processes for referrals and payment, ongoing professional development, and robust self-care plans, given that many Indigenous women are brought to this work in response to their own negative birthing experiences. Though these results are not about the improvement of mothers' experiences, they do affect the support offered to Indigenous mothers.

Moreover, the Northern Manitoba Indigenous Doulas Project has found that doulas provide necessary boundaries within the medical birthing experience (for example, by ensuring that nurses and doctors are respectful of women's need for privacy and space to observe cultural practices) and empower Indigenous women to create a positive experience for themselves by choosing birthing experiences that incorporate rituals and celebrations. The doulas from the urban project also described their experience of personal transformation that "nourishe[s] [them] through this training and practice."[73] Empowerment is a process by which those who have been historically disempowered are able to "increase their self-efficacy, make life-enhancing decisions, and obtain control over resources."[74] In traditional societies, matriarchs played an important role, but through colonization, women's place within society changed. "Broad[er] historical forces and policies that shaped [Indigenous women's, girls', and 2SLGBTQQIA people's] individual experience" are recognized as a tool of disempowerment of community structure.[75]

There is a movement throughout medical care to empower patients to become more involved in their medical treatments and processes. The Canadian Medical Association (CMA) "recognizes that collaborative care is a desired and necessary part of health care delivery in Canada and an important element of quality, patient centred care."[76] Collaborative decision making is also a cornerstone of patient-centered care.[77] According to CMA, collaborative care encourages providers to work together to provide the best care to patients based on trust, respect, and an understanding of one another's skills and knowledge.[78] This model includes empowering patients to make choices related to their care in conjunction with their health care team. "The medical profession supports collaborative care, both in the hospital and in the community, as

one of the essential elements of health care delivery in Canada," demonstrating that reclaiming birth ceremony is possible for Indigenous communities; however, the principles outlined by CMA show that more ideological shifts still need to be made.[79] Principle three demonstrates the belief that physicians are the most powerful in the relationship: "In the CMA's opinion, the physician is best equipped to provide clinical leadership."[80] This power imbalance that places medical professionals above patients continues to create a significant barrier for Indigenous women to have a voice in the care they are seeking.

Generally, midwives use the dichotomy of natural versus medical birth as part of an informed choice ideology when promoting their services to pregnant women. Though the movement in midwifery focuses on informed choice, it is distinctive from the informed consent model, which would allow Indigenous women to have a stronger voice in their health care. One distinction is that

> *what counts as authoritative knowledge in informed consent versus informed choice in midwives care differs; with the former, patients listen to health care providers impart "evidence" and clinical options to them in an accessible way and then must make a choice; the latter involves this too but midwives also grant authority to other kinds of knowledge—a woman's own knowledge, feelings, and past experience about her body and previous pregnancies as well as her lifestyle and moral orientation.*[81]

Women's informed choice includes privileging other forms of knowledge and understanding, including that of Indigenous epistemologies. In Western traditions, there is a recognized hierarchy of beings, with humans at the top. Within Indigenous ways of knowing, humans are understood as "the younger brothers [or sisters] of Creation," meaning that we need to learn from other species that have been on Earth longer and have had time to figure out how to live in harmony and reciprocity.[82] By allowing for these knowledges in the process of informed choice, Indigenous women may be more empowered and feel like collaborators in their own birth journeys.

In some cases within Canada, we are beginning to see attempts to shift biomedicine toward a more holistic approach based on Indigenous knowledge. In Akwesasne, Ontario, a group called Onkwehon:we Midwives Collective uses Indigenous knowledge to ensure a safe birthing process. The group's objective is to "provide assistance to Indigenous expectant moms and their families with reclaiming control of their birth plans, along with continued education and support throughout all the phases of an Indigenous woman's life."[83] Another promising intervention is the Indigenous Women's Health Initiative within the Society of Obstetricians and Gynaecologists of Canada.[84] This online space offers resources for health care professionals and community members to be more informed about providing culturally safe care related to Indigenous sexual and reproductive health and promoting and advancing health equity for Indigenous women.

These interventions show how appropriate care for Indigenous mothers and their children must look beyond health care outcomes to include social and cultural factors, such as identity and connection to place, when implementing new strategies to address the complex and distinct needs of an Indigenous population. This appropriate care, in turn, addresses the calls and declarations for Indigenous rights in Canada.

Conclusion

Returning birthing traditions to Indigenous communities in Canada—despite the complexities of funding and health care access—would respect and implement the commitments detailed in UNDRIP and the SDGs. Further exploration is needed on the correlation between the lack of supports for Indigenous women and the overrepresentation of Indigenous children in government care. Moreover, the literature would benefit from additional reviews on how privileging Indigenous epistemologies and ways of knowing in the context of Indigenous birth and maternal health can lead to positive health outcomes. Finally, further inquiry is required to explore encounters where tensions exist between health rights and cultural rights.

Efforts need to be made to honor the right to ceremony and rituals surrounding pregnancy and birth and to incorporate biomedical interventions only when necessary. Birth ceremonies are directly connected to the land, so recognizing the importance of birthplace (geographical location) and honoring the sacredness of birth is a significant way to recognize and implement Indigenous rights. These ceremonies would welcome children into the world in a good way by reinforcing their cultural identity and empowering the community to take care of the child, all of which would positively affect the life courses of Indigenous people and help remedy overall health disparities.

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References

1. B. Ki-Moon, *Global strategy for women's and children's health* (New York: United Nations, 2010). Available at http://www.everywomaneverychild.org/wp-content/uploads/2016/11/20100914_gswch_en-1.pdf.

2. A. Castro, "Witnessing obstetric violence during fieldwork: Notes from Latin America," *Health and Human Rights Journal* 21/1 (2019), p. 103.

3. A. Skye, "Aboriginal midwifery: A model for change," *Journal of Aboriginal Health* 6/1 (2010).

4. J. Reading, *A life course approach to the social determinants of health for Aboriginal peoples* (Ottawa: The Senate Sub-Committee on Population Health, 2009).

5. R. Saganash and P. Joffe, "The significance of the UN declaration to a treaty nation: A James Bay Cree perspective," in P. Joffe, J. Preston, and J. Hartley (eds), *Realizing the UN Declaration on the Rights of Indigenous Peoples: Triumph, hope, and action* (Saskatoon: Purich Publishing Ltd, 2010); United Nations Department of Economic and Social Affairs, *Division for Inclusive Social Development Indigenous Peoples*. Available at https://www.un.org/development/desa/en/about/desa-divisions/social-policy.html.

6. Aboriginal and Northern Development Canada, *Canada's statement of support on the United Nations Declaration on the Rights of Indigenous Peoples* (November 12, 2010). Available at https://www.aadnc-aandc.gc.ca/eng/1309374239861/1309374546142.

7. R. Kuokkanen, "Confronting violence: Indigenous women, self-determination and international human rights," in J. Green (ed), *Indivisible: Indigenous human rights* (Halifax, Winnipeg: Fernwood Publishing, 2014).

8. R. Williams, *The divided world: Human rights and its violence* (Minneapolis: University of Minnesota Press, 2010); E. Povinelli, *The empire of love: Toward a theory of intimacy, genealogy, and carnality* (Duke University Press, 2006); Aboriginal and Northern Development Canada (2010, see note 6).

9. T. Fontaine, "Canada removing objector status to UN Declaration on the Rights of Indigenous Peoples," *Canadian Broadcasting Corporation* (May 8, 2016). Available at https://www.cbc.ca/news/indigenous/canada-position-un-declaration-indigenous-peoples-1.3572777.

10. F. Cram, B. Chilisa, and D. Mertens, "The journey begins," in D. Mertens, F. Cram, and B. Chilisa (eds), *Indigenous pathways into social research: Voices of a new generation* (Walnut Creek, CA: Leaf Coast Press, 2013).

11. United Nations Declaration on the Rights of Indigenous Peoples, G.A. Res 61/295 (2007), art. 24.

12. M. Lux, *Separate beds: A history of Indian hospitals in Canada, 1920s–1980s* (Toronto: University of Toronto Press, 2016).

13. K. Anderson, *Life stages and native women* (Winnipeg: University of Manitoba Press, 2011); A. Lalonde, C. Butt, and A. Bucio, "Maternal health in Canadian Aboriginal communities: Challenges and opportunities," *Journal of Obstetrics and Gynaecology Canada* 31/10 (2009), pp. 956–962.

14. D. Carroll and C. Benoit, "Aboriginal midwifery in Canada: Merging traditional practices and modern science," *Reconceiving midwifery* 263 (2004); M. Lux, *Medicine that walks: Disease, medicine, and Canadian Plains Native People, 1880–1940* (Toronto: University of Toronto Press, 2001).

15. Lux (2001, see note 14).

16. J. Smylie, D. Fell, and A. Ohlsson, "A review of Aboriginal infant mortality rates in Canada: Striking and persistent Aboriginal/non-Aboriginal inequities," *Canadian Journal of Public Health* 101/2 (2010), pp. 143–148; P. Shah, J. Zao, H. Al-Wassia, et al., "Pregnancy and neonatal outcomes of aboriginal women: A systematic review and meta-analysis," *Women's Health Issues* 21/1 (2011), pp. 28–39; R. Oster and E. Toth, "A retrospective analysis of stillbirth epidemiology and risk factors among First Nations and non-First Nations pregnancies in Alberta from 2000 to 2009," *Journal of Obstetrics and Gynaecology Canada* 37/2 (2015), pp. 117–121.

17. K. Burnett, *Taking medicine: Women's healing work*

and colonial contact in southern Alberta, 1880–1930 (Vancouver: UBC Press, 2010).

18. A. Phelan and R. O'Connell, *Childbirth: Myths and medicalization* (Copenhagen: EntreNous, 2015), pp. 18–19.

19. C. Biggs, "The case of the missing midwives: A history of midwifery in Ontario from 1795–1900," *Ontario History* 75/1 (1983), p. 21; A. Lokugamage and S. Pathberiya, "Human rights in childbirth, narratives and restorative justice: A review," *Reproductive Health* 14/1 (2017), pp. 1–8.

20. C. Varcoe, H. Brown, B. Calam, T. Harvey, and M. Tallio, "Help bring back the celebration of life: A community-based participatory study of rural Aboriginal women's maternity experiences and outcomes," *BMC Pregnancy and Childbirth* 13/1 (2013), pp. 1–10.

21. A. Sheppard, G. Shapiro, T. Bushnik, et al., "Birth outcomes among First Nations, Inuit and Métis populations," *Health Reports* 28/11 (2017), pp. 11–16.

22. Ibid.

23. M. Chartier, M. Brownell, L. Star, et al., "Our children, our future: The health and well-being of First Nations children in Manitoba," *Manitoba Centre for Health Policy* (2020). Available at http://mchp-appserv.cpe.umanitoba.ca/reference/FNKids_Report_Web.pdf.

24. Ibid., pp. 11–16.

25. R. Allec, *First Nations health and wellness in Manitoba: Overview of gaps in service and issues associated with jurisdictions* (Manitoba Aboriginal and Northern Affairs, 2005), p. 7.

26. Ibid.

27. Ibid.

28. United Nations, *Fact sheet: Indigenous women's maternal health and maternal mortality* (2018), p. 1. Available at https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/04/factsheet_print_Mar27.pdf.

29. D. Bowser and K. Hill, "Exploring evidence for disrespect and abuse in facility-based childbirth," Boston: USAID-TRAction Project, Harvard School of Public Health (2010), p. 3.

30. Government of Canada, *Labour and birth in Canada* (2018). Available at https://www.canada.ca/en/public-health/services/publications/healthy-living/labour-birth-infographic.html; G. Muraca, S. Lisonkova, A. Skoll, et al., "Ecological association between operative vaginal delivery and obstetric and birth trauma," *Canadian Medical Association Journal* 190/24 (2018).

31. Muraca et al. (see note 30).

32. H. Vadeboncoeur, "L'humanisation des pratiques entourant l'accouchement est-elle limitée?," *Le Médecin du Québec* 40/7 (2005), pp. 77–86.

33. Public Health Agency of Canada, "Chapter 4: Care during labour and birth: Family-centred maternity and newborn care" in *Family-centred maternity and newborn care: National guidelines* (2017).

34. Public Health Agency of Canada, "Chapter 1: Family-centred maternity and newborn Care in Canada: Underlying philosophy and principles," in *Family-centred maternity and newborn care: National guidelines* (2017).

35. Ibid.

36. Public Health Agency of Canada (2017, see note 33).

37. Public Health Agency of Canada (2017, see note 34).

38. Public Health Agency of Canada (2017, see note 33).

39. T. O'Driscoll, L. Payne, L. Kelly, et al., "Traditional First Nations birthing practices: Interviews with elders in Northwestern Ontario," *Journal of Obstetrics and Gynaecology Canada* 33/1 (2011), p. 24.

40. C. Reading and F. Wien, *Health inequalities and social determinants of Aboriginal peoples' health*, (Prince George, BC: National Collaborating Centre for Aboriginal Health, 2009), p. 1.

41. K. Anderson, *Life stages and native women* (Winnipeg: University of Manitoba Press, 2011), p. 43.

42. Ibid.

43. Ibid.

44. Society of Obstetricians and Gynaecologists of Canada, "SOGC policy statement. No. 251, December 2010. Returning birth to aboriginal, rural, and remote communities," *Journal of Obstetrics and Gynaecology Canada* 32/12 (2010), p. 1186.

45. R. Olson, K. Bebee, J. Benedict, et al., "Introduction: Prioritizing Indigenous maternal and infant health," *Pimatisiwin* 10/3 (2012), pp. 267–270.

46. R. Olson, "Bearing witness: Rural Indigenous women's experiences of childbirth in an urban hospital," in H. Tait Neufeld and J. Cidro (eds), *Indigenous experiences of pregnancy and birth* (Bradford, ON: Demeter Press, 2018).

47. National Aboriginal Council of Midwives, "Stories and teachings about pregnancy," *Canadian Midwives* (February 2017).

48. H. Tait Neufeld and J. Cidro, *Indigenous experiences of pregnancy and birth* (Bradford: Demeter Press, 2017).

49. O'Driscoll et al. (see note 39), p. 24.

50. Indigenous Navigator, *Where are Indigenous peoples' rights in the Sustainable Development Goals? Explore the Indigenous peoples sustainable development matrix, which uncovers the links between the SDGs and UNDRIP.* Available at http://nav.indigenousnavigator.com/images/Documents/Tools/Navigator_UNDRIP-SDGs.pdf; Danish Institute for Human Rights, *The human rights guide to the Sustainable Development Goals.* Available at https://sdg.humanrights.dk/en/targets2?goal[]=72.

51. United Nations, *Transforming our world: The 2030 agenda for sustainable development.* Available at https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.

52. United Nations, *The Sustainable Development Goals report 2018* (2018).

53. C. Sweetman, *Gender and the Millennium Development Goals* (Oxford: Oxfam, 2005); C. Doyle, "Indigenous peoples and the Millennium Development Goals: 'Sacrificial lambs' or equal beneficiaries?," *International Journal of Human Rights* 13/1 (2009), pp. 44–71; V. Tauli-Corpuz, "Indigenous peoples and the Millennium Development Goals," in V. Tauli-Corpuz, L. Enkiwe-Abayao, and R. de Chavez (eds), *Towards an alternative development paradigm: Indigenous peoples' self-determined development* (Baguio City: Tebtebba Foundation, 2010); J. Carant, "Unheard voices: A critical discourse analysis of the Millennium Development Goals' evolution into the Sustainable Development Goals," *Third World Quarterly* 38/1 (2017), pp. 16–41; O. Odulaja and R. Halseth, "The United Nations Sustainable Development Goals and Indigenous peoples in Canada," National Collaborating Centre for Aboriginal Health (2018). Available at https://www.nccah-ccnsa.ca/docs/determinants/RPT-UN-SDG-IndPeoplesCanada-Halseth-Odulaja-EN.pdf; United Nations General Assembly, Resolution 55/2, UN Doc. A/RES/55/2 (2000).

54. Indigenous Peoples Major Group, *Position paper on proposed SDG indicators* (2015), p. 1. Available at https://www.iwgia.org/images/publications/0724_SDG_Indicators_Final_eb.pdf; D. O'Sullivan, "Indigenous peoples and the UN Sustainable Development Goals," *Impakter* (March 28, 2019). Available at https://impakter.com/indigenous-peoples-and-sdgs/; D. DeLuca, "What do the Sustainable Development Goals mean for Indigenous peoples?," *Cultural Survival* (December 2017). Available at https://www.culturalsurvival.org/publications/cultural-survival-quarterly/what-do-sustainable-development-goals-mean-indigenous; United Nations, *The Millennium Development Goals report 2015* (2015).

55. Office of the United Nations High Commissioner for Human Rights and Secretariat of the Permanent Forum on Indigenous Issues, Division for Social Policy and Development, United Nations Department of Economic and Social Affairs, *Briefing note Indigenous peoples' rights and the 2030 agenda* (September 2017). Available at https://www.ohchr.org/Documents/Issues/IPeoples/BriefingPaperIPRights2030Agenda.pdf.

56. United Nations *Maternal mortality* (September 2019). Available at https://www.who.int/news-room/fact-sheets/detail/maternal-mortality; M. Roser and H. Ritchie, *Maternal Mortality* (2013). Available at https://ourworldindata.org/maternal-mortality#:~:text=This%20is%20also%20the%20message,and%20lower%2Dmiddle%20income%20countrie.

57. N. Gilbert, N. Auger, and M. Tjepkema, "Stillbirth and infant mortality in Aboriginal communities in Quebec," *Health Reports* 26/2 (2015), pp. 3–8; Smylie et al. (see note 16); L. Xiao, D. Zhang, J. Torrie, et al., "Macrosomia, perinatal and infant mortality in Cree communities in Quebec, 1996–2010," *PloS One* 11/8 (2016); J. Kornelsen, A. Kotaska, P. Waterfall, et al., "Alienation and resilience: The dynamics of birth outside their community for rural First Nations women," *International Journal of Indigenous Health* 7/1 (2011), p. 55; F. Kolahdooz, K. Launier, F. Nader, et al., "Canadian Indigenous women's perspectives of maternal health and health care services: A systematic review," *Divers Equal Health Care* 13/5 (2016), pp. 334–348.

58. Smylie et al. (see note 16).

59. D. Glaser, "Where Canada stands: A Sustainable Development Goals progress report," British Columbia Council for International Cooperation (2017). Available at https://bccic.ca/wp-content/uploads/2017/07/HLPF-Report-Online-Version-v1-07072017.pdf; First Nations Health and Social Secretariat of Manitoba, *Maternal child health* (2015). Available at http://www.fnhssm.com/index.php/policy-areas/maternal-child-health.

60. J. Lavoie, "Policy silences: why Canada needs a National First Nations, Inuit and Métis health policy," *International Journal of Circumpolar Health* 72/1 (2013).

61. Government of Canada, *Federal role in health* (2011). Available at http://www.hc-sc.gc.ca.uml.idm.oclc.org/hcs-sss/delivery-prestation/fedrole/index-eng.php.

62. Indigenous Services Canada, *Reducing the number of Indigenous children in care* (November 30, 2018). Available at https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851.

63. M. Brownell, N. Nickel, L. Turnbull, et al., "The overlap between the child welfare and youth justice systems in Manitoba, Canada," *International Journal of Population Data Science* 3/4 (2018).

64. Ibid.

65. Society of Obstetricians and Gynaecologists of Canada, "Returning birth to Aboriginal, rural and remote Communities," *Journal of Obstetrics and Gynaecology Canada* 32/12 (2010), pp. 1186–1188; D. Tarlier, J. Johnson, A. Browne, and S. Sheps, "Maternal-infant health outcomes and nursing practice in a remote First Nations community in northern Canada," *Canadian Journal of Nursing Research* 45/2 (2013), pp. 76–100.

66. Lalonde et al. (see note 13).

67. M. Bohren, J. Vogel, E. Hunter, et al., "The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review," *PLoS Medicine* 12/6 (2015); Bowser and Hill (see note 29).

68. National Aboriginal Council of Midwives, *The landscape of midwifery care for Aboriginal communities in Canada* (2016). Available at https://canadianmidwives.org/wp-content/uploads/2017/03/NACM_LandscapeReport_2016_REV_July18_LOW.pdf; K. Lawford, "Locating invisible policies: Health Canada's evacuation policy as a case study," *Atlantis: Critical Studies in Gender, Culture and Social Justice* 37/2 (2016), pp. 147–160; K. Lawford and A. Giles, "An analysis of the evacuation policy for pregnant First Nations women in Canada," *AlterNative: An International Journal of Indigenous Peoples* 8/3 (2012), pp. 329–342; R. Olson, *Relocating childbirth: The politics of birth place*

and Aboriginal midwifery in Manitoba, Canada, PhD dissertation (University of Sussex, 2013). Available at http://sro.sussex.ac.uk/id/eprint/45299; J. Cidro, R. Bach, and S. Frohlick, "Canada's forced birth travel: Towards feminist indigenous reproductive mobilities," *Mobilities* 15/2 (2020), pp. 173–187.

69. Tait Neufeld and Cidro (see note 48).

70. K. M. Lawford, I. L. Bourgeault, and A. R. Giles, "'This policy sucks and it's stupid': Mapping maternity care for First Nations women on reserves in Manitoba, Canada," *Health Care for Women International* 40/12 (2019), pp. 1302–1335; K. M. Lawford, A. R. Giles, and I.L. Bourgeault. "Canada's evacuation policy for pregnant First Nations women: Resignation, resilience, and resistance," *Women and Birth* 31/6 (2018), pp. 479–488.

71. J. Austin, *Registered midwives and traditional birth attendants* (2012). Available at https://www.birthtakesavillage.com/registered-midwives-traditional-birth-attendants/.

72. M. Bohren, G. Hofmeyr, C. Sakala, R. Fukuzawa, and A. Cuthbert, "Continuous support for women during childbirth," *Cochrane Review* (July 2017). Available at https://www.cochrane.org/CD003766/PREG_continuous-support-women-during-childbirth.

73. J. Cidro, C. Doenmez, A. Phanlouvong, and A. Fontaine, "Being a good relative: Indigenous doulas reclaiming cultural knowledge to improve health and birth outcomes in Manitoba," *Frontiers in Women's Health* 3/4 (2018), pp. 1–8.

74. N. Prata, P. Tavrow, and U. Upadhyay, "Women's empowerment related to pregnancy and childbirth: Introduction to special issue," *BMC Pregnancy and Childbirth* 17/2 (2017), p. 1.

75. National Inquiry into Missing and Murdered Indigenous Women and Girls, "Reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls; Volume 1a," *Missing and Murdered Indigenous Women and Girls* (June 2019). Available at https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf.

76. Canadian Medical Association, *CMA policy: Achieving patient-centred collaborative care* (2008), p. 1. Available at https://policybase.cma.ca/documents/policypdf/PD08-02.pdf.

77. Ibid.

78. Ibid.

79. Ibid., p. 1.

80. Ibid., p. 3.

81. M. MacDonald, "The legacy of midwifery and the women's health movement in contemporary discourses of patient choice and empowerment," *Canadian Journal of Midwifery Research and Practice* 15/1 (2016), pp. 43–50.

82. R. Kimmerer, *Braiding sweetgrass: Indigenous wisdom, scientific knowledge and the teachings of plants* (Minneapolis: Milkweed Editions, 2013), p. 9.

83. Onkwehon:we Midwives Collective, *About us* (2020). Available at https://onkwehonwemidwives.com/coming-soon/.

84. Society of Obstetricians and Gynaecologists of Canada, *Indigenous Women's Health Initiative*. Available at https://sogc.org/en/about/what-we-do/indigenous-womens-health/en/content/about/indigenous-womens-health.aspx?hkey=e85746d2-eb7f-444b-a1c9-34748a448779.