Indigenous Relationality and Kinship and the Professionalization of Maternity Care

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We, as a group of academic learners in social sciences, argue the professionalization of healthcare providers reinforces hierarchies of knowledge that results in the exclusion of Indigenous Peoples and their knowledge sources. Through decolonizing theory and Indigenous methodology, we applied globally understood Indigenous philosophies of relationality and kinship to examine the professionalization of maternity care. Relationality is a philosophy that describes the interconnections between all of creation and kinship consists of family, community, and all extended human and more-than-human relations. Indigenous health knowledges reflect relationality and kinship, and are practiced by midwives, doulas, and Comadronas. Within the Euro-Western biomedical model, these healers are often incorporated into maternity care services for the purpose of professionalizing their roles. Professionalization, however, reinforces power differentiations between healthcare providers and advances biomedical hegemony and hierarchies of knowledge, all of which exclude Indigenous kinship and relationality. The dangers of professionalization of the health workforce result in the omission of Indigenous knowledges, because the Euro-Western biomedical model of health is built on the philosophies of colonialism and capitalism. To counter professionalization, Indigenous relationality and kinship must be prioritized in the provision of healthcare so that it is inclusive to Indigenous Peoples and their knowledges, the results of which will benefit us all.

Keywords

Indigenous Kinship, Indigenous Relationality, Healthcare, Maternity Care, Professionalization

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¹The senior and corresponding author, Karen M. Lawford, is Anishinabe from Lac Seul First Nation. In the winter 2020 semester, Dr. Lawford taught a fourth-year course, Kinship and Indigenous Relations, which engaged undergraduate and graduate students from the Department of Gender Studies at Queens University. Throughout the course, we examined processes of professionalization and colonialism with an intention to imagine decolonial futures. Together, we articulated the resulting manuscript to serve as an example of collaborative knowledge production and to acknowledge the contributions of student intellect within the academy.

Introduction

As an academic group of learners, we have critically examined the professionalization of a health workforce through the application of globally understood Indigenous philosophies of relationality and kinship. Our manuscript is grounded in decolonizing theory and Indigenous methodology, which provide us with tools to reveal Indigenous relationality and kinship as essential qualities of genuine and authentic understandings of Indigenous health and healthcare. Specifically, we refer to three broad categories of maternity

care service providers: midwives, doulas, and Comadronas. We argue the professionalization of health-care service providers is an occupational tendency across Euro-Western biomedical healthcare systems, which results in the reinforcement of hierarchies of knowledge that exclude Indigenous Peoples and their knowledges. The process of professionalization, thus, is a continuation of colonial efforts within maternity care.

In fact, we assert the ongoing pressure to bureaucratically conform (Robinson, 2017) and apply professionalization (Williams, 2017) onto Indigenous models of healthcare providers and services for the purposes of better integrating them into Western medical institutions (such as hospitals) at the expense of Indigenous Peoples and their knowledge systems. For example, “Six Nations midwives do not currently have formal hospital privileges [even though] they hold formal certification as ‘Aboriginal midwives’” (Benoit & Carroll, 2005, p. 31). The professionalization of care thus continues the process of marginalization and exclusion, which are underpinned by colonial and capitalist philosophies. We implore those who seek to advance the professionalization of healthcare services to critically reflect on qualities of Indigenous healthcare models, which should inform and influence care that is provided to Indigenous Peoples. Without doubt, the re-examination we propose can offer opportunities to improve Euro-Western biomedical approaches, and we strongly contend that when retained, will result in better healthcare services to all peoples.

Indigenous Relationality and Kinship

Relationality and kinship are foundational philosophies for Indigenous Peoples. Wilson (2008) describes relationality being a “collective, it’s a group, it’s a community. And I think that’s the basis for relationality. That is, it’s built upon the interconnections, the interrelationships, and that binds the group...but it’s more than human relationships” (p. 80). As an Indigenous way of knowing, relationality acknowledges all the relationships with and between creation, including the land, waters, air, and the cosmos (Wilson, 2001, 2008). It is a philosophy that describes an existence that is materially and spiritually interconnected, and is a web of relations that have been woven since

time immemorial.

Kinship consists of family, community, and all extended human and more-than-human relations. It links together all of these relationships because “there is no distinction between relationships that are made with other people and those that are made with our environment. Both are equally sacred” (Wilson, 2008, p. 87). Family kinship relations give Indigenous People their identity, which is described by Talaga (2019, November 14):

Attachments, kinship, and family tell us who we are and where we come from. They give us a sense of dignity, a sense of belonging, right from birth. In Indigenous cultures, family units go beyond the traditional nuclear family living together in one house. Families are extensive networks of strong, connective kinship; they are often entire communities.

Consequently, relationality and kinship are inextricably intertwined as core philosophies to Indigenous Peoples’ ways of being and knowing.

Kinship in Indigenous Healthcare – Midwives, Doulas, and Comadronas

Knowledge is relational, collective, and belongs to all of creation (Wilson, 2001). As such, knowledges related to health and wellness are also relational, collective, and belong to all of creation. The contributions of all kinship, then, also reflect roles and responsibilities of not just the individual but also of the collective. The resulting knowledges are therefore communal, relational, and experiential. For some, these are embodied knowledges that are derived from teachings, experience, and ceremony. Thus, the epistemological origins of Indigenous knowledges reflect the relational and kinship ties of Indigenous Peoples to all of creation and across all concepts of time.

Indigenous health knowledges are also relational, collective, and belong to all creation. Indeed, it is through this philosophy of being that Indigenous healers have provided care to their people. Midwives, doulas, and Comadronas, who are described in Figure 1, work within their communities and share their relational and kinship knowledges, in addition to their experiential knowledges. Thus, their care services, identities, and services become embodied knowledges.

es. They are guided by their Ancestors, their community members, and an overarching relationship to all of creation. These epistemological foundations reflect Indigenous relationality and kinship, and are translated in the categories of the Euro-Western biomedical model as maternity care. This categorization has, however, resulted in efforts to professionalize their care.

The professionalization of the health workforce has, however, resulted in a power differential between healthcare professionals and those they serve (Porter, 1992; Williams, 2017). The professionalization by a particular group of healthcare providers indicates they are autonomous and independently responsible for meeting agreed upon standards of care and codes of ethics. We argue assertions of authority

Figure 1: Definitions

Midwife: “A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery” (International Confederation of Midwives, 2018).

Doula: “a trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible” (DONA International, 2020).

Comadrona: “A comadrona is someone who sees pregnant women, gives prenatal exams, and delivers babies. However, it is also much more than that, as it involves giving advice and acting as a ‘consejera’ (counselor). Both doctors and comadronas treat medical problems, but comadronas know about a woman’s body, about pregnancy, and how to incorporate natural medicine into health care” (Mayan Families, 2015).

Colonialism and the Professionalization of Care

Colonialism is underpinned by capitalism, expansionism, and extraction (Crook, Short, & South, 2018). It is further advanced by the absolute surety that Indigenous Peoples and their ways of health and wellness are inferior—and even sub-human—to that of the colonizer. In Canada, for example, governments and healthcare providers “infiltrated [Indigenous] ways of knowing and wellbeing and replaced them with a knowledge base grounded in the Euro-Canadian biomedical model, thus promoting colonial goals of civilization and assimilation for First Nations people” (Lawford & Giles, 2012, p. 335). Current articulations of healthcare in the Americas, thus, reflect a Euro-Western biomedical model of health that is dependent on colonial ideals of health services, capitalist funding mechanisms, and the professionalization of those who provide healthcare.

and power by a professionalized group of care providers results in their active participation in and maintenance of biomedical hegemony and hierarchies of knowledge, which exclude Indigenous kinship and relationality.

Certainly, there are benefits of professionalization. Nursing, for example, has achieved occupational advancement and legitimacy through “the development of autonomous management structures” (Porter, 1992, p. 721) and through alignment with bureaucratic hierarchies of power and authority that reflect the structuring of capitalist health systems. Professionalization has resulted in specialized nursing to the extent of the development of nursing sub-categories, such as labour and delivery nurses (Turris, Binns, Kennedy, Finamore, Gillrie, & Melchior-MacDougall, 2007). Similarly, midwifery has sought the benefits of professionalization, which has resulted in the development of distinct professional bodies that are often separate from nursing. In Canada, the pro-

fessionalization of midwifery has led to the public funding of services and liability insurance, post-secondary education training programs, and provincial midwifery colleges, which can be of benefit to the midwife, the profession, and the individual consumer of these maternity care services.

The Dangers of Professionalization

The underlying prerequisites of professionalization are sources of dangers and are seemingly impossible to disrupt: The purposeful omission of Indigenous knowledges within Euro-Western education systems; the positioning of women and Two Spirit community members as subservient or even completely excluded from professional bodies; and the presumed leadership of white male physicians (Bourgeault et al., 2018; Loscocco, 2018; Vogel, 2019). The purposeful omission of Indigenous birthing practices, ceremonies, medicines, and care providers accompanied the professionalization of maternity care (Krzywania, 2018; Lawford & Giles, 2012; Olson, 2013). These are dangers that we identify, because they serve to constantly recreate hierarchies of care and denigrate Indigenous health knowledge systems and as a result, Indigenous Peoples themselves. Without a doubt, the professionalization of care is used to justify the erasure of Indigenous Peoples and their relational and kinship knowledges.

Irrespective of the presumed benefits of the professionalization of care, this process can be dangerous to Indigenous Peoples. Professionalization, as it is enacted within the Euro-Western biomedical model, follows a logic of capitalism, stresses power and hierarchy, devalues Indigenous epistemologies by claiming superiority, and neglects relationality and kinship. The professionalization of care has also translated into the medicalization of care. Correia (2017) described medicalization as originating “within a particular societal—political—historical context characterized by the dominance of professionalized (bio)medicine” (p. 1). It is linked with “social regulation and control” (Correia, 2017, p. 1), thus aligning it with logics of capitalism, and hierarchies of power and control, all of which are colonial constructs. The professionalization of maternity care providers is an example of the medicalization of care. While the uniformity of care services has created standards of care, the medicalization of maternity care has also resulted

in increasing unnecessary obstetrical interventions and the loss of physiological birth processes (Romano & Lothian, 2008; Thompson et al., 2019; Wolf & Charles, 2018). The inclusion of Indigenous kinship and relationality challenges colonial constructs within professionalized healthcare services by expanding the understanding of health and wellness to incorporate Indigenous knowledge systems.

Countering Professionalization – What Can We Do?

To counter the hegemonic and hierarchical professionalization of maternity care, Indigenous relationality and kinship must be explicitly—and without limitations—included in all aspects of care for Indigenous Peoples. Euro-Western biomedical healthcare systems and those working within those systems must recognize the multi-faceted roles and responsibilities of Indigenous care providers, which benefit individual and community wellness. Healthcare systems must directly pay Indigenous care providers, such as midwives, doulas, and Comadronas. The exclusion of Indigenous care providers from equitable payment reinforces hierarchies of professionalization via capitalism. The engagement and involvement of Indigenous Peoples in the provision of healthcare must be prioritized; their inclusion must be without coercion and manipulation.

Including Relationality and Kinship Within Care

We strongly defend our assertion that healthcare services would be improved for all peoples if relationality and kinship were to be included in the provision of care, which is more than the application of specific mechanical techniques and administration of pharmacologically-derived medicines. Healthcare is about care, something that can only be developed by recognizing relationality and kinship as foundational components of health. With this assertion, we encourage thoughtful consideration of the epistemological origins of Indigenous knowledges related to individual and community health. The relational and kinship ties of Indigenous Peoples actualize a network with all of creation and across all concepts of time, which are critical to the roles and responsibilities of midwives,

doulas, and Comadronas. We are convinced health-care must become inclusive to Indigenous Peoples' philosophies and that this inclusion will benefit us all.

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