



Association of  
Ontario **Midwives**  
*Delivering what matters.*

**Report to the  
MINISTRY OF HEALTH AND LONG TERM CARE  
from the June 22, 2015 meeting regarding**

**THE EXTENSION OF FUNDING  
FOR ABORIGINAL MIDWIVES (AMS)  
IN ONTARIO**

Submitted to the MOHLTC  
on October 5, 2015

# Table of Contents

1. Executive Summary .....	3
2. Midwifery – A Vision Submitted by Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations .....	5
3. About the June 22, 2015 Meeting .....	6
4. Foundation and Guiding Principles .....	8
5. Aboriginal Midwife (AM) – a protected title .....	10
6. Overview of Presentations from June 22, 2015 Meeting.....	13
a. Ellen Kanika Tsi Tsa Blais, Co-Chair, National Aboriginal Council of Midwives	
b. Julie Wilson, Supervisor, Tsi Non:Weionnakeratstha (Mohawk meaning “the place they will be born”) Ona:Grahsta (Cayuga meaning “a birthing place”)	
c. Richard Yampolsky, Manager, Ontario Midwifery Program, Ministry of Health and Long-Term Care	
7. Recommendations to the MOHLTC from the AOM and NACM Based on Feedback from Meeting Participants as well as Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations .....	19
8. Preliminary Path Forward.....	31
9. Appendices.....	32
Appendix A: Participant List .....	32
Appendix B: Elder teaching story from Ernest Benedict (submitted by Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations).....	35
Appendix C: Rights of Aboriginal Midwives according to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (submitted by Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations).....	36
Appendix D: Support letter from the Mohawk Council of Akwesasne (submitted by Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations).....	39

Appendix E: Resolution entitled “Onkwe:honwe Midwives” Akwesasne  
that was passed by the Canadian Association of Midwives (CAM)  
(submitted by Haudenosaunee AMs from Akwesasne, Tyendinaga  
and Six Nations) ..... 41

# 1. Executive Summary

On June 22, 2015, the Association of Ontario Midwives (AOM) and National Aboriginal Council of Midwives (NACM), with support from the Ministry of Health and Long-Term Care (MOHLTC), hosted a meeting of Aboriginal midwives (AMs) and their supporters to discuss (and provide recommendations to the MOHLTC) the ministry's commitment to move forward with a call for proposals for new practice groups from AMs in early 2015/16.<sup>1</sup>

Key recommendations to the Ontario government include:

- The creation and availability of specific AM funded care is crucial to the realization of the AM protected title as described in legislation (the Midwifery Act).
- Autonomy is imperative so that midwives can organize care around the needs of clients (women and families) and their communities and provide care in the catchment areas defined by the community. AMs provide the perfect blend of Western and Indigenous knowledge. Culturally safe care recognizes that not all Indigenous communities are the same. Self-determination of one's own culture, traditions, and protocols is key in the delivery of care. Culturally safe care also supports AMs to deliver this care based on the specific needs of the community and acknowledges that each community is unique. As such, the delivery of AM services may differ, which reflects a community-based approach to midwifery.
- An Indigenous model of midwifery care means recognizing all life stages are connected and funding should reflect this approach.
- Comprehensive and appropriate liability insurance needs to be funded for AMs.
- New initiatives should support the establishment of AM services where there is capacity as well as build capacity for the future (through education and apprenticeship). It is clear that two communities, Akwesasne and Tyendinaga, currently have AMs who have been fully trained and practice diligently within the scope of their own communities. These AMs are ready to receive funding for a specific AM model of care. Consensus was reached with all that were present at the June meeting that AMs in these two communities should receive provincial funding as soon as possible.
- When discussing AM and promoting AM care, the MOHLTC must portray AMs as equally competent, necessary, and knowledgeable to registered midwives

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<sup>1</sup> Letter from Pauline Ryan, Interim Assistant Deputy Minister, Ministry of Health and Long-Term Care, to the Association of Ontario Midwives dated November 26, 2014.

(RMs). The current terminology makes it feel like registered midwives are somehow more credible and legitimate. Every government publication and document should mention AMs and RMs. Phrasing and terminology must be more respectful. The Ministry must recognize that AMs are community members – building relationship with women, families, and community members. The roles and relationships of AMs within the community are imperative in order to explain safety issues, education, midwifery care, and dispel myths.

- Integrated care must not be restricted to medical or formal institutional concepts that predetermine the provision of care. AMs are best suited to work directly with women and families to determine what types of care are needed and wanted, which may be culturally-based, culturally safe, and culturally relevant. This care may include access to and working alongside traditional knowledge keepers and other cultural practitioners. A major barrier facing AMs is the absence of access to billing and referring numbers. This places unnecessary reliance on other care-providers for the appropriate resources. AMs welcome the idea of working in partnership and support consultative processes; however, these relationships must exist within a framework of mutual respect, not one that perpetuates the hierarchy within Western medical practices.

## 2. Midwifery Vision Statement from Akwesasne, Tyendinaga, Six Nations

*Entsikionhete ne Ka'nistenhsera aoti'satstenhsera,  
ne aontakontihawihete ne kanonronhkwahshera tanon ononhkwa'shon:a ne ionkhi'nistenha  
ohontsia kiontka:was,  
ne tho non:we tetewarahsi'takara:nions tanon neaiethiiehia:rake ne tahatikonhsontakie.*

*We will reawaken the strength of all mothers  
to bring forward the love and medicine from the mother earth we dance upon  
because we remember the coming faces.*

### 3. About the June 22, 2015 Meeting

In March 2014, the AOM submitted a proposal to the MOHLTC entitled *Improving Access to Midwifery Care for Aboriginal Women Living in Ontario: A Proposal for Funding Aboriginal Midwives*, which urged government to extend funding to AMs in Ontario.<sup>3</sup>

Later in 2014, the AOM negotiated an Agreement with the MOHLTC. As part of the agreement, it was agreed that “The ministry will issue a call for proposals for new practice groups from Aboriginal Midwives in early 2015/16.”<sup>3</sup> The agreement was ratified by AOM members on December 28, 2014, signaling a legal commitment from the MOHLTC to the AOM. The agreement also demonstrated widespread support from RMs for extending funding to AMs in Ontario.

In addition, the Liberal government referred to the legal agreement in the 2015 provincial budget. The budget stated:

*Ontario will also continue to support midwifery practice groups and Aboriginal midwives working under the Exception Clause in the Midwifery Act 1994 in Ontario.*<sup>4</sup>

The June 22, 2015 meeting between the MOHLTC and Aboriginal midwives and their supporters provided an opportunity for:

- AMs and their supporters to discuss the MOHLTC commitment to extend funding to AMs (as Indigenous midwives who are practicing as RMs are currently able to access funding through the OMP); and
- the MOHLTC to hear input on extending funding to AMs.

This meeting was not considered a consultation but a mutually respectful meeting between parties to support the planning of Aboriginal midwifery programming in Ontario.<sup>5</sup> High level objectives of this meeting were to

1. provide a space for discussion and knowledge sharing; and
2. collectively review the Ontario Midwifery Program’s questions related to the extension of funding for AMs in Ontario as well as provide input to the MOHLTC.

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<sup>3</sup>Access to Midwifery Care for Aboriginal Women Living in Ontario:

[http://www.ontariomidwives.ca/images/uploads/documents/Aboriginal\\_Midwifery\\_in\\_Ontario\\_Proposal\\_FINAL\\_PDF.pdf](http://www.ontariomidwives.ca/images/uploads/documents/Aboriginal_Midwifery_in_Ontario_Proposal_FINAL_PDF.pdf)

<sup>3</sup> Letter from Pauline Ryan, Interim Assistant Deputy Minister, Ministry of Health and Long Term Care, to the Association of Ontario Midwives dated November 26, 2014.

<sup>4</sup> <http://www.ontario.ca/page/ontario-budget-2015>

<sup>5</sup> Canadian courts have established that ‘Meaningful Consultation’ is an Aboriginal right in Canada guaranteed by Section 35 of the Constitution Act (1982). The goal of ‘Meaningful Consultation’ is the reconciliation of the pre-existence of Aboriginal societies, Aboriginal rights, with the sovereignty of the Crown.

The meeting was attended by Elder Kawennanoron, Cynthia (Cindy) White. As well as offering unwavering support to the meeting participants, the Elder conducted a traditional opening and closing. Cindy spoke to her heritage and her native name meaning “Precious Words.” She spoke to the Edge of the Woods ceremony in regard to protocol; how the European newcomers had no knowledge of that protocol and how the Two Row Wampum was created as a treaty in a spirit to allow both sides to live as they felt necessary.

The original agenda for the meeting was flexed in an effort to accommodate a request from AMs to first meet separately from the other participants who comprised registered midwives (with the College of Midwives of Ontario (CMO)) who are Aboriginal/Indigenous and may also identify as Aboriginal midwives, as well as AM supporters including representatives from the Aboriginal Health Access Centres (AHACs).<sup>6</sup>

The plan for part of the day was to have the Aboriginal midwives work with small groups of supporters to help devise our collective thoughts to answer the questions posed by the Ministry. Those questions will be referred to later in this report. The agenda was flexed and small groups did respond to questions, then reflected their answers back in the late morning in full plenary session with Aboriginal midwives in attendance. The AMs were able to respond to or augment the input provided by attendees.

Following the June 22, 2015 meeting, additional input was received from the Haudenosaunee AMs. This input is denoted in text boxes in Section 6 of this report.

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<sup>6</sup> For a complete list of attendees refer to Appendix A.



## 4. Foundation and Guiding Principles

The Kaswentha, also known as the Two Row Wampum Belt treaty, was a critical component to the June 22, 2015 meeting. Kelly Stadelbauer, Executive Director, AOM, acknowledged the Kaswentha as the foundation for the June 22, 2015 meeting as well as our hope that the Kaswentha will be used as a guiding principle for extending funding to AMs.

The Mohawk Council of Akwesasne states the following about the Two Row Wampum:<sup>7</sup>

*The Haudenosaunee are comprised of six nations of people who practice very sophisticated yet simple diplomatic principles in their dealings with other Nations. Those principles are conveyed and reiterated through Wampum Belts.*

*The Kaswentha is a sacred Wampum Belt that is the basis of agreements between Haudenosaunee nations and other nations of people. It is regarded as an important covenant agreement that sets the framework for future agreements.*

*When the Haudenosaunee first encountered the representatives of Eastern European nations, they found that the Europeans were unaware of these principles, and that they had the potential to disrupt the peaceful existence that Haudenosaunee nations had secured for their people. The Haudenosaunee believed that it was essential that these newcomers learn the principles required to build a relationship with them, based on peace, friendship and mutual respect.*

*The first newcomers and all those afterward were introduced to the Kaswentha or Two Row Wampum Belt, which embodied the principals of Peace, Friendship and Mutual Respect. These principles formed the basis of the numerous treaties and agreements between Haudenosaunee and non-Haudenosaunee nations.*

*The Kaswentha or Two Row Wampum Belt is a visual instrument that was made with two parallel rows of purple Wampum on a bed of white beads:*

- *The background of white beads was meant to symbolize the purity of the agreement and some say that it represents the "River of Life."*
- *The two separate rows of purple beads were made to symbolize and encompass the two separate peoples who were incorporated in the agreement. Some say it also represents the spirits of Haudenosaunee and non-Haudenosaunee people, past, present and future.*
- *Between the two rows of purple beads, are three rows of white beads. These were made to stand for the Friendship, Peace and Respect between the two nations. As much as the three rows keep the two nations separate, it also binds them together.*

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<sup>7</sup> <http://www.akwesasne.ca/node/118>

*We, the Haudenosaunee people, exercise control and maintain our traditional practice that rests upon the Kaswentha (the Two-Row Wampum) even though the Government of Canada broke that Treaty many years ago, we haven't. The teaching of the Kaswentha is our foundation. We already have Tsi Niionkwarihoten, "Our Ways of Knowing" and we practice our ways using Sken:nen (Peace), Kanikonriio (a Righteous/Good Mind) and Kasatsthensera (Strength). These are the fundamental blocks: our guiding principles and values. More information can be found within "The Haudenosaunee Code of Behaviour for Traditional Medicine Healers."<sup>8</sup>*

At the meeting, Kelly Stadelbauer, expressed a deep commitment to upholding the Kaswentha as a guiding principle in moving forward with the renewal of Aboriginal midwifery. She said:

*The recent release of the Truth and Reconciliation Commission's report unequivocally demonstrated the deep scars left by colonialism, the "policies of cultural genocide and assimilation" and the damage inflicted on the relationship between Aboriginal and non-Aboriginal peoples.*

*Respecting treaties, like the Kaswentha treaty, and the restoration and return of Aboriginal midwifery are steps in repairing that damage.*

*This is the work we are here to contribute to and support today; I welcome you and echo my commitment and the commitment of the AOM and of the members we represent in supporting this work with friendship and respect.*

Furthermore, the Truth and Reconciliation report urges government to recognize and implement treaty rights (like the Kaswentha) as well as the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) endorsed by Canada in November 2012.<sup>10</sup> The AOM encourages the Ontario government to use both the Kaswentha and the UNDRIP as frameworks for implementing or expanding funding to support AMs.

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<sup>8</sup> <http://www.naho.ca/documents/naho/publications/codeofBehaviour.pdf>

<sup>9</sup> <http://www.trc.ca/websites/trcinstitution/index.php?p=3>

<sup>10</sup> See Truth and Reconciliation Commission call to action #42 accessed at:

[http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls\\_to\\_Action\\_English2.pdf](http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf)

## 5. Aboriginal Midwifery (AM): A Protected Title

In 1994, following regulation of midwifery in Ontario, the title “midwife” became protected through legislation, meaning those who practice as midwives in Ontario must be registered<sup>11</sup> with the CMO.<sup>12</sup>

At the same time, this legislation recognized AMs and stated they may continue to practice autonomously, being accountable to their communities rather than the CMO.<sup>13</sup>

According to NACM,<sup>14</sup> an Aboriginal midwife is a primary health-care provider who cares for pregnant women, babies and their families throughout pregnancy and birth, and for the first weeks in the postpartum period. She is also a person who is knowledgeable in all aspects of women’s medicine and she provides education that helps keep the family and the community healthy. Midwives promote breastfeeding, nutrition and parenting skills. A midwife is the keeper of ceremonies for young people, like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation.

The Aboriginal midwifery exemption from the *Midwifery Act, 1994*, reads:

- (3) An aboriginal person who provides traditional midwifery services may,
- (a) use the title “aboriginal midwife”, a variation or abbreviation or an equivalent in another language; and
  - (b) hold himself or herself out as a person who is qualified to practice in Ontario as an aboriginal midwife. 1991, c. 31, s. 8 (3)

An exemption, was also created in the *Regulated Health Professions Act, 1991*, for Aboriginal healers and midwives. The *Act* reads:

35. (1) This Act does not apply to,
- (a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or

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<sup>11</sup> See “Regulation and Professional Organization” at <http://www.ontariomidwives.ca/midwife/regulation>.

<sup>12</sup> For information on the role of the CMO, see <http://www.ontariomidwives.ca/midwife/regulation/college>.

<sup>13</sup> See more at: [www.ontariomidwives.ca/care/aboriginal#sthash.2ae18hv3.dpuf](http://www.ontariomidwives.ca/care/aboriginal#sthash.2ae18hv3.dpuf)

<sup>14</sup> For more information on NACM see <http://aboriginalmidwives.ca/>.

(b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community.

Further, the AMs from Akwesasne, Tyendinaga and Six Nations, members of Haudenosaunee communities in Ontario, who attended the June 22, 2015 meeting have provided the following statement about the protected title of Aboriginal midwife in Ontario:

*We ask that the MOLTHC respect the AM title as a legitimate health care profession and that it is used for AMs who are specifically practicing within the non-registered model. AMs recognize and practice traditional models of health care in our communities, which are recognized by our Nations, women, families, and community members. As a result, AMs, mothers, and families in our communities determine which additional support people and care providers are best suited to them; this includes doulas, birth aides, lactation consultants, and other cultural/traditional knowledge keepers. As a collective, we resist the colonial, medicalized, and fragmentation of our work by collaborating in meaningful ways for the overall health and wellness of our Nations and communities across Turtle Island.*

*We believe that Aboriginal midwifery is described by a community that sets the standard and oversees the midwifery practitioner. The AM is accountable to that community in a formal manner that allows the community to ensure all practitioners are safe, fully qualified, authorized, and continues to update their skills and knowledge. This high standard of service is necessary to ensure that Aboriginal people receive high quality of health care and that there is accountability.*

Julie Wilson, Supervisor at Tsi Non:Weionnakeratstha Ona:Grahsta understands an AM as:

*...an Aboriginal person, usually a woman, who provides traditional Aboriginal midwifery services to her own people. She would incorporate a lot of the traditional practices, ceremonies, and medicine into her community. She would be a member of her community and she would work for her community. She's not an independent care provider. She's been chosen from her community to stand up and to provide this service. So she works for her own people.*

*The phrase 'Aboriginal Midwifery' is now widely used across Canada and encompasses a number of different approaches and experiences of women with midwifery knowledge, from traditional midwives who were taught by Elders in their communities, to women who have completed formal degrees in midwifery, or those who incorporate a blend of the two. Aboriginal midwives are diverse and the differences in their training, experience and practice must be acknowledged when speaking of Aboriginal midwifery. At the same time, Aboriginal midwives are all women of First Nations, Inuit, or Métis descent who share the common histories and experiences of being Indigenous to Canada. In this way, defining who is an Aboriginal midwife and what that means becomes a complex task that requires some generalization based on the common experiences of Aboriginal women, while also recognizing the diversity that exists among women who identify themselves as Aboriginal midwives. To date, there is not one standard definition of Aboriginal*

*Midwifery that is widely accepted.*

The international definition of a midwife is:

*A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery, International Confederation of Midwives Council.<sup>15</sup>*

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<sup>15</sup> NAHO: Celebrating Birth – Aboriginal Midwifery in Canada, December 2008.

## 6. Overview of Presentations

### a. Ellen Kanika Tsi Tsa Blais

Ellen is from the Oneida Nation of the Thames, and is currently the Co-Chair of the National Aboriginal Council of Midwives (NACM) and the Policy Analyst for the Association of Ontario Midwives.



*Natasha Smoke Santiago*

Ellen introduced herself as a graduate of the Ryerson University's Midwifery Education Program and spoke of her personal journey. She started her presentation with an analogy of Sky Woman and the Creation Story to the birthing process. The presentation took the participants through a history of Aboriginal midwifery in Ontario, the current lack of funding for AMs practicing in Ontario, the locations of AM practices and RM practices that focus on serving local Aboriginal communities as well as the paths to becoming an AM in Ontario

Ellen shared some of the traditional ways in which midwives worked and work in the community, such as being keepers of the ceremony of birth.

Ellen spoke of the role of an AM as being a protected title (refer to Section 4 of this report for further information).

Ellen explained that AMs at the meeting had requested some time to meet on their own. She thanked the Creator for providing a space for these women to work together and that AMs would return to the larger group later on and bring their voices to our meeting.

Ellen spoke about the various paths to midwifery practice in Ontario, including

- the Six Nations Birthing Centre program to train and apprentice as an AM
- Ryerson, McMaster or Laurentian universities' Midwifery Education Program to train as a RM; and
- the International Midwifery Pre-registration Program (IMPP), Ryerson Continuing Education to bridge education from another jurisdiction to the RM model in Ontario.

Ellen shared that the AOM is working in support of AMs, and created the position of a policy analyst through consultation with the Aboriginal community of midwives and that the hiring process for her position was made up of AOM staff and representatives from the Aboriginal midwifery community.

Ellen explained how, up until the agreement from the MOHLTC,<sup>16</sup> there was very limited access to funding for AMs. The Aboriginal Healing and Wellness Strategy (AHWS) of Ontario funds midwifery at Six Nations, but it is a “sunset” program, meaning that it is not able to fund new AM initiatives.

b. Julie Wilson, Supervisor,  
Tsi Non:we Ionnakeratstha Ona:grahsta'<sup>17</sup>

Julie introduced herself, noting that introductions are important from an aspect of knowing self and knowing where you come from / where you belong. She graduated from the McMaster program in 1998. Norma Hill and Gary Hill are her parents, and she has five children.

Julie spoke to Ona:grahsta’s logo and its significance. Their logo speaks to the importance of motherhood and the four cycles of life, baby, adolescence, mother and elder. The circle symbolizes the turtle. The logo was created by Arnold Jacobs.

May 17, 1996 was opening day for Tsi Non:we Ionnakeratstha Ona:grahsta’ and the centre recently celebrated its 19th anniversary.

She said the focus of the centre is community wellness, meaning that a lot of health and healing begins when a woman is pregnant, which is a time when there is an opening to their overall health. As AMs, midwives at the centre don’t practice as individual practitioners, but rather they are part of, and work for, their community. The midwives at Six Nations practice under the exemption clause in the *Midwifery Act* (see section 4 of this report).

Additional key points made by Julie included:

- Because AMs are not RMs they have challenges with access to ultrasound and lab work, it is not covered from their funding dollars.
- They lack good malpractice insurance.
- While AMs are not registered with the CMO, regulation exists through other ways, including through her role as Supervisor and through the Director of Six Nations Health.

Julie reiterated that AMs are *regulated by their community* and not an outside body. She said, “It is our inherent right to birth our babies on our own territory.”

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<sup>16</sup> Letter from Pauline Ryan, Interim Assistant Deputy Minister, Ministry of Health and Long Term Care, to the Association of Ontario Midwives dated November 26, 2014.

<sup>17</sup> Information about Tsi Non:we Ionnakeratstha Ona:grahsta’ can be found at [www.snhs.ca/bcBackground.htm](http://www.snhs.ca/bcBackground.htm) and [www.ontariomidwives.ca/care/aboriginal](http://www.ontariomidwives.ca/care/aboriginal) .

Julie explained that AMs create their own standards of practice that best meet community needs. They have the freedom to incorporate traditional teachings, practices and medicines into the client's care.

Julie spoke about the outcomes and results at the centre that demonstrate they positively impact the lives of the women they care for. She said AMs do important work.

Julie expressed concern that a course-of-care model<sup>18</sup> would not work in the Aboriginal community because the needs are complex and complicated. Julie said that the salaried model at the centre allows midwives to spend the time needed to meet clients' diverse needs. She said a salaried model also allows AMs to engage in health-promotion activities.

She said that she sees the long-term results, not only for the mother but for her children, of accessing care with an AM. She said AMs value traditional teachings and practices that allow people to reconnect with their tradition and teaching in order to make people feel good about themselves (just as good as mainstream). Julie talked about the effects of residential schools, including feelings of inadequacy. Traditions and culture make people unique and beautiful as a people.

Julie said that AMs approach their work with this respect for traditional and cultural ways. Through the integration of cultural ways, preventative care, and the appropriate use of technology, Onkwehon:we (the Original People) experience safe and quality care when they are cared for by an AM. The centre has not had a lawsuit in 19 years. At least 90% of clients use traditional medicines and love being cared for by AMs. Many have been treated badly by the mainstream. Once they are accompanied by a midwife, then the mainstream can't say what they would otherwise.

Midwifery services provided at the centre include: primary prenatal care; primary labour and birth care at home (40%) and in the centre (60%); women's health issues (menopausal support); traditional family teachings; well baby issues; infertility information and support; pap tests; pregnancy testing; traditional medicines; education and emotional support; 24-hour breastfeeding support and nutrition.

Programs offered at the centre all have a strong traditional component and include: prenatal classes; mom & tots group; female traditional self-care; traditional medicines workshops; women's wellness day; family / maternal resource library; Aboriginal midwifery training program (since 2000 for traditional trainings); traditional parenting workshops; and "woman in all her seasons."

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<sup>18</sup> The "course of care model" is the funding model used to compensate RMs.



c. Richard Yampolsky, Program Manager, Ontario  
Midwifery Program, Ministry of Health and Long-Term  
Care

Richard indicated that this meeting did not constitute a formal consultation; it is the beginning of a discussion so that the Ministry is in a position to better support Aboriginal midwifery.

Richard reiterated that the 2015 Ontario Budget: *Effective Health Care System for All*, stated “Ontario will also continue to support midwifery practice groups and Aboriginal midwives who offer support to expectant mothers and their babies<sup>19</sup>.”

Richard presented a slide deck (which had been circulated prior to the meeting).<sup>20</sup> Richard’s presentation was followed by a question and answer period.

Richard opened his remarks by clarifying, despite the statement in the email that contained the meeting materials, that the Ministry did not “approve” the AOM’s *Improving Access to Midwifery Care for Aboriginal Women Living in Ontario: A Proposal for Funding Aboriginal Midwives* which the AOM submitted to the ministry in March 2014.

Richard stated that the MOHLTC recognizes that Aboriginal midwifery services can be delivered by any woman or man, registered through the CMO or practicing under the exception for Aboriginal midwives, *Midwifery Act, 1991*, who has been recognized by her/his community as having the skills and knowledge to provide Aboriginal midwifery care.

A Q&A followed Richard’s presentation. The following reflects a summary of questions and responses.

**Q: Why did you start with these principles (not Indigenous based)?**

The Ministry needed a reference point to begin these discussions and recognized that these principles may not have met everyone’s expectations. The Ministry is open to the Indigenous community principles and for opportunities to better align them. The principles provided were the start of a conversation.

**Q: How much money is set aside for AMs?**

The dollar amount is hard to state because distinct funds have not been segregated. Midwifery in Ontario is currently growing by ~6% annually. Until the Ministry has an understanding of what the demand for Aboriginal midwifery services are, it is not

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<sup>19</sup> <http://www.fin.gov.on.ca/en/budget/ontariobudgets/2015/ch1f.html>

<sup>20</sup> Aboriginal Midwifery Engagement Consultation:  
[http://www.ontariomidwives.ca/images/uploads/documents/Aboriginal\\_Midwifery\\_June\\_22\\_Engagement\\_Final\\_\(MOH\).pdf](http://www.ontariomidwives.ca/images/uploads/documents/Aboriginal_Midwifery_June_22_Engagement_Final_(MOH).pdf)

possible to separate an amount. If demand exceeds the allocation, there may be ability to request additional funding.

**Q: Will you include us in the development of a strategy and reporting structure?**

That is, in part, the purpose of this day. The strategy for Year 1 is to build existing Aboriginal midwifery capacity. To ensure midwives' success, the ministry sees Aboriginal midwives integration into existing primary health-care programs and organizations currently serving Aboriginal communities so that midwives and their clients can be supported by a range of primary care services. The ministry is open to ongoing discussions.

**Q: There is midwifery capacity in Tyendinaga and Akwesasne. Other communities lack capacity today but may build capacity in the coming years. Will these communities be able to access funding?**

This fiscal year is the initial opportunity to increase access to Aboriginal midwifery services and there will be further opportunities as demand and capacity grows. The Ministry sees communities such as Tyendinaga and Akwesasne being well positioned to submit proposals. The funding for Aboriginal midwifery is part of the base funding; it is ongoing and *not* one-time funding. Depending on available funding, there will be opportunities to submit requests on an annual basis.

**Q: Education, will the ministry look at other education models, apprenticeship?**

The Ministry acknowledged that it is too early to determine education models but that building on the Six Nations model is one possibility.

**Q: There is nothing for women of a childbearing age after their rites of passage. There is a huge gap in most communities for integrated care. How will this be addressed?**

In the approach to proposals for Aboriginal midwifery services, the Ministry is not looking at just women of childbearing age. Proposals could extend from prepubescent to post-menopausal. Aboriginal midwifery services would support the expanded role of midwife beyond just delivering babies. The Ministry knows there's more to it, but needs to understand more, that would be part of any proposal submitted.

**Q: How do we facilitate money to go to these people who know what they need already?**

This meeting is to help the Ministry better understand what exists and what is needed. There is an opportunity to provide funding this year. Criteria still need to be defined. The Ministry does not want to set these programs up for failure and wants to ensure that they are part of their communities and part of primary health-care teams. Letters are needed from band and council supporting proposals. Details such as demographics,

services and who else in the community would be delivering services will need to be provided. At this point, the Ministry needs help in determining the criteria.

**Q: Low-risk has to be redefined. Suggestion that we need to take out the “low-risk” word with an understanding of the complex needs in Aboriginal communities.**

Richard acknowledged that there was a challenge around defining “low-risk” within the current midwifery model of care. How do we deal with that? The Ministry is open to hearing approaches to how communities use the determinants of health and how they do not necessarily mean that a midwifery client be considered clinically “high risk.”

**Q: What does this AHAC working group have to do with on-reserve?**

AHACs serve on- and off-reserve clients. The AHAC ED Circle offered to form a working group for the Ministry to inform the process. In addition, an AHAC working group member offered that AHAC’s have partnerships and services on- and off-reserve. Some AHAC’s have expressed an interest in housing AMs.

**Q: What are the outcomes for midwifery in communities? Aboriginal women set the evaluation criteria.**

That’s part of the question that we came in looking for help today, at least in the coming or current year, what kind of criteria should they be looking at? The Ministry is open to receiving input on its criteria.

Additional points were made by participants during the Q+A period, including:

- An understanding around spirit and birth and life-long care are needed, and not simply a narrow clinical focus of midwifery.
- The principles that guide the expansion of funding for AMs must reflect Indigenous ways of knowing and doing.
- Two Row Wampum and Seven Grandfather teachings provide two potential ways of approaching principles to guide the expansion of funding for AMs.
- Indigenous people must be involved in creating principles that will guide the expansion of funding for AMs.
- The existing capacity must be recognized and support provided to ensure capacity can be supported, funded and allowed to flourish. There is currently capacity in Tyendinaga and Akwesasne. In other areas in province, there is little capacity at the moment, but that could change, especially with support for education and apprenticeship opportunities.
- Indigenous communities have the capacity to ensure safe and quality care.
- The expansion of funding for AMs should prioritize midwife-led models and projects.
- The expansion of funding for AMs should be community based and specific to community needs.

- AMs should be able to provide service to their community members, regardless of whether they reside on territory.

## 7. Recommendations to the MOHLTC from the AOM and NACM based on feedback from meeting participants as well as Haudenosaunee AMs from Akwesasne, Tyendinaga and Six Nations

### **Q 1. How do we increase access to Aboriginal midwifery services where they are needed and where there is capacity to provide them?**

Increasing Aboriginal midwifery services requires increasing understanding, awareness and education about the specific scope of practice that AMs provide. This process includes dispelling myths, health promotion around traditional and culturally safe supports, as well as acknowledgment and support from MOHLTC to help dismantle negative language surrounding the AM title.

The implementation of an AM model also means having a critical understanding that funding and service models cannot be based on the same criteria that the registered model is based upon. Funding cannot be based on number of clients nor can it be restricted to specific geographic catchment areas. As members of Turtle Island, there should be no border or barrier that dictates where we are able to practice.

There has been no formal provincial regulating body for Aboriginal midwives or criteria for acceptance as an Aboriginal midwife stipulated by a non-Aboriginal body.

Key points:

Informed by Indigenous ways of knowing and doing, collaboration, access to funding and community specific models is critical.

## Recommendations:

- 1) The expansion of funding for AMs must be driven by Indigenous ways of knowing and doing.
- 2) Base funding that allows for stability and for midwives to build community trust is imperative.
- 3) AMs should be supported to work autonomously but where possible, collaboration between AMs and RMs may lead to increased access.
- 4) The expansion of funding must support community-based and AM-led projects (like the centre at Six Nations).
- 5) Supporting the education of new AMs is imperative to ensuring improved access in future and must be supported in tandem with the expansion of funding. A grow-your-own-Aboriginal-midwife type program may benefit many communities who do not currently have capacity but who need midwifery care. Community-based education programs, like the one at Six Nations, are able to incorporate ceremony and traditional medicine into the education of new AMs and this is just as important and valued as clinical expertise.
- 6) A salaried model is preferred (similar to Six Nations) because it allows for stability and sustainability; for the community to define their realities and care needs; for responding to the many and complex needs of women and families in care; for small and fluctuating birth numbers in smaller communities; and it also allows for ample time to be spent with women and families in Aboriginal midwifery care.
- 7) The criteria and process for applying for new funding from the Ministry should be clear and accessible.
- 8) NACM is an important voice for Indigenous midwifery and must be consulted and involved in the development of funding criteria and process.

**Q 2. How do we ensure services are culturally safe, appropriate and meet community needs while maintaining traditional customs (e.g., holistic care, well-women programs)?**

AMs provide the perfect blend of Western and Indigenous knowledge in the provision of midwifery care. Culturally safe care recognizes that not all Indigenous communities are the same. Self-determination of one's own culture, traditions, and protocols is key in the delivery of care. Culturally safe care also supports AMs to deliver this care based on the specific needs of the community and acknowledges that each community is unique. As such, the delivery of the AM services may differ, which reflects a community-based approach to midwifery.

Specific supports and resources for Indigenous languages, culturally specific trainings, education, and advocacy are important within the AM funding model. Access to our Indigenous languages for our babies and families is critical to our health and well-being. The inclusion of these pieces honours all generations and builds a strong foundation of identity for future generations.

One of the many strengths of the AM model is that we are best suited to provide well-women care and life-long care. The AM philosophy of continuity of care surpasses that of the registered model in this regard. AM includes services like pap smears for Elder women, preconception care, education about sexually transmitted and blood-borne infections (STBBI's), postnatal/postpartum support from birth trauma and/or obstetric violence, puberty teachings, participating in coming of age ceremonies, harm reduction for pregnant and parenting women, etc. The current RM model severely restricts the provision of this critical care for all women and families. RMs are only permitted to provide care for their current pregnant clients or within a short amount of time after giving birth. An Indigenous model of care means we do not separate who and when care is being offered – all life stages are connected and are important to recognize across the lifespan.

## Key point:

Midwives are a safe entry point for culturally safe and appropriate care.

## Recommendations:

- 1) Communities must be able to determine what culturally safe and appropriate midwifery care means to them.
- 2) Knowledge sharing about Aboriginal midwifery and understanding that every woman can benefit from midwifery is important in supporting future capacity. Histories of colonialism and residential schools have eroded Aboriginal midwifery and as a result education is needed to enable a renewal of midwifery. This could include funding community gatherings with women and families.
- 3) Cultural safety training for other providers who may come into contact with AMs funded by the Ministry will assist when women move from AM care to RM or physician-led care.
- 4) Culturally appropriate care cannot be standardized but will vary from community to community.
- 5) The services that women and families have access to under AM care are community-specific and include Elder support, medicine gatherings, etc.
- 6) There is concern about using a transfer payment agency and the influence that transfer payment agencies may have on the services delivered. There is a preference for funding to flow directly from the Ministry to the AM-led project, centre or clinic.
- 7) Recognizing and supporting the development of health councils made up of grandmothers may in some communities be essential to ensuring culturally appropriate care. Community infrastructure needs, like grandmother health councils should be valued, recognized and supported by the Ministry.
- 8) Aboriginal communities have been greatly traumatized by the effects of residential school, creating intergenerational and ongoing trauma, and have been colonized and oppressed both historically and currently by institutions that have power and control over their well-being. This has been highlighted in June 2015 with the release of the Truth and Reconciliation recommendations.<sup>21</sup> Providing culturally appropriate midwifery care is a step towards healing.

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<sup>21</sup> <http://www.trc.ca/websites/trcinstitution/index.php?p=3/>

**Q 3. What is the most effective way to stage the rollout given existing capacity (e.g., timeframe, availability of trained Aboriginal midwives), knowing that there will be annual opportunities to expand Aboriginal midwifery care?**

It is clear that two communities, Akwesasne and Tyendinaga, currently have AMs who have been fully trained and practice diligently within the scope of their own communities. These AMs are ready to begin receiving funding for a specific AM model of care. Ministry of Health and government regulations should not deter or interfere with funding allocations as these two communities have to be able to respond to the immediate needs. **Consensus was reached with all that were present at the June meeting that AMs in these two communities should receive provincial funding as soon as possible.**

We remain committed to assisting and supporting other communities in Ontario as the AM funding rolls out to ensure that the needs of specific Indigenous communities are met. We do not want to MOHTLC to prescribe a pan-Indigenous approach.

### Key points:

Commitment to base funding and development of a supportive process are necessary.

### Recommendations:

- 1) Provide immediate funding for communities that currently have Aboriginal midwives ready to provide care.
- 2) Provide support for the development of Aboriginal midwifery for those communities where there isn't immediate capacity through RM partnerships and access to AM-led midwifery education and apprenticeship programs.
- 3) Support communities to understand the benefits of Aboriginal midwifery renewal. Support NACM and the AOM to continue this work.
- 4) Use Birth Visioning Model developed by NACM.



#### **Q 4. How can Aboriginal midwives be supported to provide integrated care as part of a health-care team?**

Integrated care must not be restricted to medical or formal institutional concepts that predetermine the provision of care. AMs are best suited to work directly with women and families to determine what types of care are needed and wanted, which may be culturally based, culturally safe, and culturally relevant. This care may include access to and working alongside traditional knowledge keepers and other cultural practitioners.

Integrated care describes the entire life span and as such, the scope of practice includes both well-women care and life-long care as noted in our answer to Question 2.

A major barrier facing AMs is the absence of access to our own billing and referring numbers. This places unnecessary reliance on other care providers for the appropriate resources. We welcome the idea of working in partnership and support consultative processes; however, these relationships must exist within a framework of mutual respect, not one that perpetuates the hierarchy within Western medical practices.

#### **Key points:**

Midwives are autonomous primary care providers. Integration should be driven by the client's needs. Autonomy is key and AMs should not be supervised by another profession. Employee models, which can, for example, limit time spent with clients in labour to be compliant with the Employment Standards Act,<sup>22</sup> may prove problematic and erode AMs' ability to organize care with the client at the centre of care.

#### **Recommendations:**

- 1) Six Nations has a model that enables AMs to work autonomously and with the ability to transfer care to a physician should a woman in care need it. New models may also explore collaboration with RMs with admitting and discharging privileges in hospitals.

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<sup>22</sup> For information on limits to hours of work under the ESA, see <http://www.labour.gov.on.ca/english/es/pubs/guide/hours.php>.

- 2) The spirituality involved in birth should be validated and ceremony valued. It is its own rite of passage. Support the use of Traditional Healers. These aspects of care should be considered “integrated” care.

**Q 5. How do we encourage collaboration and partnerships with existing primary care models so that clients experience coordination and continuity of care?**

It is essential that AMs are provided with our own billing numbers and medical malpractice insurance so that we can practice within our full scope of care. These administrative tools will ensure AMs can practice in partnership and autonomously as determined by the needs of the woman, family, and community.

Continuity of care must be extended to support the learning and use of Indigenous languages. Resources are also required for the participation and intersection of our ceremonies including birth, coming of age, and other community gatherings that acknowledge the life cycle for

**Q 6. What are the best ways to ensure communities are aware of and receive appropriate information on the options available for maternal and child care?**

Public information campaigns and clinics in the various territories and regions in which we reside are necessary. It is vital that our Indigenous languages are included in these activities. The promotion of AM also needs to take part on a larger scale by the Ontario government.

A collaborative effort to support other women helper's involvement is necessary. This includes working alongside doulas, birth attendants, student apprentices, and other birth workers. This inclusion honours the way our ancestors and great-grandmothers involved all community members.

Key points:

Support autonomous Aboriginal midwifery models of care and recognizes the time and resources needed by AMs, especially those setting up new practices, to develop partnerships. Autonomy is critical for the provision of excellent care. Employment arrangements for AMs should facilitate, not restrict, autonomy and the ability to organize care around the needs of the clients and communities.

## Recommendations:

- 1) Support autonomy and flexibility that allows care to be organized around clients and communities.
- 2) Support collaboration between RMs and AMs.
- 3) Support AHAC's to work with AMs and to support the renewal of AM.
- 4) Support education about the renewal and benefits of Aboriginal midwifery.
- 5) Fund liability insurance for AMs.
- 6) Support hospital-level education projects that educate hospitals about the expansion of funding for AMs and new AM projects hospitals may encounter in their local community.
- 7) Recognize that NACM and the AOM are well placed to support education in communities and hospitals.

## **Q 7. What are the best ways to ensure communities are aware of and receive appropriate information on the options available for maternal and child care?**

### Key point:

As there are currently few (if any) options Aboriginal midwifery options available, ensure that new initiatives have funding to promote their services.

## Recommendations:

- 1) Currently there are very few (Six Nations), if any, option for Aboriginal women and the expansion of funding is an important step towards improving access to care.
- 2) Most of the information people are getting are from their family and friends. That is why groups like NACM are important in terms of supporting AM renewal. People need to see midwives in their communities and as active members of their communities to understand who they are and what they do. Separating the clinical from the ceremonial work will undermine the presence of midwives in community and this must be avoided.
- 3) Communities must be able to regulate their AMs.
- 4) Fund AMs to spread the word, inform communities and increase awareness of Aboriginal midwifery (their practice).

- 5) Funding for ceremony to celebrate births is imperative. Celebrating births, funding community-based celebrations, are a significant way of drawing attention to the benefits of midwifery and the availability of newly funded options.
- 6) Fund AMs to take up cultural responsibilities in the community (beyond narrow definition of clinical midwifery care).
- 7) The Ministry is encouraged to leverage existing resources within Indigenous communities such as NACM, which respects Indigenous epistemological approaches to understanding the role, values and importance of Aboriginal midwifery, Indigenous-driven and self-determined strategies for sharing knowledge and building strategic frameworks.

**Q 8. What mechanisms can help ensure that communities are informed about the quality and safety of midwifery care in their community?**

AMs require support for the amount of preparative work we do, as it is critical to the provision of care. AMs are community members – we need to have a relationship with women, families, and community members. AMs roles and relationships within the community are imperative in order to explain safety issues, education, midwifery care, and dispel myths.

The AMs need the MOHLTC to portray AMs as equally competent, necessary, and knowledgeable. The current terminology makes it feel like registered midwives are somehow more creditable and legitimate. Every government publication and document should mention AMs and RMs. Phrasing and terminology must be more respectful.

**Key points:**

Accountability is inherent within Indigenous approaches. Accountability is implicit and therein lays a relational, community-based understanding of accountability.

**Recommendations:**

- 1) Accountability is inherent in Indigenous approaches and should be community-based.
- 2) Communities could be asked to articulate the mechanisms they will use to ensure safety and quality care as well as autonomous midwifery practice.
- 3) Because mechanisms should be community-based, a regulatory college is not desirable. However, other supports, such as quality and safety resources may be helpful and could perhaps be developed in partnership with NACM and the AOM. Communities may want to consider mechanisms such as statements on quality and safety and a process for client's to provide input on their care experience or the voluntary adherence of applicable CMO guidelines.
- 4) The Ministry should recognize that mechanisms for quality and safety may vary from community to community and that those variations are appropriate and recognize sovereignty.

**Q 9. What are the most effective ways to ensure oversight of service quality and client safety?**

The Six Nations Birth Centre midwives have a governance model that includes community and traditional governance bodies. We feel this is a great model to replicate. Six Nations Council acts as the delivery agent and grants authority to an Advisory Committee to oversee general operation. The Advisory Committee works with community, council, and traditional bodies. This may not be the route that fits best in every community and the band council is familiar with the limitations that may arise with this mode of operation. For the Six Nations AMs, their band council acts specifically as a transfer payment agency.

Access to our own billing numbers and medical malpractice insurance are critical components of funding. AMs would work within our own communities to determine what other partnerships and transfer payment set-ups would be best suited to the specific community's reality.

**Key points:**

Service oversight must be community-defined and based on Indigenous ways of knowing and doing. For some, a TPA model may be best, for others, a direct funding relationship with the Ministry.

## Recommendations:

- 1) Effective ways of ensuring oversight of service quality and client safety must be community-defined and community-based and rely on Indigenous ways of knowing and doing.
- 2) Six Nations has an almost 20-year history of quality and safe care that is community-specific, community-defined and based on Indigenous ways of knowing and doing.

### **Q 10. What clinical partnerships and supports do Aboriginal midwives need to ensure they can provide safe and high-quality care (e.g., to make lab requisitions, transfer patients when necessary)?**

The current midwifery legislation permits the AM protected title. AMs can practice but there is nothing for us to assist us in fully carrying out what is described in our role. In many ways, this is setting us up to fail, as there is no funding or other resources available. AMs are recognized but it only goes as far the legal language, which positions AMs in a very limited place.

The creation and availability of specific AM funded care is crucial to the realization of the AM protected title as described in the legislation.

### Key point:

Aboriginal midwives need clinical partnerships and support and must be able to identify what these partnerships and support specifically look like from community to community.

## Recommendations:

- 1) Create specific AM funding for AM-led midwifery care.
- 2) Ensure AMs have access to their own billing numbers as well as to comprehensive and appropriate liability insurance.
- 3) Government can recognize that establishing clinical partnerships and supports are time and resource intensive, especially as a new midwifery practice is being developed. This kind of work should be funded and supported as it's critical to the success and sustainability of a new midwifery practice.
- 4) AMs need access to ESW and ongoing professional development.
- 5) AMs need support in developing partnerships with RMs, physicians and the health-care system that they and their clients may need to access.

- 6) AMs need access to make lab requisitions.
- 7) AMs need to be supported to explore the possibility of working within midwifery-led birth centres.

**Q 11. What practice supports can ensure Aboriginal midwives succeed (e.g., peer review, professional development, mentorship, oversight councils)?**

AMs welcome peer review, access to college and AOM learning modules, training opportunities, and access to courses that are specific to AM practice of care. For example, AMs do not do hospital births, as such, our peer review is different.

AMs want to create a solid network and connection to the specifics of Aboriginal midwifery. The funding for AMs should, therefore, promote networking that would facilitate Western and Indigenous training.

A salary model similar that of the Six Nations AMs is ideal, however, the salary should be equal pay to registered midwives regardless of the client load. It is not feasible to have the same course of care numbers as RMs, however, due to the fact that AM's provide quality & comprehensive life cycle care, the quantity of care provided by AMs cannot be compared to that of RMs, as the AM model is built upon sustainability and longevity.

**Key point:**

Practice supports may vary from community to community and AMs should be able to define which supports they will need to succeed in their particular community.

**Recommendations:**

- 1) Support the creation of a solid network and connection to the specifics of Aboriginal midwifery. The funding for AMs should, therefore, promote networking that would facilitate Western and Indigenous training.
- 2) Enable AMs to articulate what supports they specifically need to succeed. Needs will vary from community to community.

- 3) Quality assurance programs need to be defined and developed by the community; peer review as currently defined by CMO is midwife to midwife whereas in some community settings it may be best conducted among an interdisciplinary team.

## 8. Preliminary Path Forward

Next steps related to the first phase of funding:

The final group agreement on June 22, 2015 was for a three-phase process going forward:

1. a MOHLTC-funded meeting between Akwesasne and Tyendinaga to develop criteria;
2. proposal submission for available funding to be spent before the end of the fiscal year 2015-2016 for Akwesasne and Tyendinaga with feedback from an Advisory Committee of midwives and stakeholders who volunteered to help prior to submission to the MOHLTC; and
3. criteria development and proposal template for rollout of provincially funded Aboriginal midwifery across Ontario.

The participants at this meeting encouraged the Ministry to support the development of an Advisory Committee, including participation from NACM, the AOM, AHAC's and community members to support the expansion of funding for Aboriginal midwifery.

The following participants volunteer to participate on an Advisory Committee:

Janet Smylie	Jasmine Benedict	Naomi Wolfe
Sara Wolfe	Mona Loones	Jessica Danforth
Ellen Blais	Sharon Smoke	Kerry Bebee (NACM)
Joyce Leaf	Donna Rockwell	Melodie Smith
Alisha Apale	Tricia Atlookan	
Trista Hill	Roberta Pike	

The participants at this meeting also strongly recommend that the Ministry immediately expand funding for Aboriginal midwifery practices to communities that have the capacity to deliver Aboriginal midwifery services. The participants recognize that capacity currently exists in at least two communities, namely Tyendinaga and Akwesasne.



## Appendix A: Participant List

Attended In Person		
Michelle Sault	Facilitator	CornerStone Concepts
Penny Bowers	Note Taker	CornerStone Concepts
Cindy White	Elder	Six Nations
Ellen Blais	NACM Co-Chair; Analyst, Aboriginal Midwifery (AOM)	Policy National Aboriginal Council of Midwives; Association of Ontario Midwives
Juana Berinstein	Director, Policy and Communications	Association of Ontario Midwives
Kelly Stadelbauer	Executive Director	Association of Ontario Midwives
Bobbi Soderstrom	Insurance and Claims Advisor	Association of Ontario Midwives
Rebecca Carson	Registered Midwife; Vice President	Family Midwifery Care (Guelph); Association of Ontario Midwives Board
Joyce Leaf	Aboriginal Midwife	Akwesasne
Donna Rockwell	Doula	Akwesasne
Jasmine Benedict	Aboriginal Midwife	Akwesasne
Dorothy Green	Aboriginal Midwife	Tyendinaga
Mary McBride	Second Attendant	Tyendinaga Retired Pediatric Nurse
Miranda Brant	Not sure	Tyendinaga
Trista Hill	Midwifery Student	Tyendinaga / Six Nations
Julie Wilson	Aboriginal Midwife & Birth Centre Supervisor	Tsi Non:we lonnakeratstha Ona:grahsta, Maternal and Child Centre, Six Nations
Sharon Smoke	Aboriginal Midwife	Tsi Non:we lonnakeratstha Ona:grahsta, Maternal and Child Centre, Six Nations
Melodie Smith	Aboriginal Midwife	Tsi Non:we lonnakeratstha Ona:grahsta, Maternal and Child Centre, Six Nations
Kerry Bebee	Registered Midwife / Past Co-Chair	National Aboriginal Council of Midwives (NACM)
Alisha Apale	Coordinator	National Aboriginal Council of Midwives (NACM)
Cherylee Bourgeois	Registered Midwife / Midwife Co-Lead	Seventh Generation Midwives of Toronto (SGMT) / Toronto Birth Centre
Sara Wolfe	Registered Midwife	Seventh Generation Midwives of Toronto (SGMT) / Toronto Birth Centre
Roberta Pike	Executive Director	Toronto Birth Centre
Sara Booth	Clinical Director	Toronto Birth Centre
Kelly Dobbin	Registrar - CEO	College of Midwives of Ontario (CMO)

Billie Allan	Researcher	Well Living House
Janet Smylie	Researcher	Well Living House
Karen Lawford	Researcher	University of Ottawa
Jesse Dhaliwal	Member Services Liaison	Association of Ontario Health Centres -works with AHAC's
Gloria Daybutch	Health Director	Baawaa-tang North Shore Tribal Council N'mninoeyaa AHAC
Mona Loones	Gestionnaire des programmes et des services cliniques/ Clinic and Program Manager	CSC CHIGAMIK CHC (Centre de santé communautaire CHIGAMIK Community Health Centre)
Tammy Maguire	Primary Care Manager	Noojmowin Teg Health Centre (Aundeck Omni Kaning First Nation)
Tricia Atlookan	Early Years Coordinator	Nishnawbe Aski Nation (NAN)
Julie Maher	Provincial Director	Ontario Women's Health Network (OWHN)
Krysta Williams	Leader	Native Youth Sexual Health Network
Jessica Danforth	Executive Director	Native Youth Sexual Health Network
Fallon Andy	Youth Facilitator	Native Youth Sexual Health Network
Fredrika Scarth	Manager (Acting)	Salaried Models and Programs, Ministry of Health and Long-Term Care
Richard Yampolsky	Program Manager (Acting)	Specialized Models Programs, Ministry of Health and Long-Term Care
Barbara Richmond	Implementation Lead	Seniors Strategy, Ministry of Health and Long-Term Care
Jeffrey Kwok	Senior Program Consultant	Specialized Models Programs, Ministry of Health and Long-Term Care
Andrea Lennox	Midwife Consultant	Ontario Midwifery Program, Ministry of Health and Long-Term Care
Jen Vermilyea	Policy Analyst	Aboriginal Health Unit, Ministry of Health and Long-Term Care
Heather MacDermid	Senior Policy Advisor	Women's and Family Health Unit, Ministry of Health and Long-Term Care
Kristin Taylor	Manager	Women's and Family Health Unit, Ministry of Health and Long-Term Care
Maria Owen	Program Analyst	Community Services Unit, Ministry of Community and Social Services

<b>Attended by Teleconference</b>		
Lynn Brant	Aboriginal Patient Navigator, Nurse Practitioner, Kingston General Hospital	Cancer Care Ontario/ Tyendinaga
Naomi Wolfe	Registered Midwife	Midwives of Sudbury

<b>Regrets</b>		
Anita Cameron	Executive Director	Waasegiizhig Nanaandawe'iywigamig Health Access Centre
Becky Holden	Consultant	Grand Council Treaty #3
Carol Couchie	Registered Midwife	K'Tiganning Midwives
Faith Pegahmagabow	Aboriginal Midwife, Community Health Representative	Wasauksing Health Centre, Wasauksing First Nation Parry Sound
Katsi Cook	Aboriginal Midwife	Akwesasne
Diane Longboat	Elder	Six Nations BC
Janice Longboat	elder	Six Nations
Barbara Borland	President	CMO
Judy Rogers	Registered Midwife	Midwives of Georgian Bay
Wendy Trylinski	Director of Public Health Education	Nishnawbe Aski Nation (NAN)
Nettie Thompson	Midwife	Akwesasne
Sylvia Maracle	Executive Director	Ontario Federation of Indigenous Friendship Centres
Dianne Rogers	Health Promotion Consultant	Health Nexus
David Jeffrey	AHAC Work Group	CSC CHIGAMIK CHC
Carolyn Doxtator	Health Promotions Coordinator	Association of Iroquois and Allied Indians (AIAI)
Bernice Downey	Professor, Nurse Researcher; Ontario Rep for ANAC	McMaster University; Aboriginal Nurses Association of Canada
Lori Davis Hill	Director of Health Services	Six Nations
Phyllis Hill	Aboriginal Midwife	Tsi Non:we lonnakeratstha Ona:grahsta, Maternal and Child Centre, Six Nations

## Appendix B: Elder teaching story from Ernest Benedict

### Midwifery - Born at Akwesasne – Story of an Elder

Elder Ernest Kaientaronkwen Benedict is well known to many within Akwesasne, and across the entire Nation for the work he did in protecting our Indigenous rights. Ernest was born at Akwesasne. He travelled far and away from Akwesasne over the years, in pursuit of the rights of Indigenous peoples. He always came home. He loved Akwesasne and he was proud to be from Akwesasne.

Ernest was 92 years old when he went over to the Mohawk Nation Council of Chiefs office in Tekaswenkarorens and he stood in the bookstore-office that is at the front of the building and looked around for a little while getting his bearings. He then announced with a smile on his face and pointing to an area near the front of the building, that this is the place he was born. The exact place in Akwesasne which belonged to him.

A midwife assisted his mother Kiohawihton in his birth. He was the middle child of eight and that is the way it was done back then in 1918.

Within the Haudenosaunee (Iroquois) communities, many of our parents and grandparents were born at home with the help of community midwives skilled in the cultural practices associated with home birthing. Midwifery within our community was a common practice until at least the 1950s. After that, more modern birthing practices were introduced and midwifery became replaced by clinical and hospital care outside of our communities. Fortunately, our memories of these practices has not been totally forgotten.

In the 1970s, there came a rebirth of the practice at Akwesasne, as one young woman chose to bring the legacy of her grandmother's midwifery practice back to the community.

Others became interested in the fine work that a handful of woman were able to inspire and to encourage them to work on revitalizing our ancient cultural practice within a modern context.

It was very successful. Children were born. Our relationships and bonds within our communities grew stronger.

Unfortunately, our ability to bring new midwives into practice was not judicious and for a time there appeared a short gap in filling that honorable position within our community.

Today, with a resurgence toward revitalizing our culture and integrating our own cultural practices into our contemporary lifestyles, community midwifery will have an important role.

# Appendix C: Rights of Aboriginal Midwives according to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)<sup>23</sup>

For Kanienkeha:ka people, our spiritual health, our connection to the earth, to each other, our physical and emotional health are interconnected areas. Unfortunately, the negative effects of colonization – from the displacement of our traditional way of life and alienation from our lands to blatant attempts at assimilation – have left us at a great disadvantage and because our women continue to bear the brunt of responsibilities in our communities, as we are a matrilineal society, it has affected them to a greater degree. It is therefore necessary to re-invigorate our own traditional philosophies related to particular ceremonies such as birth and naming, which will effectively re-empower our people.

We come from a long history of women caring for women during childbirth and there is a need to return these Indigenous rights, regain control of our births and choice to practice in accordance to our naming protocols, and thus strengthen our cultural identity.

Birth is considered as a fundamental ceremony, and potentially one of the most sacred. These ceremonies strengthened a connection to place and land and a sense of belonging; the connection between mother and child, her relations and the earth. This connection stems from our long time belief that our People and the Land/our Mother Earth are One. It was a system that worked very well for us. Children were born. Our relationships within our communities grew stronger.

## **Indigenous human rights, particularly relevant to midwifery**

The most comprehensive of these is the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).<sup>24</sup> Although this is considered to be an “aspirational” document certain provisions – those which can be deemed part of customary international law – hold more power than others. Both the United States and Canada have adopted the UNDRIP.

The UNDRIP covers all possible issues relating to the collectively held rights of the world’s Indigenous Peoples. Particularly relevant to indigenous midwifery are the following sections:

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<sup>23</sup> Submitted to the AOM by Haudenosaunee Aboriginal midwives.

<sup>24</sup> <http://undesadspd.org/IndigenousPeoples/DeclarationontheRightsofIndigenousPeoples.aspx>

**Article 3**

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

**Article 4**

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

**Article 22**

Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.

States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

**Article 23**

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

**Article 24**

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.

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.

**Article 31**

Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

**Article 39**

Indigenous peoples have the right to have access to financial and technical assistance from States and through international cooperation, for the enjoyment of the rights contained in this Declaration.

# Appendix D: Support letter from the Mohawk Council of Akwesasne



Akwesasne Wolf Belt

Box 579, Cornwall, Ontario K6H 5T3

## MOHAWK COUNCIL OF AKWESASNE OFFICE OF THE GRAND CHIEF

September 19, 2012

Honourable Deb Matthews  
Minister of Health and Long Term Care  
10<sup>th</sup> Floor, Hepburn Block  
80 Grosvenor Street  
Toronto, ON M7A 2C4

Re: Ontario Midwifery Act

She:kon/Greetings Minister Matthews,

I hope that this letter finds you in good health and spirit.

Please know that the Mohawk Council of Akwesasne recognizes that the good health and well-being of Onkwehon:we (First People) mothers and their babies is crucial to the empowerment of Onkwe:honwe families and communities. Please also know that our Community is dissected by the boundaries of two countries and two provinces, as well, the MCA government *District* concept of our locations (which are not attached to the mainland of Canada) require our community members to travel through the US/Canada international border crossing for services in Canada. The only way to access the closest hospital is to travel to the nearest bridge crossing which can be problematic for our community if there is an incident that closes the bridge and we are left without practitioners. Because of this and the choice of birthplace for all First Nations communities (consistent with the *U.N. Declaration on the Rights of Indigenous Peoples*), we advocate for the restoration of midwifery education and the provision of midwifery services.

Now in addition to the physical borders, at this particular time we would like to bring to your attention to another barrier which is the discrimination against Onkwehon:we midwives working under the Aboriginal exemption clause in the *Ontario Midwifery Act 1991* (c. 31, s. 8 (3)) in the "Request for Applications: Establishing Midwife-led Birth Centres in Ontario."

In this RFA, Aboriginal midwives are excluded from holding the midwife positions within Management team, the Board of Directors, or voting membership. In addition, midwives working under the exclusion clause are prohibited from practicing as midwives within birth centres. This is problematic for multiple reasons. First, this denies equal access to resources for our community and other First Nations. Secondly, the exclusion limits our Peoples' ability to exercise self-determination by not allowing the meaningful participation of our indigenous midwives who choose to or are asked by their community to work in this way. This is in violation of multiple human rights we hold collectively as Indigenous Peoples, and which Canada has a duty to protect.

Mohawk Gov't Office 613 575-2348



Admin. Office 613 575-2250

Akwesasne - Land Where The Partridge Drums



The exemption clause in the *Ontario Midwifery Act* is specifically designed to ensure that midwifery can be practiced in a culturally responsive and safe manner that respects our right to self-determination. By excluding Aboriginal midwives from this Request for Applications, this clearly limits equal access to resources for communities wishing to employ midwives working under this exemption clause.

We therefore ask that the MOHLTC reconsider these exclusionary elements contained within your "Request for Applications", and provide an application process that does not discriminate against Aboriginal people. It is critical that midwives practicing under the Aboriginal exemption clause be provided with the same opportunities for resources as midwives practicing under General Registration. Midwifery as practiced by Aboriginal midwives working under the exemption clause is safe, clinically excellent, and culturally responsive, and is undeniably an integral element of maternal health for Aboriginal communities in Ontario.

Your immediate attention to this matter is appreciated,

Skén:nen/In peace,

Mohawk Council of Akwesasne



Michael Kanentakeron Mitchell,  
Grand Chief

# Appendix E: Resolution entitled “Onkwe:honwe Midwives” Akwesasne that was passed by the Canadian Association of Midwives (CAM)

## **RESOLUTION 2012-01**<sup>25</sup>

**Submitted:** October 2012

**Submitted to:** The Canadian Association of Midwives

**Proposers:** Jasmine Kahentineshen Benedict, Onkweh:honwe Midwife (AM) and Joyce Wathahiiostha Leaf, Onkweh:honwe Midwife (AM)

**Subject:** Onkweh:honwe Midwife (AM) in Akwesasne

**Background:** The Strategic Plan of the Canadian Association of Midwives (2010-15) has as its third goal to support Aboriginal midwifery and the return of birth to Aboriginal communities through the:

- promotion of the National Aboriginal Council of Midwives (NACM) as the national voice for Aboriginal midwifery;
- provision of appropriate administrative and organizational support for the autonomous development of the NACM under the CAM umbrella; and
- advocacy for the necessary regulatory, educational and policy structures to support the growth of advocacy of Aboriginal midwifery and the return of birth to Aboriginal communities.

This goal is also supported by the National Aboriginal Council of Midwives (NACM), who “exists to promote excellence in reproductive health care for Inuit, First Nations and Metis women”. NACM also supports the restoration of midwifery education, the provision of midwifery services and choice of birthplace for all Aboriginal communities.

In 2011, the Mohawk Council of Akwesasne expressed its strong support for Aboriginal midwifery, and importance of midwifery services to the community of Akwesasne.

The practice of Aboriginal midwifery at Akwesasne, and in other Aboriginal communities is of critical importance to the self-determination of Aboriginal peoples. Practicing midwifery in a manner that reinforces cultural sovereignty, without being subject to the registration procedures set by provinces is, then, of critical importance to self-determination. Provinces such as Ontario offer an exception clause for Aboriginal midwifery. While this provides limited protections for Aboriginal midwives, this exception clause also presents barriers to Aboriginal midwives.

**Expected implications:** All women and families are able to access midwifery services will be able to do so, and midwives offering services to those under federal health jurisdiction receive appropriate compensation, including liability insurance and personal and professional support and development.

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<sup>25</sup> This resolution was unanimously adopted at the CAM AGM on October 17, 2012 held in St-John's, Newfoundland.

**Recommendations:** We recommend that the Canadian Association of Midwives voice its direct support for the establishment of Aboriginal midwifery services and birth centres in communities like Akwesasne, advocating for the establishment and sustained support for these services and birth centres to Aboriginal governments and health departments, and to provincial and federal departments of Health and Aboriginal affairs.

**BE IT RESOLVED THAT** the Canadian Association of Midwives (CAM) communicate in a sustained manner to Aboriginal governments, health departments and to provincial and federal departments of Health and Aboriginal Affairs for the establishment and sustained support and funding for Aboriginal midwifery services and birth centres.

In addition, sustained support should include but not be restricted to dedicating staff to focus on lobbying and improving opportunities to secure funding for NACM and to continue to communicate with jurisdictional representatives to be aware of the needs of Aboriginal midwives and communities.