NCN OTINAWASUWUK (RECEIVERS OF CHILDREN): TAKING CONTROL OF BIRTH IN NISICHAWAYASIHK CREE NATION

By

Shirley Hiebert

A Thesis

Submitted to the School of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree

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ABSTRACT

This participatory action research (PAR) study with Nisichawayasihk Cree Nation (NCN) integrated scientific investigation and action to develop a community-based childbearing model in NCN. The multi-method ethnographic PAR study involved qualitative and quantitative methods. Qualitative methods included participant observation, modified focus group meetings, key informant and semi-structured interviews, an analysis of documents (historical NCN texts, studies, and community assessments) in addition to a field-study trip with two participants as co-researchers. A quantitative retrospective chart audit of women who received antenatal care during the years 1997-1999 was carried out to determine antenatal clinic utilization and maternal behaviors around smoking, alcohol and recreational drug use. Current childbearing services that are being provided by the federal government were found to be a continuation of other colonialist policies that have been detrimental to community life. Infrastructural barriers, as well as the lack of midwifery education opportunities in Manitoba are obstacles to returning birth to NCN. The research resulted in a project that employs women as maternity workers in preparation for the return of birth to the community. Participants envisioned an alternative community-based Aboriginal childbearing model that integrates Western expertise and knowledge. The PAR process proved an empowering means to explore this issue with women.

This thesis is dedicated to four colleagues: Heather McKay, Chair of the Kagike Danikobidan Committee (1945-2001), Sylvia Cosway PhD (c) (1950-2002), Florence Klassen, Midwifery Consultant, Manitoba Health (1955-2003) and Dr. Chris Egan (1944-2001).

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ABBREVIATIONS

AHF	Aboriginal Healing Foundation
ACOG	American College of Obstetricians and Gynecologists
BRHA	Burntwood Regional Health Authority
CAHR	Center for Aboriginal Health Research
CEO	Chief Executive Officer
CHR	Community health representative
CPNP	Canadian Prenatal Nutrition Program
CST	Critical Social Theory
DIAND	Department of Indian Affairs and Northern Development
EAWSC	Empowerment of Aboriginal Women Surrounding Childbearing
FAS	Fetal Alcohol Spectrum
FCWC	Family and Community Wellness Centre
FNIHB	First Nations and Inuit Health Branch (Health Canada)
IMR	Infant Mortality Rate
INAC	Indian and Northern Affairs
KDC	Kagike Danikobidan Committee
MKO	Manitoba Keewatinok Okemakank
NCN	Nisichawayasihk Cree Nation
NNADAP	National Native Alcohol and Drug Abuse Program
NWT	North West Territories
PAR	participatory action research

PMR	perinatal mortality rates
POV	Povungnituk (Innuulitsivik Maternity Centre)
RCAP	Royal Commission on Aboriginal Peoples report
RHA	Regional Health Authority
RD	Regional Director
SIDS	Sudden Infant Death Syndrome
TGH	Thompson General Hospital
VON	Victoria Order of Nurses
YWCA	Young Women's Christian Association

GLOSSARY

Aboriginal

According to the Canadian Constitution Act of 1982, the term Aboriginal people encompasses Indian, Inuit and Metis people.

Aboriginal Healing Foundation

The Aboriginal Healing Foundation was created by the Government of Canada in response to its Statement of Reconciliation and the Royal Commission on Aboriginal People's Report. The organization addresses the effects of the residential school legacy of physical and sexual abuse and their intergenerational impacts.

Band

A group of First Nations who have been given band status by the Minister, pursuant to Section 17 of the Indian Act.

Band Council

The elected government of the band.

Burntwood Regional Health Authority

One of twelve Regional health authorities (services 45, 000 people) in the northern region that includes Nisichawayasihk Cree Nation

Canadian Prenatal Nutrition Program:

A "comprehensive program designed to provide food supplementation, nutrition, counseling, support, education, referral and counseling on lifestyle issues to pregnant women who are most likely to have unhealthy babies" (Health Canada, 1999b, p.117).

Chief

The elected leader of an Indian Band Council.

Direct Entry Midwives

These are midwives who elect to pursue midwifery education/training directly without nursing education.

Doula or birth attendants

Attend the birth with the midwife and remain with the family up to two weeks to support the mother and newborn and provide care to the family. The emphasis is on the continuity of care (The Alternative Health Care Services Task Force Sub-Committee on Midwifery, 1991).

Family and Community Wellness Centre

This unique centre described as 'the first facility of its kind in Canada' evolved from the collaborative work of community individuals and agencies for the purpose of implementing a "A Pathway to Restoration" in June, 1999. The 13,000 square foot facility offers a fully integrated child and family health-related service for the promotion of personal, family and community wellness (Family and Community Wellness Centre brochure).

First Nation

This term is used by governments and First Nations themselves to indicate their historical position in Canada

Free-standing birthing centers

A short stay, ambulatory, health care facility with a homelike environment and with prompt access to in-hospital obstetrical and newborn services designed to safely accommodate participating family members and support people of the woman's choice, and providing professional preventative health care to women and the fetus or newborn during pregnancy, birth and the puerperim (Report on the Future Role of Midwifery in Manitoba, February 18, 1991, p.iv).

Hospital levels (obstetrics)

Level 1: A community or rural hospital that provides maternity care for women with no major risk factors and normally without specialist support.

Level 11: A community or regional hospital that provides care for low and high risk pregnancies with specialist support.

Level 111: A tertiary hospital that provides care for low and high risk pregnancies, with perinatal, neonatal and anesthetic services available on site (Society of Obstetricians and Gynecologists, 2000).

Infant Mortality Rate

The infant mortality rate (IMR) includes deaths of infants from birth to less than one year of age. It is an indicator of the level of mortality, health status and level of health care of a country, as well as the effectiveness of its preventative care and the attention paid to the health of the mother and her child.

Indigenous

Is a term used to interchangeably with Aboriginal and may include international groups.

Lay Midwife

A person, without recognized training, who offers services to child bearing families on a fee for service basis. The training may range from informal apprenticeship to a variable length of semi-organized training (Report on the Future Role of Midwifery in Manitoba, February 18, 1991).

NNADAP

National Native Drug and Abuse Program addresses alcohol, drug and solvent abuse in on-reserve communities. In Manitoba, the NNDAP program is administered by First Nations.

Native

Refers here to someone of Aboriginal descent

Nurse-Midwife

A registered nurse who has completed a recognized educational program in midwifery, whose education and experience enable her to provide appropriate care and advice to women throughout their reproductive cycle, including pregnancy, labour, delivery and following birth (Report on the Future Role of Midwifery in Manitoba, February 18, 1991, p.iv).

Perinatal Mortality Rate

The perinatal mortality rate (PMR) is calculated by including the number of stillbirths and live births that culminated in death within seven days of birth (Robinson, 1990). Stillbirths after 20 weeks of pregnancy are included in the calculation because it is believed the causes are related.

Reserve

As defined by the Indian Act "a tract of land, the legal title which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of the band" (Appendix 3: Indian and Northern Affairs, 2002)

Registered Indian

Defined as someone under the Indian Act whose name is on the Indian Register of the Department of Indian and Northern Development.

Status Indian

Is a person of Indian or Aboriginal ancestry who is registered as an Indian for purposes of the Indian Act

Traditional Birth Attendant

A respected experienced woman in a community who has been recognized informally as someone to call on in time of need related to childbirth (Report on the Future Role of Midwifery in Manitoba, February 18, 1991, p.iv).

Chapter One: The Study

1.0 Introduction

Giving birth is a natural gift from the Creator

Shirley Anne Linklater
November 15, 2001

Shirley Anne Linklater, Nisichawayasihk Cree Nation band member describes the cultural essence of birth as "natural" and a "gift" from the Creator. This participatory action research (PAR) dissertation study was undertaken to conduct a scholarly inquiry in a way that would enable Nisichawayasihk Cree Nation (NCN) to have a voice in the development of community-based childbearing practices which reflect their cultural values and beliefs. To this end, the research seeks to gain an understanding of the historical and cultural context of current childbearing practices and how these can more optimally reflect the values and needs of NCN. Nisichawayasihk Cree Nation's aspirations are especially timely in view of the recent legislation of midwifery in Manitoba.

Two communities broadly share the name Nelson House. Nisichawayasihk Cree Nation is the Cree name for the Nelson House reserve. Adjacent to NCN is a Metis settlement known as the Nelson House Community. Both communities receive their provincial health services from the Burntwood Regional Health Authority (BRHA), whereas, primary health care services are provided by First Nations and Inuit Health Branch, the largest branch in Health Canada. The maternal evacuation problem in Nelson

House that this dissertation addresses is representative of the long-standing issues in the complex and historically controversial interrelationship of Aboriginal communities, government, and health services. It also reflects the medicalization of childbearing and the colonization of First Nations people that has resulted in subjugating thousands of years of childbearing knowledge in a relatively few short years to the detriment of Aboriginal women and communities.

The maternal evacuation policy requires that all pregnant women relocate to urban centres to await birth several weeks prior to their due date. The removal of women from their families and communities is a hardship for those involved and violates First Nations autonomy. In keeping with optimum childbearing practices and in the move toward self-determination, the Royal Commission on Aboriginal Peoples (Vol. 3, 1996) argues that the control of childbearing practices should be returned to Aboriginal communities.

The literature on this subject is relatively limited. The evolution of the maternal evacuation policy, its negative impact on women, their families and communities, in addition to perceptions of culturally appropriate childbearing practices have been documented among the Inuit (Kaufert et al., 1985; Kaufert et al., 1988; O'Neil et al., 1988, O'Neil, Kaufert & Fletcher, 1998). Two more studies, modest in scope, have been carried out among First Nations women relating to the problem of maternal evacuation. A study by Guse (1982) focused on the impact of maternal evacuation on women from northern Manitoba and Ontario. *Childbirth in the North* (Webber & Wilson, 1993), a study in the Moose Factory Zone, Ontario, also addressed the changes that women might like to see made in the policy and their preference for place of birth. This dissertation

expands this perspective and aims to understand the maternal evacuation policy from the wider historical perspective of the medicalization of birth in the context of colonization and to explore how community-based childbearing practices might be re-established.

Little is known of the historical and cultural framing of the maternal evacuation policy among northern Manitoba First Nations and how an alternative childbearing model might be envisioned in view of the recent changes in the legislation of midwifery in this province. Until very recently, midwifery had been constituted as a medical act in provincial legislations. In response to public pressure, provincial governments legislated midwifery beginning with Ontario in 1992. In Manitoba, the Midwifery and Consequential Amendments Act was passed in 1997, and proclaimed on June 12, 2000. A Mandate for a Standing Committee (Part 3:8(5) b) on Aboriginal Issues Relating to Midwifery Care known as the 'Kagike Danikobidan' (KD) (Always Making Grandparents) Committee is included in the Act.

1.1 Research Context and Impetus

Nisichawayasihk Cree Nation's aim to relocate birthing practices to their community was evident prior to the initiation of this research project in July of 2000. The Manitoba Keewatinowi Okimakanak (MKO) (a political organization that represents 27 First Nations communities including NCN) passed a resolution supporting NCN's initiative to have a midwifery pilot project site located in Nelson House (see Appendix A). NCN Chief and Council followed this resolution with a request by letter to the Burntwood Regional Health Authority on May 15, 2000 for midwifery services in NCN (see Appendix B). The letter refers to the anticipated research of this study; it was

believed the research would assist NCN's aims for the development of alternative birthing practices. In addition to the initiatives of the community and MKO, First Nations and Inuit Health Branch, Manitoba Region, was approached in the spring of 2000 by women representatives from NCN, MKO, Manitoba Health and the Kagike Danikobidan Committee to explore ways the federal government might help them achieve their aims. No initiatives to change childbearing practices were taken by FNIHB as a result of this meeting. I learned of NCN's interest in establishing alternative childbearing practices through my position as an advisor to the Kagike Danikobidan Committee. I discussed the prospect of carrying out a participatory action research project in NCN with Carol Prince, the NCN health director, in the spring of 2000. She approached Chief and Council to inform them of the research opportunity and obtained the community research consent (see Appendix C).

1:2 Research Purpose

Participatory research is frequently used in circumstances where there is a need to develop or evaluate policies. The "professional expert model" that dominates policy formation is increasingly questioned by policy makers for its inability to provide a responsive approach to community needs (Simonson & Bushaw, 1993, p.27). Simonson and Bushaw describe the expert model as one where experts identify needs in the community after compiling of data, followed by recommended policy interventions. In contrast, they posit the participatory action research approach is a means for community members to work toward the identification and solution of problems. Aboriginal scholars

argue that community-based solutions to problems are more likely to reflect community values and needs, therefore ensuring a better chance of success (Hammersmith, 1992; Poonwassie & Charter, 2001). I anticipated that the research knowledge formerly under the control of experts by the participants would be an empowering experience (Gaventa, 1991). Thus, the research process itself was expected to achieve a measure of personal and community social change. Specifically, I undertook the participatory research with Nisichawayasihk Cree Nation to pursue the community's aims of re-establishing its own childbearing practices. By mutual agreement, the defined aims of the research were:

1. To examine the maternal evacuation policy from an historical and cultural context
2. To explore perceptions of current childbearing practices
3. To determine participant interest in alternative childbearing practices
4. To conceptualize an optimal childbearing model envisioned by participants
5. To identify the issues/barriers that might impact on the implementation of alternative childbearing practices

1.3 The Politics of Research with First Nations

Manitoba Keewatinowi Okimakanak's support of Nisichawayasihk Cree Nation's initiatives for community-based midwifery services is in keeping with a move toward self-determination where childbearing practices are concerned. Aboriginal organizations identify First Nations controlled health services as an integral part of a return to self-government (Bluebird & Krasaukas, 1990; Postl & Whitmore, 1988). From a broader perspective, the right of First Nations people to pursue self-determination is supported by the Canadian Constitution and the Treaties. The Charter of Rights and Freedoms (1982) refers to the early historical basis for the entrenched status of First Nations people as:

> (*a*) Any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and (Section 25) and further in Section 35 as inclusive of:
>
> (1) The existing Aboriginal and treaty rights of the Aboriginal peoples of Canada are hereby recognized and affirmed.
>
> (4) Notwithstanding any other provision of this Act, the Aboriginal and treaty rights referred to in subsection (1) are guaranteed equally to male and female persons

While these sections of the Act have been legally contested as a basis for Aboriginal self-government, it is reasonable to argue that they may be interpreted in this manner (Canadian Medical Association, 1994; Scott, 1993). Chief Tony Mercredi of Athabasca Chipewyan First Nation draws our attention to the Creator as the basis for First Nations societal structure and autonomy. He compares this orientation to a Euro-Canadian superimposed approach to governance where First Nations are at "the bottom:"

> Envision, if you will, a circle. The Creator occupies the centre of the circle and society...revolves around the Creator. This system is not based on hierarchy. Rather, it is based on harmony - harmony between the elements between and within ourselves and within our relationship with the Creator. In this circle there are only equals. Now, envision a triangle. This triangle represents the fundamental elements of the Euro-Canadian society. Authority emanates from the top and filters down to the bottom. Control in this society is not self-imposed, but rather exercised by those at the top upon those beneath them. In this system, the place of the First Nations people is at the bottom. This is alien to the fundamental elements of our society, where we are accountable only to the Creator, our own consciences and to the maintenance of harmony. By having the institutions and regulations of the Euro-Canadian society imposed upon us, our sense of balance is lost (Royal Commission on Aboriginal Peoples [RCAP] Vol. 2, Part 1, 1996, p.435).

The Royal Commission on Aboriginal Peoples report underscores the ideology of this research as it relates to the self-determination of First Nations people around childbearing practices. Cairns (2000) views Royal Commissions in Canada as being frequently established to change a current historical-social relationship in favor of a

marginalized group. Castellano (1999), an Aboriginal leader, describes the report as a "monumental work" (p.92). The report delineates four stages of Aboriginal and non-Aboriginal relations beginning with initial European contact to the current stage of 'negotiation and renewal.' In the spirit of this orientation, the Royal Commission on Aboriginal Peoples recognized the plight of Aboriginal women in their aim to regain control of childbearing practices. The report observed the congruency of these aims for community-based childbearing practices with the overall move toward self-determination (RCAP, Vol.3, 1996).

One way for Aboriginal peoples to have an active voice in how their lives are shaped can be achieved through collaborative research. Hall (1993) states it simply: "participatory research fundamentally is about the right to speak" (p. xvii). In view of the move toward self-determination, it follows that the collaborative research approach is a highly appropriate research methodology for Canadian Aboriginal communities (RCAP, Vol.3, 1996). In fact, there are few alternatives. Increasingly, Aboriginal peoples are voicing strong opposition to research carried out in their communities. Frequently, one hears comments in research circles similar to the prevailing sentiment voiced at an Aboriginal research consultation workshop: "Aboriginal communities have been researched to death" (O'Neil, Reading & Leader, 1998, p.232). The following quote by Nahanni in reference to government research represents the widespread consensus of Aboriginal people toward research:

> Our community leaders and community people expressed their dislike of the invasion of their privacy by outsiders who didn't speak their language. We know from past experiences that government research by white researchers never improved our lives. Usually white researchers spy on us, the things we do, how

> we do them, when we do them, and so on. After all these things are written in their jargon, they go away and neither they nor their reports are ever seen again. We have observed this and the Brotherhood resolved to try its best to see that, in future, research involves the Dene from beginning to end (cited in Jackson, 1993, p.51).

The perspective of research involving Aboriginal peoples from the "beginning to the end" illustrates the extent to which First Nations people feel committed to the participatory research process. This approach is assumed to be more relevant to solving problems (Nyden, Figert, Shibley, & Burrows, 1997). It is obvious that this level of involvement is a means for participatory research to further self-determination, the appropriateness of which is supported by Aboriginal and non-Aboriginal researchers alike (Colarado, 1988; Jackson, 1993; Smith, 1999; Warry, 1990). In Manitoba, First Nations' interest in the research process is evident with the formation of the Centre for Aboriginal Health Research (CAHR). Created in 2000, it is a joint organization comprising the Assembly of Manitoba Chiefs, the University of Manitoba, Faculty of Medicine, and the Foundations for Health. Collaboration between universities and communities in the pursuit of research that is both scholarly and of direct benefit to the community may be considered an ideal way to achieve mutual aims (Porpora, 1999). Postl, Moffatt and Sarsfield (1987) emphasize:

> Enabling native people to define the research objective is essential to the maintenance of the good will and collaboration that has evolved between native people and researchers. This is more likely than other approaches to succeed in the delineation of solutions to the many problems facing Canadian natives (p.220).

Participatory action research is commonly understood as a strategy that attempts to transform the lives of participants and change the status quo (Brown & Tandon, 1983).

The PAR approach is uniquely relevant to Aboriginal peoples in their quest for self-determination as opposed to traditional research approaches that are viewed as conveying an unequal power distribution and by extension, a manifestation of colonial subjugation (Smith, 1999; Warry, 1990).

Increasingly, this more democratic form of research is gaining globally in its use among the disadvantaged, as well as in mainstream research where the inclusion of common knowledge is viewed as significant to the aims of the research (Ansley & Gaventa, 1997; Brown & Tandon, 1983). This approach to research that obtains and uses knowledge for the purpose of empowering oppressed groups may indeed be described as being political in nature (Porpora, 1999; Small, 1995), where political refers to the effect of the research process on the distribution of power and resources (Nyden et al., 1997).

Collaborative research has been carried out in Canada by Aboriginal organizations since the 1970s. A wide range of topics has been addressed by Aboriginal initiated and directed projects, including social issues, health, housing and sanitation. Many of these studies were technical in nature for the purpose of ameliorating health and social conditions or addressing land use issues. Referring to these initiatives, Jackson (1993) observes that Aboriginal people increasingly began to see the merits of research activities which could further their goals of self-determination. This came about following federal government attempts at delimiting Aboriginal sovereignty as reflected in the contentious White Paper (Canada, 1969). Collaborative research with Aboriginal peoples has been favorably carried out in a number of scholarly studies, among them: Angees, Young, O'Neil, & Hiebert, 1999; Chataway, 1997; Chrisman, Strickland, Powell,

Squeochs, & Yallup, 1999; Dickson, 2000; Hagey, 1989; Huntley & Blaney, 1999; Kuhlmann, 1992; O'Neil, Reading & Leader, 1998; Wein, 1996; Young, O'Neil, Orchard, & Hiebert, 2000. Participatory research has the potential where Aboriginal people are concerned to "research them-selves back to life" as one participant succinctly captured group perspectives in an Aboriginal research workshop (O'Neil et al., 1998, p. 233).

1.4 Organization of the Dissertation

In the first chapter of the thesis, I address the politics of research in First Nations communities, specifically in the context of Nisichawayasihk Cree Nation. This chapter also includes a description of the study's early evolution and purpose where a vigorous argument is made for the research purpose and its relevance. The remainder of the thesis is presented in the following manner: Chapter Two, *The Theoretical Framework*, provides the theoretical perspective that supports and gives direction to the study. In Chapter Three, *Historical and Cultural Childbearing Perspectives*, I focus on childbearing practices over the centuries, and present alternative perspectives to them. The maternal evacuation policy in northern Canada is discussed for its use and implications. Chapter Four, *The Re-Implementation and Practice of Midwifery*, explores how midwifery has been legislated in parts of Canada, specifically in Manitoba. The practice of midwifery is discussed as an opportunity for seeking alternative childbearing services in Aboriginal communities. Chapter Five is entitled *First Nations Health and Health Care Organization*. Here, I situate northern First Nations health and health care within a wider Canadian and Western biomedical context. This chapter highlights many

of the key health and demographic issues that need to be considered by First Nations who seek to change current childbearing practices. I outline the mechanics of the research process in detail in Chapter Six, *Study Design, Methods and Analysis*. In addition, a descriptive narration of praxis events contextualizes the chapter. Chapter Seven, *How Did Childbearing Autonomy Become Subjugated?* provides an overview of how Western power and knowledge came to construct current childbearing practices. I address the impact of colonization that, by extension, includes Western childbearing practices in Chapter Eight, *What Was the Impact of Subjugating Autonomy?* Chapter Nine, *How Can Risk as a Considered Event Further Autonomy?* discusses the role of risk in consideration of an alternative childbearing model and how risk can be lowered by re-establishing community-based childbearing practices. In Chapter Ten, *Whose Autonomy are Current Childbearing Services Meeting?* I examine problems around current childbearing practices and their relevance to Nisichawayasihk Cree Nation. Chapter Eleven, *How Can Birth Re-Establish Autonomy?* is a discussion of how community-based childbearing practices will meet Nisichawayasihk Cree Nation's aims for self-determination and the empowering impact this will have on the lives of women and the community. In Chapter Twelve, *Is the Infrastructure Ready to Exercise Autonomy?* I examine the readiness of infrastructures from the perspective of the community, the province and federal governments. Chapter Thirteen, *How Can Autonomy Be Expressed in Childbearing?* explores areas where women's voices need to be heard if their aim to have autonomy in childbearing practices is to be met. Chapter Fourteen, *Conclusions*, completes the thesis. This chapter discusses the key issues around the research problem, context, approach and

framework. Research findings focus on the problem with current childbearing practices, the envisioning of an alternative childbearing model, infrastructure preparedness and potential strategies for change. In its entirety, the research as a participatory process offers a means for Nisichawayasihk Cree Nation to further their aim of achieving community-based childbearing practices. From an academic perspective, the study contributes to knowledge pertaining to participatory action research with First Nations women around childbearing practices.

Chapter Two: The Theoretical Framework

2.0 Introduction

An understanding of how current federally instituted childbearing practices evolved and how they might be changed in communities like NCN required an approach that is embodied in critical social theory (CST). This approach placed the research in a political context, and acted as a basis for the dialectics and praxis of the participatory action research process. As well, the research required a postmodern skepticism to understand how the participants have been constituted in ways that constrain women from having their voices heard. Finally, for the voices of women to be illuminated the theoretical framework included a gender sensitive approach that reflected the collective orientation of First Nations women. In this way, the research was able to elicit perspectives intimate to them, such as those around childbearing.

In this study, the political and ideological understanding of the research topic was reflexively driven. Reflexive research embraces a questioning approach to the constitution of knowledge in a particular context with the belief that all reality is interpretively known (Alvesson & Skoldberg, 2000). The theoretical framework, I have termed critical postmodern gendered praxis (see Figure 1) provided the analytical lens for understanding how cultural and social processes have arisen that came to impact NCN's life-ways and childbearing practices, and how they may be changed in view of this knowledge. Reflexivity means that in approaching cultural-social-historical information or the research findings, I engaged in purposeful reflection from the perspective of the theoretical framework. This, then, guided how the research was understood and analyzed.

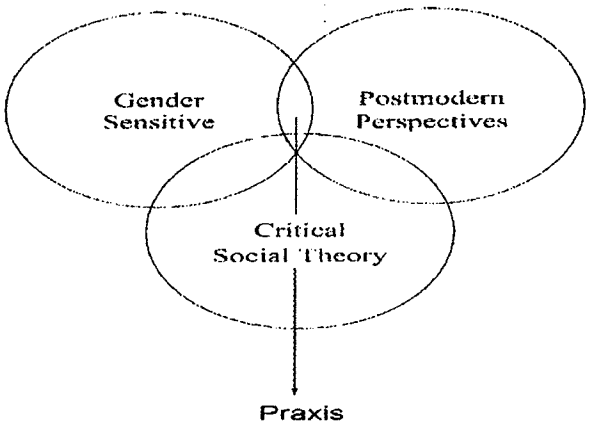


Figure 1: Theoretical Framework: Critical Postmodern Gendered Praxis

The research can be reflexively understood because reality is interpretively known; that is, we interpret reality for ourselves. This approach is also based on the understanding that our behaviors are socially and culturally constituted. We come to be who we are, rather than being pre-determined by an arbitrary set of natural laws. The participatory action research approach that engages in dialectics to understand a common reality and then uses this knowledge as a means to change circumstances is how the praxis component of the research finds a meaningful place within the theoretical framework.

2.1 Critical Social Theory

Originating in Frankfurt, Germany in 1923, the Frankfurt School conducted social research into issues arising from the failures of socialism and quickly became synonymous with critical social theory (CST). This school of thought shifted in 1931 to a critique of modernity (Stamps, 1995). Critical social theory embraces a supra-disciplinary approach to social criticism in an attempt to provide a comprehensive social theory that will radically transform current social and political conditions (Kellner, 1989).

2.1.1 Domination and Euro-Canadian Aboriginal relations.

According to Agger (1998), the theme of domination in critical social theory applies to the structural domination of people through various social groupings, such as those pertaining to political, economic, racial, gender and cultural spheres. Structural domination in society is described by Kincheloe and McLaren (1994) as one where certain groups are privileged over other groups. LaRoque (1996), an Aboriginal woman

and academic, observes of this dominance, "the history of Canada is a history of the colonization of Aboriginal peoples" (p.115). While Cairns (2000) recognized that colonialism played an overwhelming role in the history of Canadian-Aboriginal relations, he contends that Canadians generally have not historically, or currently viewed themselves as colonizers. Weenie (2000), a Canadian Aboriginal woman, observes that the control by colonizers of those who are different is an inherent tenet of colonialism which continues to manifest itself today in the government control of Aboriginal land and populations.

The early domination of First Nations peoples by Europeans was evident in the Indian Act of 1876, called "perhaps, the most significant form of oppression to shape the lives of Native people in Canada" (Emberley, 1993, p.87). The Act extended the control of Indian affairs by the federal government to include "lands, money, personal assets, law making, services and citizenship." Women of Indian ancestry fared worse. They were denied legal Indian status and any benefits this might have provided upon marrying a non-Indian person. Bear and the Tobique Women's Group (1991) emphasize how severe the patrilineal framing was that resulted from the Indian Act where Indian Status and its privileges were conferred only on women through an association with a status Indian male by lineage or marriage until the passing by the Canadian Parliament of Bill C-31 (Act to Amend the Indian Act) in 1985. This Act sought to reintegrate First Nations women. Jamieson (1978), in researching on behalf of the Committee of Indian Rights for Indian Women prior to the amendment of the Indian Act, described the social and legal sphere of Indian women:

> One thing is clear – that to be poor, an Indian and a female is to be a member of the most disadvantaged minority in Canada today, a citizen minus. It is to be victimized and utterly powerless and to be, by government decree, without legal recourse, of any kind (p. 92).

After extensive participatory research among First Nations women across Canada, Huntley and Blaney (1999) concluded that residual discrimination remains even after the passing of Bill C-31 in 1985. Their research found that the lives of many of the First Nations women interviewed were generally comparable to Jamison's depiction in 1978.

The linkage we see in the Indian Act between colonization and patriarchy is not lost on Aboriginal authors Nabigon and Couchie, who observe that "colonization is the first cousin to patriarchy" (1997, p.44). The control of birthing practices by a predominantly male medical profession (Arney, 1982; RCAP,Vol.3, 1996) is indicative of the systemic subjugation of women by men as first noted in the writings of Grimke (1792-1873), an early feminist (Donovan, 1991). The medicalization of birthing practices that saw women disenfranchised from what was formerly the domain of women is an issue that affected all women. In the instance of Aboriginal women, Nabigon and Couchie (1997) observe that the imposition of medicalized childbearing practices worsened the effects of the oppression they already suffer on account of colonization. The experience of an Aboriginal midwife from northwestern Ontario who ended her midwifery practice when nurses and doctors began frequenting her community illustrates the fundamental character of this oppression (Terry and Calm Wind, 1994).

2.1.2 Science as ideology, domination and method.

Western science as an ideology is critiqued by social theorists as a source of domination and oppression. The medicalization of birth began during the Renaissance with the rise of science (Arney, 1982). This phenomenon was based on a dichotomous approach to humankind and nature. It was assumed that whatever fell outside the area of reason was the 'Other.' The Other included everything believed to be of less significance or assumed to be irrational, such as women and nature (Donovan, 1991). Referring to the Enlightenment mindset, Sawacki (1991) posits "the new mechanistic philosophy of nature served both capitalist and patriarchal interests insofar as it opened up new territories (the earth, women's bodies) for exploration and exploitation" (p. 7). Arney argues that the ideological re-conceptualization of the body as a machine and birth as a mechanical process was more instrumental in medicalizing birth than were the scientific advances in technology that followed.

Ultimately, science came to be synonymous with what constituted knowledge itself. Habermas (1978), currently the most influential figure in critical social theory (Alvesson & Skoldberg, 2000) maintains that prior to the 19th century 'science' was viewed as a philosophical orientation to knowledge. Now, he observes it has become the philosophical view of what constitutes knowledge: "the meaning of knowledge is defined by what the sciences do and can thus be adequately explicated through the methodological analysis of scientific procedures" (p.67). The ideological inference of positivism is evident in Habermas' description of 'scientism' as "science's belief in itself:

that is, the conviction that we can no longer understand science as one form of possible knowledge, but rather must identify knowledge with science" (p. 4).

On the human element of the positivist approach to knowledge, Habermas (1978) observes that science is "an epistemology restricted to methodology, the subjects who proceed according to these rules lose their significance" (p. 69). This orientation to research has more serious implications for Aboriginal peoples. Linda Tuhiwai Smith (1999), an Australian Aboriginal woman discusses the implications of scientific positivism to indigenous peoples in her book, *Decolonizing Methodologies.* She describes the research approach as dehumanizing to indigenous peoples. Researchers like Kincheloe and McLaren (1994) concede mainstream research methods may unintentionally contribute to unequal power relations among social groups. The Western mindset and imperialist origins of mainstream research approaches project an attitude of superiority that implies an expectation of those being researched to conform to Western norms. In contrast, studies that engage in a dialogic approach to research provide a way to affirm individual and community cultural identities, in addition to being a means of carrying out scholarly inquiry.

2.1.3 Social-historical constituting of the subject and knowledge.

A social-historical constituting of the subject and knowledge provides a basis for society and persons to be seen as cultural constructs, rather than as products of 'natural laws.' Thus, culturally constructed behavior derives from cultural origins, whereas in the context of cause and effect natural laws, behavior is seen to come from a pre-determined

set of expected behaviors. Giddens (1982) describes how social theory differs from a pre-determined approach to society:

> We cannot approach society, or 'social facts,' [italics his] as we do objects or events in the natural world, because societies only exist in so far as they are created and re-created in our own actions as human beings. In social theory, we cannot treat human activities as though they were determined by causes in the same way as natural events are. We have to grasp what I would call the *double involvement* [emphasis his] of individuals and institutions: we create society at the same time as we are created by it (p.11).

Similarly, critical social theorists view knowledge as constructed in a context of social and political values that are open to change over time. Transformations in learning occur as "ignorance and misapprehensions" are replaced with more insightful understandings by means of dialectical interaction (Guba & Lincoln, 1994, p. 115). This being said, both positivism and CST emphasize the importance of a rational approach to problem solving (Morrow & Brown, 1994). However, critical social theorists posit social inquiry should embrace research as a means to change the world rather than to simply describe it.

From this perspective the 'how' of research is of less importance than the 'why' of research, and 'who' is "entitled to shape and control the research process" (Strand, 2000, p. 92). Critical theorists are not averse to quantitative methods, per se. In fact, such methods may be preferable in some research. However, if the study is of a critical social theory persuasion, then how the methods are used and for what purpose should be reflected in the research (Morrow & Brown, 1994). Agger (1998) succinctly points out the distinct difference in the two approaches:

> Positive theory attempts to formulate laws explaining variations in social behavior, whereas critical social theory rejects the concept of social laws and instead attempts to explain social history in order to gain insights into how history can be changed (p. 25).

This radical theoretical orientation to social theory and the constitution of knowledge provided a means to engage research participants in an egalitarian way that was at once humanizing and diverse in its approach. The use of dialectics as the cornerstone research method in this study afforded these opportunities and provided a means for participants to voice their aspirations and autonomy where childbearing practices are concerned.

2.1.4 A framework for dialectics.

Action science exemplifies the diverse approaches of applied research (Reason, 1994). Differing approaches to action science vary in ideology while being united epistemologically in the "fundamental importance of experiential knowing" (Reason, 1994, p. 333). Brown and Tandon (1983) emphasize that participatory research differs from action science in its collective focus on issues of dominance and conflict. PAR particularly benefited from the contributions of the critical social theorists in North America in the mid-1980s (Hall, 1992). The dialectical method distinguishes PAR from other social science research (Park, 1993; Sohng, 1995). From a critical social theory perspective, the dialectical process is conceived as a means to construct knowledge in an evolving manner (Guba & Lincoln, 1994). More specifically, Alvesson and Skoldberg (2000) describe the dialectical process in this way:

> Critical theory consistently maintains a dialectical view of society, claiming that social phenomena must always be viewed in their historical contexts, realized patterns must be understood in terms of negation, on a basis of their own opposite and of the possibility of social conditions of a qualitatively different kind (p.110).

A dialectical method produces critical, interpersonal and factual knowledge that "defines humans as autonomous social beings" (Park, 1993, p. 12). Park (1993) posits that the participants' knowing of themselves and their community in this manner is a significant reason for their participation in the research. As well, the quality of the research is higher when access to the community and its bodies of knowledge is collaboratively achieved (Cancian & Armstead, 1992; Schensul, 1987; Small, 1995).

Enkin's (1992) reference to the "profound distrust of authority" (which he sees as becoming more apparent in a society that leads people to ask, "What does the evidence say?" rather than "What do the experts say?") has relevance to the debate on midwifery in northern Manitoba (p. 13). A dialectic approach to the research created a means of vigorous discussion on topics such as various birthing practices, their implications and outcomes based on research studies and the socio-cultural perspectives of participants and stakeholders. A deliberate attempt was made to include a diverse group of participants with opposing views, an approach used in action research to compare different perspectives for reaching an alternative understanding of behavior and childbearing practices (Waterman, 1998).

2.1.5 Research as empowerment and praxis.

Best understood in the context of empowerment, critical social theory scholars posit that to be critical, research must attempt to confront an injustice in a political or social sense (Kincheloe & McLaren, 1994). Participatory action research is specifically viewed as a means to achieve both social change and advance general knowledge (Benson & Haravy, 1996). Understandably, much of the impetus for PAR came out of the

developing world in the 1960s and 1970s from work with oppressed peoples (Johannsen, 1992; Reason, 1988). PAR is seen as research that involves marginalized people, where power, empowerment, and participation are central tenets (Martin, 1996). The critical examination of current federal childbearing policies demonstrated that the empowerment of action research is a meaningful way to challenge the dominant institutional organizations (Park, 1993). It was anticipated that an understanding of conditions or circumstances that affect NCN band members in undesirable ways would act as a catalyst for social change (Fay, 1993; Freire, 1998).

The Freirean terms 'conscientization' and 'praxis' explain the process that takes place when people become aware of the ways oppressive forces impact upon their lives. This leads to 'praxis,' or an informed basis for action (Freire, 1998). These terms find their origins in Marxist ideology where 'false consciousness' refers to a lack of awareness of oppressive social conditions. I made no assumptions, however, that First Nations women research participants generally needed to be made aware of their oppression. Anne Poonwassie (2001) emphasizes that despite the overwhelming oppression experienced, Aboriginal people have been able to maintain core cultural values and have begun the process of empowerment as they reclaim their autonomy and nationhood. The research project aimed simply to reach a mutual understanding of oppressive childbearing practices and other issues that were identified as problematic to the women.

Critical social theory does not provide for the mechanics of praxis -- the 'how' of achieving social change (Hayes, 1994) – but instead relies "on the power of agency, both personal and collective" to achieve change through dialogue (Agger, 1998, p. 5). As a

Canadian First Nations educator, Weenie (2000) emphasizes: "We are not victims. Individually and collectively we are responsible for ourselves within the structures we live." (p.67). Weenie thus agrees with Fanon whom she cites as saying "the body of history does not determine a single one of my actions. I am my own foundation." Weenie proposes that an "intellectual awareness, critical self-reflection, and self-analysis are ways of transforming our lives" (p. 67). The undertaking of this critical approach to the examination by the participants of the research issues and topics generated by the research findings evolved into several 'praxis events' during the study. One such important praxis event was the formation of the grassroots NCN Otinawasuwuk (Receivers of Children) organization in January 2001. This organization, in turn, was instrumental in co-developing (along with the substantial support of community members and leaders) The Empowerment of Aboriginal Women Surrounding Childbearing (EAWSC) project that was funded by the Aboriginal Healing Foundation (see Appendix D).

The five components identified by Cancian and Armstead (1992) as basic to the PAR process were implemented in this study through group meetings and interviews. These include: research participants who varied in their active involvement in the research; the inclusion of popular knowledge as necessary for the understanding of problems and their resolution; a focus on power distribution and empowerment; 'consciousness-raising' and education of participants along with the sharing of common concerns in ways that examined unequal power relationships; and political action aimed

at transforming the circumstances around childbearing in which the participants found themselves in.

Critical social theory has an obviously important role in this research. It provides a framework for examining the 'big picture,' or macro-politics, but leaves us short in examining what is closer to the surface, or the 'micro-politics' of women's experience of childbearing. We are left with two questions: 1) How is the domination of First Nations people, and specifically women, being exercised in their day-to-day lives?; and 2) How can we identify where and how resistance to domination is taking place?

2.2 Postmodern Perspectives

Michel Foucault, a French philosopher generally known as one of the 20th century's most influential thinkers, argued that there is no over-arching power structure. Rather, this is a terminal form power takes. Instead, Foucault (1978) viewed power and control as exercised diffusely in a wide range of settings. It is important that we do not ignore the impact of dominating structural institutions in the context of Euro-Canadian-Aboriginal relations but it is also necessary that we go beyond this perspective and reflect with Foucault (1980) when he says:

> Let us not, therefore, ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of on-going subjugation, at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviors, etc. In other words, rather than ask ourselves how the sovereign appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc. We should try to grasp subjection in its material instance as a constitution of subjects.... (p. 97).

2.2.1 The docile body.

According to Foucault, the body is the "ultimate site of political and ideological control, surveillance and regulation" (Lupton, 1994, p.23). Knowledge of the human body as a biological entity is increasing exponentially. All of our physical, mental and psychological processes have been, and are, subject to investigation and labeling. In a sense, our bodies are subjugated by those who have the knowledge and power to understand and impact them. Where childbearing is concerned, it is important to consider how the institution of medicine as a locus of power and knowledge constitutes women's bodies. Lupton (1997) explains the medical encounter from a Foucauldian perspective:

> Power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies. The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility (p. 99).

In reference to the medicalization of childbearing, it is not difficult to concur with Foucault when he observes that power and knowledge are reciprocal. He argued that where there is power there is knowledge, and that the two are reciprocal and necessarily work together to create dominance. By extension, Foucault's approach to discourse analysis, which reveals the enmeshment of power relations within constituted bodies of knowledge (McHoul & Grace, 1998), enables us to understand the implications that this poses to reclaiming childbearing practices in NCN:

> We should admit rather that power produces knowledge; that power and knowledge directly imply one another; that there are no power relations without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977, p.27).

Lupton (1997) observes the discourse around health as being "central to constituting the contemporary human body" (p.6). This discourse around the body evolved beginning in the 17th century. According to Foucault (1978), it evolved into two areas that he termed biopower. He describes the first aspect of biopower as "centered on the body as a machine" including all the conditions and circumstances that are required to make it fit into an efficient socio-economic system (p.139). Where birthing practices were concerned, the body came to be seen as a mechanical entity that worked either effectively or ineffectively (Arney, 1982). Women saw themselves as "having a body rather than being a body. Each new gynecological or obstetrical advance treated the body as an object to be manipulated according to the wishes of the patient and the doctor"(Wertz & Wertz, 1977, p.105).

The other aspect of biopower is the form it takes in regulating populations. Foucault (1978) describes this as a focus on populations rather than on the individual. Information about individuals reflecting life events such as birth, death, fertility, longevity, and health status came to be used as a basis for intervention and regulatory control. The 1964 annual report for this region illustrates how birthing as a life-event became just such a locus for intervention and social control by well-intentioned government bureaucrats in their efforts to relocate birth to an institutional setting in northern communities. The report reads:

> Although we have no statistics as to the numbers confined at home, at nursing stations or hospitals, it is our impression that the majority of women are confined at nursing stations or hospitals and very few home deliveries occur. Unattended home deliveries usually occur in the more remote communities as a result of unexpected labor or lack of transportation facilities to bring the patient to the nursing station or hospital. As transportation facilities improve, there will be even fewer home deliveries anticipated. (Dept. of National Health & Welfare, 1964, p. 57).

In 1965, the annual report states the aim to medicalize birth more emphatically as: "...to increase, wherever possible, the number of confinements at the nearest medical centres" (Dept. of National Health & Welfare, 1965, p 58). The use of the word 'confinement' in the report suggests the importance of language in constituting women as objects in its colonialist approach. With the understanding that reality is socially constructed, Davis-Floyd and Sargent (1997) posit: "language is the filter through which experiences are interpreted and expressed" (p.15). Women from isolated communities are commonly told they are 'going out for confinement' to an urban setting, at a specified time, which is usually designated by a nurse. The word 'confinement' by implication subjugates a woman's autonomy to that of her health care providers. From a pragmatic perspective, the confinement of women in urban hospitals for birth is observed to have profoundly negative consequences culturally, socially and personally for women, their families and communities (RCAP, Vol.3, 1996). The term maternal evacuation has the same orientation as confinement. In this thesis, the term maternal evacuation is retained throughout as a reminder of the harshness of the policy, rather than using a term such as transporting women, for example.

2.2.2 Governmentality: power/knowledge/discipline.

The social regulation and control of populations as it is described in biopower was termed by Foucault as governmentality. He believed this approach to governing populations requires the interrelatedness of power, discipline and knowledge. Foucault was particularly interested in the self-disciplinary function of governmentality. He used Bentham's model of the Panopticon as an analogy for the social control that takes place

through self-regulatory mechanisms (Turner, 1997). O'Neil (1988) found evidence of this type of social control in an Inuit settlement where the nursing station occupies a central place in community life. The nurses demonstrated a panoptic nursing approach to community members similar to one that would be seen in their relationship to patients in a hospital setting. The self-regulatory behaviors that are needed to enable such a colonial model to be operative can be seen in the patient-like dependence of the Inuit on the nurses. Within two short decades, following the construction of the nursing stations in the 1960s, when the Inuit were asked by O'Neil (1990) "What do you do when you are sick? The response was, "I go to the nursing station" (p.62).

O'Neil's (1990) study demonstrates how a benevolent form of social control has normalized dependent behavior. A necessary component for the constitution of behaviors to a predetermined norm requires surveillance and ubiquitous mechanisms of power, embodied in what Foucault described as the "clinical gaze" (Henderson, 1994, p.936). This surveillance and manifestation of power embodied in the clinical gaze is apparent in the current obstetrical focus that emerged following the Second World War. The obstetrical focus changed from the body as the machine metaphor with parts that could fail, to the pregnant body as an ecological system. The site of surveillance and control was no longer primarily located in the hospital. It now included all aspects of the woman's internal and external environment, generally speaking before, during and following the pregnancy. Advances in technology enabled every birth and the environment to be subjected to the medical gaze (Arney, 1982).

2.2.3 Resistance and subjugated knowledge.

An aspect that is infrequently addressed by writers when discussing the 'clinical gaze' is how patients themselves view or gaze 'up' to health care providers (Lupton, 1997). The technology that made surveillance possible also made the medical profession easier to scrutinize by those outside of the profession. The public, including the women's health movement that grew out of the women's liberation movement in the 1960s (Scully, 1980) could now scrutinize scientific reports and outcomes of obstetrical clinical decision-making more effectively to determine their validity or applicability to optimal birthing practices (Arney, 1982). Foucault (1978) observes that a "discourse can be both an instrument or an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy" (p.101). He frequently observed that where there is power, there is resistance. Foucault had a particular interest in the way individuals experienced "micro-powers" in "everyday life and the ways that resistance may be generated at those levels by people refusing to engage in these techniques and strategies" (Lupton, 1997, p.103). Hekman (1990) observes that Foucault saw "'local resistance' as superior to totalizing theories that his critics claim are necessary grounding, for political action" (p. 184).

Acts of resistance by First Nations people to the policies of organizations, institutions and governments are common, including such as those documented by Mary-Ellen Kelm (1996) in her study of West Coast First Nations and those identified in the behaviors of Inuit and Manitoba First Nations women to the maternal evacuation policy (Guse, 1982; Kaufert & O'Neil, 1993). In Canada, we have witnessed a resistance that

has culminated in the re-emergence of midwifery following over 100 years of being designated a medical act in provincial statutes. Resistance requires that voices be heard and engaged in an egalitarian way. The discussion now turns to how the voices in Nisichawayasihk Cree Nation may be heard in this research.

2.2.4 Many voices in our midst.

Modernity is described as a worldview that actively pursues 'totalizing theories' to explain complex historical and social conditions in an attempt to create order out of chaos (Klages, 1997). The core principles of modernity are derived from modern science's "obsession with certainty" and its associated notion of human progress (Stamps, 1995, p. xiii). In attempting to create certainty out of uncertainty, modern societies are watchful of anything that might disrupt order. To this end, a binary opposition is drawn between 'order' and 'disorder,' as a basis for conceptualizing rational thought. Disorder becomes the 'Other' or that which is perceived as being inferior to order. In Western culture this may be perceived as that which is deemed outside the norm for the dominant group (Klages, 1997). For Foucault, "normalization of the body and populations by the social sciences and the institutions which articulated scientific knowledge" is the outcome of how discourses produce "bodies" (Turner, 1992, p. 52). In opposition to universalizing, postmodernism embraces a "constant change of reality and knowledge, a stress on the priority of concrete experience over fixed abstract principles, and a conviction that no single a priori thought system should govern belief or investigation" (Tarnas, 1991, p. 391).

An analysis of power relations and their influence on bodies of knowledge that resulted in totalizing theories around Western childbearing practices aids us in

understanding how they came to be and ultimately how they came to subjugate childbearing practices in communities like NCN. Arney (1982) acknowledges that in writing obstetrical history, he was particularly interested "in the relationships among the rules for producing knowledge, knowledge, and the uses of knowledge" (p.ix). Referring to her discourse analysis of the history of antenatal care, Oakley (1986) suggests it is important to learn how a phenomenon could come to belong to a particular domain. Similarly, Treichler (1990) observes that understanding how definitions of "childbirth come to be constructed, codified, and mobilized" is essential in the evolution of more optimal birthing policies and practices (p. 3).

Agreeing with Arney (1982) on the purpose of a Foucauldian analysis, it was not the intent of the research to develop a social theory but rather to make explicit the relationships of power and knowledge as they pertain to childbearing practices among First Nations. Through the PAR process, knowledge under the control of the participants was exercised in ways that empowered and enabled them to make informed decisions (Park, 1993). Research and subjugated First Nations childbearing knowledge provided the leverage required by the participants in deciding how childbearing practices might optimally reflect their needs. Generally, knowledge is produced by universities and industries to further goals that do not reflect the needs of the disadvantaged (Gaventa, 1993). Gaventa (1993) emphasizes that the 'expert' in knowledge production is not accountable to those who are affected by it. Rather, knowledge production is accountable to an ideology "which serves to justify the superiority of the expert – the ideology of science and objectivity" (p. 29). In contrast, the participation of common people in the

production of knowledge democratizes it by placing knowledge in the hands of the many for their use in creating a more equitable society (Gaventa, 1993).

When Marlene Brant Castellano (1989) says, "Native women of the past are a shadowy lot," she refers to the invisibility of generations of Aboriginal women within the Canadian citizenry (p. 45). A postmodern research perspective required that I, as the primary investigator, not dominate the text and "thereby undermine the dialogical and participatory nature of the research" (Walker, 1997). Instead, I strove to have many voices heard in the writing of the text and to this end, carried out a reflexive self-examination with an emphasis on representation and authority (Alvesson & Skoldberg, 2000). This is particularly important in collaborative research where the aim is "shared power and control of decision-making" (Green, Daniel, Frankish, Herbert, Bowie & O'Neil, 1997, p. 58). As the reader will observe in this text, the study provided the participants with an opportunity to contribute directly in the process and writing of the research (see Appendix N).

From a postmodernist perspective we become aware of the significance of language and how it constructs meaning and reality, of the interconnectedness of power relations and bodies of knowledge, of multiple representations of truth, of the insidiousness of power and resistance to it, and of subjugated knowledge. Critical social theory provided this study with a theoretical framework surrounding the concepts of domination and emancipation and the implications for choosing the PAR paradigm as the predominant research methodology. In the next section, I will review the appropriateness of gender sensitive perspectives in completing the theoretical framework whereby the

stance of the women involved in the research might be voiced in the context of their day-to-day lives.

2.3 Gender Sensitive Perspectives

Feminist theory is based on the notion that the historical oppression of women by men is pivotal to the understanding of gender relations, and is a basis for a feminist agenda that seeks to gain equality between the sexes. However, feminism as meta-theory that encompasses all women, regardless of race or culture is criticized for its ethnocentricity and universalism in the assumption that the experience of Caucasian women is the norm for all (Boyd, 1991). On the other hand, gender sensitive theories seek to express the diversity and complexity of women's experience in a sociopolitical context that is empowering (Im & Meleis, 2001). The authors go on to argue that the philosophical roots of gender sensitive theories are found in feminism, critical social theory and postmodernism. From a feminist perspective, gender sensitive theories embrace gender equity as a basic premise. A critical social theory perspective emphasizes the need to examine power relations in social and historical contexts. While a postmodern perspective emphasizes that women's voices are diverse and must be understood in the context that we find them. The emphasis on context and diversity that is expressed in gender sensitive theories can accommodate the perspectives of First Nations women as the following discussion demonstrates.

2.3.1 First Nations gender orientation.

Feminists attempting to organize northern Manitoba women in 1991 on behalf of the Manitoba Status of Women organization identified a diverse set of requirements that would enhance the lives of women. However, they recognized that

First Nations women needed to evolve their own ways of expressing their "sense of power and belonging" (Graveline, Fitzpatrick & Mark, 1991, p. 147). Shannon Simpson (2001), a woman of Anishinaabe and Scottish descent argues this point:

> Numerous attempts made by feminist organizations to incorporate the agendas of Aboriginal women have been instigated primarily by white, middle class feminists with a focus on 'speaking for' Aboriginal women, instead of creating a space within feminism for Aboriginal women's voices (p. 136).

Commonly, First Nations women have felt distanced from the middle-class values of Western feminists, believing that they are incongruent with their own (Graveline et al., 1991; Guerrero, 1997; Maracle, 1996; Osennontion & Skonaganleh:ra, 1989; Petersen, 1994; Weenie, 2000). These Western values are seen as yet another source of colonization (Simpson, 2001; Emberley, 1993).

Skonaganleh:ra, an Aboriginal woman, writing for a special native women's issue of *Canadian Woman Studies*, articulates her view of feminism:

> Frankly, I'm very *tired* [all italics hers] of having other women interpret for us, other women empathize for us, other women sympathize for us. I'm interested in articulating our own directions, our own aspirations, our own past, *in our own words*...it's *necessary*, for us to grow in a way that we have articulated ourselves: we don't need governments, laws, or legislative frameworks to articulate the whole concept of self-government and self-direction (Osennontion & Skonaganleh:ra, 1989, p. 7).

Linda Tuhaiwai Smith (1999) argues that Aboriginal women across many cultures view gender as constructed in relation to the land, universe, and spirituality, in addition to

the cultural orientation of a collective worldview. Eva Linklater (1997), a Nisichawayasihk Cree Nation band member, writes of the historical significance of the land from an NCN perspective:

> Through many centuries of use and interaction with the land, the Nelson House Cree had transcribed their history onto it. This was our historical text, and the landscape was an affirmation that the past had really occurred (Linklater, 1997, p. 17).

Marie Anna Jaimes Guerrero (1997) suggests that where indigenous women are concerned, the mainstream feminist movement has been ineffective in its lack of consideration of indigenous cultural and political differences. She argues the traditional communal organization of indigenous peoples is not in keeping with the individualist orientation of some in the Western middle-class feminist movement. In addition, such a feminist perspective reduces the oppression of women to one source: the male gender. In so doing, it avoids the evidence of other oppressive forces that may impact women (Guerrero, 1997; Im & Meleis, 2001).

Canadian Aboriginal women who took part in the *Aboriginal Women's Roundtable on Gender Equality* (Status of Women, 2000) in Ottawa viewed Aboriginal gender relations as diametrically opposed to Western feminism. They perceived Aboriginal gender relationships as more holistically grounded than those of Western feminism, which they believe creates divisiveness between the genders. The women agreed that the sexual discrimination women face on a daily basis cannot be separated in the case of Aboriginal women from the legacies of racism and colonialism that continue to impact their lives through marginalization and the devaluing of cultural ways. One participant emphasized: "What we're talking about here is not gender equality, but rather racial

equality. We need to obtain racial equality in our own country" (p. 6). One woman observed that "the first problem we face is language, like gender equality, I can't stand it ... Some of our languages don't even have words for male and female. And that is the number one problem and so long, as we're limited to that sort of language, we'll have this problem" (p. 7).

Janice Acoose, Misko-Kisikawihkwe (Red Sky Woman) (1995), suggests that language as being non-gender specific among Aboriginal peoples encourages a more holistic orientation toward gender relations. She cites Tomson Highway, a northern Manitoba First Nations man and playwright, as reinforcing the idea that in North America most indigenous languages do not make reference to gender. Differing classifications of gender along a continuum appeared to be practiced in early North American First Nations cultures, where children remained 'genderless' up to one year of age (Robinson, 1998). The nature of gender relations prior to European contact may have differed in its expression across Aboriginal cultures. In some Aboriginal cultures gender relations were matrilineal (Billson, 1994; Guerrero, 1997; RCAP, Vol. 2 Pt.1, 1996). The degree of equality is thought to have varied. However, what is obvious is that on European contact, the position of Aboriginal women in reference to men declined (Van Kirk, 1987). The legislation of the Indian Act in 1876, and its precursor, the Enfranchisement Act of 1869, was one such means of forcing changes on First Nations gender relations (Emberley, 1993).

2.3.2 An integrated approach to gender.

Simpson (2001) believes there is room for an integrated approach to feminism that supports Aboriginal women in their struggles and achieves a means of restructuring society for a better world. In this study, the intertwining of childbearing practices with elements of colonization and patriarchy, reflect a need to approach the research from a gendered perspective that at once provided an understanding of the issues at hand and served to illuminate the research inquiry from the perspective of women. The premise of gender equity is basic to this research process and to gender-sensitive theories that are "based on the acknowledgement and affirmation of gender equity" and "show the importance of contexts in understanding women's health and illness experience" (Im & Meleis, 2001, p.311).

2.3.3 Researcher gender perspectives.

As a non-Aboriginal researcher with a Mennonite cultural background who embarked on research with First Nations women, I was required to examine my own perspectives on feminism. In the Mennonite culture, the roles of women and men largely derive their essence from patriarchal Mennonite churches. Janet Mancini Billson (1994) quite correctly describes Mennonite women's attitudes toward the feminist movement as one of suspicion. In her study of Mennonite and First Nations groups, Billson seeks to find ways that might explain the orientation of these worldviews in the context of a feminist movement that aims to liberate women from traditional roles and by extension, from an oppressive male counterpart. As we have seen, First Nations women view

themselves as experiencing oppression collectively from external sources irrespective of gender. Mennonite women, on the other hand, experience a form of internal oppression that is reflective of Bentham's panoptic society where the culturally-held, self-regulatory behaviors posited by Foucault as necessary to mold the 'docile body' construct our reality. Coming from a culture that embraces a collective worldview, rather than a more individually centered one, my 'argument' is not gender focused but with how culturally-held Mennonite beliefs construct and oppress us all. Yet, where my role as a woman interfaces with the dominant Canadian culture, I applaud the work of feminists in the past who have made my privileged place as a woman in this society possible. Emanating from the Declaration of Independence (Jefferson, 1776), the Declaration of Sentiments set forth by the Women's Rights Convention (Seneca Falls) in 1848, reads: "We hold these truths to be self-evident: that all men and women are created equal; that they are endowed by their Creator with certain inalienable rights..." (Stanton, Anthony, & Gage, 1887). This informs my feminist perspectives and actions in a way that accommodates both cultures.

2.3.4 Gender sensitive research.

Finding a balance between social activism and research has been a core struggle for two generations of women (Spalter-Roth & Hartmann, 1999). According to Maguire (1997), for participatory research to be feminist in nature, gender must be centrally located in it. Feminist research is synonymous with collaborative, non-exploitive research, where the researcher is placed within the study to avoid objectifying participants in addition to creating a research milieu that is potentially transformative

(Creswell, 1998). Feminist aims for research to be humanizing (Creswell, 1988; Punch, 1994) are characteristic of both qualitative (Henwood & Pidgeon, 1993) and action research approaches (Stringer, 1996). Qualitative research methods are commonly preferred by feminists for their ability to achieve an in-depth understanding of knowledge where women are concerned (Epstein, 1993). This is an important consideration, given that childbearing experience and knowledge are among the most intimate aspects of a woman's life. Considered from this perspective, qualitative research can illuminate the "nuances and contradictions of real life experiences" in a natural setting (Sandelowski, 1996, p. 527) and can assure that the "most meaningful data ... [in a] changing and dynamic reality" emerge (Duffy, 1987, p. 130). In addition, where complex social behaviors are concerned, including those that comprise health care provision in northern communities, qualitative research is particularly relevant in capturing these complexities, given that health and its primary influence, medicine, are human constructs (Lincoln, 1992).

2.4 Summary

A theoretical framework that combines perspectives from critical social theory, postmodernism and a gender sensitive approach guided the research process. As a particularly controversial research approach with undeniably political overtones, it was imperative to continuously reflect on the dialogic nature of the relationship between the researcher and the 'researched' in the context of a changing socio-political environment. The hybrid research framework that I termed critical postmodern gendered praxis provided the parameters that guided the research in a reflexively, responsive way. Critical social theory has an obviously important role in this research. It established a framework

for examining the 'big picture' or the macro-politics of the concepts of domination and emancipation, and the implications for choosing the participatory action research paradigm as the predominant research methodology. However, it leaves us short in examining what is closer to the surface, or the 'micro-politics,' of women's experience of childbearing. From the postmodernist perspective, we are aware of the significance of language and how it engenders meaning and reality, of the interconnectedness of power relations and bodies of knowledge, of multiple representations of truth, of the insidiousness of power and resistance to it, and of subjugated knowledge. Lastly, a gender sensitive approach provides a framework in which the women involved in the research are given an in-depth opportunity to speak on childbearing practices, and issues related to gender in the context of their every day lives in an empowering way.

Chapter Three: Historical and Cultural Childbearing Perspectives

3.0 Introduction

Childbearing practices mirror the cultural and social context of their origins. This can be said, for example, of both Aboriginal and Western cultures. In this chapter, I will discuss how childbearing practices are constituted in an historical-cultural context and how the strategic incursions of the Western biomedical model came to dominate the childbearing ways of Aboriginal peoples. I explore the medicalization of childbearing practices to understand the role of the reciprocal relationship between power and knowledge in the strategic success of the Western biomedical model. Important to this understanding is the resistance to this model by social movements that continue to redress these oppressive practices. I will discuss these issues from the perspective of: 1) the concept of childbearing as cultural in origin; 2) Aboriginal childbearing practices; 3) the Western medicalization of childbearing practices; 4) the Canadian medicalization of birth; 5) the controversy of childbearing mortality rates; 6) resistance in Canada and the US to medicalized birth; 7) the medicalization of childbirth in northern communities; and 8) the impact of medicalized birth in the North.

3.1 Childbearing as Cultural in Origin

The culturally bound influences of childbearing practices are well known. All people are products of their culture, with "its inevitable admixture of rational and non-rational elements" (Paul, 1958, p. 234). For example, the influence of American

culture on birthing practices and the ritual use of technology in obstetrics are obvious from Davis-Floyd's (1992) book, *Birth as an American Rite of Passage.* The title aptly describes her view of "medicine as a microcosm of American society" (p. 45). Davis-Floyd (2001) asserts that "despite its pretenses to scientific rigor the Western medical system is less grounded in science than in its wider cultural context: like all other health care systems, it embodies the biases and beliefs of the society that created it" (p. S5). A combination of cultural pejoratives is evident in Scully's (1980) perspectives on the surgical training of obstetricians. She compares the pre-operative procedure of the obstetrician to that of the Catholic priest in observance of sacrificial rituals. Scully's perspectives are supported by Foucault's assumption that "medicine occupies the social space left by religion" (Turner, 1992, p. 22). The analogy of Western medicine to "some of the basic functions of religion" has also been made by Tikkala and colleagues (1999, p.1).

Anthropologists report a wide variation in birthing practices among cultural groups (Helman, 1990). Early studies relating to childbirth are not prolific. Ethnographic studies of cultures that overlooked birthing practices cannot be entirely blamed for the gender bias of the mostly male anthropologists. This also reflects a bias against biology in favor of social and cultural studies (Davis-Floyd & Sargent, 1997). In recent years, childbirth and reproduction have emerged as thriving areas for ethnographic research (Davis-Floyd, Leigh Pigg, & Cosminsky, 2001). Knowing that birthing cultures reflect their wider cultural context and in some instances have distinctly religious overtones, it is important to consider the elements that are common to them. For this understanding we turn to Brigitte Jordan and her

pioneering research which earned her the claim of "midwife to the anthropology of childbirth" (Davis-Floyd & Sargent, 1996, p. 111). In her cross-cultural comparison of indigenous birthing in the Yucatan with practices in Holland, Sweden, and the United States, Jordan identified 'authoritative knowledge' as a common theme in the birthing cultures. She describes the latter as "the knowledge that participants agree counts in a particular situation that they see as consequential on the basis of which they make decisions and provide justifications for courses of action." She emphasizes that "the power of authoritative knowledge is not that it is correct, but that it counts" (Jordan, 1993, p. 154). The authoritative knowledge of the Aboriginal midwife and the sacredness of birth as a natural process is evident in Malloch's (1989) description of birth in her culture where:

> Birth is a sacred event in the circle of life. It must be respected in this way. It is a powerful celebration of life which can strengthen the family and the nation. Birth is a natural process and must be protected rather than interfered with. Women are the caretakers of the birth process. This is a responsibility and a power which women have. This is why, in the traditional Indian way, midwives attended the birth (p. 108).

3.2 Aboriginal Childbearing Practices

The notion of childbearing as an integrated life event is frequently cited in studies on First Nations traditional birthing practices (Kioke, 1999; Malloch, 1989; Terry & Calm Wind, 1994) and that of other North American Aboriginal groups, including the Inuit (Bushnell, 1981; Kaufert & O'Neil, 1990; Loughlin, 1965; Metcalfe, 1991; Paulette, 1990; Quinuajuak, 1996; Waxman, 1990). However, academic studies that focus on First Nations childbearing practices are not prolific. Sokoloski's (1995) qualitative study in Winnipeg among Cree-Ojibway women

entitled *Canadian First Nations Women's Beliefs about Pregnancy and Prenatal Care* reaffirmed First Nations women's perspectives of pregnancy as a sacred normal life event that does not require intervention.

The normalcy of birth as a sacred life event in the Aboriginal culture is also reflected in a midwifery worldview that holistically unifies the body, mind and spirit (Sharpe, 1997). Midwives in Aboriginal communities historically were respected for their abilities to attend to women's childbearing needs. The Equay Wuk (Native Women's) Group, representing the Nishnawbe-Aski Nation of Northern Ontario describes the practice of midwifery in this way:

> Midwives were professional in their knowledge and practice of birthing. They performed safe deliveries and monitored the well-being of the mother throughout the birthing process and labor. The Nishnawbe midwife's experience included the many normal stages of pregnancy, actual birth, and postpartum. It was her duty to interpret patterns and facilitate a healthy outcome. By giving thorough prenatal care the midwife became familiar with each mother and was quickly aware of any deviation from normal. Prior to labor, the midwife would assist in the preparation of the birthing area. All the essential tools and equipment would be prepared and organized. During the actual birthing process, the midwife and her apprentice would act as a labor coach, administer necessary medications, monitor the well-being of mother and baby during labor, and prepare to deal with any complications that might arise. Every birth had some potential for complications, but the midwife's skills and competence was suited to handling these situations (Terry & Calm Wind, 1994, p. 80).

Canadian sources widely acknowledge the highly skilled birthing practices present in the Aboriginal culture prior to the medicalization of birth. It is known that on occasion, midwifery skills extended to include Caesarian sections (Graham-Cumming, 1967a). The Task Force on the Implementation of Midwifery in Ontario (Ontario Government, 1987) recounts the skilled traditional birthing practices of First Nations people and observes that there were a number of midwives in these communities in order that birth knowledge could be accessible to the wider group

during seasonal migrations. Carter (1996) cites several sources in her examination of First Nations relationships with early settlers on the Prairies. She found that it was not uncommon for Aboriginal midwives to assist pioneer women who had recently arrived, as well as, to share knowledge around childbearing and traditional medicines in highly skilled ways. Katherina Hiebert (1855-1916) (see Bradshaw, 2000) from the Mennonite East Reserve in Manitoba and a great-great grandmother to my children was one such midwife. Family oral accounts concur with these observations of her interactions with Aboriginal midwives and the incorporation of 'Indian medicines' in her work as a midwife with other settlers. An example of Aboriginal midwives providing midwifery care to Europeans is narrated by Archbishop Robert John Renison of the birth of his sister at Lake Nipigon (northwestern Ontario) in 1881: "My youngest sister, May, was born in our birch bark wigwam. Of course there was no physician; only the Indian midwives who had gained their skill from countless generations before them" (Renison, 1957, p.6). Carroll and Benoit (2001) recount the richness of the Aboriginal birthing culture in Western Canada in their discussion of events that led to their demise after years of acculturation and assimilation. In northern Canada, the skilled traditional birthing practices that Scott (1978) observed in the 1970s while working among the Inuit as a northern nurse reinforced her belief in the extensive nature of birthing knowledge possessed by this culture.

The consultations carried out with Aboriginal women prior to the legislation of midwifery in Manitoba reaffirmed this group's beliefs of childbearing as a natural life event. The resilience of the values and beliefs surrounding women and childbearing demonstrated in the northern Manitoba consultations (Albert, 1996) is reminiscent of the

close comparison of inter-generational knowledge on traditional beliefs and practices among Plains Cree women, ranging in age from 15 to 93 years (Swampy, 1982). Following their research into traditional birthing practices within the Nishnawbe-Aski Nation (28 communities in northwestern Ontario), First Nations authors maintained that subjugated knowledge still in the memories of the living midwives can be revived in these communities (Terry & Calm Wind, 1994).

First Nations groups have continued to maintain holistic cultural values and beliefs despite overwhelming attempts to eradicate them during the process of colonization (Kelm, 1996). The inability to suppress subjugated knowledge indefinitely, as Foucault (1978) emphasizes was evident in Gregory's (1986) study in a northern Manitoba First Nations community. The study corroborated that the resurgence of subjugated knowledge taking place in Aboriginal communities around traditional values also suggests a reaffirmation of individual and cultural identity.

3.3 Western Medicalization of Childbearing Practices

Childbearing practices, heavily influenced by Western medicine are in opposition to an Aboriginal worldview that embraces childbirth as a natural life event. Similarly, mothers generally tend to view childbearing in a holistic manner, believing that they possess an "authentic and valid knowledge about reproduction" and are capable of making responsible decisions on childbearing issues (Oakley, 1993, p. 134). Yet, to this day in the US, 98% of births take place in hospitals accompanied by numerous interventions (Davis-Floyd & Sargent, 1997). Simonds (2002) contends that the medical control of procreating women has only changed in style, but not in scope.

The medicalization of childbirth had its early beginnings in Europe. Prior to the 17th century, female and male midwives attended birth. Childbirth was viewed as a natural and normal event with a midwife (meaning to be with) in attendance. Changes took place with the simultaneous rise of science and the medical profession who ultimately came to dominate childbearing practices. Treichler (1990) observes "physicians did not uniformly declare war on nature, nor decide that they should adopt an ideology of intervention and subordination of women" (p.118). Rather, the mastery of midwifery by the profession of medicine is described as a strategic success (Arney, 1982). Essential, to such a sequence of events is that the group being mastered be lacking in recognized knowledge and power. Such was the case in Britain: midwives were unorganized and lacked a recognized body of knowledge to challenge the Enlightenment's emphasis on scientific knowledge and technology. However, the practice of midwifery was sustained in Britain following 75 years of struggles with a Bill that was passed in 1902 known as the Midwive's Act (Wertz & Wertz, 1977). Davis-Floyd and Sargent (1997) maintain that while the practice of midwifery in Europe has continued, mounting incursions from techno-obstetrics are increasingly making the role of midwifery a less viable option for offering truly woman-centered care.

Although the history of midwifery in the United States parallels that of Britain's, American midwives did not have access to education, an organizational base, or the support of more powerful groups that the British midwives enjoyed. In addition, science played a greater role in the US in the medicalization of childbirth. In general terms, American society reflected the Protestant ideology that among other beliefs valued advances in science and technology (Wertz & Wertz, 1977). American women gradually

acquiesced control of the process of birth to physicians (Sawacki, 1991). The choices of women reflected a belief in science and its methods. Reasons for choices varied among women according to their position in life and perceived needs. For example, urban, middle-class and upper-class women were particularly attracted to the notion of a perceived safer and less painful childbirth. On the other hand, impoverished women were inclined to let themselves be used for medical teaching purposes, in exchange for the economic advantage of giving birth in a hospital (Sawacki, 1991). Rifkin (1998) maintains that midwifery's fall in status in the US generally was due to an advancing medical profession, not to the advances that technology or obstetrical care had on improved birth and maternal outcomes.

3.4 The Canadian Medicalization of Childbirth

Canadian midwifery succumbed to the same fate as its American counterpart. Demographics influenced the pattern and rapidity of this event. For example, in areas where the population was sparse, the demise of midwifery was hastened by the need for physicians to earn an adequate livelihood. The Task Force on the Implementation of Midwifery in Ontario (Ontario Government, 1987) observed that the first attempt at controlling the practice of medicine was enacted in 1795 in Upper Canada (Ontario). The statute was referred to as the 'Act to Regulate the Practice of Physic and Surgury.' An overabundance of physicians in Ontario created a move West in the 1870s. As a result, midwifery was contested in Manitoba on several fronts, with midwives often reported by physicians to the College of Physician and Surgeons. Legal recourse was taken against Mrs. Thiessen (a midwife from the Mennonite West Reserve) who was convicted in court for practicing midwifery. Mrs. Thiessen defiantly told the court she intended to gain

licensure from the College of Physicians and Surgeons, an objective she did not pursue. The Task Force suggests had Mrs. Thiessen pursued licensure, midwifery history would likely have taken a different path in Manitoba and Ontario. Generally, the midwives focused their attention on those to whom they provided services. Remuneration and power were not important considerations for the midwives. As well, they lacked the organizational structure to mount an effective resistance (Appendix 1, Ontario Government, 1987).

The general compliance of the Canadian consumer to a physician-attended hospital birth became apparent around the Second World War. Enkin (1992), an obstetrician maintains that home-birth had almost disappeared in Canada by the 1940s. According to the home-birth records of the Victorian Order of Nurses (VON) in Winnipeg, there was a substantial decrease in home-births beginning in the early 1930s. Margaret Mackling former VON Director attributes this to the move toward hospital births (email communication, October 27, 2002). Home-births in the Manitoba Metis population with Metis midwife attendants were the norm until the 1940s. Following this period, Metis women gave birth in hospitals attended by physicians (Hourie, 1997). *The Canadian Mother and Child* publication in 1949 (Couture, 1949) does not state that it was inadvisable to have a home-birth. Instead, no mention is made of a midwifery alternative. In the event of a home-birth, the mother is advised to seek her doctor's direction. However, hospitalization is encouraged, "There is today, a great deal to be said in favor of a confinement in a well-managed hospital" (p.61). The medical orientation and inherent overtones of the dominant Canadian culture of a hospital birth is not lost on

the reader: "Children are never permitted to enter the Maternity Department of a hospital, which is added protection for you and your baby" (p.61).

To a lesser extent, midwifery continued to be practiced in most provinces including Manitoba, especially in northern areas and hospitals according to the Manitoba Advisory Council on the Status of Women Report on Midwifery (1987). The Department of National Health and Welfare (Health Canada) recruited midwives to work in the North and in isolated areas of the provinces beginning in 1939. According to May, nurses with midwifery training were recruited to work in northern nursing stations from such Canadian sources as university-based programs at the University of Alberta (1943), Dalhousie University, Nova Scotia (1967) and Memorial University in Newfoundland (1979) (May cited in Plummer, 2000). In addition, nurse-midwives were recruited from Great Britain, Australia and the US (Rita Dozois & Kathleen Jo Lutley, personal communication, 2000). Plummer (2000) refers to these well-trained nurse-midwives as an invaluable link between the community-based midwifery of early Canada to the present 21st century midwife.

Some other exceptions to the general disappearance of midwives in Canada were in Newfoundland and Labrador where they practiced for the most part until the Hospital Insurance Act was passed in 1958. The popularity of midwifery in this area resulted in the passing of a Midwifery Act in 1920 with a Board that included the licensing of midwives in its mandate. By 1961, midwifery licensure was no longer issued by the Newfoundland Board. However, midwives continued to graduate from the Memorial University of Newfoundland program until 1986. These midwives worked in under-

serviced areas designated by the Association of Registered Nursing, the Newfoundland Medical Board, and the Department of Health (de Cent, 1999).

3.5 The Controversy of Childbearing Mortality Rates

A common reason given for the medicalization of birth is the risk to mother and child in the event of death or complications. Maternal, infant and perinatal mortality rates are cited in various ways to substantiate past decisions around childbearing practices. As well, they are refuted as an argument to explore alternative birthing practices. The perinatal mortality rate (PMR) is calculated by including the number of stillbirths and live births that culminated in death within seven days of birth (Robinson, 1990). Stillbirths after 20 weeks of pregnancy are included in the calculation because it is believed the causes are related. Thus, a role for prevention is seen during pregnancy (Peron & Strohmenger, 1985). The PMR has come to be used as an indicator of the quality of health care for the newborn and woman because of the rarity of maternal mortality rates (Robinson, 1990). The infant mortality rate (IMR), on the other hand, includes deaths of infants from birth to less than one year of age. The IMR was commonly used until the late 1930s. Obvious reasons for the IMR that lie far outside of the birthing process itself does not make it informative for events around birth as the following narration in Rath's (M.D., M.P.H.) 1967 submission to the Medical Services Branch annual report for this region demonstrates. He observes that in an analysis of the more than double infant death rate of Indians as compared to the general population from the most prevalent illnesses in decreasing incidence includes: respiratory disease, accidents/violence, cardiovascular disease, unknown causes, diseases peculiar to the first year of life, cancer, nervous system disease, gastroenteritis and other. He emphasizes that

social causes are largely responsible for preventable illnesses such as pneumonia and gastroenteritis. According to Rath these illnesses are:

> primarily a reflection of the substandard environmental conditions under which these people live; both could be reduced to a very large extent by ensuring the provision of adequate food, clothing and shelter to these people; these requirements do not come under the jurisdiction of health services but rather the welfare agency, who are endeavoring with all the resources at their disposal to improve living conditions (p.5).

The relationship between low socio-economic status and the IMR was also evident during the time periods of 1930-1932 and 1949-1953 in England and Wales, where the IMR was twice that of the highest social class (Friedman, 1974). Protective factors such as breast-feeding were also found to impact the IMR. For example, in one Canadian location where more affluent women who bottle-fed their babies lived, the IMR was higher compared to poorer women who breast-fed their infants (Appendix 1, Ontario Government, 1987). It was also observed as early as 1967 by Graham-Cumming where First Nations women who made "good use of available prenatal services" that the IMR was not "greatly in excess" to that of the Canadian population (1967b, p.31). Although commonly cited as 'evidence' by hospital birth advocates, the epidemiological data for the IMR suggests that their 'evidence' is ambiguous. Maternal mortality rates were unreliable, as well. It is noteworthy that in the three decades following the hospitalization of women for birth, the rates were higher in this group as compared to women who were attended by midwives in their homes (Appendix 1: Ontario Government, 1987).

3.6 Resistance to Medicalized Childbearing Practices

In the US, despite the efforts of physicians to eradicate midwifery and the acceptance by women of medicalized childbirth, it was not total. Immigrant women, North American Indians and women of color frequently resisted the advances of biomedicine and continued to practice midwifery (Abel & Browner, 1998). There are several distinct types of midwives found in the US. The "granny" midwife of the south and the "parteras" of the southwest continued to practice in the isolated areas where they served the poor and offered little threat to the medical profession. In addition, there are nurses-midwives who have both nursing and midwifery training from accredited schools, as well as "uncertified" midwives whose practice is legal in some states (Trevathan, 1987, p.45).

Midwifery, as we know it today in North America arose from the counter-culture climate of the 1960s and 1970s (MacDonald, 2001).The time of civil unrest in the 1960s created an environment ripe for change. The "power to define reality" that came out of the feminist self-help movement according to Treichler (1990) was the genesis of "alternative health care" for women (p.131). The women's health movement in the US grew out of the women's liberation movement in response to dissatisfaction concerning male dominated obstetrical and gynecological practices (Scully, 1980). The research of anthropologists like Margaret Mead that provided notions of alternative and less intrusive childbearing practices in other cultures (Benoit, 1991) was undoubtedly a source of circumspection for women who were challenging the prevailing biomedical culture. The era saw the evolution of a midwife known as the lay midwife, or as Jutta Mason (1990) refers to her, as the "neighborly midwife"(p.1). Various terms are used to describe what

is commonly termed 'direct-entry' midwives who become midwives without first receiving nursing education (Davis-Floyd & Sargent, 1997). Responsive to a clientele that reflected the period, the midwives coming out of the 1960s era saw themselves as re-creators of the traditional midwife. To avoid being co-opted into the biomedical approach to midwifery, they sought to become midwives through apprenticeship and self-education (DeVries & Barroso, 1996).

Manitoba midwives of this orientation emphasized personalized maternal care, as well as a minimal use of technology. They sought to apply superior observational skills and traditional approaches in their practice of midwifery (Manitoba Subcommittee Midwifery, 1991). Sharpe (1997) observes that from the 1950s onward, consumers began to critique the medicalization of childbirth in Ontario. By 1981, the Ontario Association of Midwives (OAM) was created. In Manitoba, as in other provinces, an important impetus to changing childbearing services came from a consumer demand for them:

> Greater consumer participation in all areas of health care, the demand for more personal birth experiences, more sensitive health care professionals, and the decreased use of dehumanizing technology are all factors which have impacted on the increasing demand for the availability of midwives by the public (Manitoba Sub-Committee on Midwifery, 1991, p.11).

The report does not indicate who the voices of consumers were, whether or not they included those of Aboriginal people. However, in the context of a northern Manitoba First Nations community for example, women demonstrated their resistance to the medicalization of birth by attempting to circumvent the maternal evacuation policy (Guse, 1982).

3.7 The Medicalization of Childbirth in Northern Communities

Health services in the North are described by O'Neil (1988) as "one of the most powerful symbols of colonial relations between northern people and the nation state" (p.47). The colonial model of modernity in health care provision was implemented by the federal government in the 1960s with the construction of a nursing station in every Inuit community (O'Neil, 1990). By the mid-1960s, the nursing station was recognized as the core unit of medical provision among the Inuit (Waldram, Herring & Young, 1997).

O'Neil (1990) observes: "Colonial attitudes permeated the system and policy decisions which fostered cultural assimilation and dependence on southern medical institutions" (p.157). In keeping with this colonialist orientation, the nursing stations served as bases for sending patients south in increasing numbers due to medical reasons for extended periods of time (O'Neil, 1986). (O'Neil's observations of the Keewatin may also be applied in the context of Manitoba and northwestern Ontario since these areas were all included within what was then known as the Central Region of Medical Services Branch, Department of National Health and Welfare). Based on the events that followed, childbirth was interpreted as a medical reason for sending women south. By 1968, 97% of births in the Keewatin took place in hospitals (O'Neil & Kaufert, 1990) and virtually all births were institutionalized by 1982. Whereas prior to 1965 essentially all births in the area took place in Inuit homes with community members and traditional midwives in attendance (Chamberlain, Moyer, Nair, Nimrod, England, & Smith, 1996).

A shortage of qualified nurse-midwives and efforts to reduce the infant and maternal mortality rates (O'Neil, 1988: Appendix 1, Ontario Government, 1987) are among the reasons given for the initiation of the unwritten maternal evacuation policy

that evolved gradually over time (Daviss-Putt, 1990). The initial evacuations that began with high risk women were expanded to include women with first, or three or more, pregnancies. This gradually led to the relocation of all women to hospitals (Appendix 1: Ontario Government, 1987). It was believed necessary for safe childbirth (England, 1996).

O'Neil (1986) observes the PMR in the Inuit population was only slightly improved after the initiation of maternal evacuation. Despite the widespread policy of evacuating women to larger centres for childbirth, the PMR in the North remains higher than in the general population (Robinson, 1990). Significantly, a decrease in maternal mortality is among the benefits demonstrated in the institutionalization of birth the world over (Obermeyer, 2000). However, referring to the medicalization of birth in the Navaho culture, Waxman (1990) observes that while "maternal and infant health, have shown marked improvement some of this improvement can be appropriately attributed to the application of medical technology. It also results however from improved socioeconomic conditions and from improvements in preventative services" (Waxman, 1990, p.199). The relationship between prenatal preventative services and a beneficial birth outcome was observed in an analysis of Canadian Indian births as early as 1956-1965. The study found that the IMR, although demonstrating a downward trend was twice the rate of the Canadian population. However, among those First Nations women who made "good use of available prenatal services," the IMR was not "greatly in excess" compared to Canadian women (Graham-Cumming, 1967b, p.31).

It is ironic that northern Canadian Aboriginal birthing practices were becoming medicalized in the 1960s at the same time that the biomedical birthing model was being

challenged by social movements further south. This tendency to medicalize the birthing practices of indigenous cultures is common the world over (Waxman, 1990). In fact, the institutionalization of birthing practices in indigenous cultures is generally used as an index of modernity (Cosminisky, 2001). O'Neil and Kaufert (1990) observe that among the Inuit, the institutionalization of birth in far-flung urban cities subtly began with the initial relocation of birth from the snow-house to the nursing station.

3.8 Impact of Medicalized Birth in the North

The Royal Commission on Aboriginal Peoples Report (Vol.3, 1996) is among those sources which has observed that the routine evacuation of all pregnant women from northern isolated communities to urban hospitals has profoundly negative consequences culturally, socially and personally for women, their families and communities. The de-centering of childbirth as a family and community event results in feelings of isolation and loneliness for the pregnant woman (Binns, 1990; Guse, 1982; Webber & Wilson, 1993). These feelings are exacerbated by concerns for family left at home (England, 1996; Webber & Wilson, 1993). It is believed that the adverse stress created by maternal evacuation has a negative impact on pregnancy and labor (Binns, 1990). This is consistent with what we know generally of how stress affects women during pregnancy and labor (Klusman, 1975; Crandon, 1979; Hodnett, 1997; Newton et al., 1979; Gorsuch & Key, 1974; Rutter & Quine, 1990). While a linkage in Heaman's study (2001) was not made between maternal evacuation and a "high level of perceived stress" as a risk factor among Aboriginal women for a pre-term birth (p.127), it is conceivable that a correlation may be there.

In addition, profound social and cultural losses have been incurred at the expense of purported improvements in maternal and infant health. The subjugation of traditional birthing knowledge is seen as including a loss of kinship ties. As well, the self-esteem and identity of women is adversely affected (O'Neil et al., 1988). Inuit midwives argue that their culture has been generally undermined as a result of the maternal evacuation policy (O'Neil, Kaufert & Fletcher, 1998). A similar argument is made by the Equay-Wuk's research into northern Ontario First Nations traditional childbearing practices:

> The oppression of traditional midwives by the medical establishment along with the dominance of foreign religions, technologies, education, and other Euro-Canadian institutions have contributed to significant cultural losses and the further erosion of family kinship ties and kinship systems of the Nishnawbe people (Terry & Calm Wind, 1994, p. 82).

3.9 Summary

Current northern childbearing practices have changed to reflect the cultural-social-historical dominance of the Western biomedical childbearing model. Aboriginal cultural childbearing practices have been largely subjugated by the Western biomedical model. The implementation of the maternal evacuation policy by non-Aboriginal health care providers employed by the federal agency responsible for First Nations health care on reserve has resulted in childbearing practices that have created significant losses to the Aboriginal identity and cultural fabric. A re-emergence of subjugated birthing knowledge and a shifting of power and knowledge to some extent from the dominant medical profession to women and organizations continue to challenge Western biomedical birthing practices.

Chapter Four: The Implementation and Practice of Midwifery

4.0 Introduction

In the last 10 to 15 years, midwifery as a viable option for birthing in Canada has re-emerged. Prior to this, Canada had the dubious distinction of being the only developed country in the world without formal provisions for the practice of midwifery (Blais, 2002; Bourgeault, 1999). Rather, each Canadian province had a medical act, generally dating back to the 19th century granting the medical profession control over birthing practices (Benoit, 1991). In this chapter, I will provide an overview of the re-implementation of midwifery in the Canadian and Manitoba contexts and its implications for First Nations.

4.1 Canadian Perspectives on the Resurgence of Midwifery

Speaking to the Canadian context, Bourgeault (1999) posits that midwifery met with success in becoming a "legitimate, self-regulating profession" for several reasons : 1) lobbying by midwives, their supporters and consumers was effective; 2) the professions of medicine and nursing which were significant barriers to the practice of independent midwifery were preoccupied in other areas during this time; and 3) governments were open to alternative ways of providing health care services that reflected public interest and a potential economic benefit (p.1). Canada has received world recognition for the woman-centered midwifery legislation recently enacted in Ontario, British Columbia, and other parts of Canada (Shroff, 1997).

Although some provinces have yet to formally recognize it, midwifery is progressively expanding across Canada with diverse legislation and models of midwifery.

In 1997, Manitoba was the fourth of six provinces to pass midwifery legislation. Four of the six provinces provide publicly funded midwifery services. Scurfield (2002) goes on to argue that while there are many commonalities among the provincial legislations, there are also variations. She observes legislation provides a framework for midwifery to be practiced with the safety of the public in mind while it enables an expression of midwifery that is responsive to the needs of consumers.

4.2 Midwifery Implementation in Manitoba

Beginning in the 1980s, a series of committees and task forces recommended that government re-implement midwifery as an autonomous profession in Manitoba. The Manitoba Advisory Council on the Status of Women in their midwifery discussion paper (1987) recommended the "incorporation of midwifery into the health care system" (p.50). Several questions remained unanswered around the implementation of midwifery and the education of midwives that were addressed by subsequent committees.

The Joint Committee of the College of Physicians and Surgeons and the Manitoba Association of Registered Nurses (formed in May 1990) identified various problems with maternal-child services in their review of the work of previous committees. An area of concern was the need for more comprehensive, preventative and supportive care for marginalized women and adolescents. Aboriginal women and women affected adversely by health and social problems, poverty, geography and environment were among those identified as being in need of such care. The committee also identified a projected shortage of obstetricians as problematic. As previously noted, an important impetus to

changing childbearing services came from consumer demand (The College of Physicians and Surgeons and the Manitoba Association of Registered Nurses, 1991).

The Alternative Health Care Services Task Force Sub-Committee on Midwifery (Manitoba Sub-Committee on Midwifery, 1991) was established by the Manitoba Health Advisory Network Steering Committee "to review alternative health care systems appropriate to reduce expensive health care services without compromising quality of care. One of the potential alternatives cited was the practice of midwifery" (p.2). The Task Force recommended that the practice of midwifery should be legalized. Several concerns remained unresolved. Among them programs for the preparation of midwives, the integration of midwives into the current health care system and a means to evaluate midwifery practice.

In June, 1991, the Minister of Health established the Manitoba Working Group on Midwifery, chaired by Dr. Patricia Kaufert, of the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba. Following an extensive examination of "childbirth literature and of provincial, national and international reports on midwifery" the group recommended that regulated midwifery be legislated in Manitoba (Manitoba Health, 1993, p. 1). Among their recommendations, the working group emphasized that midwives be able to practice in nursing stations and birthing centres. Aboriginal self-government and control over health services were among the issues the working group included in their aim to address the needs of First Nations people (Manitoba Health, 1993). Forty-four recommendations were made that "formed the beginning of the policies that shaped midwifery in Manitoba" (Scurfield, 2002, p.47). Scurfield emphasizes that "their most critical recommendation was that midwifery should

be recognized as a legal autonomous health profession available for Manitoba women and that it should be a service funded by the Manitoba government as an insured health service" (p.47).

In December 1994, the Minister of Health created the Committee for the Equity and Access of the Midwifery Implementation Council (MIC) to oversee the implementation of midwifery in Manitoba. A component of the committee's mandate was to obtain extensive consultations from the Manitoba Aboriginal population regarding their perspectives surrounding the legislation. Where northern Manitoba Aboriginal women were concerned, Freda Albert (1996) initiated and compiled the community consultations on midwifery (on behalf of Manitoba Health) involving more than 200 women from 20 communities, among them Nisichawayasihk Cree Nation. The consultations met with a widespread positive response for a return of midwifery to Aboriginal people and for their inclusion in the forthcoming legislation (Scurfield, 2002).

In his address to the legislature on The Midwifery and Consequential Amendments Act (1997) Hon. Darren Praznik, Minister of Health refers to northern communities and midwifery within a primary care model:

> I am thinking of particularly very remote, isolated communities where it is very impractical to have a physician available all of the time to those communities. Midwifery offers another option for care and delivery in low-risk births. It also develops and strengthens appropriate community-oriented and alternative services for the women of our province. It is also congruent; it focuses on provincial priorities for women, children and Aboriginal people. This initiative also fits with the focus on the development of primary care models within an interdisciplinary practice model (3^{rd}-36^{th}, Volume 029 – Orders of the Day).

Based on the consultations carried out with Aboriginal women, it was decided that there would be no exemption in the legislation for Aboriginal midwives. Instead, on Aboriginal land, Chief and Council would have the authority to decide who might function as a

midwife. However, a midwife would not be allowed to practice off reserve without being registered with the College of Midwives of Manitoba. This approach differs from that of Ontario where Aboriginal midwives working on reserves are exempt from the legislation (Scurfield, 2002).

The Midwifery Implementation Council used the definition of a midwife adopted by the International Confederation of Midwives to develop its own definition and practice of midwifery (Scurfield, 2002). The definition reads:

> A midwife is a person, 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.
>
> She [sic] must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her [sic] own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She [sic] has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She [sic] may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

In Manitoba, midwifery has been established as an autonomous profession. Regarding midwives as primary health care providers the Act reads:

> 2(3) A midwife may, in accordance with this Act and the regulation, engage in the practice of midwifery as a primary health care provider who:
>
> a) is directly accessible to clients without referral from another health profession;
> b) is authorized to provide health services within the practice of midwifery without being supervised by a member of another profession; and

> c) consults with other health professionals, including physicians, if medical conditions exist or arise during pregnancy that may require management outside the scope of the practice of midwifery (Part 2).

Further, the Act defines the practice of midwifery as:

> the assessment and monitoring of women during pregnancy, labour and the post-partum period, and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous vaginal deliveries (Part 2 (1)).

The Burntwood Regional Health Authority, the Manitoba provincial organization that provides midwifery services to the region including Nelson House also envisions the role of the midwife in the region in an empowering context:

> Traditionally, the midwife is not seen as a medical person, but a friend and a support. The midwife has a great advocacy and empowering role to play in the lives of the women she/he encounters. By projecting a positive influence in the woman's life, the midwife can improve the health of the woman and her family for years to come (BRHA, 1999, p. 3).

The Midwifery and Consequential Amendments Act provides multiple routes to meet the four core competencies required for registration with the College of Midwives of Manitoba. Currently, Manitoba is without a university midwifery education program, unlike Ontario, British Columbia and Quebec. Entry to practice to midwifery is gained through an assessment process based on competence, rather than on the ability to produce a certificate (Scurfield, 2002). While the Act does not indicate a preference for a type of midwifery education program, the Manitoba Working Group on Midwifery (Manitoba Health, 1993) suggested that a four-year Baccalaureate program in midwifery for entry-to-practice would reflect the skills required for an autonomous professional. The strategy behind recommending multiple routes of entry into midwifery was to more optimally reflect the various strata and women in society. Decentralized education was seen as a

means by which women from northern communities might more optimally access a midwifery program.

Although midwifery itself was slowly being reintegrated into the mainstream the issue of home-birth remained very contentious. It was broadly included under out-of-hospital births. This designation also encompassed births in birthing centres (Scurfield, 2002). The Midwifery Regulation that reads: A midwife shall comply with the standards of practice approved by the college, including standards concerning out-of-hospital births (Section 15(b)) makes it clear that the same standards of midwifery care apply in this setting.

The legislation of midwifery in Canada and specifically in Manitoba has provided a means to explore childbearing alternatives for women. Aboriginal midwifery legislation in this province through the Kagike Danikobidan Committee ensures a means for Aboriginal women to participate in the continuing evolution of midwifery education and practice. In its diversity, midwifery provides a mosaic of choices that responds to the needs of women. The Midwifery and Consequential Amendments Act provides an opportunity for the creation of a diverse expression of midwifery. The differing models of midwifery find their expression in community midwifery with its de-emphasis on technology, nurse-midwifery, commonly seen as a more biomedical approach to midwifery, and the direct-entry university-educated midwife. All midwifery models subscribe to a more personalized, interactive approach surrounding the events of normal childbearing. Ideally, within this framework, Aboriginal women will be able to exercise their autonomy in a manner that optimally reflects their needs.

4.3 Midwifery as an Alternative for Women

Generally, rigorous research studies affirm that midwives deliver safe care, economically (Mitchell, 1989). Midwifery is a safe and holistic approach to childbearing services for women whose pregnancy and childbirth falls within a normal continuum. This emphasis by midwifery on the care of low-risk pregnancies is also a means of de-medicalizing birth (McCourt 1986). Research over a period of 70 years has shown midwifery care to be "not only safe but also exceptional in positive maternal and infant outcomes" (Kennedy, 2000, p. 4). Care by midwives has especially been found to excel where low risk women are concerned. (Buhler, Glick & Sheps, 1988; Harvey, Jarrell, Brant, Stainton & Rach, 1996; Manitoba Sub-Committee on Midwifery, 1991). This is an important consideration given that childbearing is a normal life event. It does not place most women at risk for an adverse outcome. It is reasonable then to assume that midwives are in a unique position as primary care providers to best meet the needs of childbearing women.

4.4 Midwifery and the Use of Technology

The fact that midwives are uniquely situated to provide primary care to low risk women does not preclude a role for technology in their practice. However, the role of technology in the care of pregnant and birthing women is a controversial one. Oakley (1993) refers to the "technological imperative" in obstetrics as remaining dominant and problematic. An increase in technologies such as "induction of labor, electronic fetal heart-rate monitoring, ultrasound, episiotomy and Caesarean section" has increased over the last 20 years, although randomized controlled trials do not justify their intervention

(p. 80). Sawicki (1991) maintains that while radical feminists take an altogether negative approach to technology, there are many instances where technology may be of benefit. The Manitoba Working Group on Midwifery's (1993) report emphasized that the use of technology may have either a positive or negative impact on the childbirth experience. The report suggested the routine use of some technologies such as fetal monitoring increases the number of caregivers involved in the birthing event and aids in making the birth a medical experience. They maintained, however that it is not the aim to eliminate technologies but to use them with prudence.

According to the Manitoba Working Group on Midwifery report, the re-introduction of midwifery into the Manitoba health care system may lessen the use of technology surrounding birth, since midwives advocate the use of minimal technological interventions (Manitoba Health, 1993). Midwives are generally less inclined to intervention while at the same time, showing no significant difference in rates of mortality and morbidity (Mitchell, 1989). A study by Harvey and colleagues (1996) demonstrated that midwifery care involved not only "less technologic assessment and fewer interventions" but also "shorter hospital stays, fewer neonatal intensive care unit admissions, and less maternal morbidity" (p. 134). However, where women are concerned, the role of technology in communities like Nelson House is also influenced by the biomedical birthing culture that has evolved locally. Lock and Kaufert (1998) argue that "historical, cultural and political" events not only produce biomedical technologies but the responses of women to them (p.2).

4.5 Aboriginal Childbearing Models in Canada

Currently, there are two well known birthing centres in isolated locations in Canada among the Inuit population. The Inuulitsivik Maternity Centre, located in Povungnituk in the Ungava region of northern Quebec (referred to simply as 'POV' by community members) opened its doors in 1986 (Stonier, 1990). It is a small unit located inside the Innuulisivik health centre. Perinatal care is not limited to midwives, midwives in training and maternity workers. It is also carried out by nurses and physicians. In 1996, approximately 20% of the women who birthed at the centre were from Povugnituk. The majority of women (80%) are evacuated to the centre at 38 weeks gestation from the six surrounding communities (Chatwood, 1996). The birthing centre has shown to be a "great success" (RCAP, Vol.3, p. 136). The Equity Committee of Ontario suggested that POV's birthing centre serves as a model where traditional and biomedical approaches have been well integrated (Schroff, 1997).

A birthing centre was located in the nursing station in Rankin Inlet, NWT (500 km North of Churchill, Manitoba and 250 km east of Yellowknife, NWT) in 1994 so women might give birth in the their community (Chamberlain, 1996; Morewood-Northrop, 1997). The impetus for it arose in response to strong community support (Scurfield, 2002). The facility employs three midwives, two Inuit maternity workers, and a clerk-interpreter (Carroll & Benoit, 2001). Hospitals in Winnipeg (1002 km by air) provide high risk care (Level 111). Twenty-four births took place at the birthing centre in the study period of March 31, 1995 to March 31, 1996 (Chamberlain, 1996 et al.,).

The infrastructure of the Inuit birthing centres differ in several ways from that in Nelson House. Both Inuit centres have a physician on site. Both centres access hospital services by air where an emergency Caesarean section or neonatal care is available. On the other hand, Nelson House women can access these services at the Thompson General Hospital (a level 11 facility, approximately 75 km by ambulance on an all weather road).

The Six Nations of the Grand River, Ontario is home to a First Nations birthing centre named "Tsi Non: WI Ionnakerastha" (The Place They Will Be Born). Founded in 1996, this maternal and child centre is 20 minutes by road from a hospital in Brantford, Ontario. In this province, unregistered Aboriginal midwives may provide services to Aboriginal families on and off reserve. However, if they are not registered, they are unable to provide services in hospital, or to write prescriptions. Some women from this community have traveled to the Maternidad El Luz in El Paso, Texas for their midwifery education. Upon returning home, they undertook additional training at the birthing centre before becoming eligible to practice. No published studies currently exist on birth outcomes at this centre where, on average, 40 births take place yearly (personal communication, June 4, 2001). NCN is similar to Six Nations of the Grand River, Ontario in that both communities are First Nations and are approximately the same distance by road to a hospital.

4.6 Is Birth Safe in Northern Communities?

The Inuulitsivik Maternity Centre recognizes that risk has both medical and cultural components (Paulette, cited in Chatwood, 1996). Stonier (1990) maintains that

screening for risk occurs through prenatal care and teaching. Small numbers and different time periods make it difficult to compare the perinatal mortality rates. However, the findings suggest a positive trend supports the impression that childbirth takes place safely in POV (Stonier, 1990). For example, in the five years after the centre opened (1987-1991) there was no perceptible change in the PMR. That there were fewer interventions taking place during birth is of particular note. A perinatal committee which includes all caregivers has been established at POV to review the progress of a woman's pregnancy and care and to assess the risk involved in birthing there (Daviss, 1997).

Chatwood (1996) carried out the POV study (1989-1991) analyzing data for 411 women (using descriptive statistics). Three hundred and fifty women (85.2 %) of the births took place at the Inuulitsivik Maternity Centre. Seventeen births (4.1 %) occurred in one of the surrounding nursing stations. Forty-four (10.7 %) of women were transferred from the Inuulitsivik Maternity Centre. Clinical conditions were responsible for the majority of transfers (80 %). Premature labor (61.4 %) was the most prevalent variable in the transfer group. The study could not determine whether the Inuulitsivik Maternity Centre perinatal committee or the clinical staff at the time of emergency was responsible for transfers. It appeared that the higher rate of neonatal complications in the transfer group reflected an overall high level of functioning of the maternity staff. Chatwood observes that the defining of risk in a northern setting which would clearly indicate reasons for a transfer appears to be an unlikely goal. She suggests that due to the "clinical variability in pregnancy and the logistical problems which present in the North, it is unlikely that clear guidelines are a realizable goal" (p.93). Rather, local staff training and cooperation that combines both "logistical and cultural considerations with

biomedical parameters" (p. 94) is a more reasonable aim. Logistical factors such as transferring women by aircraft are not a consideration for Nelson House. However, the approach to transferring women in POV would appear to be one that could apply to northern communities like Nisichawayasihk Cree Nation, where the aim is to incorporate safe, culturally appropriate childbearing practices.

A preliminary study in 1995 of the Rankin Inlet pilot project birthing centre indicated that midwife-attended low-risk births were safe. The study also found that women who were attended by a midwife were more satisfied than those who went to a hospital to give birth (Chamberlain et al., 1996). According to England, (1996) the first two of the three goals have been met: 1) low risk births take place safely in Rankin Inlet; and 2) the community is satisfied with the midwifery practice offered. The third goal, financial feasibility, was not evaluated because the numbers were too small.

4.7 Safety of Out-of-Hospital Births

The safety of out-of-hospital births is a controversial issue. A long tradition in North America of hospital-based births has made out-of-hospital births suspect, if not irresponsible in appearance. Indeed, the numbers are low; in 1999, out-of-hospital births accounted for 0.6 % of all Manitoba births according to the *Perinatal and Maternal Welfare Committee Annual Report* (College of Physicians and Surgeons of Manitoba, 1999). A storm of controversy met the establishment of the Maternity Center Association (MCA), the first free-standing birthing centre in the US in New York City in 1975. Feminists maintained a milestone had been achieved in "woman-centered birth" while

some physicians labeled this alternative as "baby killing" and a "disgrace to modern obstetrics" (Treichler, 1990, p. 124). However, wide-ranging studies of out-of-hospital births do not support such a negative response. Out-of-hospital births attended by midwives are found to be safe and advantageous where low risk women are concerned (Albers & Katz, 1991). An important study, the National Birth Center Study of 11, 814 low risk women who sought care in freestanding birthing centres in the US found health outcomes were excellent. Less use of childbirth procedures and lower costs were additional advantages. Certified nurse-midwives attended the majority of the births (80.6 %). Most of the remaining births were attended by physicians and uncertified midwives (Rooks et al., 1989).

Fraser and colleagues (2000) compared process and outcome in Quebec pilot projects (birthing centres) to those of hospital-based medical services. The study found midwifery care to be less interventionist and to have lower indicators in some areas of morbidity. Blais (2002) reports that a home-birth study in British Columbia had comparable outcomes to the Quebec study. Both studies raised a concern around neonatal outcomes (a trend toward more stillbirths and a higher need for neonatal ventilation), although the outcomes were not statistically different from hospital births. Several problems were noted by the Quebec government-appointed panel relating to midwifery care, including:

> difficulty experienced by midwives in recognizing an abnormal condition or their failure to act appropriately following identification of a problem, delays encountered in accessing specialized care when faced with emergencies, and ambiguous definition of midwives' and physicians' responsibilities when transfer of care and joint follow-up have taken place (p. 335)

Blais suggests that the recommendations coming from the expert panels associated with these studies should be disseminated to other provincial sources so that measures "can be taken to avoid problems before they arise" (p.336).

An argument for community-based birthing in First Nations communities is put forward from several sources. Manitoba First Nations women's views were similar to those expressed in Ontario (Albert, 1996). Based on interviews carried out by the Equity Committee of Ontario, Aboriginal community members and non-Aboriginal health care providers alike maintained low-risk women would fare better to birth in the communities with community based midwives (Schroff, 1997). In every community that members of the Equity Committee of Ontario visited, they were repeatedly told low risk women could birth in the community. This view is in keeping with the ideology of Canadian midwives who aspire to provide primary care to low risk women (Rice, 1997).

4.8 Summary

The re-implementation and practice of midwifery in Canada and specifically Manitoba has created many more opportunities for women to give birth in a way that reflects their autonomy, beliefs and values. The Midwifery and Consequential Amendments Act in its inclusion of a Mandate for a Standing Committee on Aboriginal Issues Relating to Midwifery Care (Kagike Danikobidan Committee) was an important milestone for Aboriginal women toward achieving alternative community-based midwifery practices. Studies concur that the practice of midwifery is a safe, viable alternative for women. Birth centres among the Inuit also demonstrate how community-

based birthing centres can meet the needs of Aboriginal communities, safely. Positive indicators surrounding out-of-hospital births make community-based birthing centres an increasingly optimistic alternative for Aboriginal communities like Nisichawayasihk Cree Nation.

Chapter Five: First Nations Health and Health Care Organization

5.0 Introduction

Health care services in isolated First Nations communities reflect historical relations between Aboriginal peoples and the federal government that provides primary health care. They also reflect the environmental reality of an isolated geography in northern latitudes. How these circumstances intersect to meet the health care needs of Aboriginal peoples is made more complex by provincial jurisdictional roles and responsibilities for the provision of health care to all Manitobans, First Nations included. In this section, I explore health and health care services to be considered in the development of alternative childbearing services in NCN. These include: 1) organization and control of health care services; 2) the ideology of health and primary care; 3) social-demographic perspectives of First Nations, specifically women; and 4) antenatal care perspectives.

5.1 Organization and Control of Health Care Services

Since the early 20th century the federal government has been primarily responsible for providing health care to First Nations on reserve. Since July 2000, the agency working in this role under the auspices of Health Canada refers to itself as First Nations and Inuit Health Branch (FNIHB). Despite its historical role, however, the federal government does not acknowledge any constitutionally mandated legal or financial obligation for First Nations health; these services are provided simply as a matter of policy. First Nations, on the other hand, assume they have the right to health services from the federal government based on the Royal Proclamation of 1763 and the Treaties

(Assembly of First Nations, cited in Culhane Speck, 1989). Furthermore, First Nations people believe the loss of lands and resources and the health problems associated with colonization justify their right to special health services, as minimal compensation. The federal government's historical provision of such health care services lends support to the notion that it acknowledges its responsibility and obligation to First Nations people (Culhane Speck, 1989).

The British North America (BNA) Act (The Constitution Act of 1867) established the federal government's jurisdiction over the affairs of Indian people. Section 91 of the Act indicates that the Indians and Lands were the responsibility of the federal government. Section 92 ascribed health-related institutions and organizations as a provincial responsibility. Krasnick (1991) argues that the Fathers of Confederation wanted Indian people to consider them-selves "federal citizens." He further argues that Section 91 (24) "does not mean that the Fathers of Confederation believed Indians could not govern them-selves." However, the same section (Section 91 (24)) gave the government the right to regulate Aboriginal government. Clearly, these various perspectives in the BNA Act are contradictory and confusing, especially where responsibility for First Nations health care is concerned.

Treaty No. 6, signed in 1876, proved to be a controversial treaty in reference to health care. It contains the following clause that would form the basis of dispute in succeeding years: "That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent." Aboriginal peoples interpret this clause to mean a right to health care from the federal government. The federal government, on the other hand, has succeeded in court proceedings in arguing that

health care is not a right for Aboriginal peoples but a policy of the federal government (Waldram, Herring & Young, 1997). In the same spirit, in a 1967 Medical Services Branch report, Rath, M.D., M.P.H., a physician refers to the government's responsibility for the provision of health care to First Nations as based on a "moral" as opposed to a "legal" obligation (Rath, 1967, p. 1). He emphasizes that it is a "common misconception that Indian and Eskimo people are legally entitled to such services which have been traditionally supplied by the federal government" (Rath, 1967, p. 9). Historically, the Manitoba government has taken a "hands off" policy to First Nations health care summarized by the refrain, "that is Ottawa's responsibility" (Manga & Lemchuk-Favel, 1993, p. 120). Unlike their Ontario counterparts, Manitoba First Nations prefer only to negotiate with the federal government (Manga & Lemchuk-Favel, 1993).

Successive legislation has broadened and included the role of the provincial governments in the provision of First Nations health 3care in an attempt to standardize health care for all Canadians. This has been achieved by various Acts, including: the Hospital Insurance and Diagnostic Services Act (1957); the Medical Care Act (1966); the Established Programs Financing Act (1977); and the Canada Health Act (1984) (Manga & Lemchuk-Favel, 1993). An important additional program for the Aboriginal population is the Non-insurable Health Benefits (NIHBs). NIHBs include health insurance premiums, transportation for patients, drugs, dental care, eyeglasses and prosthetic devices (Manga & Lemchuk-Favel, 1993; Waldram et al., 1997). The NIHB budget is frequently cited as being excessive, with medical transportation costs as one of the largest expenditures (Waldram et al., 1997). Transportation costs that are considered to be excessive merit attention in view of expenses resulting from the maternal evacuation

policy. The complexity of the organization and financing of First Nations health care notwithstanding, the federal government's reluctance to accept legal responsibility for it raises important issues for the re-implementation of midwifery services in First Nations communities.

Following years of controversy and reports recommending the furtherance of First Nations self-determination, generally and specifically, in the area of health, such as those of Berger (1980) and Penner (1983), the federal government moved to give administrative control to First Nations people for their health services. The intention to transfer control was announced by the Hon. Jake Epp, Minister of National Health and Welfare, in April 1986 and approved by Cabinet in March 1988. The decision to initiate the transfer or not was left with each band. According to Culhane-Speck (1989), the transfer proposal is contentious in that it allows the federal government to abdicate its responsibility for health care to First Nations. Indeed, First Nations leaders questioned the transfer of health services that are designed by a non-Aboriginal bureaucracy without adequate recognition of Aboriginal cultural orientations or understanding of the communities it was intended to serve. In addition, they suggest that the financial restraint surrounding both the initial transfer process and the ongoing control of real financial power by government sources undermines First Nations goals of self-determination, as well as the ability to create a responsive, locally-based model of health care (Thompson, 1993).

According to O'Neil and Postl (1994), self-determination in reference to health services has important implications for "the health of Aboriginal peoples" (p. 67). Dickson (2000) points out the theory that "social participation, self-determination, self-

reliance, and empowerment enhance health and well-being and these phenomena are cornerstones of primary health care, community development, and health promotion" (p. 188). Despite the concerns over transferred health services, a number of First Nations communities are succeeding with band-controlled services (see Thompson, 1993; Angees, et. al. 1999; Moore, Forbes & Henderson, 1990).

In Manitoba, 30 of 62 First Nations have transferred some aspects of health services since the process began in 1989. All First Nations communities have administrative control of community-based programs, such as the National Native Drug and Alcohol Abuse Program (NNADAP), through a contribution agreement (federal funding provisions). Since the early-mid 1990s, the transfer process has decreased substantially. This is believed to be primarily due to apprehensions on the part of First Nations around funding issues. Only one of the 22 isolated communities where nursing stations are the mainstay of health care has assumed administrative control of primary health services. Nisichawayasihk Cree Nation has assumed administration for the Nelson House Medicine Lodge (FNIHB management, personal communication, November 4, 2002). In addition, NCN administers public health services.

Provincially, Nisichawayasihk Cree Nation is within the provincial jurisdictional area of the Burntwood Regional Health Authority. The BRHA includes approximately half of the province geographically (543, 900 square km) in its region but only four percent of the provincial population (BRHA, 1998).

The nursing station is the only medical facility in an isolated First Nations community. Patients seeking health care in these communities are generally attended by nurses (acting in the role of nurse-practitioners) employed by the federal government. By

necessity, they assume the roles of several health care professionals and provide a variety of services (Canitz, 1990; Chaytor Educational Services, 1993; Ferrari, 1976; Martin & Gregory, 1996). They are frequently described as functioning "essentially as doctors" (O'Neil, 1988, p. 38). It is generally accepted that nurses are the most appropriate primary care providers in isolated communities (Stewart & Procyk, 1994). The scope of a practice of a northern nurse includes diagnosis, treatment, prescribing of medication from a formulary, carrying out laboratory and x-ray work, and a wide range of duties related to health care in collaboration with other health professionals. Liability for northern nurses who are employed as nurse practitioners is assumed by the federal government. The College of Registered Nurses of Manitoba takes the position that nurses who are federally employed in the nurse practitioner role in isolated communities are working within a nursing scope of practice (Legislation Committee discussions [as committee member], 1999- 2000).

It is recognized that northern nurses provide primary prenatal and postnatal care. In addition, they are frequently the only caregivers available in the event of pregnancy complications or in the case of a birth (Ontario Government, 1987). Dooley and Mundy (1990) observe that in Manitoba and the Keewatin, 86 % of isolated nursing stations do not have a permanent physician in the community. Access to a practitioner, be it a general practitioner or obstetrician is dependent on the availability and practice of the physician. "In many of these isolated communities, the first person to treat an emergency is a nurse acting as a nurse practitioner" (p. 191). The wide-ranging scope of practice of the northern nurse, as someone who assumes a medical role in isolated communities has important implications for how relations with midwives will evolve. While not speaking

directly to the issue of northern nurses in the nurse practitioner role, Van Wagner (2001) posits that in general nurses might be involved in midwifery births in the way of second attendants to accommodate the needs of midwives and to utilize health care resources effectively. She emphasizes that the midwifery model should be appropriately flexible to meet the needs of the individual woman and the health care system.

5.2 The Ideology of Health and Primary Care

How health is holistically conceptualized by Aboriginal people has a direct bearing on childbearing women, if one is to believe that pregnancy and childbirth are not medical problems. First Nations people have traditionally regarded health as encompassing all aspects of individual and collective life, including the social, natural and spiritual domains (Culhane Speck, 1989). Lesley Malloch (1989), an Ontario Aboriginal woman contrasts a holistic perspective of health that has its origins in the Creator with ill-health:

> Good health is a gift from the Creator ....Good health is a balance of physical, mental, emotional and spiritual elements. All four interact together to form a strong, healthy person. If we neglect one of these elements, we get out of balance and our health suffers in all areas. For example, a troubled mind or spirit may cause sickness in the body; a poorly nourished body may weaken a person's mental function or contribute to mental illness. (p. 106).

Malloch's integrated perspective of health is not one that can be achieved by optimal health services alone such as those around childbearing. The Royal Commission on Aboriginal Peoples observed that social determinants are believed to have a more significant impact on the health of Aboriginal peoples than do health services and individual lifestyle choices (RCAP, Vol.3, 1996, p. 216). A Medical Services Branch report recognized this fact as far back as 1967:

> There is a direct correlation between the health of the people and their socioeconomic status. It follows therefore, that the health status of the Indian people will reach a plateau and will not continue to improve until such time as their socioeconomic situation is improved considerably; it is this major problem that the Indian Affairs Branch and the Department of Citizenship and Immigration, in conjunction with the provincial welfare agencies, is seeking to improve (Rath, 1967, p. 4).

A recent Manitoba report concurs that health services alone are not sufficient to meet the health needs of Aboriginal peoples (Martens et al, 2001). Instead, broader initiatives are seen as necessary for optimizing health, including the realization of First Nations self-determination, economic resources, improved living conditions, and a supportive role by the Canadian public (Culhane Speck, 1989).

The World Health Organization (WHO) endorsed a broad approach to health in its 1978 *Alma-Ata Declaration*. Here, it envisions health as a "state of complete physical, mental and social well-being, and not merely the absence of disease" (WHO, 1978). By extension, where the re-implementation of midwifery in First Nations communities is concerned, it is important to consider that a change in services alone will not improve the health status of childbearing women. Instead, the aim is to achieve a holistic perspective of childbearing health illustrated by the Medicine Wheel concept described below:

> The lines intersecting at the centre of the circle signify order and balance. They help people examine experience by breaking down complex situations into constituent parts, while reminding them not to forget the whole. The centre of the circle is the balance point where apparent opposites meet. The flags at the ends of the intersecting lines signify the four winds whose movement is a reminder that nothing is fixed or stagnant, that change is the normal experience and transformation always possible (RCAP, Vol.1, 1996, p. 647).

5.3 Social-Demographic Perspectives

As the concept of the Medicine Wheel suggests, a demographic description of First Nations health status and population distribution requires that we examine complex situations from their constituent parts. According to a Manitoba 2001 report, between 1994 and 1999 there were 97,635 Registered First Nations in Manitoba, with similar distributions between male and female. In 1999, the Registered First Nations population was 7.63% of Manitobans. In 1998, 57% of RFN were living 'on reserve.' In the same year, 39% of RFN were under the age of 15 years old as compared to 20% in the general Manitoba population. This report suggests undercounting is due to not including Manitoba band-affiliated First Nations living out-of- province; therefore, many First Nations living in Manitoba who have band affiliation elsewhere were not counted because the information was missing from the data base (Martens et al., 2001).

Generally, Aboriginal Canadians have a disproportionately poorer state of health than the general population (Tookenay, 1996). While patterns of morbidity and mortality are decreasing in such areas as infectious diseases, there is an increasing incidence and prevalence in chronic and lifestyle related diseases (Health Services Review Committee, Subcommittee on Indian Health Care, 1985). The life expectancy of Registered First Nations females (73.2 years) is eight years lower than the life expectancy of all other Manitoban females (81.4 years) (Martens et al., 2001). The large Aboriginal population in the BRHA region is described as similar to that of developing nations, where infectious diseases like tuberculosis emerge as community outbreaks. The BRHA recognizes that without improvement in community infrastructures, such as housing, plumbing and running water, the current health status of the Aboriginal population is not

expected to change significantly (BRHA, 1998). Oakley (1993) suggests there is a need to explain the problem of differences in social classes relating to socio-economic determinants rather than only to identify them. Socio-economic determinants are generally recognized as contributing to risk in pregnant women (Oakley, 1993; Parboosingh, 1986).The Registered Indian birth rate according to Indian and Northern Affairs Canada (INAC) is double the Canadian average (27/1000 as compared to 13/1000) (Canada, INAC, 2002). Manitoba had a higher fertility rate (42.4/1000) in the adolescent group than the general Canadian population (26.6/1000) in 1990 and even higher in the Aboriginal treaty status adolescent (71.2/1000) as compared to the non-Aboriginal population (31.3/1000) (Postl, 1995).

Several determinants of health around birth in the BRHA reflect a need for more optimal childbearing services. Caesarean sections (C-section) are often seen as reflecting a medicalized birth. Compared to the First Nations in the area, the C-section rate is 1.3 to 1.5 times higher in the general non-Aboriginal BRHA population. The higher incidence of C-sections among Manitoban women as compared to Registered First Nations women is reflected in most regions of the province (173 versus 142 per thousand). The lower C-section rate in the First Nations population in the BRHA may reflect the younger average age of First Nations women as compared to non-Aboriginal women. It has been observed that the C-section rate is lower among younger women (Martens et.al., 2002). The Manitoba C-section rate increased three percent in 1994/94 to 18% in 1999/2000 (College of Physicians and Surgeons of Manitoba, 1999). The World Health Organization is among those organizations that cite 10 to 15% as a recommended rate.

Breastfeeding is associated with a decrease incidence of "otitis media, respiratory infections, gastrointestinal illnesses, increased cognitive development, lower incidence of diabetes and few hospitalizations" (Manitoba Health, 1999, p 34). Disconcertedly, breastfeeding rates (57.1% versus 80.5%) are lower in First Nations as compared to all other Manitobans at the time of hospital discharge. Breast-feeding rates are slightly higher among women who live on a reserve as compared to First Nations women who do not (60.5% versus 54.3%) (Martens et. al., 2001).

Sudden Infant Death Syndrome (SIDS), accounted for 18% (age 29 days to 14 years) of Manitoba childhood deaths in 1990 (Postl, 1995). An increased relative risk (RR) of 3.09 for the incidence of SIDS in the Aboriginal population is believed to have more socio-economic origins than familial ones (Moffat, Gray & Postl, 1988). Prenatal alcohol exposure, however, was not found to be a risk factor for SIDS, according to Manitoba study (Burd, 1997). The impact of dose-response relationships and exposure during different periods of pregnancy could not be excluded as potential risk factors.

The Burntwood Regional Health Authority population is 60% Aboriginal of the approximately total population of 45, 000 in the area. The region has the highest population in the province younger than 15 years of age. Currently, nearly one half of Aboriginal people are under the age of 20 years (BRHA, 1998). Health indicators reflect the demographics of this young population: sexually transmitted illnesses and teen (ages 15-19) pregnancy rates exceed those of other regions (144.7/1000 as compared to 64.6/1000) (BRHA, 1999).

Deaths due to violence and accidents remain elevated in the Aboriginal population (Young, 1988). The Manitoba First Nations Regional Survey (Manitoba First

Nations Regional Health Survey, 1998) determined that 47% of First Nations people believed that alcohol abuse is a problem in their household (p. 42). The extent of alcohol consumption in the childbearing population is difficult to determine. Instead, an approximation of alcohol abuse is estimated by the social and physical effects. The BRHA speculates that reported high rates of fetal alcohol syndrome/effects (FAS/FAE) indicate a high prevalence of alcohol abuse (BRHA, 1998). The Royal Commission on Aboriginal Peoples report observes that the extent of FAS/FAE in Aboriginal communities is unknown (RCAP, Vol.3, 1996). The effects of alcohol use during pregnancy on the fetus are believed to produce a continuum or range of symptoms rather than an all or nothing effect. The principal characteristics of the syndrome are evident in altered facial features, central nervous system dysfunction, and growth deficiencies. A focus on alcohol use during pregnancy arose in the 1970s with the increased emphasis on fetal alcohol syndrome (FAS). The term FAS was coined in 1973, by Jones and Smith, based on their observations of 11 children with malformations believed due to alcohol consumption during pregnancy (Clarren, 1988). The term fetal alcohol syndrome has recently been changed to fetal alcohol spectrum and includes fetal alcohol effects.

A study by Williams and Gloster (1999) carried out in the City of Thompson, included First Nations men and women from 21 surrounding reserves. It found a majority of women (51%) reported using alcohol in one or more of their pregnancies, 10% reported sniffing solvents, 61% reported smoking tobacco, and 39% reported using other drugs. Eighty percent believed that alcohol consumption during pregnancy could be harmful to the fetus although there was relatively low level of knowledge of FAS; 61 % of the respondents believed there is a safe amount of alcohol that can be consumed during

pregnancy. Thirty-six percent had prior knowledge of FAS, with a higher level of knowledge among younger females. There also appeared to be a low level of knowledge between drug use and effects on pregnancy. The authors suggest more education is required but the study does not support education alone as sufficient to overcome these problems.

The high incidence of smoking (61%) among pregnant First Nations women is of concern (Williams & Gloster, 1999). It is well known that smoking has harmful effects on the fetus. It has been identified as the most significant contributor to low birth weight in developed countries (Shipp, Croughan-Minihane, Petitti, & Washington, 1992). Smoking the month prior to pregnancy and inadequate prenatal care were among risk factors for pre-term birth according to a Manitoba study of Aboriginal and non-Aboriginal women (Heaman, 2001). In addition, the study found that: "Risk factors for Aboriginal women included rupture of membranes before labor, high perceived stress, and anemia, while age less than 19 years and single marital status were protective factors" (p. iii). Importantly, "there were no associations between alcohol use or recreational drug use during pregnancy and preterm birth" (p.73). A study in Spokane, Washington found that "mothers of all races, age, socioeconomic, and educational backgrounds use illicit drugs during pregnancy;" however, "there is a greater association of maternal complications with tobacco use compared to drug use" (Shogan, Seaburg, Knight & Hedaya, 1997, p. 12).

Smoking, from a First Nations woman's perspective may be also be seen as means whereby a woman "acts out her responsibility to that child...to everyone for whom she cares, as smoking helps her to cope and to claim some authentic activity and

personal space in an otherwise crowded and impossible life" (Oakley, 1993, p. 136). This may be especially applicable to northern First Nations women, given their need to cope with the multi-faceted problems related to colonization like issues surrounding poverty.

Manitoba on-reserve perinatal mortality rates (PMR), neonatal mortality rate (NMR) and infant mortality rate (IMR) during the period 1985-1999 were as follows: PMR 15.9/1,000 total births; NMR: 6.4/1,000 live births; IMR 11.9/1,000 live births (First Nations and Inuit Health Branch (Data File) 2003). The *Perinatal and Maternal Welfare Committee Annual Report* for 1999 indicated the PMR was 9.1/1,000 births with a three-year average of 8.4/1,000 births. The report concluded First Nations women were 1.4 times as likely to have their baby die in the perinatal period as compared to other Manitoba women. This rate is lower than the average (2.4 times) for 1996-98. The 1994-98 Canadian PMR was 6.7/1,000 births as compared to 7.5/1,000 births in the Manitoba population. The report concludes that the higher PMR among First Nations is related to "poor socio-economic status and limited access to appropriate health care services. Nutritional factors including low folic acid intake and metabolic factors including diabetes are more common in these women" (College of Physicians and Surgeons of Manitoba, p.26). (The name of this committee was changed to Maternal & Perinatal Health Standards Committee in 2001).

5.4 Antenatal Care Perspectives

Researchers have found that antenatal care as a primary health care service is beneficial to the outcome of pregnancy (Graham-Cumming, 1967b; Lia-Hoagberg, Rode, Skovholt, Oberg, Berg, Mullett & Choi, 1990; McDonald & Coburn, 1988; Mustard,

1993; Norwood, 1994). It is a means to assess the progress of pregnancy (Binns, 1990; Mustard, 1993) and an opportunity to provide preventative care (Wotton & Macdonald, 1982). Pregnant women are generally expected to frequent antenatal care monthly until the seventh month and bi-weekly until the ninth month, during which time weekly visits are suggested. Controversy remains as to the number of visits deemed prerequisite for adequate antenatal care (Hall, Chng & MacGillivray, 1980). A definite relationship has been shown to exist between the utilization of antenatal care and the reduction of infant mortality among First Nations as early as the 1960s (Graham-Cumming, 1967b).

Lack of antenatal care is suggested by Hall (1994) as one of the most significant risk factors predictive of an adverse outcome. Low utilization of antenatal care is usually only identified following childbirth. Notwithstanding, an awareness of problems identified during pregnancy can lower the risk of an adverse outcome. Binns (1990), an obstetrician, observes that a woman may be scored as high risk in early pregnancy but with prenatal interventions the risk level of a poor outcome can be lowered.

According to two studies of northern Manitoba First Nations women, antenatal care was well utilized on average (Hiebert, 2001; Young, Horvath & Moffat, 1989). These findings do not reflect antenatal care utilization generally among the socially disadvantaged. In this group, antenatal care is frequently less utilized (Cooney, 1985; Donabedian & Rosenfeld, 1961; Greenberg, 1983; Norwood, 1994; Mustard, 1993). Three earlier studies involving Aboriginal women found that antenatal care was under-utilized (Graham-Cumming, 1967b; Hildebrand, 1970; Wotton & Macdonald, 1982). In addition, a recent Manitoba study found Aboriginal women initiated antenatal care later and utilized it less often (Heaman, 2001). A dislike of vaginal exams and babysitting

problems were identified as barriers to the utilization of antenatal care among urban Winnipeg First Nations women (Sokoloski, 1995). This study found some of the women perceived antenatal care as being valuable, while others did not. They also believed pregnancy to be a natural event that did not necessitate antenatal care unless problems with the pregnancy arose.

What we find in these studies is that the means of delivery of antenatal care is according to the current Western model norm. The studies explore reasons why women may or may not utilize antenatal care. The studies do not examine whether the way antenatal care is provided is appropriate for women, especially Aboriginal women. An American study of Aboriginal women found that the primary reasons for the under-utilization of antenatal care were due to the Westernization of childbearing practices, substance abuse and domestic violence (Long & Curry, 1998). Where the initiation of antenatal care is concerned, Berenson and colleagues concur that women who are abused during pregnancy are more likely to initiate antenatal care during the third trimester (Berenson, Wiemann, Wilkinson, Jones & Anderson, 1994). These factors point to the effects of colonization and a need to develop childbearing services that are more congruent with the culture and the needs of Aboriginal women. NCN's aim to re-establish community-based midwifery is means to address issues arising out of colonization around childbearing including by extension Western health services.

5.5 Summary

The complexity of northern health care services in an isolated environment requires consideration as to how federal and provincial organizations might ultimately be able to meet NCN's aim to achieve alternative childbearing practices. The role of the

northern nurse, as someone who provides the majority of primary health care and emergency services in isolated communities has implications for how the role of the midwife as a new primary health care provider will be integrated. An Aboriginal ideology of health concurs in spirit with that of the World Health Organization (WHO) Alma –Ata Declaration of 1978. It is known that health services alone are insufficient to meet health needs in the Aboriginal population. Instead, social determinants are predictive of poor health in general, and specifically among childbearing women where they have a significant role in birth outcome. Yet, studies also point to the need for more comprehensive services to childbearing women to meet the needs of this group. The role of the midwife appears to be especially well poised to provide an integrated approach to childbearing service.

Chapter Six: Study Design, Methods and Analysis

6.0 Introduction

A collaborative study with First Nations women aimed at finding alternative solutions to current childbearing practices required a broad theoretical framework. As we have seen, the theoretical framework I have termed 'critical postmodern gendered praxis' provided the basis to guide the research reflexively. Methodologically, however, the research had several further requirements. For example, its participatory aspect demanded a research design that was highly flexible and responsive to the needs of the participants, to the extent that they wished to be involved passively, or actively, in the research process. Participatory research where the data guide the research (Dick, 1997) is also a journey of scholarly inquiry. As a PAR process, the research aimed to "integrate scientific investigation with education and political action" (Cancian & Armstead, 1992, p. 1427; Green et al., 1997; Hall, 1993). To this end, the trustworthiness and integrity of the research was conscientiously guarded during data collection, analysis and presentation. It is characteristic of action research that both the methods and research foci can change as the research evolves (Small, 1995). These characteristics are best illustrated in the direction the research took with the implementation of the praxis events. In turn, the praxis events themselves provided research data that was analyzed and included in the findings.

This chapter is divided into two sections to reflect the thesis as an academic text and the dynamic nature of the PAR process. The first section follows an academic format that includes: research settings, fieldwork schedule; data collection methods and analysis,

etc. Reference throughout this section is made to elements of the following section, which focuses on the praxis component of the research. In the second section; Praxis Based on Analysis, three research praxis events are discussed. They include the formation of NCN Otinawasuwuk, the midwifery field study trip and the development of the Empowerment of Aboriginal Women Surrounding Childbearing Project. This separate discussion allows the reader to follow the evolution and application of the research in greater detail. In addition, the introduction and discussion of the praxis events provides the reader with an understanding of how they are being applied to the findings in the following chapters. A descriptive narrative that includes the voices of women research participants contextualizes the chapter. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

6.1 Research Settings

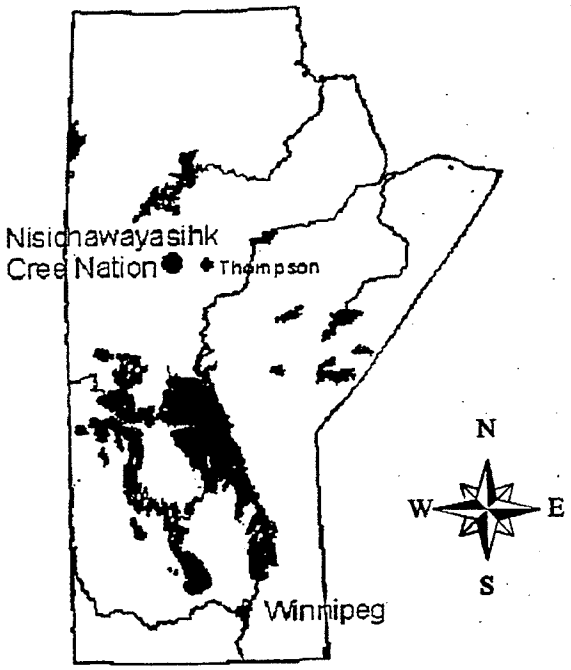
Data were gathered in seven geographical settings - three in Manitoba, two in Ontario and one in Texas: these are respectively, Nisichawayasihk Cree Nation (NCN) and the adjacent Metis settlement, the Nelson House Community; the City of Thompson; the City of Winnipeg; the City of Toronto; Tsi Non: we Ionnakeratstha (the place they will be born) on the Six Nations Reserve, and the Maternidad La Luz "The Birth Place" in El Paso, Texas. With the exception of the Nelson House and Winnipeg settings, the remainder of the settings evolved from the impetus of the research itself. As the research developed, research sites were included to reflect the direction that the research was

taking. The Ontario and American research sites are discussed in the second section of the chapter entitled: Praxis Based on Analysis.

6.1.1 Nisichawayasihk Cree Nation.

The majority of the research took place in Nisichawayasihk Cree Nation (see Figure 2). Settings in NCN included the Family and Community Wellness Centre for most of the group meetings. Key informant and semi-structured interviews were conducted in homes, place of work, or the Family and Community Wellness Centre. I visited many businesses and agencies to gain community perspectives and support for the praxis component of the research. An attempt to raise funds for a proposed midwifery study trip and the activities of the newly formed NCN Otinawasuwuk through a bingo lottery gave me an ethnographic opportunity to become involved in each of the neighborhoods in NCN and the Nelson House Community. This activity involved extensive organization and planning that took me into many aspects of the two communities. For example, a bingo lottery license had to be obtained over a period of several months through band administrators. A loan of $5000.00 had to be negotiated for the bingo prizes. Planning and carrying out game related activities included television and radio scheduling when the response would be high, and the advertising and selling of $40.00 tickets in each of the neighborhoods etc.

Early in the fieldwork, I stayed at the nursing station while I was in the community. For most of the time, I lived at a furnished house provided to me by First Nations and Inuit Health Branch. Here, I was able to plan and organize activities, as



The two communities, generally referred to as Nelson House by the residents, are located 813 km northwest of Winnipeg and 75 km west of the City of Thompson by all weather road. This is where the Burntwood, Rat and Footprint Rivers meet and from whence NCN derives its Cree name. NCN signed the Adhesion to Treaty 5 on July 30, 1908. The population is distributed as follows: around 2,200 members live in NCN; 1,016 members live on Crown land at South Indian Lake with an additional 1,300 members living in other locations. The community of South Indian Lake separated from Nelson House in the 1930s following the decline of the fur trade (Linklater, 1997). The adjacent Metis settlement, the Nelson House Community, was created as a result of the disenfranchisement of women through the Indian Act on marrying non-Aboriginal men. Previous to the establishment of the Nelson House Community, these families were forced to live on islands as directed by the Department of Indian Affairs to the band. Currently, the community is governed by a Mayor and Council. While it is described as non-status community, most of the 80 residents are 'Status Indians.' Women in the community have regained their status through Bill C-31.

Figure 2 Map

well as transcribe taped interviews. In the spring of 2001, I lived with a traditional healer by arrangement of band administrators. Chief and Council availed facilities at the band office for photo-copying, computer and printer use. One Councilor was formally interviewed at the band office. Several meetings took place with Chief and Council. I frequently engaged councilors and band office administrative staff in conversations about the research. On some occasions, group participants took part in the discussions at the band office. Fieldwork sites beyond the Nisichawayasihk Cree Nation community included: Mile 20, a traditional ceremonial site; Notigi, a site for the Manitoba-Nisichawayasihk Cree Nation Hydro Power Dam, and a camp site

6.1.2 Nelson House community.

Key informants and semi-structured interviews took place in this Metis community in December 2000. Several women from this community took part in meetings held at the Family and Community Wellness Centre. I took part in a Fishing Derby here in March 2001.

6.1.3 City of Thompson

Located above the 55th parallel, the City of Thompson lies 75 km southeast of Nisichawayasihk Cree Nation on Highway 391. The highway is an all-weather road that appears to be about two-thirds asphalted. The City of Thompson (referred to as 'town' or 'Thompson' by NCN residents) has a population of 15,000, the majority being of Aboriginal origin. The city originated in the 1960s as a result of rich nickel deposits in the area. It serves as a regional shopping centre with several malls. Thompson is accessed

by road, rail and air. The Burntwood Regional Health Authority regional office is located in Thompson. Approximately, 60 % of patients who are admitted to the Thompson General Hospital (TGH) are Aboriginal (interview, Cal Tant, BRHA CEO, 2001).

I interviewed several key informants in Thompson, among them a retired nurse-midwife and two midwives employed with the BRHA. The midwives gave me a tour of their midwifery offices in the Community Health Resource Centre. In addition, two meetings took place with senior BRHA administrators (February 12, 2001 and April 9, 2001). Both meetings included women from the NCN acting in the capacity of co-researchers. In January 2001, a research participant and a Doula (birth support facilitator) educator from Calgary, Alberta and I toured the labor and delivery floor at the Thompson General Hospital with a senior BRHA administrator. As well, I attended the Consultation on Women's Health on March, 16, 2001 that featured Diane McGifford, Minister responsible for the Status of Women in Manitoba. There, I submitted written perspectives on childbearing issues that pertained to Nisichawayasihk Cree Nation. In addition, I visited the Young Women's Christian Association (YWCA) where pregnant women reside while they are evacuated.

6.1.4 City of Winnipeg.

The City of Winnipeg was the interview site for three interviews. As well, meetings took place in Winnipeg on a formal and informal basis with a FNIHB nursing administrator, Kagike Danikobidan Committee board member, and a retired nurse-midwife. There was also a meeting in September 2000 with members of the Kagike Danikobidan Committee to gain their insights into the research topic and familiarize them

with the research content. Two meetings took place in my home over a period of several days with Shirley Anne Linklater in January 2002 and February 2003 for the development of the Aboriginal Healing Foundation proposal work-plans (Years 2002-2003 and 2003-2004). Following my employ with FNIHB beginning February 1 2002, the study was frequently discussed with colleagues and management in the Winnipeg regional offices. Interviews took place with senior management in November 2002 here in the regional office.

6.2 The Fieldwork Schedule

The fieldwork schedule reflects the evolution of the participatory action research process. The fieldwork (see Figure 3) was initiated July 18, 2000 and conducted until the Christmas break of December 2000. The duration of my stays in the community ranged from two to 20 days, with an average time of 10 days, for a total period of 74 days. The research resumed January 5 and carried on until May 7, 2001, ranging from 8 to 20 days per study trip, for a total of 73 days, including a Doula Workshop in early January and meetings at the BRHA in Thompson. Attendance at the Canadian Institute for Health Research (CIHR) Aboriginal Research Graduate Student Gathering in Vancouver, B.C., with Kim Linklater Beardy took place between February 28 and March 4, 2001. The seven-day field-study trip took place from June 2 to June 8, 2001. Field-work in NCN to fill in some gaps took place in July 2001. In August 2001, I traveled to NCN to develop the Aboriginal Healing Foundation proposal, The Empowerment of Aboriginal Women Surrounding Childbearing (EAWSC)(see Appendix D for summary), with several research participants and band leadership.

Date	Location	Activity
July 2000 – December 2000	Nelson House, Thompson and Winnipeg	Interviews and meetings
January 5 – May 7, 2001	Nelson House	Interviews and meetings
January 7 – 8, 2001	Nelson House	Doula Training 15 participants/2 midwives
January, 2001	Nelson House	NCN Otinawasuwuk organization is formed.
February 28 – March 4, 2001	Vancouver	Graduate Student Gathering (CIHR) with Kim Linklater Beardy
June 2 – June 8, 2001 Midwifery Study Trip with Shirley Anne Linklater and Lenora Spence	Dufferin Grove Park, Toronto Six Nations of the Grand River, Ontario El Paso, Texas	The Midwives Collective of Toronto annual meeting, and CBC radio interview Meeting with midwives and tour of Tsi Non:Wi Ionnakerastha (The Place They will be Born). Meetings with midwives of Maternidad La Luz Birthing Centre, tour and observation by Shirley Anne Linklater
July, 2001	Nelson House	Chart audit
August, 2001	Nelson House	Collaborative writing of Aboriginal Healing Foundation proposal # 1(2002-2003)
December, 2001	Nelson House	Meeting

January, 2001	Winnipeg	Partial analysis of research with Shirley Anne Linklater and development of Aboriginal Healing Foundation proposal work-plan #1 (2002-2003)
August, 2001	Nelson House	Thesis writing review and preparation for CBC television interview: *FAS Buddy System* aired October 7, 2002; Co-development of #2 Aboriginal Healing Foundation proposal (2003-2005)
February, 2003	Winnipeg	Writing of second Aboriginal Healing Foundation work-plan with Shirley Anne Linklater and a maternity worker.

Figure 3 Fieldwork Schedule

A research follow-up analysis took place in NCN in December, 2001. In January 2002, NCN Otinawasuwuk president Shirley Anne Linklater traveled to Winnipeg to analyze the research to date and complete the requirements requested by the Aboriginal Healing Foundation for the EAWSC project (see Appendix E: EAWASC conditional approval). Telephone follow-up interviews occurred throughout the field work time period. I returned to NCN in late August of 2002 to review the research findings and prepare for a Canadian Broadcasting Corporation (CBC) television interview. Shirley Anne Linkater and another maternity worker stayed with me in February, 2003 to develop a detailed work-plan for the proposal submitted to the Aboriginal Healing Foundation for further funding (Years 2003-2005) of the EAWSC project.

6.3 Fieldwork Schedule as Reflected by PAR

The PAR process and fieldwork is reflected in the following diagram of concentric circles (see Figure 4). Early in the fieldwork the research begins with a core group where I, as the researcher, carry out conventional research activities such as interviews. As time progresses it becomes evident the fieldwork reflects how the research has taken on more of a participatory orientation and praxis approach. The research was anchored by keeping the research purpose and general questions at the forefront. A second diagram (Figure 5) illustrates the general direction the research took based on the research questions that guided the research. This includes further field work around NCN and onward to include Ontario and Texas.

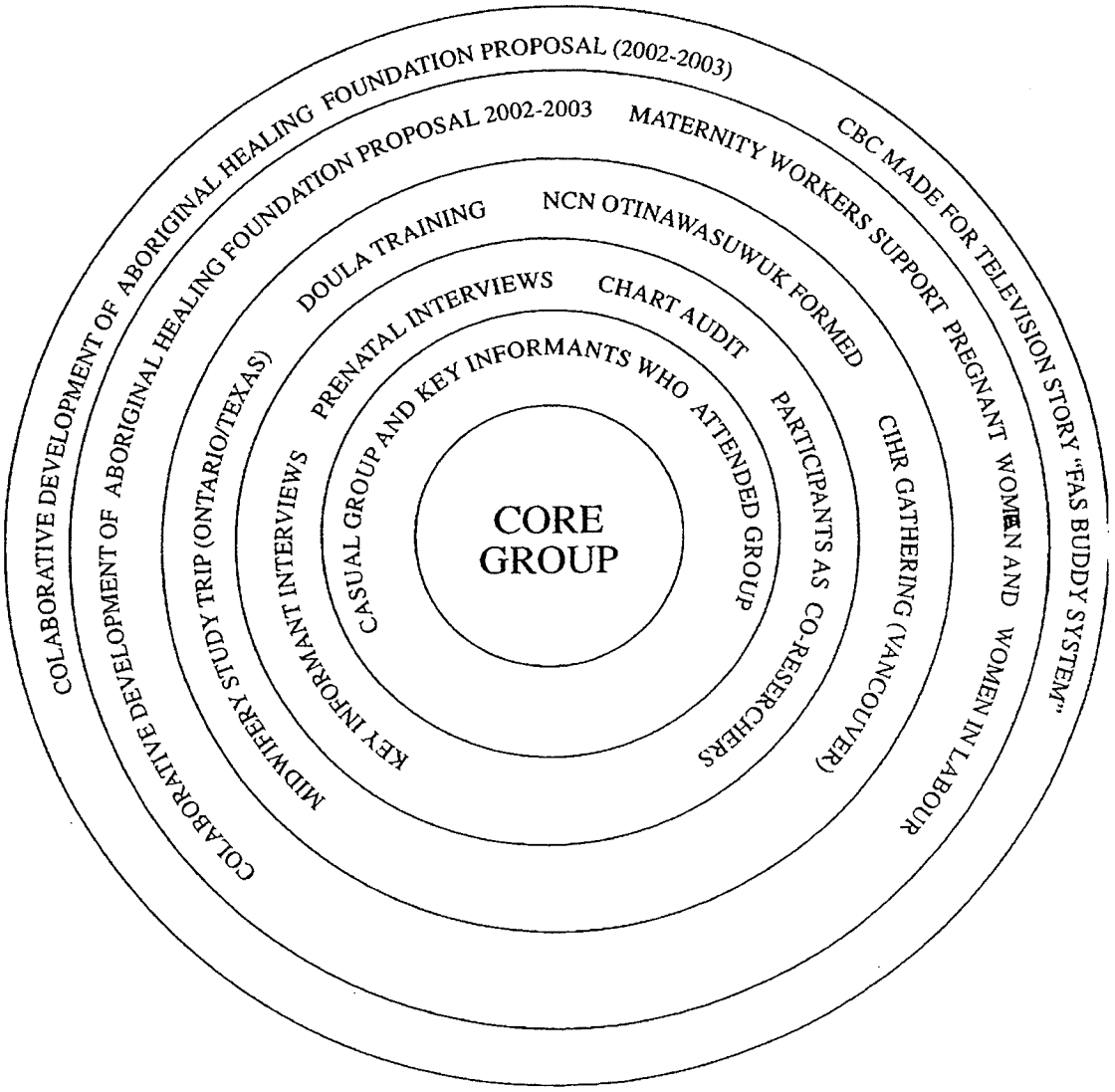


Figure 4: Evolving Research

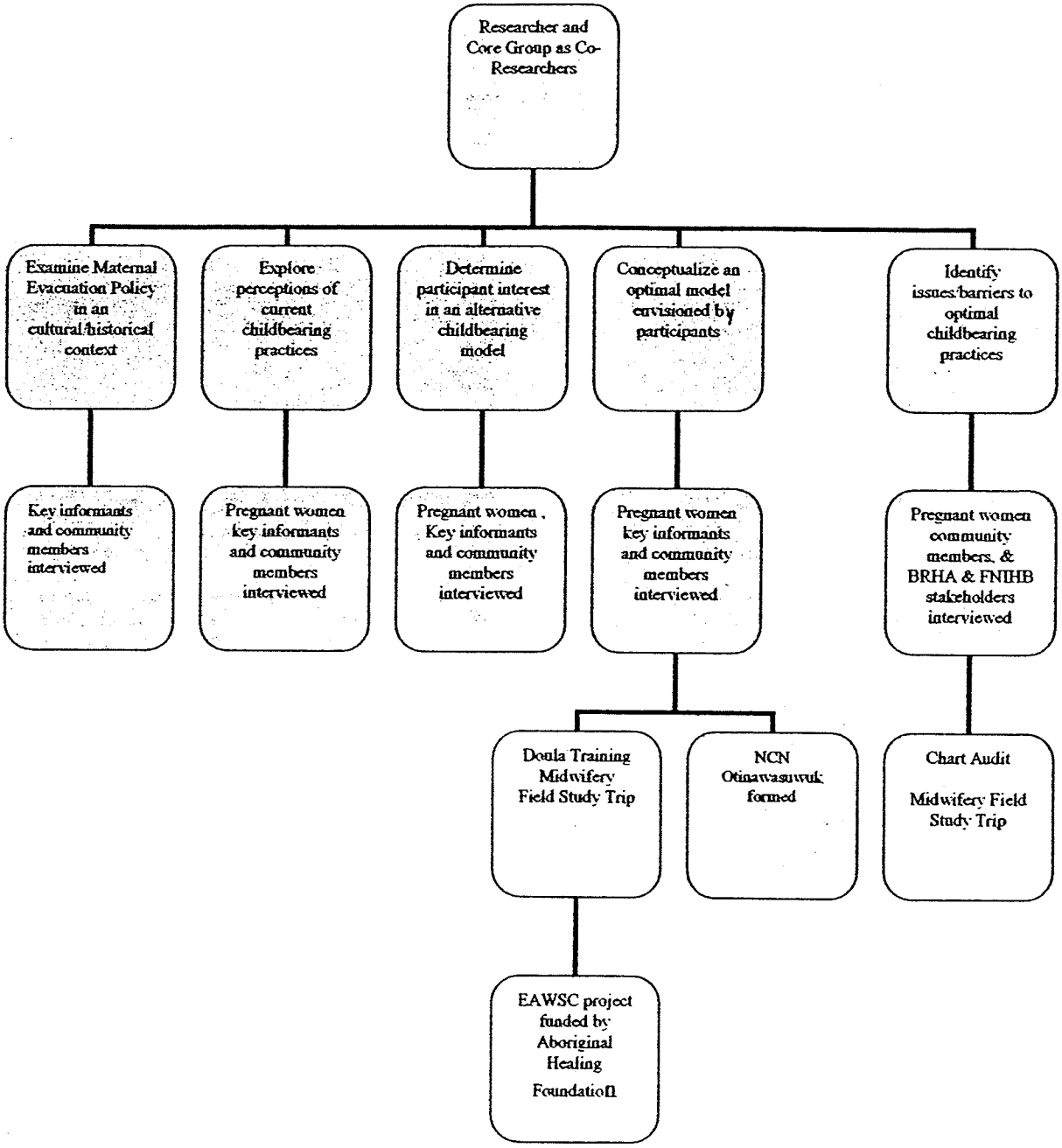


Figure 5: Questions Guide the Fieldwork

6.4 Data Collection Methods

This study incorporates several data collection methods in its PAR framework, with the understanding that action research is not identified with any specific method (Holter & Schwartz-Barcott, 1993) and can incorporate either qualitative or quantitative methods (Martin, 1996). Furthermore, to achieve the aims of the study from an ethnographic perspective, the choices of gender sensitive research methods required that they be responsive to the changing needs of the research inquiry. A 'bricoleur' approach met this need. "Bricoleur" is a French term meaning "Jill/Jack of all trades." In this research design, it reflects the incorporation of the diverse methods that were used to conduct the study. From a historical perspective, ethnography has been an important influence on qualitative social science. Invariably, ethnography involves fieldwork of some length using multiple sources of data collection within a contextual setting (McLeod, 1999). The appropriateness of a bricoleur approach to ethnography is best described by McLeod:

> An ethnographer carrying out field research over periods of time that may stretch for years has the scope to try out a range of tools and perspectives. In addition, the complexity of the ethnographer's task – the study of culture – is inherently so complex and refractory that flexibility and opportunism, and the mentality of the 'bricoleur' are desirable and productive (McLeod, 1999, p.2).

The data collection methods are: key informant interviews; semi-structured interviews; modified focus groups; quantitative prenatal retrospective chart audit; analysis of documents (world-wide web, historical NCN texts, NCN studies and community assessments, newspapers); and conversations. One hundred and eight signed consents were obtained for interviews.

Data collection was facilitated by several means. Participant observation is frequently used by ethnographic researchers when observing and interviewing people (Spradley, 1979). Bernard (1988) describes participant observation as a strategy that "facilitates data collection in the field – all kinds of data, both qualitative and quantitative" (p.150) rather than a data collection method, per se. He argues that it would be impossible to conduct anthropological research as a "complete stranger" (p. 150). Data collection was also facilitated by arranging the times of group meetings to minimize barriers to attendance. To facilitate ambience for discussion, meetings were held where I prepared the lunch (Krueger, 1994). These meetings proved to be an inconvenient time for the participants and my role as hostess became too time-consuming and distracting. Following several luncheon meetings, stipends of $20.00 were provided to each group attendee to assist in covering childcare and transportation costs until January 2001. The practice was stopped at this time because funding was not available to continue the practice. This did not change the way participants responded to interviews. Pregnant women who participated in the research were also provided with stipends during the same period as incentives and in recognition of their participation. The amount of the stipend that was used is consistent with one provided in a Native American women study on antenatal care (Long & Curry, 1998). Key informants did not receive stipends. Childcare and transportation costs were generally not an issue in this group. Elders received gifts of tobacco or kerchiefs.

6.4.1 Key informant interviews.

Key informant interviews took place with persons such as elders or leaders with significant historical and social perspectives on birthing issues, or those with expertise that was considered necessary to address the research questions (professionals, and past or current government administrators). Many of the key informants were suggested to me by group participants. The interviews were conducted to gain an in-depth perspective of issues pertaining to the research topic (see Appendix F). In some cases, interview guides were developed beforehand specifically for interviewees, among them: the BRHA and FNIHB (see Appendix G: BRHA; Appendix H: FNIHB). Band leadership provided a letter of support to expedite interviews (see Appendix I).

Key informants were interviewed by type and times that coincided with the needs and the direction of the research. For example, elders and those who had a diverse knowledge of community history and politics were interviewed early in the research, followed by key informants such as nurses, midwives and physicians, whose expertise could benefit the timeliness of the research agenda and direction. As the research deepened, key informants included those who had knowledge of traditional practices, and a wider scope of politics and community services. Eventually, key informants such as the BRHA administrative personnel were approached for interviews. Some key informants remained active throughout, such as midwives, the nurses, and a Kagike Danikobidan board member. In addition, to the interviews given, many interactions took place with community members, professionals, and Chief and Council that could be described as 'informal interviews'.

In total, 36 key informants were interviewed, 25 of whom were interviewed in NCN. Generally, the key informants varied in age and background. With the exception of six, they were women. These included: a senior FNIHB nursing administrator; a Kagike Danikobidan Committee board member and retired nurse-midwives/administrators (2), a BRHA CEO, and BRHA administrators (2); a physician (1) and FNIHB administrators (3). In NCN they included: NCN community health nurses (4), a Councilor, a traditional healer, NCN health director, NCN prenatal public health nurse, physicians (2), NCN justice worker, elders (3), NCN business leader, Caucasian man married to a Status Indian (joint interview), school teachers (2), mental health counselors (2), midwives (3), Mayor of Nelson House Community, and a retired NCN nurse-midwife. Most of the interviews were carried out in the interviewee's home or business address and with the exception of two interviews, all were recorded. Additional midwives and staff were interviewed at Six Nations and in El Paso. The interviews ranged in length from 30 minutes to more than two hours, averaging more than an hour. Two interviews took place with elders where an interpreter was required to relate the questions in Cree and interpret answers back to me in English. These interviews were tape-recorded.

6.4.2 Open-ended interviews.

Since interview times were difficult to arrange with many pregnant women, repeat visits to homes were frequently required. Generally, they were unavailable in the morning and shortly after lunch as they were already in the community on errands or other activities that included the evening. After awhile, rather than seeking appointments in some cases, interviews were mutually arranged with the pregnant woman at an agreed

upon location. Some were invited for interviews when they came to the Family and Community Wellness Centre for the Canadian Prenatal Nutrition Program (CPNP) 'snacks' following their prenatal clinic visit at the nursing station on Monday afternoons. Others were approached at the nursing station when they came for a prenatal clinic visit. Frequently, they were approached on errands. All but one was open to being interviewed. The women preferred to be interviewed individually or in pairs instead of in larger groups. Twenty-three pregnant women were interviewed - nine prior to the Christmas break of 2000, (see Questions: Appendix J) and the remainder in April and May 2001 (see Questions: Appendix K). They ranged in age, socio-economic background and parity. The interviews ranged in length with the average being a half-hour. All were recorded with the exception of two at the participants' request.

6.4.3 Group meetings.

A modified focus group was used for the group meetings to reflect the needs of the study while at the same time retaining the main purpose of the focus group method: obtaining information in an open-ended way guided by an agenda with the use of a moderator (Krueger, 1994). The focus group method is appropriate for research among marginalized people like Aboriginal people to elicit information in a group setting. It is especially appropriate when studying sensitive issues such as those around childbearing (Benoit & Carroll, 1995; see Long & Curry, 1998). Traditionally, focus groups are not educative; rather, information is elicited from participants based on prepared questions. However, in this study where informed dialogue was an important component of the research, the focus group approach was modified to reflect the needs of the research. The

ideal focus group comprises seven to ten members of similar backgrounds (Krueger, 1994). In this study, however homogeneity was restricted to the participants being First Nations women. In keeping with Frierean premise that given the opportunity to critically reflect on a problem which impacts them, people from all social strata can resolve them. An effort was made to include women from various backgrounds who were generally without a health or social service background. As well, a deliberate seeking out of opposing views is a means by which action research attempts to compare different perspectives in reaching an alternative understanding of behavior and practices (Waterman, 1998).

An over-recruitment of about 20% is generally believed will result in the required number of participants (Krueger, 1994; Morgan, 1988). Eleven meetings were held from the initiation of the research in September until Christmas 2000. Attendance ranged from four to eleven with the average number of participants between six and eight. In addition, another 25 participants attended with less frequency, often for one or two meetings. Five meetings took place from January 2001 to April 2001. Two additional meetings took place with BRHA administrators (February and April, 2001). These meetings were focused on topics pertinent to the research at any given time. When the research resumed in January 2001, the group commonly included four to six women, most of who had participated in the research since it began. It became known as the core group. The total number attending the group meetings overall was around 37 participants. Those taking part over a period of time, as well as women who were not voicing their views openly in the group setting, were interviewed individually to ensure that their perspectives were

heard. Additional meetings took place in August and December 2001 surrounding the EAWSC project and in August, 2002, and December 2002 to review the thesis writing.

A question guide was used and agendas were continually revised (see Appendix L). As well, photo novella (Sohng, 1995) of Tsi Non:we Ionnakeratstha, taken by me in 1998 were used to stimulate discussion. The video film *Ikajurti: Midwifery in the Canadian Arctic*, (Inuit Women's Association of Canada, 1990) which describes the evolution of the POV 'Innuulisivik Maternity' was shown and discussed in September 2000.

On a continuing basis, the research findings were analyzed thematically, and presented to the group. They evoked discussion of topics surrounding childbearing practices. In addition, two physicians and two midwives brought their views to the group, and a Kagike Danikobidan board member participated via conference call. The perspectives of nurses and nurse administrators (current and past) also were brought to the group following a thematic analysis of the interviews.

Prior to the cessation of research for the Christmas 2000 break, the meetings were larger and less focused than when they were reinitiated in January 2001. They were more like public meetings, which, according to one source is the "ideal stuff of social research," allowing for the opportunity to observe "social connection" with more transparency (Frankenberg, cited in Kaufert & O'Neil, 1993, p. 42). On these occasions, a wider exploration of the issues and nuances pertaining to childbearing practices took place with the addition of more recent participants. However, this attendance pattern meant that the research process and the tentative agenda for the group meetings provided to the participants at their request in September 2000 had to be continually revised. This

was however, not seen as detrimental given that when focus groups meet using the same participants a group agenda evolves which reflects group dynamics (Morgan, 1998). The meetings reflected the responsive needs of the research where the discussion topics included: health care policies, federal-provincial jurisdictional issues, maternal/child health care protocols, historical/social perspectives of birthing practices, alternative birthing practices, research theory and methods. To anchor the discussions, participants were provided with a substantial amount of informational material including pertinent references and a thematic analysis of the research findings as the research evolved. Several of the regular attendees began to find the erratic attendance disturbing, and suggested the group be limited to those who attended routinely. When the research resumed in January 2001, this problem remedied itself and the meetings became more focused and smaller.

Participatory action research is responsive research. At different points in the research process it became apparent that the direction of the research had to be adapted to the evolving research findings, and, in some cases, the needs of the research participants themselves. Research in First Nations communities must consider the reality of the lives that many people live due to the circumstances of colonization. Several Aboriginal sources refer to the difficulties of carrying out research in Aboriginal communities, where women suffer from the effects of colonization (Hammersmith, 1992; Huntley & Blaney, 1999; Smith, 1999).

6.4.4 Participants as co-researchers.

As early as October 2000, the group participants had clear ideas as to how they wanted me to proceed: 1) explain the research to the community and show the film *Ikajurti: Midwifery in the Canadian Arctic* (Inuit Women's Association of Canada, 1990) on the band channel, followed by a call-in show which I was to host; 2) discuss the research on the local Red Dog radio talk show; 3) write a piece on the research for the local community newspaper; 4) host workshops in the community to assist band members to understand how midwifery might evolve in NCN; and 5) carry out an extensive community survey. In any and all activities, they emphasized that elders should be involved. Some of the activities they agreed to were too early, such as an extensive survey which was also cost prohibitive. The video film was aired but it was not possible to plan when it would actually be shown, so that a 'talk back' could be included due to technical and staffing issues at the band television station. The group participants understood the reasons why this component of the presentation was excluded. I submitted some information on the research topic for a community newsletter.

Anticipating that someone in NCN would take a leadership position in the research, I found that once the research was initiated, the consensus of the participants was, "You do it." Throughout the project, I encouraged anyone from the group, or otherwise, to take the initiative and lead the research. I frequently invited participants to formally take part in the research. Like Kuhlman (1992) in her collaborative research with an Aboriginal culture, I saw my role as one of a coordinator, assisting in areas such as identifying issues and the appropriate methods to address them. The participants acted as co-researchers when individuals thought to have significant knowledge were invited to

speak, and the participants asked questions. Of the above key informant interviews, seven took place within the group setting where the participants asked many of the questions of the midwives, physicians and BRHA administrators. In addition, two women interviewed several pregnant women with me, in addition to assisting with aspects of the retrospective antenatal chart audit. Preparation for the co-interviewing included discussions and role playing around open-ended interviewing.

Several women interviewed elders based on foci that we had identified as a group and brought this information to the group. Frequently, participants raised points they had learned from discussions with their friends or others in the community. Many women and some men brought information to my attention that they believed related to the research. The involvement of community members in the research made information and documents available that would otherwise not have been accessible to me (Gaventa, 1991). I was told of radio shows, newspaper clippings, the book; *Anna and the Indians* by Nan Shipley (1955), the article; *Archaeology, Historical Landscapes and the Nelson House Cree* by Eva Linklater (1997), a mercury survey being carried out at the nursing station, the *Kangas Associations Evaluations* (Kangas & Associates, Inc. 1998), the report by Shawkat Kibria (1997) entitled *Prenatal Risk Assessment: Analysis of Pregnancy Risk Factors Affecting Prenatal Patients in the First Nations Community of Nelson House,* band demographic statistics, etc.

Several of the participants were able to engage the research as co-researchers away from Nelson House. Such was the case for Kim Linklater Beardy, who attended the Canadian Institute for Health Research (CIHR) graduate student gathering (Aboriginal focus) with me in Vancouver in February/March 2001. At the two-day conference in

Vancouver, she was very active in engaging Aboriginal researchers from across Canada about research concepts and process. She also met with a FNIHB administrator in Winnipeg on our return. Kim had known this administrator previously and asked many pointed and detailed questions of her pertaining to the research in NCN. In addition, the field study trip undertaken with two participants provided opportunities for them to act as co-researchers.

6.4.5 Epidemiological component.

Following the Christmas break in 2000, the research findings indicated a need to explore the impact of colonization on the behaviors of pregnant women in consideration of risk, and in exploring alternatives for optimal childbearing practices. An audit of Manitoba Post-Partum Referral Forms was carried out (1997-1999) for the purpose of: 1) identifying patterns in antenatal clinic attendance (time of first visit, average number of visits); and 2) identifying maternal characteristics and behaviors (alcohol, drug and tobacco use) that would place the fetus at risk (see Appendix M: Data Collection Guide). The number of births was determined by reviewing the charts of babies born during these years, and the charts of mothers referenced from the Post-Partum Referral Form. This method for determining the number of births to women in NCN who received antenatal care at the nursing station was verified as highly reliable by the clerk.

6.5 Social and Research Context of the Researcher

Parallels between my Mennonite culture and that of Aboriginal people were drawn at a symposium held at the University of Winnipeg in late 2000. It was said that

"Canada's Aboriginal peoples and Mennonites have lived parallel lives with many similarities: their close ties to the land, their minority position, their emphasis on equality, their commitment to spiritual values and with many points of contact" (Reimer, *The Carillon*, 2000, 7B). Mennonites in Manitoba were established on reserves in southern Manitoba known as the East and West Reserves divided by the Red River. While social and cultural parallels appear to exist, the two cultures differ widely. The open acceptance of First Nations people to outsiders became very meaningful to me during the time I tragically lost my husband, Abe, in an airline crash in Sandy Lake, Ontario in 1993. Abe was well known in the northern communities from his work as a pilot. Northern peoples were a very significant source of solace for me during my grieving; extending their hearts, prayers, gifts and comfort, individually and through ceremonies. These experiences deepened my appreciation for First Nations people and the warmth of their culture. It renewed a desire I had to find ways to contribute to the betterment of their lives.

From my observations and interactions during the fieldwork over an extended period, I found the collective, spiritually-oriented mindset of NCN community members to be an inclusive one. I was able to compare my observations with my Mennonite culture that embraces a similar mindset. My clinician background through northern nursing work experience (1988-1998) and MSc Family Nurse Practitioner education provided me with valuable insights into clinical issues that might impact the development of alternative childbearing practices. It also provided me with an insider status to the research with the nurses. Prior northern research aided this fieldwork, particularly my MSc thesis fieldwork in four isolated Manitoba First Nations communities on antenatal care utilization

(Hiebert, 1997). As well, the research experience that I gained as an associate with the Northern Health Research Unit in two collaborative studies (Angees et al., 1999; Young et al., 2000) was valuable. My role as the Manitoba Region, Tuberculosis Unit Coordinator with FNIHB beginning in February 1, 2002 provided many opportunities to engage senior management and colleagues about the research, individually and at meetings.

6.6 Reflections on the Research Process

The personal growth that I gained from the research experience largely had its origins in the way the research participants accepted me as a woman. In addition, my reflexive circumspection of the research topic, with the aid of the fieldwork journal opened many personal vistas that I had not previously considered. I was given an Indian Spirit name; 'Black Thunder Horse Woman,' by a traditional healer in May 2001. Symbolically, the name is interpreted as: 'Black' for the midnight sky and the stars in that sky illustrated the First Nations communities I travel to; 'thunder' for my teachings; 'horse' symbolizes wind, meaning that I bring change. I was honored in a ceremony with the name, an eagle feather, a sacred song and sacred colors. I was told I belong to the wolf clan (teachers/leaders). Were my interactions with all people always positive? By far, they were. A few were not. Once, I was 'blamed' by two participants for the way people were nominated to NCN Otinawasuwuk (Receivers of Children) leadership positions at the time the organization was being formed. They felt that some of these individuals had not been involved long enough, or to the extent that would merit their having a leadership position. I explained that I had not named the organization

leadership; they had been appointed by the group. This explanation seemed to be satisfactory and our relationships resumed.

Generally, I wasn't perceived as a researcher in the traditional sense, since PAR is non-traditional. However, when it came to stakeholders, like those working in bureaucracies, the name 'researcher' for the most part created apprehensions, especially the idea of having interviews or meetings tape-recorded. I felt that my lack of work experience in government bureaucracies at this time was a minor disadvantage in conducting this aspect of the research. One woman in a federal government position, a personal friend, and another woman in a provincial position furthered the research efforts greatly. The latter woman and I developed a collegial relationship. Early in the fieldwork she felt somewhat uneasy about our interactions saying that she didn't know when I was interviewing her or just conversing. I explained that I would let her know when and on what I would interview her, so that she could think about it. As well, I would advise her how I might quote her. Another government stakeholder said to her of me, "I'm not going to help Shirley Hiebert get her PhD!" The government stakeholder, who advised me of the remark, also acted on my behalf in ameliorating the situation by explaining my role in a participatory research project. In addition, I reiterated the steps that NCN leadership and the research participants had taken in their initiatives in exploring alternative childbearing practices and my role in them.

As a researcher, I was deeply committed to the research and the PAR process because I believed this was the most appropriate way to address the topic and the needs of the participants. It was not, however, a pragmatic or expedient way to carry out a dissertation. Participatory action research of this magnitude was complex and very time

consuming. Much of my time was not under my control since I was making decisions collaboratively with other people as it is required by both action (Coutu, 1987) and ethnographic research (Spradley, 1979). It is difficult for a doctoral student to be this open-ended. It meant always being wary and asking myself about what I was doing to the point of paranoia. Knowing that I would be critiqued by some academics for this not being 'research' but rather community development work (Frideres, 1992), I strove to be very conscientious in my methodology. It meant continuing to access literature on an ongoing way, always asking myself if I was acting in the confines of recognized research, as well as following where the research was taking me, while facilitating the education needs of the group. PAR research in this project involved community capacity building. It meant having to have time and energy to do this which included collaboratively writing two large proposals with detailed three-year work-plans involving the people who would be employed by the project. It meant having to be flexible with the time and funds to go on a field study trip and largely organize and obtain the funding for a Doula training workshop.

The project demanded a high level of organizational skill in not only these areas but overall. A dissertation in and of itself is very challenging. From my perspective, the PAR project doubled the work and effort of the dissertation. It also meant having to deal with funding rejections. A funding organization that more explicitly included their comments about the rejection suggested I needed to demonstrate how the research would be organized and the duties and resumes of those involved, as well as the number and type of interviewees. This suggested to me that urban researchers were really not familiar with conditions that for many people place their lives in a seemingly constant crisis state

arising out of colonization, and how this might impact on people's abilities to organize or utilize their time. It also suggested to me that some funding organizations did not really understand how flexible the research would need to be in a northern community. In addition, the funding organization's year time line for completing the study was unrealistic to both ethnographic and PAR research. The PAR approach to research does not allow you to be unequivocal about some of these specifics since PAR is an evolving process that is carried out collaboratively.

In addition, as a doctoral student I was required to have a proposal written prior to embarking on the research. In my case, where I had a close familiarity with isolated northern communities, as well as intimate contact with many northern people who I could draw on in writing the proposal, I was able to approximate what the proposal should have ideally been. I would have preferred to have spent considerable time in Nisichawayasihk Cree Nation for the proposal writing while at the same time making potential participants aware of PAR and their anticipated involvement in the research since it is difficult for people to comprehend the PAR process in a discussion format. Conducting a pilot study with several people in the community while developing the proposal would have assisted in this understanding and pointed to how the study might be best approached, as well as what human resources, skills and funds would be needed to carry it out rigorously. This preparatory period would have required funds and time, both of which are limited for a doctoral student. PAR is well known as a process that requires considerably more work than conventional research (Dick, 1997). For this reason, the researcher and co-researchers involved in PAR need to have a lot more resources and commitment than conventional research demands.

The PAR approach is an important one for First Nations. It furthers their aims of self-determination by enabling them to obtain and provide "valid information, make free and informed choices (including the choice to participate) and generate internal commitment to the results of their inquiry" (Argyris & Schon, 1989, p. 613). It is also my belief that it is a highly effective research approach. By having many people involved in the research in various ways including acting on the findings, areas are illuminated that would not be accessible to the researcher otherwise. I believe that this study is much richer for it. There is a high level of transparency in the study because of the active involvement of many of the participants. I did not ask questions formally of participants as to their perspectives of the research. On the other hand, as suggested earlier, Kim Linklater Beardy's observations following the CIHR graduate student gathering in Vancouver provided insights: "Everything here is first-hand. It's First Nations that are doing the project and not someone just going in there to do the project. We're actually doing the delivery and the administration of the project – we're taking ownership of the project. Some researchers come and select a few people, but here it's different" (group meeting, April 2, 2001). Others volunteered their appreciation for the changes that were taking place in NCN because of the research, such as the funded projects and a greater understanding of the issues around childbearing and colonization.

Certainly, PAR requires a firm commitment (Dick, 1997). However, it does not have to be carried out in the depth that this project demonstrates to make it action research. It is in the interest of the researcher and the participants to choose wisely as to their aims and resources before they proceed. For me, the research went beyond a dissertation. Freire's (1998) premise that a researcher needs to approach research such as

this with love appears fitting to me. Perhaps, it is an unusual way to describe reasons for carrying out academic research; nevertheless, it is true when one decides to go beyond that which is required. In return, I received more than I gave. I came away more whole as Black Thunder Horse Woman.

6.7 Enhanced Validity

The issue of validity in participatory research is also a controversial one (Reason & Rowan, 1981; Sohng, 1995). Achieving validity in research assumes the notion of truth: "to somehow get it right" (Reason & Rowan, p. 241). The authors observe that in new paradigm research, it is also important that research be "useful and illuminating" (p. 243). Morse and colleagues (2002) challenge the controversy that exists around the terms validity and reliability in qualitative research. The terms credibility, transferability, dependability and confirmability are used by Guba and Lincoln (1985) to describe 'internal validity,' 'external validity,' reliability,' and 'objectivity," (p.300). They posit these terms are more appropriate for the naturalistic paradigm. They suggest the credibility of a study can be achieved by prolonged engagement, persistent observation and triangulation, peer debriefing, negative case analysis, referential adequacy and member checking. Transferrability can be achieved through thick description of the subject. The authors caution that it is the responsibility of those who wish to make the application to another setting. One of the techniques that are put forward to achieve dependability is through triangulation of methods. Finally, confirmability is achieved by auditing the study on completion from raw data to analysis. Triangulation and the keeping of a reflexive journal are among the techniques used to obtain confirmability.

However, Morse and colleagues (2002) argue that the terms validity and reliability should be retained in qualitative research with an emphasis on the researcher for ensuring that verification strategies are central to the inquiry itself. Their incremental approach to rigor in qualitative research, which encompasses a need for congruence between the research question and methods, an appropriate sampling of participants, the concurrent collection and analysis of data, reconfirmation of data with new data and, finally, a conceptual/theoretical understanding of the data have been applied rigorously in this study. In addition, validity techniques are appropriately applied where they impact focus group and action research.

The modified focus group approach proved to be an appropriate method of inquiry. The focus group enabled the participants to exchange their views in a highly interactive and dynamic manner, in an environment where they felt secure. Group participants who were less vocal were invited to express their perspectives with my encouragement, or on a number of occasions they were interviewed separately. In addition, a deeper perspective of data was achieved by having several of the participants attend most of the meetings (Morgan, 1998). Convergent validity addresses the extent to which the research confirms or predicts future "behaviors, experiences or events" (Krueger, 1994, p. 32). The research findings that arose from the focus group research were generally validated in interactions with additional participants who attended the group meetings in addition to those which took place with community members or group participants in individual interviews.

Sandelowski (1994) describes the researcher as having two paradoxical roles in qualitative research. In one capacity, the researcher is involved in the research process.

At the same time, the researcher assumes an insular role in attempting to maintain distance from the data, in order to avoid bias. In this study, it was not my aim to distance myself from the participants or the research topic. Yet, it was necessary that I not become overly involved with the research so that I could be open to understanding the data and findings anew. A high degree of bias is possible where the researcher is the sole instrument of the research (Reid, 1991). The first technique to enhance data credibility was to decrease possible bias by recognizing that in action research, validity is influenced by the researcher (Reason & Rowan, 1981). Action researchers suggest that the recognition of bias is a vital means for demonstrating the validity of a project (Waterman, 1998). It is more realistic to make biases explicit than to be under the impression that they do not exist (Patton, 1978). By making "specific biases explicit"– such as my desire to see the participants have a direct voice in how events that impact their lives are shaped – the influence of these biases may be reduced (Fetterman, 1998, p. 473). Sources suggest that these influences need to be bracketed. My fieldwork journal aided me in this regard. For example, I was able to identify areas readily where I believed that I was becoming overly involved. By engaging in this process I was able to set aside preconceived ideas and biases, so as not to unduly influence the research (Beck, 1994; Reid, 1991). In the moderator role, care was undertaken not to become over-involved in the group dynamics to avoid inadvertently influencing the research (Krueger, 1994).

Reid (1991) suggests that the keeping and sharing of a fieldwork journal with a trusted colleague or supervisor such as I did, assists in examining biases, and in providing direction to the research. Fetterman (1998) maintains, "Writing clarifies thinking. In sitting down to put thoughts on paper, an individual must organize those thoughts and

sort out specific ideas and relationships. Writing often reveals gaps in knowledge"(p. 499). By inference, bias is decreased when data is more fully acquired. Reflexivity is significant in avoiding bias in action research. Action research explores the forces that shape society and individual thinking, including that of the researcher. A reflexive approach to the documentation of my perceptions in an extensive journal and thoughtfully scrutinizing their influence for possible biases on the research (Henwood & Pidgeon, 1993) is a fundamental component of action research (Henwood & Pidgeon; Tichen & Binnie, 1993). I carried out a reflexive approach with the participants throughout the research. This deliberate interpretation and reflection (Alvesson & Skoldberg, 2000) required of reflexive research enables the researcher to examine how she contributes to dominance in the research relationship (Lather, 1991). The role of the researcher is to refrain from being a universalizing spokesperson. Instead, she acts as a cultural worker whose role is to remove barriers that inhibit the expression of participants (Olesen, 1994).

Data comprehensiveness and accuracy were achieved in several ways. Participants' views were regularly sought to validate their meaning (Maxwell, 1998). In addition, group participants were interviewed individually to clarify their group interactions and explore further perspectives (Morgan, 1988). In instances where key informants or participants were interviewed on more than one occasion, data could be verified during a subsequent interaction. On some occasions, I reviewed a previously transcribed interview with participants. I obtained feedback from participants, community members, professionals and colleagues on an ongoing informal basis (Maxwell, 1998). As well, I noted key points of these conversations, observations and recollections in my

journal. For example, in my discussions with community members, including members of Chief and Council, I would relate the general findings of the research as it was progressing and ask for their perspectives. Once I had been in the community for a time, people frequently approached me to share their views. They were generally affirmative of the research. Where someone might offer a less affirmative view, I made a point of engaging that individual in more depth for her or his perspectives, either through a formal interview or deeper discussion. Challenges to the research process and findings were welcomed to elicit deeper perspectives (Reason & Rowan, 1981). Community feedback in this manner provided an important means for validating the general research findings and aided in identifying other aspects of the research topic as yet unexplored. The long period of time in the field that ethnographic research usually entails, provided the opportunity for the participants and me to generate a level of mutual comfort and trust. I believe that the protracted fieldwork and the insider status that this afforded was conducive to achieving greater depth on the research issues and yielded more opportunities for the validation of the research findings (Bernard, 1988).

Finally, a significant means of ensuring validity in qualitative research is to use a design that garners a wide and diverse representation of research data. In this study, this was achieved through theoretical and methodological triangulation. Multi-method research or triangulation of methods (Duffy, 1987; Marshall & Rossman, 1989; Webb, 1989) adds validity to the research findings by achieving a comprehensive perspective of the research topic (Fetterman, 1998; Reason & Rowan, 1981; Webb, 1989). By not adhering strictly to a prescribed method on the initiation of research, but rather in

adapting to the needs of the participants and the research itself, a deeper perspective of the research topic could be achieved.

Waterman (1998) maintains that the validity of action research does not depend on the extent to which it can effect change but on its capacity to improve people's lives by attempting change. On the other hand, the empowering process of collaborative problem solving has a positive impact mentally and physically for those involved in the process (Lasker, 2002). It was beyond the scope of this research to attempt to measure this effect.

6.8 Voice and Representation

Cairns (2000) observed: "the issue of who can speak for whom, and who can write about whom, is a major contemporary issue in social sciences and humanities" (p. 14). He argues that Aboriginal peoples are at the centre of this crisis in research. The silencing of Aboriginal voices in the past has resulted in Aboriginal people challenging the credentials of those who speak on their behalf because they speak as outsiders (Cairns). La Roque (1996) maintains that contrary to being "anti-white," Aboriginal scholars are currently merely attempting to set "the record straight" (p. 121).

Implied community ownership and access to research findings are intrinsic to the political nature of PAR (Simonson & Bushaw, 1993). Increasingly, universities are becoming more involved in the "solution of critical societal problems" (Brown & Tandon, 1983, p. 286), which is consistent with the aims of the Centre for Aboriginal Health Research (CAHR), University of Manitoba Faculty of Medicine. Collaborative research by its nature implies bilateral ownership and a methodology where dialogue

enables participants to voice their ideas in a context that is in keeping with their culture norms. O'Neil (1993) asserts that "ownership of health information has clearly been recognized by Aboriginal communities as a component of self-determination in health care" where Aboriginal self-determination goals are seen to be consistent with Aboriginal ownership of research information and its intended use (O'Neil et al., 1998). O'Neil (1993) suggests that until Aboriginal communities have a more optimal representation in research, their only recourse is to attempt to "control the dissemination of information that reflects their everyday lives" (p. 35). The ownership and dissemination of the research in this study are jointly the responsibility of Nisichawayasihk Cree Nation and the University of Manitoba. The ownership of the study by the participants was recognized early with the naming of the study by them. At the initial group meeting they named the study: Kagike Aniskotabidan (Always Great-Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation. This was later changed to NCN Otinawasuwuk (Receivers of Children): Taking Control of Birth in Nisichawayasihk Cree Nation to reflect their evolving role in the research. The extent of involvement of NCN in the direction of the research and ownership of research findings was generally left to their discretion. Following the initial band consent to conduct the research in NCN, Chief and Council were regularly apprised of the research process and an invitation was extended for their direct involvement. This participatory approach was mutually beneficial to the community and the university.

Ideally, the research findings in a collaborative project are written jointly with the participants (Kuhlman, 1992). In this research where there were occasions to seek specific consent to disseminate the research findings, an elder who was a participant

provided the consent with the general consensus of the working group. However, the participants could not become more deeply involved in the presentation of the research. Such was the case for two university presentations and a journal article that arose out of the research. The journal article was circulated to a number of participants in the core group, as well as community members in general for their perspectives. In the case of the writing of the dissertation, it was discussed with core group participants in an ongoing manner and on draft completion, was reviewed during personal discussions in NCN. Decisions were jointly made as to where the emphasis of the research might more appropriately reflect the research findings and in keeping with the self-determination aims of NCN surrounding childbearing practices. The integrity of the research process was maintained both from the perspective of the research itself and the sovereignty of the band.

I made every effort to represent the voices and language of the participants as completely as possible in the presentation of the research findings. Quotations are frequently presented verbatim. Where editing occurs, it is minimal and grammatical. This is deemed to be especially important considering that the purpose of the research is ultimately about First Nations women speaking for themselves on a very personal issue. Generally, this research seeks to reflect the aspirations of NCN.

6.9 Ethics

The ethics of the research is assured in several ways. Research Ethics Board approval for the fieldwork was obtained from the University of Manitoba to include a span of three years. I was aware of the need to remain cognizant of issues pertaining to

fieldwork such as "consent, deception, privacy and confidentiality of data" (Punch, 1994, p. 89). In my interactions with participants, I attempted to the best of my ability to keep all promises that I made and to be as honest as I could be (Punch). The health organization structure of NCN was respected by first approaching the Health Director regarding the opportunity for collaborative research. The Health Director subsequently discussed the nature of the research with Chief and Council. She was instrumental in obtaining their written research approval. Written consents were obtained from all participants (see Appendix N). In the instance where the two women interviewed pregnant women as co-researchers, a confidentiality oath was obtained for the woman not employed by the Family and Community Wellness Centre (FCWC) since the list of pregnant women in the community was obtained from the FCWC. The other woman involved in the interviews as a co-researcher had already signed a confidentiality oath with the FCWC. Complete anonymity could not be assured to individuals participating in the research since others in the community would likely be aware of any such participation. In fact, in some situations to accommodate the participants' ability to have a direct voice in the portrayal of the research findings, they had the option of including their name in quotes. Of the 108 consents signed, over 60 % requested this option. To ensure privacy of surroundings, meeting places and times were arranged to secure the interview environment. I transcribed most of the recorded interviews. Coding was assigned to recordings transcribed by a transcriptionist. Verbal consent for a retrospective chart audit was received from FNIHB management and followed up by a witnessed written confidentiality oath from me. Chart audit data was analyzed with anonymity by

using a coding system to maintain confidentiality. Identification of individuals from the chart audit was not shared with the group participants.

6.10 Data Analysis Process

Extensive data were generated through participant interviews, group meetings, participant observation activities, and document analysis. To avoid delayed closure during data analysis, an awareness of the aims of Nisichawayasihk Cree Nation in carrying out the study and its potential usefulness to them provided the necessary parameters for ensuring that only the most meaningful concepts were included for final analysis (Ammon-Gaberson & Piantanida, 1988). Krueger (1994) cautions that the data from focus group research may be extensive, necessitating that the primary questions and purpose of the research be kept at the forefront in determining which data should be included in the analysis. Similarly, the use of quotes should reflect the purpose of the research. In this study, the inclusion of quotes reflects views from diverse perspectives to portray the intent and spirit of the project.

Data analysis is described as a process that structures data meaningfully (Marshall & Rossman, 1989). A distinctive characteristic of qualitative research is that the collection and analysis of data occur simultaneously (Krueger, 1994). Krueger (1994) explains of focus group research and by inference, qualitative research in general, that a systematic approach to analysis as a process forces the "researcher to examine and challenge ... assumptions" (p. 129). He suggests that the analysis of the research is made more efficient by examining the assumptions throughout the research process that build on previous experiences. This approach to data analysis that occurred throughout data

collection was also instrumental in guiding further data collection (Hoepfl, 1997; Mauthner & Doucet, 2000). In keeping with effective and rigorous action research, a "deliberate and conscious reflection and challenging of interpretations" was used systematically in the analysis of data (Dick, 1997, p.5). Structured and informal interviews were discussed with the group. On some occasions, a flip chart was used to examine and summarize converging and diverging perspectives of the research (Stringer, 1996). Rival explanations were provided for the interpretation of the research findings as the analysis proceeded throughout the research (Krueger, 1994).

Critical social theory and gender-sensitive perspectives were frequently discussed with the group in analyzing the research findings as they evolved. As a researcher, reflexivity involved my immersion in the data and the repeated examination of the research findings with respect to the research questions and the perspectives that the theoretical framework brought to the research (Mauthner & Doucet, 2000). By choice, research participants were not involved in the formal aspects of the data analysis. Data analysis is a tedious, time-consuming process that would require the participants to be in Winnipeg with me. Alternatively, I dialogued with several of the participants following the development of the thesis outline at a meeting held in NCN in December 2001. They were satisfied that the analysis reflected their knowledge of the research findings. In addition, the president of NCN Otinawasuwuk spent four days at my home in January 2002 writing the work-plan relating to the praxis project entitled, The Empowerment of Aboriginal Women Surrounding Childbearing Project, funded by the Aboriginal Healing Foundation. During this time we reviewed areas of the analysis where it affected the development of alternative antenatal and birthing practices. This process was repeated in

February 2003, with the president of NCN Otinawasuwuk and a maternity worker employed with the project, in order to submit an additional proposal for the years 2003-2005.

I personally transcribed the majority of the recorded interviews soon after they took place. The simultaneous analysis of the research during the collection of data provided a preliminary thematic analysis of the interviews to share with the participants as the research was taking place (Waterman, 1998). A formal analysis of data was carried out using the NVivo software program. The data were arranged according to focus groups, key informants, pregnant women, participants and stakeholders. Data were also separated for analysis depending on the format. Emails, documents and the journal were used to provide a context to the research and as source of data. Postpartum prenatal data were analyzed using the variables relating to risk-taking behaviors and persons, e.g., smoking, drug and alcohol taking behavior, initiation and average number of antenatal visits.

Initially, beginning concepts were coded as they emerged from the data. These early impressions were then organized into more general conceptual categories or themes (Miles & Huberman, 1994). Analysis of the focus group interviews presents methodological issues surrounding the consensus and strength of opinions and the generalization of this information (Sim, 1998). This was addressed by noting how the more vocal participants made their views known and if this was at the expense of others. During the fieldwork, an effort was made to interview participants individually if it appeared that they were unable to verbalize their perspectives fully during group meetings.

Converging and diverging perspectives garnered from the examination of texts was compared and contrasted with data derived from meetings and interviews. Texts include my field-notes, emails, published works, policy guidelines and chart data. While all such data provide valuable perspectives to the research, they are not given equal weight in the analysis. A reflexive theoretical understanding based on the research framework provides the insight to aid in determining how the research findings might best be weighted to illuminate the study findings. The three primary research themes identified were: 1) autonomy subjugated; 2) autonomy re-sought; and 3) the conceptualization of an alternative childbearing model. These themes started to become apparent in a general sense from the ongoing analysis with the core group of women early in the research. They further evolved based on a continuous analysis of comparing and contrasting minor themes in the formal analysis until their obvious place in the larger thematic framework was identified.

6.11 Praxis Based on Analysis

Several significant praxis events took place to further the aims of the research based on the major themes. The decision to act on a theme took into account the extent to which the aims of the research would be furthered and the availability of the necessary resources to carry out the praxis event. The cyclical approach of action research of planning before action, followed by a review, was undertaken for each of the praxis events (Dick, 1997). In this context, each of the three primary themes was acted on. The following discussion describes the purpose of the three praxis events and how they took place. They include: 1) the formation of the NCN Otinawasuwuk (Receivers of

Children); 2) the Empowerment of Aboriginal Women Surrounding Childbearing Project; and 3) the midwifery field study trip. A detailed discussion in succeeding chapters describes how various aspects of the praxis events are being applied in the context of the research findings.

6.11.1 NCN: Otinawasuwuk (Receivers of Children).

NCN Otinawasuwuk was formed in January of 2001. The women identified a need to be recognized as a non-profit organization in order to reflect their evolving identity and autonomy, provide a framework for their grassroots infrastructure, and develop the childbearing model they envision for NCN. The NCN Otinawasuwuk membership is made up of 15 women, who received training as labor and birth support facilitators in NCN during this time (January 2001). Elaine Montgomery, an obstetrical nurse from Calgary, Alberta provided the birth support training after the research findings identified a need for this. It was funded by the NCN Human Resource Development Authority.

6.11.2 The Empowerment of Aboriginal Women Surrounding Childbearing Project

The proposal for funding was written in August 2001 in NCN with several of the core group of women, key informants and women involved in band administration, in addition to the support of health services, businesses, organizations and Chief and Council. Wide community involvement was necessary for the development of the proposal. In addition, the proposal needed to demonstrate how existing health services would complement and act as a resource for this project. In itself, it proved to be an

ethnographic opportunity to become more knowledgeable about the community. As well as a means to further gather, interpret and validate data. As a praxis event, it is based on all three major themes, addressing issues surrounding autonomy subjugated, autonomy re-sought and the envisioning of an alternative birthing model. The funded project (see Appendix D) was implemented under the administration of the Family and Community Wellness Centre NCN: Otinawasuwuk (Receivers of Children) program. The project employed one coordinator (Shirley Anne Linklater) and six facilitators (maternity workers). A second proposal was collaboratively written in August 2002 and conditionally approved by the Aboriginal Healing Foundation for an additional two years of funding (2003-2005).

6.11.3 Midwifery field study trip.

The field study trip (see Figure 6: Itinerary) was undertaken in June 2001 to Ontario and Texas with Shirley Anne Linklater and Lenora Spence, two study participants. The praxis and research component of the study trip had its basis in each of the three primary themes. The purpose of the study trip was to assist the women in the re-establishment of childbearing practices in NCN. This would be achieved in several ways, the first of which was through engaging in dialogue and building a network of Aboriginal midwifery resources to draw on. We would also gain firsthand knowledge of the philosophy, infrastructure and birthing model implemented at the Tsi Non:we Ionnakeratstha (the place they will be born) Ona:grahsta' (A Birthing Place) at Six Nations near the Grand River. Finally, we would explore educational opportunities at this centre and the Maternidad Del Luz birthing centre in El Paso, Texas. En-route to

Toronto, Shirley Anne shared her perspectives of going on the trip: "... I'm looking forward to this trip... I can't wait until I meet the other midwives, and I hope I learn lots."

A failure by several of the women to raise the necessary monies through an NCN bingo lottery game for a planned trip that would have included a number of participants resulted in limiting the trip to two women. The trip was facilitated financially with the use of airline passes that I obtained from a friend. Chief and Council provided the nominal funding necessary for expenses. The trip date itself came up somewhat abruptly in a span of a few days. Traveling with airline passes in this case required that we travel when there was space available for three people on the aircraft from Thompson to Phoenix. This came about in early June, 2001. The women chose to travel to The Tsi Non:we Ionnakeratstha (the place they will be born) Ona:grahsta' (A Birthing Place) in order to interact 'Nation to Nation' instead of first traveling to Innuulisivik Maternity in Povungnituk, Quebec. Time constraints did not allow for us to travel to Povungnituk at a later date.

June 2, 2001	Traveled by air to Toronto. From airport to Dufferin Grove Park to attend annual Midwives Collective of Toronto picnic. Interviewed by CBC radio reporter Sandra Bartlett.
June 2 – June 5, 2001	Stayed with Carol Couchie, Aboriginal midwife.
June 3, 2001	Sight seeing with Carol Couchie, and family. Interview with Carol Couchie.
June 4, 2001	Travel to Tsi Non: We Ionnakeratsha (The Place Where They Will Be Born): Ona:grahsta' (A Birthing Place) at Six Nations, near the Grand River to discuss the functioning of the birthing centre and barriers to midwifery with the director and midwifes. Follow-up interview with Shirley Anne Linklater and Lenora Spence.
June 5, 2001	Traveled to Phoenix, AZ by air and then on to Tucson, AZ
June 5 & 7 2001	Stayed in Tucson, AZ with daughter of researcher
June 6, 2001	Traveled to El Paso, Texas by road. Toured Maternidad La Luz birthing centre. Interviewed midwives. Shirley Anne Linklater stayed at birthing centre as observer for eight hours.
June 7, 2001	Morning participant observation at birthing centre. Traveled back to Tucson.
June 8, 2001	Traveled to Winnipeg via Toronto. Shirley Anne and Lenora stayed in my home for night.
June 9, 2001	Field Study Trip follow-up interview with Shirley Anne and Lenora, who then traveled to Thompson by air. I shared the video recording of the trip with a Kagike Danikobidan Committee board member in her home.

Figure 6: Midwifery Field Trip

6.12 Praxis Research Settings

The praxis research settings in this section arose during the time (July, 2000 to April, 2001) of the fieldwork in Nelson House. It was decided during this period by several of the participants involved in the core group to engage in further fieldwork in other locations. Several gaps in knowledge had been identified around education and birthing centre infrastructures that were believed could be best met by obtaining this information firsthand in their natural setting. These settings also afforded the participants, as co-researchers with an opportunity to form collegial relationships with other First Nations women in the case of the midwives employed with The Tsi Non:we Ionnakeratstha (the place they will be born) Ona:grahsta' (A Birthing Place) at Six Nations of the Grand River.

6.12.1 City of Toronto.

Toronto was the setting where Shirley Anne Linklater, Lenora Spence and I stayed with Carol Couchie, Aboriginal midwife, for several nights in the summer of 2001 en route to El Paso, Texas. We attended a gathering of the Midwives Collective of Toronto at Dufferin Grove Park. Informal interviews and discussions took place with several midwives and some were recorded.

6.12.2 Six Nations of the Grand River, Ontario.

The Tsi Non:we Ionnakeratstha (the place they will be born) Ona:grahsta' (A Birthing Place) is a maternal and child centre at Six Nations of the Grand River, near Brantford, Ontario. I visited the community and birthing centre with Shirley Anne

Linklater, Lenora Spence and Carol Couchie during the field study trip. We recorded and videotaped interviews with staff and midwives in a group setting and toured the facility. We chose this facility for a visit because it is well established, easily accessible and preferential to the women who wished to discuss childbearing issues and midwifery with other First Nations women.

6.12.3 City of El Paso, Texas.

El Paso is located in the western most area of the State of Texas and shares a border with Mexico. The Maternidad La Luz birthing centre that we visited primarily serves Mexican clientele from border communities. This site was chosen for several reasons. A number of women from Six Nations traveled to this site to obtain their midwifery education. The facility was highly spoken of by these women in addition to Manitoba women who obtained components of their midwifery education at the Maternidad La Luz. I visited the site over a two-day period with Shirley Anne Linklater and Lenora Spence during the field study trip in the summer 2001. A videotaped discussion took place with one midwife and the facility was toured. I observed and engaged midwives in discussion on several occasions. As well, on one morning, I observed the midwives reporting to each other and took part in their sharing circle prior to beginning their day's work. Shirley Anne Linklater took the opportunity to spend eight hours in uniform one evening at the centre, where she was mentored by a midwife and interacted freely with women in labor. Lenora asked many questions when she visited the facility on several occasions. I recorded my observations and interactions into my hand tape recorder for discussion later with Shirley Anne and Lenora. The video tape was

reviewed with the women as well. In addition, the tape is being used by the NCN Otinawasuwuk in educating women and community members of birthing centres in other locales.

Chapter Seven: How did Childbearing Autonomy become Subjugated?

7.0 Introduction

In the previous chapters I have discussed how the theoretical approach provided direction to the research and served as the analytical lens for understanding the research findings. In addition, I examined childbearing practices and issues that could impact an alternative childbearing model. As well, I discussed the research design and methods. In the remainder of the thesis, I am presenting the study findings and a discussion of their implications. In this chapter I will examine how childbearing autonomy became subjugated in northern communities, including NCN, to provide historical accuracy; and to assist with the decolonization of community members through qualitative and documentary analyses. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

7.1 Implementation of Maternal Evacuation: The Medicalization of Birth

Childbearing practices in Nisichawayasihk Cree Nation came to be subjugated gradually, over time. The changes took place through federally employed health care providers who were carrying out the policies of their employer. The changes also reflect the biomedical approaches of the health care providers to their work and the people they came to serve.

Shirley Anne Linklater received her second name in honor of nurse, Anne Wieler, who attended her birth. When the young Anne came to work in the matchbox style

nursing station in Nelson House as a nurse from 1954 to 1956, births were already taking place routinely in the nursing station. Local midwives attended births in the bush if they were in the vicinity. A husband, friend, family member or a midwife would accompany a woman who was going to give birth at the nursing station. However, they were not involved in the birthing process. The Nelson House nursing station catchment area also included that of South Indian Lake. Some women from that community traveled to Nelson House to await birth in the nursing station. A log house was used for women to stay in (Anne Wieler, telephone interview, September 23, 2002). The evacuations began in the 1960s. Women from Nelson House were initially evacuated to Wabowden by float or ski aircraft. They then traveled by train to The Pas to await birth at the hospital. Several participants recalled that their mothers had been evacuated for months at times due to the freeze up or break up of the lake.

Rita Dozois and Kathleen Jo Lutley are highly respected former nurse-midwives who I interviewed for their historical perspectives during their employ in northern Canada beginning in 1956. Jo Lutley arrived in Canada in 1956 as an experienced British nurse-midwife to begin her work in the Grenfell Mission in Labrador. Her diverse and committed career took her into the Arctic and Manitoba until 1983. She received the Order of Canada for her work in 1986. Rita Dozois, Saskatchewan-born of French descent, is also widely known and respected for her work in northern Manitoba and Ontario. She retired in 1989. She relates that at the time of her graduation from the Misericordia Hospital, births in the City of Winnipeg were generally carried out in hospitals. Following her graduation, Dozois began working in the Big Trout Lake nursing

station in northern Ontario. Dozois' was also responsible for six surrounding communities. Here, as the only nurse, she attended to her first births, alone.

The two nurse-midwives are unaware of any official directive from Ottawa that initiated the general maternal evacuation of all pregnant women. It was their belief that the general and extensive nature of maternal evacuation required the involvement of persons in authority other than the (mostly Canadian) nurses working in the field or in management. However, Dozois relates: "I never heard of that decision" (January 28, 2001). During their extensive tenure (some three decades) in senior management positions, neither has ever seen a document that frames the maternal evacuation policy.

Canada's long history of restricting the birthing process to the realm of physicians who preferred to practice in southern locations resulted in a need to recruit out-of-country nurse-midwives where possible, to work in under-serviced northern communities. According to Lutley, nurse-midwives were recruited who received their midwifery education in Britain, New Zealand, Australia and the US. Dozois maintains that the federal government had a preference for recruiting British nurse-midwives. She observed that out-of-country nurse midwives were continuously recruited until around 1980. There was a brief cessation in the early 1970s when the Department of Immigration prohibited their immigration.

The difficulty recruiting and retaining nurses and nurse-midwives is apparent from a 1964 *Medical Services Central Region Annual Report*, (The Central Region during this period included the registered Indian population of Manitoba, northwest Ontario, and the Inuit of the Keewatin District). The report reads: "Three of the 10 midwives who went back to England are reported as having returned to the Region"

(Dept. of National Health and Welfare, 1964, p. 5). It is also noted that 51 of the nurses who were recruited terminated their employ. According to Dozois, out-of-country nurses comprised about one-third of the nurses working in the North.

Canadian nurses without formal midwifery education for the most part gained midwifery skills on the job, in the same manner in which they learned to provide primary health services. A 1963 Central Region annual report reveals that the nurses: "did not always have much midwifery experience" (Dept. of National Health and Welfare, 1963, p. 46). In 1967, the Outpost Nursing Program for northern nurses began at Dalhousie University. The two-year program had a one-year midwifery component that was equivalent in time and content to British midwifery preparation. It was expected that nurses who graduated from this program would function at the same level (May, 1967). The autonomy and isolation of the nurses and their varied background, education and culture was to play a role in the differing ways they approached the northern childbearing culture. In addition, the unwritten policy directives of their federal employer provided flexibility in the way policies were implemented.

7.2 Reflections of Aboriginal Child-bearing Practices

I found the early observations of Aboriginal childbearing practices by Rita Dozois and Jo Lutley to be positive and insightful. They concurred with those of NCN participants at several junctures. Lutley relayed a poignant story of visiting a family following a birth in a snow-house in Frobisher Bay in 1960:

> I didn't do the delivery; it had been done at home. There was a father proudly skinning an enormous white hare ... He skinned it – keeping the whole skin in place all in one piece and then he turned it inside out and that is when I arrived. I couldn't think what was going to happen, there was the fur inside and the bloody

> sort of skin outside and he took the little baby and put it in the there and I thought "baby, baby bunting, daddy's gone a hunting, to fetch a fine little rabbit skin to wrap the baby bunting in" [she sings it to me as a lullaby]. I saw it done right in front of my eyes (November 28, 2000).

According to Carol Prince, NCN band member, the use of rabbit skins for bundling a newborn differed in her culture. She relates that several rabbit skins were cut into strips. After they had dried and the edges had been turned up, they were woven together into a warm blanket (personal communication, September 20, 2002). Although there were cultural differences in childbearing practices among Aboriginal peoples, Lutley observed in general that Aboriginal women were superior in knowledge of the underlying principles of the anatomy of childbirth as compared to their European counterparts.

> You could have all this group of people together and their own interpreters explaining various points and the first thing you would realize how much more knowledgeable the Inuit or the Cree people were about the anatomy of childbirth than ...Caucasians (November 28, 2000).

Another story, told by one Nelson House participant, illustrated the expertise that Aboriginal midwives possessed. She described how her grandmother, a traditional midwife, carried out a Caesarian section on a woman who died of an accident on the trap-line in her eighth month of pregnancy:

> XX: Sad thing, one time one of the ladies was trapping and she slipped and she hurt herself and my granny got called out ... this lady had died.
> SH: Oh really?
> XX: And she was pregnant, about eight months pregnant.
> SH: Oh.
> XX: And they had to take the baby out, otherwise the baby would die.
> SH: How did they do that?
> XX: I don't know but they got the baby out anyway.
> SH: And the mother was dead?

XX: Uh huh.
SH: And did the baby live?
XX: The baby lived
SH: Wow. Was the baby normal?
XX: Uh huh. She's a grandma now…

This participant had given consent to use her name in quotes. However, given the sensitive nature of the topic, I asked whether she would prefer to remain anonymous in this particular quote. She responded in the affirmative. The date of the interview is also excluded to protect her identity. The subjugation of Aboriginal knowledge historically (RCAP, Vol.3, 1996) has made First Nations reticent to disclose practices that may appear controversial from the perspective of non-Aboriginal people. In many instances, government policy was restrictive of Aboriginal cultural practices and expression. In addition, Western health care providers knowingly or unknowingly undermined traditional practices. For example, reference is made to this effect in Rath's (M.D., M.P.H.) submission to the annual 1967 report for this region of medicine men still "exert a strong influence." He suggests this creates a "communication and social barrier" between Indian people and the non-Indian health care provider (Rath, 1967, p.4).

The ability of traditional midwives to manage difficult situations is evident from Dozois' observations of a home-birth that took place in a northwestern Ontario First Nations community:

> A 16-year-old came and told me the baby had died … I ran for a mile and a half … and when I got there the grandmother had the baby on her knee and she was mashing the cord … They had cut the cord – the baby was turned over on its side with its head hanging on her leg … and they told me it was alive and I thought well, at least they got it so it will drain a bit of that junk (January 28, 2001).

However, the abilities of Aboriginal midwives were unrecognized by policymakers in the federal government. According to Dozois, "the department did not acknowledge that there was such a thing as a traditional midwife..." (Dept. of National Health and Welfare) (January 28, 2001). On the other hand, nurse-midwives did not have "any particular reason to think that local or untrained midwives were a danger or anything like that" (Lutley, November 28, 2001).

Nurse-midwives differed in their approaches to the work of Aboriginal midwives. Dozois gives two examples of how her approach differed to two midwives. Of one midwife she relates: "she was quite happy with not having to do it but if she had to do it she would." In another case, her instructions suggest a closer working relationship with the midwife, whom she told: "I'll be back tomorrow night so if something happens you can bring her (woman in labor) to the nursing station and have the baby there if you want to or do it at home" (January 28, 2001). Generally, as Dozois recalls, "The families always made sure that the woman was brought back (from the bush) to the community near her date so she could be delivered at the station" (January 28, 2001). This orientation reflects the general policy of the federal employer. A 1964 government annual report reads:

> It is the general policy in this Region to ensure that confinements are conducted in hospital wherever possible or in nursing stations where a qualified midwife would be in attendance (Dept. of National Health and Welfare, p. 57).

There is an unspoken acceptance in these narrations and reports of the right of the federal government to intervene in the birthing practices of First Nations communities with federally employed health care providers. This colonialist orientation is reflective of the historical relations between Western and Aboriginal peoples.

7.3 The Vagaries of Statistics: The Risk Controversy

Prior to the initiation of the maternal evacuation policy, Jo Lutley recalled it would have been difficult to keep reliable statistics of births since many of them still occurred on trap-lines. She says of statistics: "I never had any reason to put a figure on them, because I never heard of any deaths" (November 28, 2000). The isolation of northern nurses, their autonomy, and varied backgrounds resulted in differing ways of assessing the risk of childbirth. Dozois indicated risk was assessed where possible from a woman's previous obstetrical history. She relates that in Manitoba and Ontario high risk First Nations women were initially evacuated beginning around the mid-1950s. A policy later developed where first pregnancies and women with four or more pregnancies, in addition to women with a questionable medical history were evacuated for childbirth. She recalls that there was no written directive from her federal government employer to this effect but that it was discussed at various regional workshops. The 1964 *Medical Services Branch Central Region Annual Report* indicates a general understanding of this policy: "Wherever possible, also, all primiparas and grand multiparas are sent to hospital for confinement where medical officers are in attendance" (Dept. of National Health and Welfare, 1964, p. 46). Lutley maintains the time interval (two to three weeks) for evacuating the women was derived from a perceived need for the women to improve their nutritional status during the time they were awaiting delivery.

The variance with which nurses and nurse-midwives felt comfortable dealing with risk was not based solely on education. Dozois found that unless the British nurse-midwives had first begun their work in a setting like the Grenfell Mission, in Labrador,

they were not psychologically well-prepared to practice midwifery in an isolated northern setting. The nurses' autonomy ensured that they were able to evacuate women, if they believed it necessary. "If the nurses weren't comfortable in doing it, they were allowed to send them out." An alternative means of achieving a comfort level for the nurses came from the use of their network with each other through the two-way radio. Trained nurse-midwives were especially revered in their capacity as consultants to other nurses by way of radio back up. They were told: "Leave your radio on in case we need you..." (January 28, 2001).

Rita Dozois maintains there was a concern about the IMR at the time that may have provided an impetus for some nurses to "send women out," possibly reinforced by a few maternal deaths. Of a perceived increase in the PMR, Lutley recounts:

> I've never heard that or anyone prove that there was any. I doubt very much; my hunch is that that didn't happen unless it was something that was going to happen naturally anyway, something like it was a very premature delivery ... Now we're talking back in 1956 and 1960, statistics were not a part of the language of doctors and nurses working in isolated communities at that time [laughs]. It just wasn't. You did what the day required of you, and you kept numbers and such like (November 28, 2001).

She goes on to say "Childbirth had a healthy connotation ... in the 1950s, 60s, early 70s. I wouldn't have had any qualms about attempting any kind of delivery." The PMR and maternal mortality rates were not believed by either nurse-midwife to have played a significant role in the initiation of maternal evacuation. The following rates are related with caution since they take place over a small time period in addition the rates do not discriminate if the rates pertain more to some areas rather than others. The PMR rates were not collected until 1963, according to the 1964 Medical Services Branch Central Region annual report. This report indicates the rates were: PMR as x 1.3; neonatal rate as x 1.6 and

the IMR as x 3.5, that of the general Canadian population. The three maternal deaths in Central Region are described as:

> Probably preventable; if their confinements had been in hospital, these women would probably be alive today. Correct management of the third stage of labor was shown to be of utmost importance; and when problems did arise they sometimes proved difficult for the field nurse to cope with (Dept. of National Health and Welfare, p. 47).

This admission that the field nurses were not likely trained well enough in an earlier quotation is likely to have contributed to their inability to cope with difficult problems. The expedient answer to these situations, according to government reports, lay in institutionalizing birth. The 1964 annual report suggests that most of the women were giving birth either in the nursing station or hospital. During 1964, the report indicated that in the previous five years, there was a downward trend in maternal mortality rates (Dept. of National Health and Welfare, 1964).

A 1967 submission by Otto J.S. Rath, M.D., M.P.H., in the annual report makes particular reference to Manitoba in his summary of the government's position:

> Mothers are encouraged to have their children in hospital or in one of our nursing stations when qualified midwives are available. It is a general rule in isolated areas that all primiparas, all gravida IV and over and those with suspected complications, be sent to the nearest hospital for confinement and treatment of complications. Approximately, 85 to 90 percent of mothers are confined to hospital. In this manner, we minimize the number of maternal deaths. For people who live in isolated areas, one would expect the maternal death rate to be much higher than it is (Rath, 1967, p. 5).

This report like the others emphasizes the need to institutionalize women for childbirth as a logical means to circumvent potential problems. There is no acknowledgement that Aboriginal midwives, better trained nurses, or more Western prepared midwives might be an alternative to addressing the problems. Frequently, antenatal care is cited in the reports

as a means to optimize birth outcomes, but this observation is deemphasized in favor of mortality rates.

In First Nations and Inuit Health Branch reports from the mid-70s to the current time, the importance of antenatal care is repeatedly emphasized as a means for an improved birth outcome. A higher number than usual maternal mortality rate in 1965 was believed to reflect:

> In large measure, irregular attendance of pregnant women to receive prenatal care on a regular basis in order to detect complications; the high rate is also due to the scattered nature of the population in isolated areas, which we do not have ready access to a medical centre. We must continue our efforts to increase attendance at prenatal clinics (Dept. of National Health and Welfare, p. 58).

As well, an analysis of the infant mortality rate that decreased by 50% in one decade (96/1,000 live births in 1956 to 48/1,000 live births in 1965) found that birth outcomes were improved in women who had more antenatal care (Graham-Cumming, 1967b). However, despite the knowledge that antenatal care was a significant contributor to an optimal birth outcome, policy-makers responded by increasingly institutionalizing women for birth. It is also significant that in nearly 10 years (1974-1982) the PMR did not decrease even though most women were being evacuated to hospital for birth. The IMR, a controversial rate, was seen by sources including those in Medical Services as being influenced by socio-economic status in the Aboriginal population. Yet, it was frequently cited as a reason to institutionalize women for birth. Even the IMR was considered to be a target for medicalized solution, according to a 1967 report. The report indicates that there was a potentially higher IMR in larger families. To counter this, it was thought the contraceptive pill could offer a solution. However, after analyzing the demographics of birth in 1967, policymakers concluded that the rates were not higher in larger families.

Instead, they recommended that the contraceptive pill be prescribed for "social and economic" reasons (Dept. of National Health and Welfare, 1967, p. 20).

7.4 Infrastructure Preparedness in Thompson for Maternal Evacuation

The implementation of maternal evacuation on a routine basis required that an infrastructure be in place to accommodate greater numbers of women. The transportation of women was an important mitigating factor in the initiation of maternal evacuation. European nurse-midwives were familiar with maternal evacuation and one can assume would not have been adverse to its use. Maternal evacuations by aircraft were taking place, for example, in Sweden as early as 1929 of women with childbirth complications. As well, medical aerial services were generally in place in Australia and in Canada by this early period (Kerr, 1933).

According to Dozois, the nurses generally had concerns about the transport of patients by air in case of an emergency. They felt there was no back up if something went wrong. The vagaries of weather aside, in optimal weather it could take up to nine hours to get a patient out of the community (six hours for an aircraft to arrive and three hours air time travel to the city). In 1960s and 70s aircraft were not coming in at night because airstrips were poor and without lighting. Pilots were not always reliable either. Some liked to 'party' and would not arrive in time or in good enough condition to navigate the skies. The nurses believed it was preferable to evacuate the women prior to their expected due date with scheduled flights which were less costly, rather than trust the reliability of emergency aviation services.

Infrastructure needs to accomplish maternal evacuation expediently also required that the women have a place to stay while they waited, as well as a hospital where they

could give birth. A larger hospital became necessary in the Thompson area to facilitate the growing First Nations population that included Nelson House. According to a letter read to me by Jo Lutley from the Assistant Deputy Minister in Ottawa to Dr. Black, Regional Director for Medical Services Branch (Dept. of National Health and Welfare) dated February 26, 1973 a plan was in place to provide the hospital coffers with further funding for hospital expansion. The additional funding by the federal government was believed by government as necessary in anticipation of increased hospital utilization by First Nations in the region. The letter also states: "visiting physician services are now being provided in Thompson to the communities." According to Lutley, from around 1968 onward, physician visits to the surrounding communities took place on a more regular basis (e.g. a on a weekly basis in Nelson House). She observed that with the increase in physician services to communities like Nelson House, the routine relocation of birth to a hospital site became more common (December 3, 2000).

The routine hospitalization of women for childbirth also required that they have a convenient place to stay during their evacuation. The Young Women's Christian Association (YWCA) or the Y came to provide this service. According to Lutley, the organization came into existence with the generous gift of a building by Inco, the main employer in Thompson. At the time, Lutley suggests the modern amenities were appealing to the women; in addition, the facility provided a place to stay when they came to shop (November 28, 2000).

An overview of childbirth-related entries by nurses at the Nelson House nursing station reflects the infrastructure changes that were taking place in Thompson (Chart records prior to 1975 have been destroyed). Entries in the nurse's record keeping books

from February 5, 1971 to March 28, 1978 indicate births in Nelson House were sporadic and were generally taking place in The Pas prior to 1973. The infrastructure development vis-à-vis the hospital, the Y, and increased physician services is reflected in the record book which indicates that after 1973, most births took place in Thompson with a few exceptions where a birth occurred in the nursing station.

7.5 Summary

The examination of the evolution of medicalized childbearing practices including the maternal evacuation policy in northern Manitoba and specifically Nelson House provided a means to explore how Western childbearing practices came to be predominant. In Foucault's approach to discourse analysis, which requires "studying the history of ideas, as they evolve...how one or another object could take shape as a possible object of knowledge" (Kritzman, 1988, p.31), he used text to understand how mechanisms of power are exercised (Jupp & Norris, 1993). The recollection of historical events in this section provided topics for reflection among the participants.

The reason for the origin of maternal evacuation of all women is unclear. Perinatal and infant mortality rates are frequently cited by government reports as a basis for institutionalizing women for birth. Yet, the reports conceded the fundamental role of antenatal care in reducing the rates, as well as the contributory factors of social determinants and the need for nurses trained in obstetrics. We know that some nurses working in the North were concerned about the risk of childbirth that such an isolated environment posed to mother or child. There is no clear indication, however, if it was more of an issue in some communities than others, or if it differed depending on the

expertise of the health care provider, frequently a nurse. The availability of nurses, and especially trained nurse-midwives, appears to have played a role, as well as their level of comfort in attending births in an isolated community. Generally, the move toward institutionalizing all women for birth where physicians were in attendance reflected the social norms of the time. O'Neil and Kaufert (1990) maintain because midwifery was generally not recognized in Canada, that "in the medical view, a midwife managed birth did not count as medically attended" (p. 63). They suggest that the dissonance between northern midwives and physicians must be seen in the greater Canadian historical context of the medicalization of birthing practices (O'Neil & Kaufert, 1990).

Increasingly, a more sophisticated infrastructure and services in the North also played a part in medicalizing birth. Certainly, the availability of air services in different communities made the evacuation of women more expedient and cost-effective. An expansion of physician services into isolated communities likely contributed to an increase in the medicalization of birth. Finally, a health services infrastructure was put in place that would allow women in northern Manitoba to be evacuated with increasing ease. The expansion of the Thompson General Hospital and the availability of the YWCA as a place for women to stay played no small role in normalizing maternal evacuation.

In all the above decisions, what we find generally lacking are the voices of women and First Nations communities in the initiation and continuance of maternal evacuation. The services were inaugurated by non-Aboriginal people in distant cities and for the most part were well-intentioned. It is not difficult to observe the insidiousness of power that Foucault describes in the many decisions which took place in making maternal evacuation a reality. Neither is it difficult to see how First Nations knowledge

was subjugated in favor of Western knowledge. The medicalization of childbearing practices resulted in changing thousands of years of culturally-held birthing norms to the detriment of northern communities in the space of a relatively few short years.

Chapter Eight: What was the Impact of Subjugating First Nations Childbearing Autonomy?

8.0 Introduction

Colonization is described by Weenie (2000) as taking place when one group controls another group that is different. The control of Aboriginal women and children by non-Aboriginal people through various initiatives such as the maternal evacuation policy and the residential school system, separately, and together, have created a situation that is especially destructive to childbearing women. In this chapter, I will discuss how these initiatives by outsiders have had negative and long term effects on Aboriginal childbearing beliefs and values, the self-esteem of women, and the social fabric of the community. The discussion will demonstrate how the safety of women and their babies continues to be compromised by Western childbearing policies and the effects of colonization such as the ones we see reflected in the maternal evacuation policy and the residential school system. In this chapter I will also address how the NCN Otinawasuwuk, (Receivers of Children) organization is bringing healing to their community in anticipation of establishing a birthing centre in Nelson House. Based on the research findings, I developed a collaborative proposal with the NCN Otinawasuwuk and community members to address the effects of colonization on the childbearing population. The project entitled: The Empowerment of Aboriginal Women Surrounding Childbearing was funded by Aboriginal Healing Foundation (see Chapter Six). Although this praxis component of the research is based on all the identified major themes, its primary impetus arises out of the need to address colonization specifically, as it relates to

the residential school legacy. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

8.1 Historical Perspectives on Colonization

The following section places colonialism into an historical perspective and provides a context for understanding the implementation of such devastating policies as the maternal evacuation policy and the residential school system. Such a context allows for a critical exploration of the gradual domination of NCN band members by non-Aboriginal people in their everyday lives. This understanding enables the research participants to challenge the power relations that perpetuated their domination where childbearing practices are concerned.

8.2 European Contact with the Western Cree

This summary on the early introduction of colonization is primarily taken from the writing of Eva Linklater (1997), a Nisichawayasihk Cree Nation band member who was born in Nelson House. Her article, *Archaeology, Historical Landscapes and the Nelson House Cree,* is based on her Master's thesis in archaeology at Simon Fraser University. She currently resides on Gabriola Island, B.C.

The first known recorded European contact with the Western Cree that led to colonization began with the arrival of Thomas Button in 1612 on Hudson Bay where he named the Nelson House River that finds its origins at Hudson Bay. The ensuing fur trade was soon to become the most significant factor of change in the traditional lifestyles of

the Nelson House ancestors. The population plummeted, with an estimated fall of 22 to 50% between 1778 and 1784 due to the smallpox epidemic. The first documented effort to assimilate the Cree came with the aspirations of Sir George Simpson who believed their conversion to Christianity would further assimilation into the Western culture. This was based on the idea that closer ties between the two would be advantageous to the Europeans economically.

In 1840, Christian missionaries arrived in Norway House; from there they traveled by dog team or canoe to visit the northerly Nelson House groups. Their aim was to change the beliefs of Aboriginal people to their own. Traditional ways however, were slow to die out. Reverend E.R. Young, of Threepoint Lake, made the following observation in 1869:

> Here on this hill top were all these sad evidences of the degradation of the people, I wandered around and examined the idols, most of which had in front of them, and in some instances on their flat heads, offerings of tobacco, food, red cotton, and other things. My heart was sad at these evidences of such degrading idolatry... (Young, 1890, cited in Linklater, 1997, p. 13).

The Reverend S. D. Gaudin established the first Christian church (Protestant United denomination) in Nelson House in 1891 (Linklater, 1997). Much of the above setting described by Young in 1890 can still be experienced by NCN band members. I was provided the opportunity to visit an important traditional site referred to as 'Mile 20' with an elder who, with much reverence showed me Cree ways of honoring the Creator. I witnessed much of what Young described, and more. Over 100 years of Christian contact had not succeeded in eradicating traditional beliefs.

Anna and the Indians is a biography written by Nan Shipley about Anna Gaudin, wife of the Reverend S. D. Gaudin. Anna was the first nurse and Caucasian woman in

Nelson House. She began her journey from Quebec to Nelson House to marry Samuel Gaudin in 1895. Nelson House was described to her in a letter by Samuel as a "land full of Rachels weeping for her children" due to a measles epidemic that the community was experiencing (Shipley, p. 4). The impact of European contact became further evident with her introduction to the Cree. On her journey into the area by York boat, she recollects how she heard women beautifully sing "Jesus Saves" in Cree. She also encountered men with Anglo-Saxon names that they had taken upon converting to Christianity. The removal of children from the community to attend residential school began during the time of the Gaudins. Eight children of mixed background who had come to reside at the Mission in Nelson House, in addition to the three children the Gaudins had adopted, were sent by them to Red Deer, Alberta to attend residential school. Five of the children died of tuberculosis. In 1906, after 11 years in Nelson House, Rev. Gaudin was deployed to Cross Lake. The couple was asked to bring as many school-age children as possible with them to attend the new residential school in Norway House. Most parents refused, recalling what had happened to the children who were sent to Red Deer.

8.3 The Upheaval of the 1960s

The 1960s comprised a period of profound change in Nelson House. Eva Linklater (1997) observes that "large-scale disruption of life-ways in Nelson House did not come about until the 1960s, with the opening of Highway 391 and the planning, and later development, of the Churchill River Diversion project" (p. 14). Today, she describes Nelson House as dominated by Canadian government bureaucracies, including the federally administered nursing station that was established in 1943. With regard to the

relationship of the Cree to the land, the 1960s proved to be particularly disruptive because of the enforced enrollment of children in residential and reserve schools. Community life became more sedentary for families where children attended school in Nelson House. According to Linklater, the opening of the Highway 391 in 1969 brought the relative isolation of Nelson House to an end. Easier access to Thompson wrought negative changes in the community, among them an increased reliance on consumer goods. Families continued to use the campsites on special occasions which provided a valuable link to the land. This, however, decreased in the 1970s with the Churchill River Diversion Hydro-Electric Program which flooded these lands (Linklater, 1997).

Record-keeping books that I was shown at the nursing station from the early 1970s reflected the changes that took place in Nelson House in the previous decade. My attention was drawn to the increase in the incidence of deaths by violence and accidents following the construction of the Highway 391. These deaths were allegedly due to increased vehicle transportation and access to alcohol. According to one elder, the use of alcohol was first noted in Nelson House as early as 1946. However, women were first known to abuse alcohol when access to Thompson became easier. On reviewing the record book with women employees at the nursing station, memories were recalled and stories emerged. Various events were related, including the disappearance of an infant who was hospitalized for a respiratory problem in the Thompson General Hospital, and of the disappearance of newborns following birth in distant communities. It was during the 1960s that the maternal evacuation of women for childbirth evolved into a general policy. It was also during this time that a very high number of children found their way to residential schools or became victims of the 1960s scoop (child apprehensions) by

government child welfare authorities. The tuberculosis evacuations and their often tragic outcomes were also in recent memory. It is not difficult to understand how the cumulative effects of these colonial impositions are still evident in the community today.

8.4 Colonization of Women: Maternal Evacuation

In contrast to Chapter Seven, with its portrayal of the perspectives of non-Aboriginal health care providers and policymakers, this discussion focuses on the responses of NCN women to the implementation of the maternal evacuation policy. From their perspective, the maternal evacuation policy embodies the subjugation of Aboriginal childbearing practices. It also represents the ways other initiatives such as the residential school system and the tuberculosis evacuations were implemented in the context of colonization.

The maternal evacuation policy in Nelson House is seen as "just another form of colonization and oppression...because they don't value our beliefs and our culture " (Jackie Walker, April 27, 2001). A consensus of opinion to this effect was expressed by an elder at a group meeting. In a discussion on the group's perceptions as to the reasons for the implementation of the maternal evacuation policy, she said: "We don't have choices, do we, as native people? We are just told, do this, do that, breathe that way, move that way" ("EL" group meeting December 4, 2000). According to band councilor Agnes Spence, "The mothers didn't want to go out. They were forced to go out. They were forced to go to the hospital to have their babies, even if they didn't want to" (November 30, 2000). Elder Madeleine Spence observed that the maternal evacuation policy was implemented at a time when the chiefs were generally not fluent in English

and that as Aboriginal people, they felt intimidated by non-Aboriginal people and thus yielded more readily to their decisions (group meeting, August 24, 2002).

The continued resistance of women in isolated communities to the maternal evacuation policy is evident in the following narrations taken from a 1981 government annual report: "in some areas it was difficult to persuade expectant mothers to be delivered in hospital" (p. 1). It further observes that "in isolated communities we continue to counter the desire for home deliveries by providing community education on the risks of deliveries in nursing stations and encouraging the use of alternative birthing centres in urban locations" (p. 3). An annual report from 1982 notes that the alternative of a midwife-attended birth in the community was considered a viable option to being evacuated:

> Nursing station births have increased e.g. 38 in 82 compared to 17 in 1981. The increase is partly attributed to trained midwives in the community that band members are aware of resulting in the reluctance of individuals to leave their home communities for extended periods prior to their due date. Staff continues to encourage expectant mothers to be hospitalized for delivery (Dept. of National Health and Welfare, p.1).

Darlene Mason views the domination by Euro-Canadians of childbearing practices as simply a part of a broader trend to control their lives. In the following passage, taken from a group interview with Kim Linklater Beardy, Shirley Anne Linklater and me, she compares maternal evacuation with the tuberculosis (TB) evacuations in the following passage and angrily reflects on tragic the outcomes:

> DM: A long time ago when people were sent out and we were told that babies had to stay behind - a lot of these babies were sold or given away,
> KLB: Uh huh.
> DM: This was done without the authority of the parent and some of them ended up across the sea, down in the States, B.C. or Nova Scotia or elsewhere...
> SL: Especially the young girls.

> DM: Years ago, lots of things were underhanded. No wonder we feel so bitter.
> SH: Some people have talked about it as colonization.
> DM: Recently, they have been digging up a baby's grave. They couldn't find anything.
> SL: No remains.
> DM: It angers me just thinking about it - what they used to be able to do. They used to use us as guinea pigs, too. All these people that had TB in Clearwater Lake - they were just cut up and they were just put in graves, unknown graves (November 8, 2000).

Frequent references during interviews and conversations were made to the disappearance of newborns at birth. The "digging up a baby's grave" refers to a grave that was exhumed in Nelson House in the fall of 2000, following phone calls from a woman claiming to be an NCN band member. A body was not found in the grave, leading the family involved to conclude that the person calling every year on her birthday was a sister they were told died at birth. Like the fate of other newborns, it was believed that the little girl had been adopted-out at birth and the mother told her child had died. The tuberculosis reference to the Clearwater Lake Sanitarium near The Pas is currently creating a political stir due to the voracity and extensiveness of stories of abuse in the facility (McKinley, *Windspeaker,* September, 1998). In addition, there are numerous stories of children who had been placed for adoption either out-of-province or out-of-country during the '1960s scoop' (child apprehensions) by government child welfare authorities. As adults, they would telephone or return to Nelson House in an attempt to contact their families. A former Awassis (child care agency) worker informed me she terminated her employment because she was unable to cope with the number of calls and tragic stories that these individuals told.

8.5 Colonization of Children

The children who were institutionalized in residential schools became adults; many of them childbearing women. As the analysis indicates, often they survived their experiences, but never really recovered from them. When they became parents, their own children experienced the horrific legacy of the residential school system through them, known as the inter-generational impact of the residential school legacy.

The following analysis and discussion demonstrates how detrimental the residential school legacy has been to childbearing women in NCN today. In the following dialogue, where I asked for interpretation of their animated Cree discussion, Kim Linklater Beardy begins by saying they were talking about maternal evacuation. She then goes on to compare the maternal evacuation policy with the residential school system. Kim's reference to the financial gain to outsiders of the residential school system is one she is also making to the maternal evacuation policy. The levity of this group discussion carries an underlying sarcasm of the policies that perpetuated it.

> KLB: We were talking of evacuation. Usually, there is a price tag to everything. When these guys went to residential school they thought that the government was making money off of them [referring to an elder in the group by name]. It was all because of a price tag [economics].
> SH: Uh huh.
> MH: The more children they collected, the more money they got.
> SH: Oh, I see.
> SL: Everybody came home with glasses, brand new teeth and they weren't needed. [They laugh and laugh.]
> MH: So, it cost a lot...[Speak in Cree.]
> SL: Everything had a price tag, your eyes, your teeth.
> MH: See, there you go: there was a reason why they started sending us out and shipping us out. We're expensive.
> KLB: We were very valuable [Lots of laughter all around this time.]
> MH: We were very valuable [More laughter]
>
> (Kim Linklater Beardy, Mona Hart, Shirley Anne Linklater & Shirley Hiebert, November 15, 2000)

The women view the government-enforced policies of maternal evacuation and residential schools as necessarily intertwined. In both colonial incursions they perceive the government as the source of policies that are financially driven. In this case, they cite that the health care offered through the distribution of eyeglasses and dental care was of questionable benefit to the children. Rather, it is seen as a source of financial gain for the government. The more serious impact of the residential school legacy came from the indoctrination of the children and in many instances the physical and sexual abuses that they were subjected to.

8.6 Learning by Precept and Example

In addition to the horrific impact of the physical and sexual abuses suffered by some children who attended residential schools and the ensuing cultural and social upheaval in the community (see Section 8.9), a loss of cultural knowledge and skills around childbearing and childrearing took place. Eleanor Carriere, Traditional Healer explains: "When you are in residential school you don't learn parenting skills." She adds, "We learn by precept and example" (April 27, 2001).

The concept of learning by precept and example can also include learning childbearing behaviors like those relating to pregnancy and birth. Children who were removed from their communities to attend residential schools were not present to observe how their pregnant mothers or other women cared for themselves. Neither were they able to observe childbearing values and beliefs like those related by an elder. Her mother counseled her not to drink or smoke when she was pregnant: "They were strict. You had

to follow their rules" ("EL" group meeting, December 4, 2001). In addition to children not being present to observe these behaviors as a consequence of the residential school system, the maternal evacuation of women, often for months at a time when the policy was first initiated, also eliminated the opportunity for children to learn by "precept and example." Neither were they able to observe activities around birth as an event, like those told to me of when births took place in Nelson House prior to the maternal evacuation of all women. Children did not take part in the birth event; however, they were aware of what was taking place. Sometimes, they were given specific errands, like fetching others to come to assist. They also heard stories, such as the one of the mouse coming to bring the baby. Their young minds confirmed these stories by feeling for the tooth marks of the mouse with their fingers along their own inner ear lobe ridges.

Children were placed at an additional disadvantage in residential schools, where they were taught to devalue their cultural ways and prohibited from speaking their own language. As a result, when children encountered their own cultural values in the home and community they would have been less likely to accept them. One can also assume that to an extent the children would have been perceived as outsiders by their own families and the community. Such was the case of one family, according to Rita Dozois, regarding a child from a northwestern Ontario First Nations community who had been evacuated due to tuberculosis for a number of years. She recalled how the mother brought the child back to the nursing station after he returned to the community. Dozois paraphrased the mother as saying: "He's not an Indian anymore! He doesn't talk, eat or sleep like an Indian!" She was able to persuade the mother to have the child spend time

on-the-land with his father to become reacquainted with his family and culture (January, 2001).

The severing of traditional cultural knowledge in children was not only caused by their physical removal from Aboriginal communities to residential schools. It was also the result of the physical removal of pregnant women in the community for extended periods of time during maternal evacuation. This compromised the transmission of cultural childbearing knowledge to children, and added to what was becoming an ever-more-vicious cycle.

8.7 Loss of Identity and Autonomy among Women

The lack of transmission of cultural values among them, those relating to childbearing practices and the role of women has created a significant vacuum where individual and community life is concerned. For example, the loss of cultural beliefs and values has undermined the identity and autonomy of community members. The weakened ability to identify with Aboriginal values and beliefs potentially creates a basis for low self-esteem among women. Furthermore, low self-esteem increases the likelihood that childbearing women will be susceptible to behaviors that are not conducive to an optimum pregnancy and birth.

Jackie Walker believes community members need to acknowledge the impact of colonization in their lives before progress in healing can be made. In the following April 27, 2001 interview excerpts, Jackie relates her observations of how community members perceive colonization, as well as the relationship of colonization to individual identity:

> JW: People are still in denial about colonization ... about what is affecting them today. They don't try and look at the way our ancestors lived. They don't see

> what the government has done to us as Aboriginal people. They use the example of that's not good, so let's just move on with our lives. How can they move on with life when they don't know that they have been colonized?
>
> JW: A lot of our people have a sense of hopelessness. I shouldn't say hopelessness, but they don't have that pride anymore.
> SH: Because they don't know who they are.
> JW: Exactly.

Jackie's question "How can they move on with life, when they don't know that they have been colonized?" is cause for reflection. The unacknowledged negative impact of colonization addresses an important issue in this research where childbearing behaviors are concerned. The lack of acknowledgement of the processes which have placed community members in their present circumstances make it unlikely they will understand how to make positive changes. As Jackie concedes, the denial of colonization precludes a basis for self-reflection about behaviors that have resulted in a loss of pride and ultimately, a loss of identity. This is especially significant to this research where childbearing women are concerned.

The need for an identity that is congruent with an Aboriginal woman's cultural background becomes self-evident in Bella Leonard's observation. As the Mayor of the Nelson House Community, Bella Leonard speaks from the experience of a woman with a strong sense of cultural identity. She argues that the revoking of her Indian Status under the Indian Act following her marriage to a non-Aboriginal man did not change her identity:

> People shouldn't be labeled [laughs] ... When I first married my husband, I was an Indian myself ... and as soon as I married him ... she's not an Indian anymore ... Why is that? ... You're a person and you'll always be a person (December 2, 2000).

According to Jackie Walker, such a strong sense of identity is not found among many childbearing women. In this April, 27, 2001 interview, she observes that Western childbearing practices have reduced the role of women to mechanical reproducers and sustainers of life:

> JW: Now, there is a negative stereotype of women - as giving life and that's it. ... They don't see the meaning of the whole purpose of that. You are the woman, you have the kids, you take care of the kids – that kind of attitude. But it's deeper than that for them.
> SH: The sacredness is missing.
> JW: Yeah, exactly.

The enormity of what took place with the implementation of Western childbearing practices was not lost on a Kagike Danikobidan Committee board member when she said that "they didn't know what they were doing when they initiated the maternal evacuation policy" (spring, 2001). Carol Couchie, a registered Aboriginal midwife currently practicing in Manitoba, reflects on the loss of control over cultural birthing practices and its implications on women in an unpublished paper:

> As Aboriginal people we look at birth as a ceremony, a re-creation in physical form of our cosmological stories. We have now allowed strangers to conduct this major event in our lives, and thus to transform it into something that no longer belongs to us. The self-esteem of the women and children of the Nation are affected by this loss of power (June, 2001).

These observations of losses incurred to women and children are similar to Jackie Walker's: "A lot of our people have a sense of hopelessness. I shouldn't say hopelessness, but they don't have that pride anymore" (April 27, 2001). One obvious outcome of this loss of power can be seen in the dependence the women have come to have on Western childbearing practices.

8.8 Dependence and the Westernization of Childbearing Practices

The dependence of women on biomedical childbearing practices evident in NCN needs to be seen in the wider context of colonization, rather than simply as a normalization of Western health care services. One might anticipate that the biomedical cultural approach to childbearing practices which have been instituted as a cultural and societal norm in NCN over the past four decades has become the expected way to approach childbearing. However, one might also anticipate that it reflects a resignation to power beyond their control. One participant explained the general sense of powerlessness that I observed among many in the community as apathy, which has arisen from having been disappointed many times. The apathy and dependency is also apparent from an elder's description of the increasing dependency on the nursing station as compared to several decades past, when people were more self-sufficient.

> No one bothered them [nurses] during the night except if it was a delivery – not like now when nurses are up all hours of the night with accidents because of drinking. But in those days nobody bothered the nurse except if it was a real emergency, when someone was in labor (September 26, 2000).

One Aboriginal nurse describes the dependence of community members on the nursing station this way: "A lot of people respect us but they still blame us because they can't take responsibility for their own health" ("EX," October 4, 2000). By extension, in reference to childbearing women, Agnes Spence, band councilor observes that the women have come to "depend on the hospital. They are already in the stage where they have accepted it" (November 30, 2000). The dependent behaviors that are exhibited by community members on the nursing station and by women on Western childbearing

services are consistent with colonization. The behaviors also reflect the medicalization of people and childbearing practices discussed in Chapter Two in reference to the dynamics of biopower. Susan Kobliski 'Spirit Flight Woman,' offers her observations on the Westernization of health care practices in the context of the Family and Community Wellness Centre:

> We're all Aboriginal people. We've got beautiful buildings ... but there's no culture. We're just Aboriginal people, First Nations people, still living the non-Aboriginal way. ... My people are not taking the initiative to find what is in their hearts – what the elders would like – who they are as a Cree nation ... It's just brown people still living the way the non-Aboriginal people want us to live. I don't speak this in a racist manner. I just speak from what I see. I am part non-Aboriginal, and I had to live my life respecting that culture. I'm now in my 40s and I owe it to my ancestors to regain the respect that was here at one time - the spirituality (April 30, 2001).

8.9 Intergenerational Effects of the Residential School Legacy

The residential school legacy in Nelson House is held responsible by community members for drug and alcohol abuse, breakdown of family values, unemployment, cultural genocide, and dependent behaviors. The sexual, physical and emotional abuse that took place in residential schools resulted in dysfunctional behaviors in the victims. The legacy of these behaviors on subsequent generations is referred to as an inter-generational impact. The effects may be seen in the childbearing population in various ways, including alcohol and drug abuse. Eleanor Carriere, NCN band member, traditional healer and social worker, offers this explanation in the following April 27, 2001 interview excerpts:

> Those that suffered abuse never fully recovered from being institutionalized. When they came back to their communities they turned to alcohol as a crutch to lean on – that was their coping mechanism. They couldn't deal with the issue of being abused....

> This is what you see here in some women taking drugs, abusing alcohol - That's the effects of the boarding school system.

Other women frequently showed concern for pregnant women who abused alcohol or drugs. Lorraine Parisien, a woman pregnant with her fourth child, relates the worry she and her husband share regarding alcohol abuse among pregnant women: "We'd say we should show some pictures of what it does to a baby" (November 23, 2000). The effect of alcohol consumption on teen pregnancies was also noted by two young women who were pregnant for the first time:

> NW: Girls around here have babies at 12 or 13.
> SH: How come?
> CQ: Drunk (September 26, 2000).

A similar concern was shown about substance abuse in the school-age population by two school teachers in an interview May 3, 2001. They made an urgent request of me to relay a need for assistance in the school regarding children with behavioral problems and someone to provide "mental health education" that would address the effects of "drug and alcohol abuse ...on the body."

Shirley Anne Linklater (January 7, 2003) reflected that as the research progressed, she more clearly came to understand the causes of alcohol abuse among childbearing women as a consequence of colonization. She related that an understanding of the source of alcohol abuse in the community enabled her to more fully experience healing herself, and to extend forgiveness to others who had previously grieved her due to this abuse.

8.10 Women as De-colonizers and Healers

The understanding that Western childbearing practices and specifically the maternal evacuation policy has, and continues to have a detrimental impact in NCN is one that requires addressing. The belief that there is a need for 'decolonization' in NCN was generally identified by women participants as necessary for the development of self-respect and the re-learning of cultural ways, including childbearing values and beliefs that have been subjugated through colonization. Eleanor Carriere (April 27, 2001) explains that the process of decolonization involves people taking back their identity and the relearning cultural values. In the second interview excerpt, she explains that she sees the role of women in the process of decolonization as one of healer:

> EC: Well, how do you decolonize a people?
> SH: Yes, how do you do that?
> EC: It was through colonization that this happened. To give them back their identity - they have to learn who they are by going back ... to learn their old customs and ways, like respect for women and respect for life - respect for themselves as a human being.
>
> EC: The women will be the ones that change the society.
> SH: Why is that?
> EC: Because it begins in the home. The women will heal their children, then they will heal their men and then the community will be healed. It starts with the family.
> SH: So, it starts with the women?
> EC: It has to start with the women. The women are going to be the ones that make the changes. But correct me, I should say it will be mainly women, because there will be some men, the gifted men that will be helping as well. So, if there is a gifted man, then he will be the one healing the family. I can't say it's just mainly the women because the grandfather just corrected me there ['grandfather' refers to a spirit].

Carol Couchie (unpublished paper, June, 2001), Aboriginal midwife and research participant, includes returning "service institutions" to the control of Aboriginal women in her vision of how women will bring healing to Aboriginal communities:

> At the conference I sat and listened to women from many different nations across Turtle Island. I remember being awestruck and inspired by their strength and wisdom, and encouraged by the leadership skills of these women. Art Solomon, an elder who was the only male speaker on the agenda, gave the closing address. He told a story that is repeated in a video. Art explained that the women themselves were medicine, and that this medicine was essential in bringing healing to the people. These words and the example of these women changed my life forever. Any work towards reconciliation and restoration of our First Nations communities must include strengthening the women and restoring the healing of service institutions that were largely considered to belong to the women. These institutions were taken away from our people and need to be returned to the women.

Her reference to service institutions as belonging to women, are those around childbearing currently under the control of non-Aboriginal people. Agnes Spence, band councilor, observes that reclaiming community-based childbearing practices will require that women be re-educated to think of birthing as a natural process:

> AS: Right now, it's the society that has come in to tell us, to scare us, it's not natural you have to go to the hospital. You have to re-educate people
> SH: Re-educate the people?
> AS: Re-educate the people that it's normal and encourage them and extra education for the moms...of course educate the people that will be helping to deliver those babies (November 30, 2000).

Nurse Carol Prince, the NCN health director, also indicated that educating women of the merits of midwifery would be required to re-normalize childbearing according to Aboriginal beliefs and values:

> We have to start teaching that it is okay to everyone, including the pregnant women. ... The older people, would approve because they know it's okay, they've lived all this time doing it (November 30, 2000).

Jackie Walker's (April 27, 2001) acknowledges that community members have become normalized to the Western notion of childbearing, but she sees this as a problem that can be overcome. She believes this process of overcoming can become an empowering experience.

> The notion of childbirth ... it's been ingrained into people that it is a medical condition. So, we will have to change that. It will take time to de-medicalize childbirth to a natural process. ... When you empower people ... after awhile it becomes a strength for them.

The decolonization of childbearing practices and the empowerment of women have already begun. The NCN Otinawasuwuk in the administration of The Empowerment of Aboriginal Women Surrounding Childbearing praxis project is actively making changes in the community. The following section describes how they are approaching this aspect of the research findings.

8.11 The Process of Decolonization and Empowerment

As I discussed in Chapter Six, The Empowerment of Aboriginal Women Surrounding Childbearing project addresses all of the research themes but it finds its impetus in the residential school legacy and the loss of cultural childbearing knowledge and values described in this chapter. Since the initiation of this funded project in April 2002, the women who refer to themselves as maternity workers have been pursuing several approaches to decolonization. In the initial two months of the project, they met in sharing circles with elders to dialogue on issues arising out of colonization that the research identified in this chapter. Participants were encouraged to share their own stories. Decolonization is compared to labor during childbirth, a metaphor that illustrates the work that needs to be done in each of their lives for their own cultural rebirth, and that of others. This process of dialogue brings about a release of emotion and through this catharsis, healing begins. The women have also been visiting the school to discuss issues relating to colonization, especially substance abuse, and ways to surmount them with adolescents. Throughout the project, the women continue to explore issues of

colonization and ways to initiate healing and restoration. One such approach involves taking part in culturally meaningful events while simultaneously rebuilding social networks. The women participate in on-the-land activities in camp settings, 45 minutes from Nelson House by skidoo (snow-machine), at a place known as Left Rook. Here, they deepen relationships with the land as their historical text, and with each other, while learning to trap and set up winter camps. Pivotal to this process of decolonization is the restoration of Aboriginal childbearing knowledge and values and social networks among childbearing women. This component of the project is more fully discussed in Chapter Eleven.

8.12 Summary

The denial of Nelson House band members' autonomy on decisions around medical and maternal evacuations has created feelings of loss, anger and alienation that are similar to those experienced by other Aboriginal groups (Jasen, 1997; O'Neil, 1986). The colonization of Aboriginal groups like the Nelson House Cree is demonstrated dramatically in the maternal evacuation policy and the residential school legacy. This chapter has shown that colonization is reflected in both of these federally instituted policies that have separately and jointly undermined Aboriginal childbearing values and practices. The Westernization of childbearing practices that resulted in their removal from the realm of women had several very significant effects. The supportive social networks around childbearing that also served as a means of transmitting cultural values and beliefs were largely destroyed. As a result, women were deprived of their former social support systems and culturally-held beliefs and values that were consistent with

what we know today are safe childbearing practices. In addition, the meaningful role of women as one having a sacred identity with childbearing was subjugated in favor of a Western model, of women as reproducers. The loss of the sacred significance of this role had negative implications for women's sense of self-worth. As a consequence of the imposition of Western cultural beliefs of the body and childbearing, the women were forced to assume a more passive role. Inevitably, their less active stance led to dependence on the Western health care model and resulted in compromised childbearing practices.

The evacuation of women for childbirth, especially in the earlier years where it was likely to take place for extended periods, annihilated the opportunity for transmitting cultural values and beliefs around pregnancy and the birth event to other women, children and community members. This was intensified where children were concerned, since many of them were absent from the community by being institutionalized in residential schools. The institutionalization of Aboriginal children who gained knowledge with a 'look, listen and learn' approach (Miller, 1996, p. 21) was further compromised by the residential school system's "emphasis on purging the young mind of language and spirituality" (Milloy, 1999, p. 295). From this perspective, they were indoctrinated not to value their own culture, making the transmission of cultural values circumspect to the young mind. Benoit and Carroll (1995) concur with this study, agreeing that institutionalization had a significant role in depriving children of traditional knowledge like that around childbearing practices.

Another major blow to safe, culturally-significant childbearing practices resulted from what came to be known as the intergenerational impact of the residential school

legacy. Several reasons point to this conclusion. Many children returned to communities like NCN suffering from severe cumulative effects (Grand Chief Edward John, cited in Milloy, 1999). The detrimental effect of the residential school legacy and the colonization process in general, is demonstrated in the dysfunctional coping mechanisms of those who experienced it. These behaviors were transmitted to a segment of the childbearing population, where they are manifested in the use of alcohol and illicit drugs. Not only do these practices compromise optimal childbearing practices, they serve as a means of negative role modeling and encourage continuation of these behaviors in subsequent generations.

A need for decolonization and restoration has been identified as necessary to address individual, family and community healing. Women are seen to be fundamental to this process. To this end, the NCN Otinawasuwuk maternity workers have undertaken to address the issues arising out of colonization in the praxis project, The Empowerment of Aboriginal Women Surrounding Childbearing. Initiatives such as this are supported by Aboriginal women, including Wapass (1992), who emphasizes a need for indigenous people to gain control of their societal structures, and calls for a return of a once shared maternalistic orientation.

Chapter Nine: How Can Risk as a Considered Event Further Autonomy?

Introduction 9.0

> Uncertainty is a permanent part of life and life's beginnings. It is also at the heart of the definition of risk (Hall, 1994, p. 1239).

The notion of risk is a key dimension of modernity in a modern society preoccupied with it (Giddens, 1990). Since the time of Hippocratic writings, it has been known that some pregnant women will have a poorer outcome than others. While risk factors identified over the centuries since Hippocrates have changed in their nature, the concept of predicting which pregnancies potentially will be at risk remains constant (Alexander & Keirse, 1989). The epidemiological, clinician and lay perspectives on risk posited by Gifford (1986) as demonstrating different constructs of risk are applied in this chapter in the context of returning birth to NCN. An epidemiological approach to risk is one where the frequency of an event that occurs in one population is used to project its potential for reoccurring in another group. Kaufert and O'Neil (1993) observe that while epidemiological measurements provide a statistical orientation to the risk event, they do not enlighten our understanding of how risk is perceived as "political and moral construct" (p. 43). For a contextual understanding of how epidemiological data is perceived by populations it is necessary to seek the perspectives of the people themselves. Lay people or in this instance, community members, are concerned with how risk impacts individuals (Bennett, 2001). In addition, they "have different, broader definitions of risk, which in important respects can be more rational than the narrow ones used by experts" (Morgan, 1993, p. 32). Another approach to consider in the assessment

of risk as a basis for intervention is that of the clinician. In reference to a pregnant woman, a clinician will review her prenatal and medical history, and monitor the progress of the pregnancy and the labor process for indicators that might suggest some type of intervention is required (Wall, 1988).

In this chapter, the community member, epidemiological and clinician perspectives to risk will be discussed in the context of the research findings. These varied perspectives will provide an understanding of how the risk of re-establishing community-based birthing practices is conceptualized. This understanding will also provide a means to address how the inherent risk of such an endeavor can be approached. I will argue that community-based childbearing practices will conceivably reduce the risk of an unfavorable outcome to mother and child. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

9.1 Community Members' Perspectives

Jackie Walker (April 27, 2001), as a young woman, suggests that the notion of risk is too entrenched in medical discourse. In her narrative, Jackie intuitively recognizes the complexity of attempting to re-constitute childbearing into a more traditional model, while at the same time having to address a medicalized articulation of risk and the broader implications of a Western health care system. She observes birth has become medicalized and "everything is a risk." Traditionally, however:

> the people believed that there is always a reason for everything. And if a woman or child didn't make it when they were giving birth, there was a reason for that because they believed that things work in mysterious ways. ... Look at it now ...

> the advanced technology ... people want treatment ... to be healed right there and then (April 27, 2001).

Elder Emma Hart, a former midwife, takes the position that a hospitalized birth isn't necessarily a risk-free birth. Speaking through a translator, she pointed out that "in a hospital there are babies that are born that don't make it and it would be the same thing in the community" (August 1, 2000). For Emma, clearly, risk cannot be eliminated, regardless of the circumstances. Leta McDonald, elder and former councilor, stated that birth can take place safely in the community. She elaborated on these comments through a translator:

> It's a good idea. A few young women that gave birth on their own, in the community. There's a nursing station here, just in case of complications. One of my sons was born here (August 1, 2000).

The idea that Nelson House women could birth safely in their own community seemed reasonable to many women. Hilda Primrose and Shirley Anne Linklater did not express any reservations about the viability of community-based births. Shirley Anne's knowledge of birth having taken place in the community uneventfully on previous occasions in Nelson House led her to believe that it is neither a new or radical notion.

> SH: Do you think it's possible to have a baby safely in this community?
> HP: Oh sure.
> SL: There have been babies born in this community (November 20, 2000).

This focus on the normal as compared to the abnormal was summarized by Hilda Primrose and Shirley Anne Linklater in conversation in Winnipeg, January 2002. They responded to my question about the risk of potential problems when birth will take place in Nelson House as: "if you're going to look for trouble, you will find it." Their focus of birth as normal is evident in their statement.

These community perspectives suggest that risk is viewed as an intrinsic component of life events, like birth. Risk is seen as an inevitable part of life; not as an overwhelming obstacle that would negate the possibility of re-establishing childbearing practices in NCN. In a discussion about how to return birthing to the community safely, Ella Moose and Elder Madeleine Spence exchange perspectives on the need to proceed with caution. They raise the issue of being held accountable for a bad birth outcome in a December 4, 2000 group meeting:

> EM: We have got to think about these people's lives [mother and child].
> MS: They would get charged if something went wrong.
> SH: Okay.
> EM: Ya, you know federal law.
> [others talk]
> EM: You have to think about what if something happens and you get slapped with a big law case.
> SH: Uh huh.
> EM: You know, things like that are going to happen.
> SH: Uh huh.
> EM: That's not what we want.

No one ever put forward arguments that suggested birth should not be returned to the community because of the risk of a bad outcome. Instead, it became clear that some people needed more information about the possibility, or assurance that an infrastructure would be in place to decrease risk. Jerry Brightnose, a business man, observes: "I think a lot of people could be educated. A lot of people are kind of skeptical. For me, maybe, I need more education to make a sound judgment" (April 23, 2001).

9.2 An Epidemiological Perspective

A project entitled *Prenatal Risk Assessment: Analysis of Pregnancy Risk Factors Affecting Prenatal Patients in the First Nations Community of Nelson House* provides a demographic perspective of the women who utilized antenatal care in Nelson House. It was carried out in 1997 by University of Manitoba medical student Shawkat Kibria. The retrospective chart audit of NCN pregnant women (1995-1996) determined the prevalence of identified risk factors that were being used as a basis for a risk scoring system. Kibria used the Manitoba Prenatal Records as a source of data collection. The Manitoba Prenatal Record is composed of two parts: Part 1 includes demographic and medical information; and Part 2 refers to the visits made by the pregnant woman to the clinician. Risk scores were tabulated by assigning each risk factor a numerical weight. They were then added according to categories. Final numerical scores were labeled with designations that ranged from low risk to extreme risk. However, such risk scoring generates poor predicative outcomes, especially where the risk scoring is largely based on demographic attributes and past obstetrical history recorded at the initial visit (Hall, 1994). In Kibria's project, it is important to note that the risk factors, with the exception of anemia and recurrent urinary tract infections were entered on the prenatal record when the initial history was taken. The scoring of risk factors at 36 weeks that were entered on the woman's initial visit suggests that the risk factors are not modifiable. For example, smoking, alcohol and drug behaviors are not re-entered on the record. Therefore, it is not possible to determine if the behavior continued near the end of pregnancy when the risk scoring took place.

The risk-scoring system, as Kibria (1997) indicates, has met with controversy – so much so that in 2000, alternative prenatal records were developed by the Manitoba College of Physicians and Surgeons. According to Hall (1994), a review of Canadian prenatal risk-scoring guides found the risk designations to be seemingly poor indicators for determining risk. As well, even though women with high risk scores have more adverse outcomes when they are applied to individual risks, they become "polyphonic and outcome discordant" (Hall, 1994, p.1241). Furthermore, risk scoring is based on maternal characteristics when the "preponderance of adverse outcomes are fetal" and "for the most part, obstetric risks are undefined and unmeasured, and where numerical weights are assigned they are arbitrary" (Hall, 1994, p. 1241). The inclusion of Aboriginal status as a risk factor in the current scoring form has a racist undercurrent. As we have seen from previous discussions in Chapter Five, social determinants play a key role in predisposing a childbearing woman to a poorer outcome. In addition, the labeling of women according to arbitrary numerical values objectifies them in a colonialist manner. For these reasons, and the fact that the Kibria (1997) study project spans only two years, cumulative percentages of individual risk scores are not included in this discussion. Instead, the perinatal mortality rates (PMR) (1985-1999) of Nelson House at 19/1,000 births is placed in the context of the range for other on-reserve rates ranging from 2.5/1,000 to 45.5/1,000 (First Nations and Inuit Health Branch, [data file] 2003).

A demographic description is provided here of the women who became pregnant in 1995 and 1996 from Kibria's (1997) project. In each of the two years, there were 95 pregnancies. Ages ranged from 14 to 38 years, with an average age of 23.4 years. Twenty-eight percent were teenage pregnancies. The average age for a first pregnancy

was 17.3 years. The majority of pregnant women were between 20 and 30 years of age (62 %). Approximately 20% of pregnancies were primagravidas (Kibria, 1997).

Kibria's (1997) project determined smoking, alcohol and drug behaviors of pregnant women based on self-report at the initial pregnancy visit whereas, in this (1997-1999) study, the extent of these behaviors following the birth of the child was determined as follows: 85% of the women smoked, 33 % consumed alcohol, and 16 % admitted to using drugs. Entries on the Manitoba Postpartum Referral Forms that were used for data collection do not generally include the amount of smoking, alcohol or drug use. In conversations with pregnant women, community members and health care providers, it was related that if women used alcohol during pregnancy it was generally described as recreational use.

Hall (1994) suggests that lack of antenatal care is one of the most significant risk factors predictive of an adverse outcome. However, the extent of antenatal care utilization by a woman is usually only determined following childbirth. Notwithstanding, an awareness of modifiable problems identified during pregnancy can obviously lower the risk of an adverse outcome. The quantity of antenatal care does not necessarily reflect quality of care, (Kaufert et al, 1990) however; due to the potential significance of antenatal care, it was decided to determine the extent of antenatal clinic attendance in the NCN population. An analysis of the Manitoba Postpartum Referral forms during the period of 1997 – 1999 (224 births), of which 60% (134) were complete, indicated that on average, the first visit took place at 15 (SD 6.1) weeks gestation. According to the Kessner scale, 38% of women utilized antenatal care adequately. Two parameters were taken into account in this calculation; 1) eight or more visits took place between 34-35

weeks gestation and 2) the first visit was initiated at 13 weeks or less gestation (Kessner, Singer, Kalk, & Schlesinger, 1973).

The high teen pregnancy rate (28%), smoking, and alcohol and drug use rates would appear to be prohibitive to the prospect of returning childbearing practices to NCN because of a perceived higher risk of a poor outcome. On the other hand, alcohol and recreational drug use in and of themselves do not necessarily affect birth adversely. Whereas, smoking is predictive of a pre-term birth (Heaman, 2001). A risk of pre-term birth should not be weighted against re-establishing childbearing practices in NCN. Women who have a pre-term birth will do so whether or not there are birthing services in the community. Currently, the women are transported to Thompson as an emergency, if time permits. On the other hand, antenatal care can have a role in modifying risk factors around pre-term birth, for example like anemia and smoking (Heaman, 2001). These epidemiological findings are merited further consideration in the following discussion on how clinicians and community members think childbearing practices can be re-located to Nisichawayasihk Cree Nation safely. The findings were shared with group participants to facilitate their understanding of potential risks from an epidemiological perspective. One FNIHB nursing administrator envisioned how NCN might mitigate perceived risks:

> Probably they have to look at a lot of their records from the past, what kind of problems did they have in the past, what is the potential for these problems to occur in the future, how do they see the future of that community in terms of eliminating a lot of these risks?("NI" August 9, 2000)

The nursing administrator proved correct in her observations of NCN when she suggested they would look to their past to extrapolate what kind of problems might arise and how to mitigate them as the following sections demonstrate.

9.3 An Awareness of Risks

The notion of risk around pregnancy and childbirth, particularly where Aboriginal women are concerned was frequently discussed in meetings and in interviews with visiting physicians, midwives and nurses. In reference to re-locating childbearing practices in NCN, a senior FNIHB nurse administrator observed, based on her own fieldwork experience in NCN, that community members: "are well aware of the risks that they are dealing with..." ("NI" August 9, 2000). An elder, reflects: "In my mother's time when she was a midwife, there wasn't any alcohol or drugs or sugar diabetes. ... Now there are all kinds of risks" ("EL" December 4, 2000).

An awareness of risks like those described above was not uncommon among community members. Dennis Linklater, a paramedic and community health representative (CHR) who was supportive of returning childbearing practices to NCN addressed the concerns of a family physician. He was against birth taking place in NCN due to the fact that "women that have a lot of medical problems like diabetes, obesity, chronic smoker or chronic ethanol abuser. ... It is quite risky you know. ... I wouldn't recommend it," Dennis defended the idea of relocating birth to the community:

> Dr. -----, I agree with your perceptions ... the risk factors ...alcohol abuse things like that ... for me - my personal feeling as an ambulance worker - I think we should just go ahead and do it. This way we're a little more proactive. There are still going to be women out there who are going to refuse to go out for confinement no matter what. I've seen it within the last three years. ... We've almost delivered in the ambulance, and you have to consider that too. I still would like to see it go forward. I mean all our social problems – we're trying to look after them. Eventually, one day, we're not going to be in this situation. ... Hopefully, we'll have a brighter future but we must always be *proactive* instead of being *reactive* [emphasis mine](group meeting with family physician November 8, 2000).

Dennis responded to the physician's argument by acknowledging there are problems that increase risk. However, he also spoke from his own experience as community health representative and paramedic when he noted that giving birth on the way to Thompson increased maternal and child risk. He spoke as someone familiar with the behaviors of the women. In his argument, Dennis separated the social issues from the direct connection to the birth event, exemplifying the principles of community health in his approach to health promotion, education and assessment of community health needs (RCAP, Vol.3, 1996, p. 270). Dennis regarded social problems as separate issues that are being currently addressed and should not impede the prospect of returning birth to the community.

Current Western childbearing practices that include the maternal evacuation policy may be seen to increase the risk to a woman's pregnancy and birth as the following illustration by Jackie Spence suggests. She offered her perspectives of risk in the context of the maternal evacuation policy. She relayed that her evacuation two weeks ahead of her due date was "very stressful."

> That was something that I would never wish upon anybody else. It was awful; it was - it was really quite an experience, very stressful experience for me. ... I had to leave my son two weeks early to go have my baby and I knew for a fact that I was all right. I felt healthy. There was no risk to my baby or myself (May 7, 2001)

Jackie Spence's awareness that there was "no risk to my baby or myself" suggests a confidence in her own ability to discern risk for herself. However, the notion of risk to mother and child was not taken lightly as the following group discussion illustrates of the need to have a cautious approach in returning birth to the community. A woman elder emphasized the need to "go slow" for the well-being of mother and child:

EL: We have to go slow on this, you know.
SH: Okay.
EL: There's ...
SH: There's what?
EL: Because there's a mother's and a baby's life.
SH: That's right
EL: You have to be really sure of what you're doing ("EL" & Shirley Hiebert, group meeting, December 4, 2000).

These perspectives demonstrate that community members are well aware that there are risks which need to be considered for birth to take place safely in NCN. They are also aware that there are alternatives to addressing risk other than institutionalizing all women in hospitals for birth. On the other hand, Jackie Spence's observation of how stressful the maternal evacuation experience was for her is a consideration in assessing the risk to women the policy itself incurs. A study by Crandon (1979) found that maternal complications were statistically higher among women who were anxious as compared those who were not.

9.4 Clinician Perspectives on Risk

Clinician perspectives vary on the issue of the risk in relocating childbearing practices to NCN. They also vary in their educational preparation, backgrounds and experience. It is important to understand how risk is perceived by clinicians and their approaches to addressing it. A perspective most commonly related by clinicians was of birth in the context of the abnormal. The following excerpts taken from interviews with nurses and physicians illustrate this perspective.

> ST: It's nerve wracking until it's all over and it's everything is fine.
> EQ: Then it's fine.
> ST: Then it's a wonderful experience. Until we know everything is going well its just nerve wracking ("ST" Caucasian and "EQ" Aboriginal nurse, September 27, 2000).

The perception of birth as potentially abnormal led a senior FNIHB nurse administrator to associate the notion of risk with birth in the same way:

> NI: Where I would look at things, a little risk is a risk too big to even venture with.
> SH: To accept?
> NI: Yes. No risk is acceptable for any kind of outcome. That's the way I would look at it ("NI" August, 2000).

By framing the birth event in the abnormal, it appears to be anticipated that births will be abnormal. In a group interview on November 8 2000, the visiting family physician takes the view that birth is a natural process. However, he indicates that a hospital setting is an optimum environment for safe childbirth:

> SI: It's a natural process, like eating or going to sleep, but what can be done to avoid complications, to give the newborn the best conditions of living, is to have the baby in a hospital setting.
> SH: To have the least risk to the child you would, no matter who [risk level] have the baby in the hospital in case complications came up? Is that what you're saying?
> SI: Yes.

The possibility of an abnormal birth taking place in NCN appears to have made another one of the visiting family physicians decide not to become involved when community-based midwifery services are re-established. In conversation with an Aboriginal nurse, he advised her he would not make himself available as medical backup:

> EX: He felt that he didn't like the idea of it because if complications happen, he doesn't want to be responsible if the baby needs to be in-tubated.
> SH: Yeah.
> EX: And if a baby dies, he doesn't want to have that responsibility
> (October 4, 2000).

A clinician perspective that situated birth as a normal life event was less frequently voiced. Where this perspective was voiced, it was often qualified with the concession that something could go wrong. However, less medicalized observations were also made. For example, the visiting pediatrician placed an emphasis on the naturalness of childbirth and the low incidence of complications that increase risk:

> It [childbearing] is not a disease. ... The baby comes out in due course whether or not you like it [group laughter]. ... The majority of babies come out quite normally; only a small number of babies may have problems
> (group meeting, September 18, 2000).

Carol Prince, nurse and health director for the band shared her views of childbirth with the pediatrician and the group, as a clinician and a Nelson House band member. Like Dennis Linklater, she argued that it would be safer for birth to take place in Nelson House than on the road to Thompson. "It's more dangerous, I think, having the baby on the road at 40 below zero in the middle of the night" (September 18, 2000). This perspective and that of the pediatrician suggest a view of childbirth as a routine event. The choice of place of birth, as Carol's argument demonstrates is one that is consistent with this perspective.

The definition of birth and risk as abnormal appears to lead inevitably to the conclusion that all births need to take place in a hospital setting. It follows that this is an accurate association, since hospitals are settings where pathological events are normally

confined. However, knowing that most births take place along a normal continuum, as the pediatrician suggests, the defining of birth in the abnormal does not justify the institutionalization of all women for childbirth. Clearly, the way an event is conceptualized has direct implications for how it will be acted on.

9.5 Screening as a Means to Control Risk

A significant way to reduce risk is to avoid having women believed to require more complex care give birth in NCN, where the level 1 infrastructure will only support uncomplicated births. Screening for risk may be approached from the perspective of the woman, clinician and community members. Optimally, screening for risk will involve all of these perspectives, which is consistent with a community approach to problem solving.

The position that births considered high risk should not take place in Nelson House was voiced from a range of perspectives, as the following interview excerpts illustrate:

> I am not sure what the definition is for high-risk pregnancies but I've heard of the term – if they are going to have their baby early or carrying twins...If they are high risk, then they certainly should go out. They should not jeopardize their health in anyway (Jackie Spence, May 7, 2001).

> SH: You're thinking that high risk women shouldn't give birth here?
> EX: Obviously (Aboriginal nurse, October 4, 2000).

> If everything went well this is where they would give birth (Emma Hart, August 1, 2000).

> I can see sending out high-risk pregnancies. Why can't we look after the low risk? Most of them come back [from being evacuated] (group meeting, Darlene Mason, November 27, 2000).

> I'm worried about the high risk. If you're going to be concentrating on the healthy, normal pregnancies, that's alright to have it here, but for high risk I don't recommend it (Councilor Agnes Spence, November 29, 2000).

The importance of screening was emphasized by clinicians like the pediatrician who was cautiously optimistic at the prospect of women giving birth in NCN, either in the home or in the nursing station, if "proper selection" (screening) took place. "I'm not saying that everyone should have their baby at home. I think with proper selection a fair number of babies can be delivered at home or in the nursing station. It's safe but they have to be screened (Visiting pediatrician, September 18, 2000). Carol Couchie, Aboriginal midwife, suggested that "very, very careful risk screening" is carried out at the Inuulitsivik Maternity Centre, in Povungnituk which is a factor in its success (June 3, 2001).

Participants suggested various ways to screen women. An Aboriginal nurse suggests that risk can be reduced by being aware of the woman's background:

> SH: How do you think they might be screened to ensure that high-risk women go out?
> EQ: Usually, you know which women are pretty healthy. When you've been in the community for a while, you know them (September 27, 2000).

This community-based approach to risk assessment was shared by Dr. Janet Smylie. She concurred with the Aboriginal nurse's perception of the significance of being familiar with a woman's background in determining risk (interview, Ottawa, February 10, 2003). Dr. Smylie is a Metis family physician with a substantial obstetrical practice in Ottawa. She is intimately familiar with the Tsi Non: we Ionnakeratstha Ona:grahsta birthing centre at Six Nations of the Grand River and is a past Aboriginal committee chair with the Society of Gynecologists and Obstetricians of Canada. She emphasizes that it is important to screen a woman for potential problems, as well as to identify her resilience and support network in determining risk. For example, she suggests a good

support system can offset risk by enabling the woman to focus on her pregnancy and the birthing process. Dr. Smylie further indicated it would be beneficial to have a committee that would involve community members in the process of screening for risk. Unlike an elder who thought the assessment of risks should be left with doctors or professionals: "I think it would be best to ask the doctor if the woman can have a safe delivery ... or a midwife, ask the professionals" ("EL" group meeting, December 4, 2000).

Dr. Smylie suggested that a physician's expertise could be one perspective for deciding the advisability of a birth taking place in NCN. This perspective is consistent with that of the Aboriginal nurse who put a woman's level of risk in a community context. "Usually you know which women are pretty healthy. When you've been in the community for awhile, you know them" (EX" October 4, 2000). It is also apparent that a community approach to problem solving has been taking place with regard to childbearing issues where women are at risk. An Aboriginal nurse informed me of how Chief and Council identified a woman at risk and took the initiative to meet her needs. She described how they arranged for a young pregnant woman who was a substance abuser to be buddied with someone to ensure she did not indulge in substance abuse while pregnant. A community-based approach to addressing issues around pregnant women at risk can be extended to include a system for determining which women might birth safely in Nelson House. Importantly, the women themselves need to be a central component of this process. Confidentiality issues will need to be addressed by the committee.

9.6 Infrastructure Requirements to Decrease Risk

An important aspect of lowering risks associated with birthing in NCN involves the appropriate access to human resources and technology. None of the participants ever made unfavorable comments about the use of technology. Like the example used in the following interview excerpt with Emma Hart, elder and former midwife, a place was seen for technology if it was necessary: "They should have instruments available just in case the baby couldn't breathe on its own ..." (August 1, 2000). The pediatrician suggested a role for the use of technology to decrease risk before birth: "Nowadays, because of the ultrasound and everything available, we can assess the baby and the mother before birth" (September 18, 2000).

Another important consideration to decrease the risk of birth in NCN that was frequently discussed was the need for medical backup and an adequate transportation system. Eleanor Dumas, a pregnant woman, shared her tragic story of inadequate medical backup and transportation system when she witnessed the death of a baby that was born on the way to the hospital in Thompson. The baby was a footling breech: "If there is a birthing centre here and there's any complications, I think having a doctor and the ambulance – knowing that they are available – is our reassurance" (April 23, 2001). However, the pediatrician regarded the proximity of Nelson House to a level 11 hospital in Thompson to access medical expertise in the event of an emergency as a reasonable alternative to having a physician on site in the community.

> SH: What makes this a good community, do you think, for this prospect?
> ES: It's well accessible to Thompson, by road. So if there was any problem, they could easily evacuate to Thompson (September 18, 2000).

The decision as to whether or not a physician should be based in NCN in the event of an emergency was mixed. According to Bella Leonard, such a decision would rest on the comfort levels of the pregnant woman and the midwife. "I guess it would just depend on each individual - how they feel about having only the midwife around" (December 2, 2000). On the other hand, Carol Prince, R.N. and NCN health director suggested the physician need not be based in NCN:

> We've had so many different emergencies. There's doctors here three days a week, four days a week, except Mondays and weekends. We've been doing this for years – delivered on weekends when there's no doctor here. I mean, what is the big deal? But if that's the only way we can push this program, then fine (November 30, 2000).

Just how appropriate a physician based in Nelson House would be in the event of complications during childbirth is debatable. A physician's comfort and expertise with obstetrics is an important consideration. For example, some visiting physicians to Nelson House have not been actively involved in obstetrics for many years. As well, there are limited medical resources for a physician to draw on at the nursing station.

Not only are some of the physicians who provide services in NCN without obstetrical proficiency, some are not predisposed to providing their medical expertise, as the Aboriginal nurses relate:

> EX: I think the women would like to have their babies delivered here but I know for a fact the physicians here have already stated that they don't want to have nothing to do with it.
> SH: What about Dr. ------?
> EX: I don't know if Dr. ------ said anything but I know Dr ------ said he would not want to have anything to do with it. I know for sure he said that.

SH: Yeah.
SH: Why do you think he feels that way?
EX: I don't know [laughs].
SH: He's getting older though, too, maybe.
EX: Yeah.
CX: People are afraid of change.
SH: Yeah.
CX: They don't think it's going to work (October 4, 2000).

Instead, the nurses believed that access to medical expertise in the event of complications should be planned into the infrastructure. Like the other nurses, these nurses repeatedly said they did not want to provide medical backup. "They [midwives] can handle the complications, if, there's any complications" ("EX" October 4, 2000). They suggested they would be unable to provide the expertise that would be needed. The FNIHB nursing administrator, agreed with this assessment: "Sure they [nurses] know CPR, your basic emergency care, but when it comes to neonatal intensive care, they wouldn't be qualified"("NI" September 3, 2000).

9.7 NCN Otinawasuwuk: Decreasing Risk

We have seen that social behaviors, like smoking are included as risk factors for a poor birth outcome. Other behaviors, like the recreational use of alcohol and marijuana, do not have a direct impact on birth, although they may have an impact on the fetus. The research participants had insightful views on how to decrease such risks from a community perspective.

Barbara Peters embraces an American Aboriginal group's exemplary goal: "Six months before conception you have to be clean [of alcohol or drugs]." Shirley Anne Linklater supports Barbara's perspectives with her knowledge of fetal alcohol syndrome.

> We heard that at the FAS workshop the other day: f you're going to be wanting to start a family, both the man and the woman have to be off alcohol or drugs for six months before pregnancy in order to have a healthy baby, and not to consume any kind of alcohol or drugs during the pregnancy, especially the first three weeks of conception (December, 13 2001).

These orientations to a healthy pregnancy and birth are a means to reduce the risk of an adverse outcome. It is obvious from the outset that risk reduction in the area of alcohol and substance abuse in NCN would be better met with a community-based approach than with a biomedical one. The visiting physician emphasized in a November 8, 2000 group interview that the biomedical approach is not satisfactory in meeting these needs. "Brochures, pamphlets, posters and videos ... I don't think they pay attention to them." On the other hand, Kathleen Jo Lutley offers a holistic approach to addressing social problems like alcohol abuse:

> Good prenatal care is a part of it, but that isn't enough. We have to start with the education of children ... when they are about seven or eight years old that, they have to be good grandparents, that they are going to be grandparents three generations ahead. They have to learn to think in the way of the Indian teaching of always preparing for the seventh generation. You would teach that healthy childbirth only comes from very healthy daddies and mommies who haven't been boozing or sniffing or taking drugs (December 3, 2000).

Western biomedical prenatal care approaches that include technology are not sufficient to address issues of risk attributed to smoking for example in pre-term births (Heaman, 2001), according to two Aboriginal nurses:

> SH: Do they [pregnant women] all have ultrasound?
> CX: Yeah, they all have ultrasounds but even that doesn't work. People smoke a lot. So, there's a lot of pre-term births. A lot of the women drink.
> EX: Probably 90 % of them smoke. When its prenatal afternoon they're all out there, standing there and smoking (October 4, 2000).

An approach to antenatal care for women who are at increased risk that involves more extensive interaction with the midwife is described by a staff member at Tsi Non: we Ionnakeratstha Ona:grahsta birthing centre at Six Nations of the Grand River as preferential:

> The majority of our clients are high need clients. They're not high risk, just high need. ...The traditional practice of providing services to our people is by not cutting down the time that we spend on an average prenatal visit, which is about 45 minutes (June, 2001).

The framing of 'high risk' women as 'high need' humanizes problems instead of objectifying the women. These culturally congruent approaches do not minimize the need to address the underlying issues resulting from colonization that have been discussed in the previous chapter. Instead, they offer a more holistic way of interacting with high need women than the Western biomedical model. The latter approach, as we shall see in Chapter Ten, is one that currently offers little in the way of time for interactions with pregnant women. Generally, the clinician, as the physician observed, approaches issues like substance abuse with reminders not to abuse substances that is reinforced with pamphlets.

For Rose Moore Spence, nearing the end of her fourth pregnancy, a more comprehensive approach to social issues would address substance abuse problems among pregnant women: "...so they stay away from alcohol and drugs" (April 19, 2001). One such program that has been developed came out of this research. The NCN Otinawasuwuk maternity workers currently apply cultural and educational principles in supporting high need women through the Empowerment of Aboriginal Women Surrounding Childbearing project. CBC television, Manitoba North, documented their work in a program entitled *The FAS Buddy System* which aired October 7, 2002. The

maternity workers monitor high need women, including those affected by substance abuse, or women who appear to be suffering from excessive stress. Home-visiting and frequent interactions are core components of their approach, during which time the maternity workers explore underlying reasons for the behaviors with the women and attempt to address them. In addition, the maternity workers conduct educational outreach activities, including presentations to school students and the involvement of the students in the various activities of the project. They also raise substance abuse issues with Chief and Council and incorporate the expertise of the Nelson House Medicine Lodge traditional healers and elders.

9.8 Summary

The consideration of risk by the research participants suggests in-depth perceptions and reflections of this important concept as it applies to the development of an alternative childbearing model in NCN. Risk, as it was seen from an epidemiological perspective, does not provide a basis for decision-making about whether birth can take place safely in NCN or ways that the risk of birth can be lowered. Perspectives by clinicians were divided, yet generally supportive of the community's aim to re-establish birthing practices. Screening, health promotion, prevention and infrastructural supports were emphasized. Community perspectives underscored the pragmatic and cultural constructs of risk and its intrinsic place in life events. According to community members, a need exists to proceed prudently in considering risk and how it may be addressed to bring about changes in NCN childbearing practices, safely. In the interim, the NCN

Otinawasuwuk maternity workers are aggressively approaching ways to decrease behaviors among women that predispose them to a compromised pregnancy.

Chapter Ten: Whose Autonomy are current childbearing services meeting?

10.0 Introduction

In this chapter, I will examine policies and practices around antenatal care and childbirth that are being implemented by health care providers at the nursing station in NCN, and in the Thompson General Hospital. In this discussion, I will argue that they are not meeting the needs of childbearing women. I will demonstrate that these policies and practices reflect the ideology and culture of governments and institutions. Finally, I will argue that these policies and practices create a stressful situation for both the women and health care providers. From a praxis perspective, I will discuss how the NCN Otinawasuwuk maternity workers are beginning to address the issues arising out of this analysis. All names are used with participant consent. Where a quote is of a sensitive nature, the name is not identified and the date of the interview is withheld.

10.1 An Overview of Childbearing Services for NCN Women

This overview of childbearing services in NCN and Thompson provides the context in which to consider the policies and practices that are administered by government and institutions. The source for the provision of childbearing services differs in NCN from Thompson. In the former, they are federally administered, while in the latter they are provincially administered. Health services in NCN are provided by public health nurses, nurse practitioners, and community health representatives (CHRs). Visiting doctors provide medical services to the community several days a week. Community members access specialist services in Thompson, or Winnipeg. An emergency ambulance service is available to transport patients to Thompson. All routine antenatal care is

provided at the nursing station to most women on Monday afternoons by the predominantly Aboriginal nurses who have worked in the community as nurse practitioners for many years. Previously, when births took place in nursing stations, both trained midwives and nurses attended births, the latter becoming 'nurse-midwives' by virtue of practice, not education. During conversations with Bill Rutherford, director of operations, FNIHB, Manitoba Region (May 2002), he suggested that northern nurses are routinely meeting two components (prenatal and postnatal care) of the four core competencies required to be eligible for midwifery registration in Manitoba with the College of Midwives of Manitoba. As well, the nurses in the nursing station attend births, care for women in labor prior to being evacuated, and provide care in the event of obstetrical emergencies, such as spontaneous abortions, pre-term births and placenta previas.

According to the nurses, in recent years the nursing station has been severely understaffed due to a general nursing shortage. Transportation is provided to the nursing station for antenatal care. Supplemental antenatal support is provided by Health Canada through the Canadian Prenatal Nutrition Program (CPNP) at the Family and Community Wellness Centre (FCWC). This program is administered by an Aboriginal public health nurse with the assistance of a CHR. The CPNP program provides pregnant women with a nutritious snack on Monday afternoons, in addition to prenatal educational materials and an opportunity to ask questions and relay concerns. Pregnant women who choose to have routine antenatal care by a physician or a midwife in Thompson must provide their own transportation. Currently, the women are evacuated at 38 weeks gestation to await birth in Thompson.

In Thompson, the Burntwood Regional Health Authority provides antenatal and childbirth services with either physicians or midwives. A one-person policy guides the number of people who may be present at a birth. Caesarean sections are performed on both an elective and emergency basis. Limited midwifery services have been available at the Burntwood Community Health Resource Centre since 2000. Women who seek midwifery services may visit a midwife by appointment. However, during the fieldwork, there was frequently only one midwife employed by the BRHA and half of her duties included BRHA administrative work. Midwifery services are available without charge to on-reserve and off-reserve First Nations, as well as other Burntwood Regional Health Authority residents. Births are attended in the hospital where the midwives have admitting privileges. However, midwifery care is constrained to the City of Thompson. Midwife attended births reflect the low number of midwives working in the BRHA. Women who are evacuated to Thompson stay at The Young Women's Christian Association or with friends/relations.

10.2 The Maternal Evacuation Problem

The maternal evacuation policy raises a number of questions as to the suitability of the policy and the infrastructures that make it possible: Is the Young Women's Christian Association meeting the needs of the women? How is the policy impacting pregnant women? How is the policy impacting their families? What is happening to the children left at home?

Unhappy voices were frequently heard in NCN on a policy that appears to have lost its relevance for this community and the infrastructures that surround it. The YWCA

in Thompson was one such component of the infrastructure that was unfavorably looked upon. The 'Y' was a frequent focus for derision or laughter and no dialogue was ever supportive of the service provided by this organization. The accommodations were seen as generally inadequate and issues such as the additional cost of having a baby stay with a mother was something most women could not .afford. Kim Linklater Beardy related that when she recently attended an Aboriginal women's group meeting in Thompson, the northern women taking part had come to the consensus that the Y "takes advantage of all the Aboriginal women coming from the communities. They're supposed to be a non-profit organization ... helping women and all that, and really they're just taking advantage of them. It's us that runs the YWCA, the communities" (group meeting, November, 2000). Jackie Spence, who elected to stay with an extended family when she was evacuated, summarizes the feelings of others about staying at a boarding home in general: "... It is full of strangers and people you don't know ... I wasn't going to subject myself to any undue stress ..." (May 7, 2001).

By far most pregnant women I spoke with voiced their unhappiness about being evacuated. Others reflected upon when their maternal evacuations in a negative light. The following excerpt is taken from a luncheon group meeting. The young woman tearfully empathized with a woman from another reserve while visiting someone in the same hospital room: "She started crying. She was alone ... so lonely she didn't even want to see her baby" ("LN" November 8, 2000). In NCN, an Aboriginal nurse recalled that on the reserve where she grew up, "the women hated it when they had to go out." She described the experience of women being away from their children and home communities as a form of "separation anxiety." "They hate going out, even over here, and

they're only an hour away. They're so family orientated, like their children, their children, their children ... That's why we have such a problem with them. Geez." Later in the interview she explained: "with women who live on the reserve all their lives, they hardly go to Winnipeg or travel or see the world or know there's other things out there. That's why they have such a hard time." ("EX" October 4, 2000).

Loneliness for family and children was not easily soothed for some women where having a telephone is a luxury. Transportation for their family to come and visit is an issue: many women and families on social assistance do not own vehicles or have a driver's license. Women frequently said that they missed their children and worried about them. Having babysitters for extended periods of time, or the money to pay for them, was also problematic in many cases. The women believed that extended family members were not prepared to care for children for long periods of time without remuneration. In fact, in some exceptional situations, Awassis, the childcare agency places the children in foster care. A pregnant woman revealed that her children were already in care at the time of the interview. She said she planned to leave them with Awassis: "They are in care until I have my baby," she explained, so that she would have childcare when she was evacuated. On a previous occasion when she returned home after four days, her daughter, whom she'd left in the care of a husband who was abusing alcohol, "was still wearing the same clothes as when I left" ("MN" fall, 2000). Sylvia Wood, a pregnant woman, said she returned before giving birth from being evacuated due to her concerns for her child. "He got depressed. He didn't eat for two days because I didn't see him for a week" (October 3, 2000). Jackie Spence summarizes the opinions of most women on maternal evacuation: "It's one thing after another with these pregnancies and it's undue stress, like,

you're stressing the mother out. The mother is stressed out, the baby is stressed out and you know that's no way for a baby to come into the world (May 7, 2001).

Susan Kobliski, 'Spirit Flight Woman,' spoke of the harsh impact of colonization in general, and specifically about the removal of women for childbirth. She described it as one where a woman is overcome with the challenges that these conditions present:

> Our people are survivors. If they are taken out [on maternal evacuation] they will survive but ... in a very harsh way. A woman will not really have time to be emotional about it because she will be too worried about surviving (April 30, 2001).

On the other hand, women from a higher socio-economic background had fewer problems with the notion of being evacuated and away from their children. One such woman said she had private accommodations and that her family would be coming to visit. "When I had [child's name], my mom came in on the weekends, and she brought everyone with her" ("TX" October 11, 2000).

The hardships that the women face with the enforced implementation of the maternal evacuation policy, begs the questions: Why is it being implemented? Whose needs is it meeting? The next section discusses the resistance shown by the women to the policy and the seemingly irrelevance of its implementation.

10.3 Resistance to the Maternal Evacuation Policy

Resistance to the maternal evacuation policy, as this discussion will demonstrate questions the usefulness of the policy. The strong resistance to the policy by many women suggests they do not see it as a reasonable choice for them. The women are within easy driving distance from Thompson. They travel back and forth to Thompson for appointments, shopping, and to carry out errands – sometimes several times a week.

Many women do not have a driving license or a vehicle. However, they find ways to get to Thompson and back. Such is the case when they are evacuated by taxi-van from Nelson House. Most of the women make their own arrangements to return from Thompson with a taxi-van or with someone from Nelson House before they give birth. If, a woman goes into labor in the community, two nurses accompany her in an ambulance to Thompson.

'They come back' was generally accepted as a part of the ritual, of being 'sent out.' When I asked how often the pregnant women come back [prior to giving birth], nurse observes: "every time they go out. We send them out - they're back here right away" ("EX," Aboriginal nurse, October 4, 2000). It is general knowledge in the community that the women come back. No one is surprised to see pregnant women in the community who were earlier evacuated, or those who are resisting evacuation.

I frequently encountered pregnant women whose due date was imminent. They would tell me with a chuckle that they were unsure of their due date. I knew it was evident they were avoiding evacuation by claiming ignorance. One woman, whom I tried to interview, told me she had to go to Thompson that day. I found out later that she had been in labor. When I asked her why she had decided not to be evacuated, she said, "I didn't want to leave my boy. He is three years old" ("FT" October 5, 2000). Another woman at the end of her sixth pregnancy refused to be evacuated. She told me that she was planning to have her baby at the nursing station when she was due, in five days. She reasoned her sister had given birth to her baby in Nelson House and all had gone well. In addition, she expressed confidence in the nurses and the "equipment" at their disposal. From her experience, the Y was a "crappy" place to stay. Nor did she want to leave her

five children for any length of time. She was also unhappy with the Thompson General Hospital's one-person birth accompaniment policy (spring, 2001).

A birth that took place at home in Nelson House is suggestive of resistance to maternal evacuation. Leona Moore, a young pregnant woman, shared the woman's story followed by the observations of two Aboriginal nurses.

> LM: I don't think the nurses knew she was pregnant. They got a call; they went there. They did what they had to do. The baby was delivered already. She delivered the baby herself.
> SH: She did? She cut the cord herself too?
> LM: She said she busted the cord.
> SH: Didn't she tie it?
> LM: I don't think so. She said she just ripped it off. She ripped off the cord and just blacked out after that (October 1, 2000).

In an interview on October 4, 2000, the nurses responded to my questions on this birth:

> SH: Now, somebody was telling me there was a woman last year that hid her pregnancy. She had her baby at home and ripped the cord herself, a homebirth.
> CX: It was ------
> SH: Now why would she do that?
> CX: Hid her own pregnancy, hid her own pregnancy.
> SH: And then had the baby herself and ripped the cord?
> CX: Yeah.
> SH: Now why would she be that secretive?
> EX: She's kind of crazy, I guess.
> CX: People don't want to go out.

The pregnant woman was matter of fact in relating the birthing event of the desperate woman, while the nurses were more reflective. The repetition of the comment, "she hid her own pregnancy" by one nurse suggests a measure of disbelief in the woman's behaviors. The other nurse however labeled the woman as abnormal rather than perceiving the birth as an act of resistance to the maternal evacuation policy.

The resistance of many women to the maternal evacuation policy suggests they do not see the policy as being in their best interest. The women have chosen to

exercise their common sense in circumventing the policy. What purpose does the policy have in a community that has easy access to a hospital relatively close by? One might also ask: if the policy generally does not meet the needs of the women, then whose needs, or perhaps more accurately, ideology, does it meet?

10.4 Nurses as Policy Enforcers

The federally employed nurses are expected to implement the maternal evacuation policy. As the previous discussion demonstrates, most of the women are unhappy with the policy. The policy therefore places the nurses and the women in an adversarial relationship. The relationship undermines the autonomy of the woman and the role of the nurse, as a patient advocate. A non-Aboriginal nurse related that when pregnant women return to Nelson House following evacuation: "most of the time they will go back on their own, get a ride back. They don't come through us because they know they'll be in trouble if they do" ("ST" September, 2000).

This adversarial relationship comes out clearly in the following quote from a woman whose need to be in Nelson House prior to giving birth was in conflict with the nurses' 'need' to have her stay in Thompson. "If I was in labor in Nelson House, right now, and something went wrong with the baby, I'd blame the nurses if something happened to my baby on the highway. ... That's what the nurse said to me (name and date of interview withheld).

The woman felt she was coerced into being evacuated. The nurses, in turn, believed that if something went wrong, they would be held accountable. They said they weren't "set up" to have women give birth at the nursing station. As well,

when women begin labor in Nelson House, two nurses are required to accompany the woman by ambulance. This leaves the nursing station short-staffed for the time they are accompanying the woman to Thompson.

Women also perceive the nurses as having power over access to health services. One woman recalled her experience during a previous pregnancy: " I was told that if I didn't go out on the date that they send us out for confinement ... that they couldn't help me, should I go into labor after that date" (name and date of interview withheld). This denial of access to health services also includes transportation to Thompson, as the following dialogue reflects:

> Woman: You get in trouble if you go into labor in Nelson House.
> SH: What kind of trouble?
> Woman: They said if you go into labor in Nelson House, you have to pay your own way.
> SH: Okay.
> Woman: Two hundred dollars.
> SH: Oh dear.
> Woman: [The nurse said] maybe in a few months from now we're going to be starting to do that, so pregnant ladies won't keep coming in and out of Nelson House, going back and forth to Thompson (Name and date of interview withheld).

This quote implies that the women will be punished for not complying with the maternal evacuation policy by being denied transportation to Thompson. It also illustrates the colonialism that underlies the policy. It is difficult to imagine that mainstream Canadian women would tolerate such directives. In any event, most Nelson House women who are on social assistance would not have two-hundred dollars or more to pay for transportation.

The nurses, too, are placed in a difficult situation. They are expected to enforce the policy of their employer, at the same time, they have valid concerns for the safety of

attending birth in a nursing station without adequate training and resources. They often empathize with the women, as the earlier quote by an Aboriginal nurse suggests: "They hate going out. Even over here, and they're only an hour away. They're so family orientated, like, their children, their children, their children. ... That's why we have such a problem with them. Geez"("EX" October 4, 2000). According to a senior nurse administrator with FNIHB, the "women usually have pretty good reasons why they don't want to go out. It's not because they're being obstinate." She suggested there is room for negotiation with women in her reference to a 'fly-in' community:

> NI: You sit down and talk to them, you can usually figure out what's going on in their life and that's when you say, you know, in your first sign of labor you get in here and get on a plane and get medovaced
> SH Uh Huh
>
> NI: You know, it's not something you would spread around the community – that -that's what you're doing – but there are ways around things. You still give that woman a certain amount of control or autonomy; instead of sending her out two weeks in advance, get her out closer to the date – if you are following her and you know things are going okay (September, 2001).

She cautioned, however, that dialogue with pregnant women over the date of evacuation should not become general knowledge in a community. This suggests it is desirable for the nurses to have a measure of control over the women. Later in the interview, she observed that there are reasons the nurses may not be more resistant to the policy. She said the nurses seek to fit into the dynamics of relationships that are already in place when they arrive in a nursing station:

> NI: Nurses tend to go along with the flow in order to survive. We have found over and over in our orientation session that once they get to the field, they go along with whatever the nurses in the station are doing because they want to survive.
> SH: Yeah, yeah.
> NI: You know so (September, 2000).

After the interview she gave an example of a nurse-midwife who was consorting with some women to have them birth in the nursing station. This nurse-midwife was carrying out planned births in a nursing station without fear of reprisal from her employer, which suggests that resistance to the policy is taking place among some nurses to a varying degree.

One nurse in NCN pointed out that the maternal evacuation policy was an extravagant waste of money. However, the nurses fear that if the maternal evacuation policy is stopped, the women will think they can have their babies at the nursing station, or that they will arrive at the nursing station when birth is imminent and too late to transport them to Thompson. It appears the purpose of the maternal evacuation policy is to serve as a reminder to the women that they should not entertain the idea of currently having their babies in Nelson House at the nursing station.

The maternal evacuation policy in NCN has lost its relevance. The women are less than an hour away from Thompson on an all-weather-road. If they do 'go out,' most of the women return before they give birth. The policy places the nurses in an adversarial relationship with the women, instead of a position of advocacy. The nurses are vulnerable and desperate. They do not want to attend births routinely in the nursing station; they are without adequate training and the resources to do so. The NCN Otinawasuwuk maternity

workers are informing pregnant women that they have the right not to be evacuated two weeks before their due date. They are educating them on the signs of early labor and the need to go to Thompson to give birth until they have a birthing centre in NCN.

10.5 Antenatal Care Practices Examined

Antenatal care is an important component for an optimal pregnancy outcome. Antenatal care is potentially important where women live under stressful conditions, such as those that can be attributed to manifestations of colonization. Kim Linklater Beardy reflected on the reasons women may not be able to access antenatal care: "A lot of people are in situations where they have a hard time getting out. For instance, some of them are living in fear because of abuse and stuff like that" (November 30, 2000). In the following analysis, women utilize their common sense in deciding if the antenatal care provided at the nursing station is of optimal benefit. Their approach to antenatal care is similar to the one they use to decide on the benefit of the maternal evacuation policy.

Generally, dissatisfaction with the way antenatal care was provided stemmed from the lack of time nurses spent with pregnant women. In a November 6, 2000 group meeting, Darlene Mason recalled the time she was employed at the nursing station as a clerk. She stated patients who came in for medical reasons took precedence over the time set aside for pregnant women. "There was always another patient that came in for something and they had to be seen." Other women at the group meeting continued in an animated discussion about the antenatal care they received when they were pregnant:

TM: I remember when I went to prenatal years ago.
OU: I remember going to prenatal clinics and I didn't get any counseling [much talk and all negative].
LC: Take your vitamins. That's it (Pseudonyms given).

Overall, pregnant women and women with previous pregnancies suggested that the interactions with the nurses lacked depth. From their perspective, pregnant women were given cursory attention. Long waiting times, "It's too slow" (Rose Moore Spence, April 19, 2001), transportation and childcare were cited as barriers to accessing antenatal care. The women indicated that the transportation provided was inconsistent. After some discussion on barriers, Leona and Dianne Moore agreed they would be more inclined to seek prenatal care if these various problems were addressed.

SH: So, if you a sitter, and you had a driver and you didn't have to wait at the nursing station, you might be more inclined to go?
DM/LM: Yeah (October 1, 2000).

Like other women, they placed importance on the experience of childbirth as a valuable source of knowledge. They believed it made routine antenatal care less necessary. "It's probably why I don't go for my regular checkups anymore [laughs]" ("LM," October 1, 2000). Instead, reasons for seeking antenatal care surrounded a need for reassurance that the pregnancy was generally going well, or for a problem like bleeding. The following interview with the mother of several children represents a general consensus of how prenatal care was perceived:

SH: What's prenatal care for you, do you think?
CN: I don't know.
SH: Do you see a need for any prenatal care?
CN: No.
SH: So if you had a problem, you would go there?
CN: Uh huh.

SH: So how do they get you to prenatal care?
CN: They come looking for me (May 4, 2001).

The nurses do not subscribe to a general policy of sending someone to look for a woman. They believe it is a woman's choice if she wants to access antenatal care in Nelson House or Thompson.

Generally, the nurses were well informed of what was happening with the pregnant women in the community. They knew who was pregnant and, intuited what women might be thinking, planning or doing. For example, if I told them that I spoke to someone who was planning on having her baby at the nursing station, they would immediately acknowledge whom I might be referring to. If they had seen me speaking to someone, they would quite accurately tell me how the woman would have responded to my questions.

There was a general tone that demonstrated the trust that women of Nelson House had in the nurses. One assertive and well-educated woman observed that the nurses were quite accessible to her and the nursing station model of health care was a good one for northern communities. I walked with her to the nursing station where she was going to see a nurse for reassurance that her baby was alright. She didn't have a specific reason for going other than that her pregnancy was now approaching the gestational stage of a previous pregnancy loss. In addition, she had had a disturbing dream the night before that prompted her to seek the reassurance of a nurse. She emphasized how easy it was to walk into the nursing station and see a nurse to do this. I noticed she had an unusually brief wait to see a nurse:

SH: Can you do that here, ask to see someone [in particular]?
TX: Yeah, they're pretty good about that here. You can't get that anywhere else.
SH: No.
TX: You can't just walk in to a nursing station and make yourself at home either [laughs].
SH: [laughs] That's true.
TX: That's the thing about Nelson House, though.
SH: There's advantages to the health care system up here?
TX: Oh yeah (October 11, 2000).

In the same interview, the pregnant woman indicated even though she was not adverse to being 'sent out' she would trust the nurses in the event that she birthed at the nursing station: "I would feel comfortable and confident in ...the nurses here. I've known them long enough now to be comfortable with them." The confidence that this pregnant woman exhibited in the nurses' abilities is demonstrated in the behaviors of women who seek out the nurses when they are in labor:

CX: Some of them have contractions and come back here [from Thompson] ... for us to confirm and then we take them back [to Thompson].
SH: They are in labor in Thompson and they come back here?
CX: Yeah, then we take them back ... or they phone from somewhere in Thompson saying these are the symptoms I am having and they are afraid to go to the hospital.
SH: Uh huh.
CX: That happens a lot (October 4, 2000).

The dialogue raises questions as to the relevance of a policy (once again) where women are to await birth for two weeks in Thompson but return to Nelson House when they are in labor to be assessed by the nurses! It also suggests that the women are more comfortable with health care providers in their own community than with strangers in Thompson. The women's trust in the nurses was generally expressed by many in all strata of the community. The nurses are Aboriginal and they have been in the community over a

period of years providing primary and emergency services which inspires confidence in them.

10.6 The NCN Otinawasuwuk's Approach to Antenatal Care

The NCN Otinawasuwuk seeks to address the antenatal care issues. A home visiting program and frequent interactions with women are two such ways of doing this. Kim Linklater Beardy suggested that antenatal care needs to reflect and use community resources, such as the maternity workers, to be beneficial: "You'll be spending time with the prenatal, you're getting to know them, and from there you'll know their needs. You can also build on the resources we have in the community around the prenatal. ... That's the only way you can ever help a person come out of their shell is be there to provide the services for them" (November 30, 2000). The NCN Otinawasuwuk maternity workers are integrating their services with those of the Canadian Prenatal Nutrition Program as well as those of the public health nurses who carry out home visits to high need pregnant women and following the birth of a child. In addition, the maternity workers take advantage of learning opportunities offered by the nurses when their busy schedules allow.

10.7 A Critique of Hospital Policies

In this analysis, I will examine whether the Thompson General Hospital is meeting the needs of NCN childbearing women. From this discussion, I will identify hospital practices that are not compatible with NCN culture or notions of optimal birthing practices. Susan Kobliski, 'Spirit Flight Woman,' offered this overview of how policies

and practices are seen from the perspective of NCN in the following comment on childbearing policies:

> They are designed so ... the priority is liability. ... It is all based on accountability and liability on a political level. They look out for themselves and nobody else, really. ... If there was any consideration or any respect, it would have been handled a lot more ... appropriately for both cultures, you know ... the whole process of bearing a child is designed by non-Aboriginal people ... for them and not for First Nations women (April 30, 2001).

An area of frequent concern was what appeared to be an unwritten policy at the Thompson General Hospital of nurses routinely attending births. An Aboriginal nurse who worked at The Pas General Hospital related that the nurses frequently attended births there as well:

> When we worked at the hospital, there were a lot of deliveries the doctor never made it. Half the time the baby was born already by the time because he had to come an hour and a half, sometimes an hour, from somewhere so by the time he got there, the baby's born (October 4, 2000).

According to Shirley Anne Linklater, during a birth attended as a labour support person at the Thompson General Hospital in April 2001, the doctor gave directions to the nurse not to disturb him over lunch because he had gone without sleep the night before. When the baby was born, he had a thick umbilical cord wrapped around the neck that the nurse had a difficult time cutting. Diana Moore related how the same nurse attended the delivery of both of her children: "The doctor didn't get there in time, so the same nurse delivered my two kids." In one birth, "the cord was wrapped around my daughter's neck" (October 1, 2000). Despite the obvious abilities the nurses have in attending births, it is evident that by raising the issue of an umbilical cord around the neck, the participants are suggesting a physician should have been present.

In the September 18, 2000 group meeting, Kim Linklater Beardy noted that her last child's birth was attended by a nurse. She suggested physicians are not always present at births in the Thompson General Hospital:

> I automatically assumed they have doctors there. ... Every other time when my other nieces had their babies there was no doctor there ... just nurses. They did all the deliveries. ... I guess they just give it to the nurses to do. The only time they would call him [physician] is if it was really high risk. ... One of my nieces had to have an episiotomy – had to call the doctor in. That was the only time. The same thing with my sister: never had a doctor, just the nurses

The Thompson General Hospital restriction of the birth accompaniment to one significant other was a contentious issue for many of the women. Lenora Spence, in a joint interview with a young pregnant woman, said of the one-person policy: "When you had your baby, you get mad at the doctor for not listening to you, or trying to kick out who is with you. Saying only one person and stuff – we are trying to change that" (April 28, 2001). The following incident where the one-person policy was enforced illustrates the views of many other women. A 17-year-old, Clarissa Parisien, pregnant for the first time was contemplating having her baby in Nelson House. She reflected on telling her mother of her intent:

> I told her that I wanted to have my baby at home, because my baby will be born here. And I can, you know, have my family actually be here and support me here, because in the hospital they only let you have one person with you there. And I wanted to have some people there actually helping me and telling me what to do. Just to calm me down. (December 1, 2000).

She described how she and her partner, Durmond Spence were preparing for the birth. In this excerpt she spoke of how she took her partner to the Family and Community Wellness Centre to view some videotapes on childbirth.

> Clarissa: I said this is how it is going to look. I just want to let you know how it is going to be.
> SH: Good, good, good.
> Clarissa: He was watching with me and he goes, "Okay this is what's going to happen. Yup. Just be prepared." So I just had to show him the videos and how it's going to be when I go into labor. He knows what to expect.

Clarissa said she planned to have her baby at home to avoid maternal evacuation, explaining that the hospital environment is not conducive to the kind of birth she envisions.

> He [Durmond] says, "Well, at least we don't have to go to stay there." And I said yeah, not to be there and have my baby here ... have my family here instead ... Sometimes my family can't actually make it to Thompson (December 1, 2000).

Her family felt too apprehensive to have the birth take place in NCN, given it was her first pregnancy and, as she was to learn, she was pregnant with twins. Clarissa's birth experience at the Thompson General Hospital proved to be far from the birthing experience she had envisioned. From her narration, the twin birth was uneventful. However, according to her, labor progress was slow and medical personnel indicated a Cesarean section might be required. In anticipation of possible surgery, the one-person policy was enforced. She chose to have her mother with her. The father of the twins could not be present, to which he said: "That sucked." Excerpts from an interview that took place in April 2, 2001, following the births, are included below. People involved in the interview include Clarissa, her mother, Lorriane Parisien, Durmond Spence and Shirley Anne Linklater, the aunt. All were present at the hospital. They had planned that they would all be present at the birth. The aunt, Shirley Anne Linklater would be present in the capacity of a birth support person. Her voice is not heard in this excerpt.

> Clarissa: I wanted him to be there.
> Shirley: Sure you did.
> Clarissa: And I wanted Shirley Anne to be there.
> Shirley: Sure you did, yeah.
> Durmond: Yeah, I wanted to be there. But it didn't feel good when I wasn't allowed in there.
> Shirley: No. You feel like you missed out on something, eh?
> Durmond: Yeah ... I wanted to see them come out too.
> Clarissa: They told me the first time when they told me to start pushing. That's when they told him that he had to leave.

Clarissa described how the doctor said her partner could not stay because of the one-person policy. The family said they observed three doctors, four nurses and two student nurses in the delivery room. Her mother was holding her one hand and Clarissa asked that someone hold her other hand so that she could push better:

> Clarissa: They weren't helping, though. I asked them to hold my hand and they kept on shaking their heads.
> Shirley: Why?
> Clarissa: When I was pushing, I need something to squeeze on, something like a hand, and none of the doctors wanted to come and help me. They were just shaking their heads and no one wanted to come and help me. ... Somebody should have come and held my hand, at least. There were lots of them in there.
> Shirley: Well, yeah, like you had, what, 10 people in there?
> Durmond: Twenty hands.

The incident was raised on an April 9, 2001 meeting with BRHA administrators, several participants and myself. One of the administrative officials responded to the incident from a hospital policy perspective:

> What I'm hearing...is that there were some student nurses in the room that day...The student thing is challenging ...they want a meaningful experience. But also, if you're a practitioner ..you're worried about a woman's condition because not all births go normally. For example, there was one time when they had a very young girl giving birth who was out of control and it was very concerning. They wanted minimal stimulation in the room, they didn't want people hanging around who didn't know what they were doing, they didn't want the student aggravating her...it's not that people want to control always because they are control freaks, they are concerned about the health of the individual.

The administrator assessed the young woman's plans to a have family-centered birth with the father present in a hospital environment in the context of birth as a medical experience rather than as a natural life event that occasionally requires some intervention. This rationalization and the fact that the student nurses need a "meaningful experience," took precedent in the mind of the administrator over the needs of the family. At this meeting, I provided the BRHA administrators with *A Guide for Health Professionals Working with Aboriginal People*, a policy statement developed (in three parts) by the Society of Obstetricians and Gynaecologists of Canada (Smylie, 2000).

10.8 NCN Otinawasuwuk: Building Relations around Birth

An important precursor to the formation of the NCN Otinawasuwuk was the training of women to provide support for women during labor. The maternity workers who are currently employed with the Empowerment of Aboriginal Women Surrounding Childbearing project act in the capacity of birth supporters to women who want this assistance. Several of the maternity workers and others, like Kim Linklater Beardy, also see this work as a learning opportunity for women who want to become midwives. She related how she envisioned this training would assist women and the community: "It would benefit because we would have first hand experience. You are also building trust and bonding relationships and you are always there to help them ..." (November 30, 2000). One elder saw a role for herself in offering birth support: "I would gladly go and sit with the mother. ... I was scared when that [birth] happened I wanted somebody but at that time we didn't have anybody. What I hear you saying, it would be very nice to have a someone ... just being there to help" ("EL" December, 4, 2000). The maternity workers provide birth support in pairs when they accompany or join women in Thompson. It is a

means to build relationships, as well as to ease the stress of a woman having to birth in an environment with strangers.

10. 9 Summary

Up to this point in the analysis, the research has demonstrated the deep weakness of institutional childbearing policies and practices for First Nations women living in Nelson House that serve health care providers. As I have demonstrated from the analysis, the current childbearing practices and policies vis-à-vis the maternal evacuation policy, antenatal and institutionalized care have created conditions that adversely affect the well-being of the women and their families, as well as the community overall. The NCN Otinawasuwuk praxis component of the research addresses issues arising from antenatal care and birthing by offering supportive care in both areas.

Chapter Eleven: How Can Birth Reestablish Autonomy?

11.0 Introduction

In previous discussions, I have demonstrated that Aboriginal and Western childbearing practices conform to the notion that cultural behaviors are acquired and create a template for how we live our lives (Helman, 1990). As well, I have discussed the impact of colonization on NCN, specifically where it affects childbearing cultural notions and the behaviors of pregnant women (see Chapter Eight). In this chapter, I will establish how the basis for childbearing autonomy in Nisichawayasihk Cree Nation resides in cultural childbearing concepts and an identity with the land. I will argue that cultural childbearing concepts have an inherent agency for bringing about dramatic changes to individual, family and community life in NCN. As well, I will illustrate how the breadth of cultural knowledge and traditions currently present in the community can be integrated with evolving cultural childbearing practices. The research will reveal sources of subjugated knowledge from which restoration of cultural childbearing practices will take place. Lastly, I will demonstrate how the NCN Otinawasuwuk praxis component of the Empowerment of Aboriginal Women Surrounding Childbearing project is being applied to the restoration of cultural childbearing practices and values, with the aim of regaining childbearing autonomy in NCN. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

11.1 Childbearing as Agency

In this section, I will illustrate how cultural childbearing notions and an identity with the land provide a basis for autonomy and agency. In addition, I will show how birth, children and women are culturally constituted and that these worldviews provide an understanding of their role in restoring childbearing practices in NCN.

The spiritual significance of children was frequently referred to in interviews with childbearing and pregnant women of various ages and backgrounds, in addition to older women, elders and women with either traditional or Christian beliefs. The question "What does having a baby mean to you?" was posed in open-ended interviews with pregnant women who overwhelmingly responded that a baby was a gift from God. Prior to using the question guide, I reviewed it with five women over the age of 30 from various socio-economic and cultural backgrounds. During this group dialogue with Hilda Primrose, Donna Spence, Shirley Linklater, Barbara Peters, and Mona Hart, the empathic "of course" from Hilda Primrose reflected the general consensus of the cultural meaning of children.

SH: Next question: What does having a baby mean to you?
HP: Having a baby means to me wanting to have a baby...
DS: Planned.
SH: A gift of God?
HP: Of course

Later, in the interview, Barbara Peters added that "they are gifts from our Creator and they are loaned to us" (November 20, 2000).

The continued relationship of the child with the Creator implied by the "loan" was frequently voiced in interviews and conversations. In the following interview excerpt

with Jackie Spence, she observed that children are loaned by the Creator "for a little while."

> I think we've all heard that term that a child is a gift from God and that is certainly how I look at it too. That's how I look at my children. They are gifts from God ... it's the Creator lending you this child for a little while (May 7, 2001).

The child's origin from the Creator with the parent as a temporary caregiver illustrates that the child has an intrinsic and lasting autonomy ultimately rooted in the Creator. A philosophical orientation such as this has implications for how the child who grows into an adult views him or herself, others and societal structures. This relationship to the Creator provides a basis for identity and agency that is not dependent on human relationships, institutions, organizations or government. Chief Mercredi emphasizes this perspective when he says First Nations are accountable ultimately "only to the Creator, our own consciences and to the maintenance of harmony" (RCAP. Vol. 2, Pt. 1, 1996, p.435).

A First Nations person thereby is assured a strong, autonomous, and self-sustaining identity by being identified with the Creator who is sacred. This orientation places a high value on an individual life. Such an orientation differs from that of the Western secular mindset, where subjects are constituted as products of their environment and heredity. Many NCN band members are Christian in orientation. The traditional First Nations perspective of an identity with the Creator is similar to the Judeo-Christian worldview that holds people are created in the image of God.

In the Aboriginal culture, a deeply symbolic horizontal relationship with the family takes place at the time of birth itself. By using birth metaphors, Jackie Walker explained how the roles of the family arise with the birth event:

> When a mother gives birth to the child – you know how during pregnancy the umbilical cord is connected to the mother and the baby? Once birth takes place, the father becomes the umbilical cord to the child and to the mother. They take on that different role (April 27, 2001).

Her imagery illustrates the nature of the intimate bond that takes place between the parents and the child and the parents with each other during the birth event. It is not difficult to imagine that this very intimate and meaningful time would benefit from an environment that is nurturing and empowering as opposed to a medicalized setting which is objectifying to women.

When Eleanor Carriere, a traditional healer, described birth as being "sacred to all Anishinabe," she also observed that the meaning of birth as a sacred event is threatened if it takes place in an environment that is not conducive to nurturing:

> EC: Life is sacred. It takes away that sacredness when they are born in some sterile place.
> SH: Becomes mechanical.
> EC: Yeah, it's mechanical and the loving part of it is not there. As First Nations people we are very spiritual people. So, because it is sacred and life is a gift then birth is something special (April 27, 2001).

The sacredness of birth reflects the place of the Creator as one being central to this event. The multiple meanings of birth and their implicit spirituality and holistic orientation are evident in the observations of Susan Kobliski,' "Spirit Flight Woman":

> Birth is an honor the Creator has given to women. When a woman gives birth to a child it doesn't just mean one thing. There is a lot of meaning to the whole aspect of bringing a life into the world. You're continuing the Medicine Wheel ... the spirituality. ... The birth of each child that comes into our First Nations communities will bring back the spirituality because everything is a cycle and spiritual things go, and come back. Our First Nations spirituality ... it will come, but it's only going to happen through the birth of children (April 30, 2001).

Susan includes both women in their role of bringing life into the world and children in her imagery of birth. By placing birth in the context of the four core concepts of the

Medicine Wheel (mind, heart, body and spirit) with an emphasis on the spiritual, Susan demonstrates the centrality of the spiritual as a basis for agency in "continuing the Medicine Wheel." In this context, the cyclical nature of birth is seen as having the agency to reclaim "First Nations spirituality." Her observation that birth is an honor given to women by the Creator illustrates its importance to a woman's self-esteem, especially given the sacred imagery of birth. In addition to being an honor for women to give birth, Jackie Walker portrayed it as a revitalizing experience for women. In her Sweatlodge imagery, she also illustrated the centrality of birth in Aboriginal teachings and culture:

> For me, the teaching behind the Sweatlodge represents the mother, the mother's womb. And when we are in the Sweatlodge Ceremony, we splash the grandfathers, the grandmothers, nine times with water, representing the nine months the woman carries. Everything that happens throughout the process of that ceremony represents the woman as they are giving birth. And that's why they describe it as being the renewal of life, of the rebirth, or you know, because a lot of us need to go back into that inner child to feel new again.

Later in the interview, following a dialogue on the eventual return of birth to NCN, Jackie Walker emphasized that it will provide women with the opportunity to embrace cultural practices in a meaningful and empowering way:

> JW: Doctors and nurses view pregnancy as a medical condition, when the process is giving life. In that way, it will change that image alone... because it will bring back more of the role of a woman, what the woman can do. You know, when they talk about women having power.
> SH: So it will empower women?
> JW: It will empower women and they will be respected again for who they are (April 27, 2001).

The beauty and meaningfulness of these images leaves no doubt in the reader's mind as to their ability to empower those involved in the birth event, especially the woman. Jackie's reference to the medical perspective of "pregnancy as a medical condition" illustrates quite another image, one of sickness and dependence. It is an image that is

disempowering, without agency where the meaning is derived from those who have the power and the knowledge to use it.

The cultural construct of birth as having an empowering role for women is evident in the name the women chose for their grassroots organization, the NCN Otinawasuwuk (Receivers of Children). The women who were actively involved in the research over a period of several months took an empowering stance by creating the organization to reflect their cultural orientation for reclaiming childbearing and childrearing practices. In a group meeting, Cynthia Spence clarifies the meaning of the name for me:

> SH: Otinawasuwuk. It means the ones that give birth?
> CS: Help.
> SH: The helpers?
> CS: The ones that receive birth, women helpers, yeah
> [Lots of laughing and talking in Cree as they choose the name]
> (group interview, January 12, 2001).

The empowerment of the women is evident from the name they gave their organization. By prefixing their organization with "NCN," they are identifying the organization as their own, and as community driven. The name Otinawasuwuk was chosen to portray the cultural orientation of the women toward childbearing and childrearing as 'receivers of children,' which places the parturient woman in an active role. This conceptual orientation is in contrast to the biomedical model where the health care provider is generally referred to as having 'delivered' the baby. In this orientation, the power resides with the health care provider. It is noteworthy that the women chose a Cree name. Eighty percent of band members cite Cree as their first language. The use of the Cree language in naming their organization illustrates another tie with their

community and culture. We know language is not simply a way to communicate but a means to construct our culture and lives thorough ideas. Davis-Floyd and Sargent (1997) emphasize "language is the filter through which experiences are interpreted and expressed" (p.15). From an ethnographic perspective, is also seen as a means to "create and express a cultural reality" (Spradley, 1979, p.20). By using the Cree language to describe birthing, they are constructing the event to conform to their notion of what it means in their culture. Language is a powerful means to construct our reality and be constructed by it.

11.2 A Relational Identity with the Land

The meaningfulness of the empowerment that is derived from having purposeful roles in a cultural context for the children, women and their families is further extended to the physical environment for those who are deemed fortunate enough to have been born on the land of their ancestors as the following discussion illustrates.

"I think people will have pride in the fact that they born on their reserve" (Eleanor Carriere, April 27, 2001). Eva Linklater (1997), NCN band member, summarized the significance of the land to her people: "Cree culture and our world view teaches us that we are an inherent part of our land, connected to it spiritually, emotionally and physically" (p. 17). She cited Lynch (1960) in her Master's thesis framework as capturing the essence of the social role that the land has in binding the group together through a common history and experience:

> The landscape plays a social role. The named environment, familiar to all, furnishes material for common memories and symbols which bind the group together and allow them to communicate with one another. The landscape serves as a vast mnemonic system for the retention of group history and ideals (p. 18).

Significantly, Linklater described a connection to the land as also being spiritual in nature. Her depiction of this relationship encourages the reader to reflect on the sacredness of the relationship of someone born on the land with their environment. It is not difficult to understand how the spiritual, emotional and physical connection to the land of people who are born in Nelson House gives them a strong sense of identity. According to Jackie Spence, band members who are born on the land have a stronger sense of identity and live fuller more meaningful lives. "I think it's got a lot to do with identity. I am really looking forward to seeing these babies that are going to be born here. They are going to be very, very, strong in my mind (May 7, 2001). Jackie Walker gave birth to her 12-year-old daughter in Nelson House at the nursing station. She told of her daughter's sense of pride "knowing she was born in Nelson House." The birth was attended by a midwife who came from Thompson at the request of the nurses when it was believed that the labor had progressed to the point where the birth was imminent. "It was a good experience. Some of the stories that I heard from the elders being born here or being born at this lake or that lake ... it makes you feel part of the community" (April 27, 2001).

The relationships that are nurtured as a result of being born in the community are seen as creating closer ties among community members. At a November 15th 2000 group meeting, Hilda Primrose, Mona Hart and Kim Linklater Beardy make these observations in response to my question "What do you think will happen if birth comes back to the community?"

HP: I think it would be a change.
MH: Maybe the closeness will start again.
KLB: It will reestablish a lot of ties.
MH: We will be able to talk to each other and be more...
KLB: Open
MH: Be more open.

11.3 Birth as a Relational Event

While the following birth did not take place in Nelson House, it does demonstrate the agency of birth when community members are involved together in this important cultural event. This birth has had a lasting and meaningful impact on relationships. It took place in Thompson with Shirley Anne Linklater acting in the capacity of labor support person to a woman from NCN. Shirley Anne and I made a home visit when we heard the woman, who had eight children was pregnant and that she was not receiving antenatal care. At the time of the visit, we were met by a very angry husband who accused us of coming to apprehend his children. (Shirley Anne had previously worked for Awassis Child and Family Services). He told us he was a good father. After many reassurances on our part that our intent for the visit was not harmful, we were allowed into the house. Not being fully persuaded of our good intentions, he kept pointing out how well his children were doing by showing us the many awards they had received in sports and academics. We were able to haltingly convey the purpose of our visit to his wife who sat at the table, not speaking. We left the house after a short visit. I suggested to the woman that she might call Shirley Anne if she needed her when giving birth. Several days later when she was in labor, she asked the nurses at the nursing station to ask Shirley Anne to come with her to Thompson to assist her. The husband joined her later, after I assisted him in

obtaining a sitter for the eight children. He said how much more convenient it would be if the birth could take place in Nelson House. As a result of the birthing interactions that followed between Shirley Anne, the woman and the husband during the birth event, the relationship has changed to a highly positive one. After the birth of another healthy boy, the couple thanked Shirley Anne "over and over" for being there with them. The woman's pregnant sister, who also was present during the labor, asked if Shirley Anne might attend her baby's birth. When Shirley Anne met the spouse in the community, he proudly invited her to come and visit the little boy and "see how big he is getting." He says when they have their tenth baby he wants Shirley Anne to be there. In addition, he has been telling others in the community of Shirley Anne's abilities to the extent that several pregnant women have requested that she be with them during labor. Shirley Anne related how the man's behavior was in such contrast to his previous behavior toward her when, on meeting her, he would look at her with intense dislike because of her affiliation with Awassis. Now, she has come to feel like an extended family member. Traditionally, women who attended births were seen as extended family. They were frequently referred to as 'aunties' and the children of the birth attendant became 'brothers' or 'sisters' to the birth child.

It is expected there will be both an individual and a community impact when birth is restored to the community. In the following group dialogue, Donna Spence and Shirley Anne Linklater agree that the impact of returning birth will be a positive one because women will have a greater respect for birth and ultimately themselves:

DS: There won't be so many teenage pregnancies or unwanted pregnancies. Maybe, there will be more planned pregnancies with the birthing centre here
SH: Because birthing will seem more special?
DS: More respect.
SL: I think they will take care of themselves, too.
DS : The whole community (group meeting, November 20, 2000).

11.4 Birth as Community Healing

It is apparent that when control of birth is restored to NCN that it will have a deep impact on childbearing women and the children born in the community, and on community relationships. According to Eleanor Carriere, the agency of childbearing is also expected to create a re-vitalization of traditional practices beyond those associated with childbearing. On viewing the film *Ikajurti: Midwifery in the Canadian Arctic* (Inuit Women's Association of Canada, 1990) that depicts how women in POV reclaimed childbirth in their community and its positive impact on the resurgence of traditional practices, Eleanor shared her perspectives in the following interview excerpts:

EC: If they bring back midwifery, you will see changes like in that film.
SH: You'll see a community impact in other areas of life too?
EH: Yeah, because there would be that balance. Like, things are going back into place, where the wheel is turning and righting itself and going back to the way it should be.

EH: It would start the effect of decolonization, where people are going to use the traditional ways. It's bringing back that part that didn't exist for many years, that piece that was missing in the community. As they bring more traditions back into the community, the community will become more stabilized, more functional (April 27, 2001).

In her observations, Eleanor indicated how the return of birth to the community would have wider implications than those immediately related to the birth event through the child, mother, family and ultimately the community. She sees the wider positive

effects that the return of birth will have to NCN as similar to those experienced in POV. According to Eleanor, the return of cultural traditions, in addition to those surrounding birth, will result in the community becoming "more stabilized, more functional."

Jackie Walker summarizes the significance of restoring birth to NCN and its broader implications to the community. She extends the imagery of the child with permanent origins in the Creator as a gift on loan to the family, to birth itself being a gift on loan from Creator to the community. The imagery reinforces the sacredness of birth and its holistic and integrating effect on community relationships. From her perspective, the restoration of birth to NCN has an inherent agency to bring about community healing and a "way of life":

> It was such an honor to bring life into our community. They need to bring that back because it's a gift to our community – it's a gift from our Creator that's loaned to the community. If we did try and bring it back, I think it would bring a sense of hope and esteem to the community. Even for myself, part of my own healing is my community's and my family's healing, because everything is interrelated. We're all related in some way. Even so, everybody would benefit from it because it's teaching our people that this is part of who we are and that we have to take that responsibility for everybody. It would bring back a way of life (April 27, 2001).

Jackie's reference to the honor of bringing life into the community reveals a deep respect for the community itself, in addition to a collective mindset that has been apparent in many of the interviews cited. It has also been apparent that this community mindset is relationship driven. It is for this reason that childbearing as agency will have a very significant impact on the community. The cultural constructions of birth, children and women, and their roles in the community are uniquely Aboriginal. They cannot fit into a Western childbearing model that is highly individualistic and pragmatic. The secular perspective that suggests we are merely products of our environment and heredity

is a pragmatic one. One would expect that many choices coming out of such a worldview would also be pragmatic and mechanical. How we view ourselves and the world we live in determines what actions we will take to express our worldview, including those involving childbearing practices. The spiritual orientation of Aboriginal culture and Western secular culture are not compatible where they affect cultural childbearing choices.

11.5 Traditions and Historical Perspectives

In this section, I will describe the traditions and historical perspectives that many community members once practiced, and still practice to various degrees, in addition to sources of subjugated knowledge. In bringing birth back to NCN, the maternity workers are not working in a cultural vacuum. There are already rich cultural resources in the community from which to draw on in re-seeking autonomy in childbearing practices.

Some written accounts of midwifery in Nelson House and the surrounding area are recorded in the book, *Anna and the Indians,* by Nan Shipley. Regretfully, Anna does not share her memories widely on the role of women or birthing practices. Reference is made to a Caucasian woman in Norway House who was treated for a difficult labor with an "Indian potion." They are described as "tiny white roots," thought to be seneca root (Shipley, 1966, p. 92). A Nisichawayasihk Cree Nation elder gave me a white root after I interviewed her, explaining that it was to be used for labor.

This and other traditional medicines are still available in NCN. I spoke with elders about medicines they availed to those who sought them out for the healing of many ailments. Susanna Thomas, a well-known midwife in Nelson House, was raised by Anna

and Samuel Gaudin (Shipley, 1966). Susanna grew to be a woman, midwife and grandmother to several of the participants who took part in the research, including Susan Kobliski, 'Spirit Flight Woman,' who was named after her grandmother. At a group meeting on November 15, 2000, Mona Hart, Kim Linklater Beardy, Shirley Anne Linklater and elder "EL" talk about Susanna's attendance at births that is obviously relationally binding to the women in a very positive sense:

> MH: She delivered me about four or five o'clock in the morning in January.
> KLB: Uh huh.
> [Others talk excitedly simultaneously]
> MH: She delivered ------
> SH: ------ is your daughter, too?
> EL: Yes
> SH: I know ------. So, what year was that?
> SL: Early 50s, I would say.

Fifteen people, mostly women, acknowledged they had attended births in an informal survey carried out by Carol Prince, NCN band member and health director, in 1999. One former midwife, and elder, Emma Hart related her willingness to be a resource of traditional childbearing knowledge for new midwives in NCN.

There are several traditional healers in NCN. One traditional healer, referred simply to as the 'Medicine Man' lives outside of the main reserve on Highway 391 East, in a cabin. Some elders also provide traditional medicines to those who seek them. In addition, Eleanor Carriere, traditional healer, NCN band member and social worker has recently returned to Nelson House from Winnipeg, where she had been living. People who practice traditional beliefs may attend 'sweats' at the Medicine Lodge on Sundays, or at one of the sacred ceremonial sites, like "Mile 20" on reserve land, off Highway 391 East. A guided visit to this site (see Chapter Eight) was like stepping back a 100 years. It

appeared in many respects to be like the site described by Young (see Linklater, 1997). The richness of this traditional cultural site suggests how strongly the Nelson House Cree have maintained their underlying traditional beliefs. An expression of these beliefs takes place with the annual Pow Wow every summer that draws people from many of the surrounding communities. Family camps are held in the summer on-the-land for all who want to take part in traditional cultural events and return to a more traditional lifestyle. Susan Kobliski, 'Spirit Flight Woman,' facilitates the Grandmother Moon ceremony at a site some distance from NCN, usually on a monthly basis, for women seeking a traditional approach to revitalizing their individual and collective lives as women. In NCN, Susan Kobliski, in her capacity as a mental health worker, also facilitates in-services and workshops for groups, with an emphasis on Aboriginal cultural practices for healthier lifestyles.

Community members are increasingly expressing a renewed interest in re-introducing First Nations 'spirit' naming practices as a result of women recently attending the births of neighbors and friends in the community. Several women suggested that naming ceremonies could play an important role in an individual's identity formation and offset colonialist incursions. It was suggested a naming ceremony for an individual can also be seen as a means for healing by obtaining a new identity as reflected by their 'spirit' name. The tradition of honoring children with spirit names was described by Anna's Gaudin of her baby, Irene, who was the first Caucasian baby born in Nelson House. She was given the spirit name 'White Swan' by the first Chief of Nelson House, Peter N. Moose, who had recently lost his daughter. He 'adopted' Irene, which meant that

he was able to treat her as his own daughter although she remained with her parents (Shipley, 1966).

A cross-section of traditional and Western cultural ways is evident in NCN. Differences between traditional and Christian beliefs and groups were made known to me at various times and occasions. Many people in NCN take part in either the Roman Catholic Church or United Church, with an increasing number of Evangelical Christians in what is referred to as the 'new area.' As a professing Christian, I was able to share spiritually with both traditional and Christian groups. I took part in a Sweat Lodge ceremony but informed the participants that I was a Christian and did not hold to some of their beliefs around atonement. A man in the group said, "She respects our beliefs, and so we will respect hers." Similarly, when I was asked by an Evangelical Christian why I, as a Christian, was taking part in a Sweat Lodge ceremony, I explained that I had informed the group of my Christian beliefs. This explanation was acceptable to the Christian Evangelical. I found some elders and other band members embraced both Christian and traditional beliefs and ceremonies.

Another illustration of the openness around Christian and traditional beliefs comes from a memorial service I attended. With permission from Susan Kobliski, 'Spirit Flight Woman,' I am including my observations of the combined traditional/Christian service for her son, Aiden, in May of 2001, following his accidental death in British Columbia. The service was an eclectic mix of traditional and Christian beliefs. Evangelical Christian leaders in the community facilitated much of the service. Susan embraces traditional beliefs but kinship ties and compassion proved stronger than keeping ideologies distinct. I observed Susan sing an honor song using her drum as a

tribute to her son and observed how the community overwhelmingly responded to Susan's loss. They called her son their son, yet only a few had ever seen this young man, who was estranged from his mother at three years of age. This approach to overcoming ideologies in favor of the needs of community members is necessary for the development of combined cultural orientations to childbearing. It was impressed upon me on several occasions, how strongly kinship ties and the collective good are favored over ideologies.

When asked how differing beliefs might be accommodated in an alternative approach to childbearing between traditional and Christian beliefs, Eleanor Carriere replied:

> [People] feel an attachment because you are from the same community, even though you might not believe the same way...you can't judge people because you are not the Creator. You can't go around saying ... this is the right way, this is the wrong way. Through trial and error, people learn what they have to learn through their life journey (April 27, 2001).

The diverse and progressive perspectives in the community were evident in several areas, such as in openness to change, social services and economic development. On my initial fieldwork visit, community members informed me, with a sense of pride that there were over "a hundred young people in university from Nelson House." Many people in NCN hold either university or college degrees, or they are pursuing them. It was not unusual for a woman to tell me she was completing high school in NCN, seeking entrance to an educational program or already enrolled in one. The pursuit of education and training is also demonstrated with the opening of the $6.5 million dollar Atoskiwin Training and Employment Centre of Excellence in Nelson House this fall (O'Brien, *Winnipeg Free Press*, 2003). This progressive stance with a mixture of the traditional and Western is evident everywhere. The Nelson House Lodge chemical abuse treatment centre, the Family and Community Wellness Centre and a recently opened personal care

home are among a series of accomplishments achieved by the band. Outside of the community in Thompson or Winnipeg, for example, I was also frequently made aware of the community's ability to move forward and to meet a variety of challenges. The Family and Community Wellness Centre and the band's aim to establish an urban reserve in Thompson were cited as enviable. Chief and Council's progressive commitment to improving the economic status of Nelson House, and the articulateness of the people, were among the additional strengths that were identified.

11.6 NCN Otinawasuwuk: Re-Constituting Childbearing Knowledge

The group of NCN Otinawasuwuk maternity workers includes Elder Madeleine Spence. The women are working toward restoring subjugated childbearing knowledge, values and practices. Every day is begun with a smudging ceremony led by Madeleine in Cree, which is frequently accompanied by informal prayers of supplication and thanksgiving or the Lord's prayer. Elders are invited to meet with the group in sharing circles to explore traditional practices and to identify their place in a safe childbearing model. In the case of elders like Emma Hart, a former midwife who is having difficulty ambulating, the women visit her and record her thoughts on paper. As is the custom for organizations and businesses in Nelson House, an artist was commissioned to develop a logo that is reflective of their work. Their logo depicts an elder, a mother and a baby. Visual aides such as this and *Ikajurti: Midwifery in the Canadian Arctic* (Inuit Women's Association of Canada, 1990) video are used as foci for dialogue, in addition to the video films and pictures that were taken on the midwifery field trip to Tsi Non:we Ionnakeratshtha (the place they will be born) Onagrahsta (a birthing place) and the

Maternidad La Luz. Traditional and non-traditional speakers are invited to dialogue with the women. Traditional beliefs are explored, such as the rites of women, naming ceremonies and the Grandmother Moon ceremony. A reclaiming of traditional practices includes those of honoring the placenta. A ceremony took place on-the-land on February 28, 2003 where placentas were taken into the woods and ceremoniously commemorated to the Creator, as opposed to being disposed of in a hospital incinerator. Christian and traditional beliefs intermingle in these ceremonies and in the work of the women. The knowledge and practices the women are learning are being compiled for later analysis and sharing with the community. In addition, they are being integrated into their current approaches and strategies in their interactions with pregnant women.

11.7 Summary

In this chapter, I have demonstrated how childbearing autonomy finds its agency in cultural childbearing concepts and in an identity with the land. Children, who grow into adults, have their origins in the Creator who is sacred. This relationship and identity with the Creator provides a basis for autonomy that is distinct from human relationships, organizations, institutions or government. Conceptually, this cultural orientation potentially ensures a high view of the self, and an agency that finds its source ultimately in the Creator. As well, as this sustaining relationship, children who are born on-the-land of their Cree ancestors have an identity which is inscribed in an historical text that serves to bind them relationally as a group. Our actions find their origins in our worldview. In the context of birthing autonomy, a worldview that embraces the sacred and a physical identity with the land requires that there be a meaningful congruency between these beliefs and childbearing practices. It is apparent that this spiritual worldview is not

compatible with a Western worldview that is largely secular. The Western worldview based on the notion that we are products of our environment and heredity places an emphasis on the scientific over the sacred. In childbearing practices, this is generally expressed in a mechanical approach to birthing that conforms to a scientific orientation. The significance of how the Western worldview redefined the body and birth is evident from Arney's (1982) observation that the ideological re-conceptualization of the body as a machine and birth as a mechanical process was more instrumental in medicalizing birth than were the scientific advances in technology that followed.

The relational identity to the group that being born on-the-land provides is one that reflects a collective mindset. The research demonstrates that culturally congruent childbearing practices possess the agency to bring about positive changes to individual, family and community life. Relationships will be strengthened and healed, and meaningful cultural traditions, in addition to those relating to childbearing will be enhanced and in turn, foster community healing in other areas.

In preparation for the return of birth to Nelson House, the maternity workers, as the praxis component of the research that is being applied to these findings are actively engaged in re-constituting cultural childbearing practices. To this end, they have extensive cultural and traditional resources in Nelson House to build on, and draw from. Despite the ravages of colonization from an outsider perspective, it is apparent the community has shown considerable resilience in resisting assimilation. The community strength demonstrated in this resilience and an empowering cultural orientation to childbearing provides the NCN Otinawasuwuk maternity workers with a formidable arsenal for regaining control of childbearing practices.

Chapter Twelve: Is the Infrastructure Ready to Exercise Autonomy?

12.0 Introduction

Community members generally agree that there is a need to implement alternative childbearing practices in Nelson House. It is not difficult to imagine that perspectives differ regarding how current policies and practices might be changed. However, there is unanimous agreement that the initiation and implementation of alternative childbearing practices should be First Nations driven and developed. In this chapter, I will explore whether the infrastructure is ready to exercise autonomy at the community, federal, and provincial levels. The praxis event in this chapter addresses out-of-province midwifery education opportunities that were investigated during the midwifery field trip. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

12.1 Community Preparedness for the Restoration of Childbearing Practices

Community preparedness is an important consideration for the restoration of childbearing practices in Nisichawayasihk Cree Nation. The analysis identified several areas that have significant implications for how childbearing services will evolve from the perspective of community leaders, community members, health and social service providers. How health and social services are delivered in NCN, and by whom, have important implications for the way community-based childbearing practices will be integrated into the existing services. Currently, First Nations and Inuit Health Branch, Health Canada provides primary health care services in NCN (including childbearing

services), primarily through nurses employed in the nurse-practitioner role. However, it is the band that is responsible for administering public health and social services. For example, the Nelson House Medicine Lodge has been transferred to band administration. The two public health nurses and three community health representatives under band administration are funded by FNIHB. It is important to consider how the current infrastructures might accommodate the integration of community-based childbearing services. In addition, it is important to consider how health and social service providers and administrators perceive the future direction of these programs, as well as the potential for integrating community-based childbearing practices into the existing services. This section will address these issues from a community perspective.

In general, the reclaiming of childbearing practices in NCN is congruent with self-determination. "It would fit because we are taking control of our lives" (Eleanor Carriere, April 27, 2001). It would be advantageous if NCN had control of its own primary health services in anticipation of restoring childbearing practices to the community. It would allow for more control over how the childbearing services could be integrated into the existing primary health care services. An important component of this control would be the ability to employ primary health care providers of their choice, like physicians. Lorraine Parisien, pregnant with her fourth child, reflects on the benefits of community control over health services:

> LP: It would be nice if we had our own nurses or doctors.
> SH: Where you were in control?
> LP Yeah, that would be nice (November 23, 2000).

However, it does not appear that the band will gain control of primary health care services in the near future. This became apparent from meetings and discussions with Chief and Council, in addition to interviews, group meetings and conversations with women and community members and leaders.

At a May 2, 2001 community meeting with Chief and Council and executives from First Nations and Inuit Health Branch, Manitoba Region, band leaders clearly indicated it would not consider transferring primary health care services under the current fiduciary terms FNIHB was offering. The FNIHB representatives had traveled to Nelson House to encourage the band to take control of these health services. They suggested the band was doing well generally, and specifically cited the band's administrative accomplishment of the Family and Community Wellness Centre as a reason to transfer primary health care services. The band was offered an additional $200,000.00 a year, according to one councilor, if they would agree to them. The response of Chief Jerry Primrose was succinct: "If we want to make a mess of things, we can do it ourselves. We don't need your help to do it." In conversations, council members repeatedly explained to me that the financial provisions offered by the federal government would not in any way meet the needs of the increasing illness burden of the NCN community.

Councilor Agnes Spence said of the issue of transferred health services: "I think the way Manitoba is set up – it's set up for failure" (November 29, 2000). Carol Prince, R.N. band member and health director offered a more expansive perspective of transferred health services:

> We're not even looking at it with all the cutbacks. They're [FNIHB] cutting back all their services, like non-insured services. We don't want to take them if they're a skeleton. I agree with Chief and Council. We don't want to touch it with a 10 foot pole right now – too political. We've heard all the horror stories. If FNIHB wants to transfer, then make sure we have enough resources (November 30, 2000).

Additionally, inadequate resources were cited as undermining self-government aspirations. In a group meeting, Kim Linklater Beardy and Mona Hart observed the political nature of transferring health services, especially with regards to self-government:

> KLB: It's a delicate issue right now. They [Chief and Council] don't know what they're getting themselves into [can't hear, several speak at once about 'cutbacks' as a reason not to transfer health services]
> ?: all these cutbacks already
> SH: You don't like the idea of self-government?
> MH: Well no, not exactly. I don't see anything that we can self-govern ourselves with right now...(group meeting, November 15, 2000).

The implication by Mona Hart is that the resources are not available to pursue self-government effectively. It is evident that the prospect of band controlled health services is onerous at this point due to inadequate federal resources. However, it is ultimately the aim of Chief and Council to secure self-directed programs and services, as this vision statement demonstrates:

> The Chief and Council of the Nisichawayasihk Cree Nation hold a vision for their community as one that is self-directed, locally controlled, prosperous, well managed and a safe, secure place to live, work, learn and play in. Chief and Council further believe that they can secure the financial and human resources necessary for such a vision to be achieved; and that the necessary structures, policies and strategies can be developed to ensure the effective, efficient delivery of programs and services to the community and its people (Kanga & Associates, 1998).

The control of public health and social services by the band has already illustrated the importance of community-based programs and services to the integration of alternative childbearing practices. Early in March 2000, Chief and Council amalgamated public health and social programs under one administration in an effort to coordinate existing services. The unique centre that is home to the community-based programs is known as the Family and Community Wellness Centre, reported the first facility of its kind in Canada (Nisichawayasihk Cree Nation, n.d). It evolved in June 1999 from the collaborative work of community members and a federal-provincial partnership for the purpose of implementing "A Pathway to Restoration." The project is jointly funded by the Department of Indian and Northern Affairs (INAC) and the province.

The Nisichawayasihk Cree Nation signed an interim agreement with government representatives in May of 2001 that enabled the band to have control over Child and Family Services. Nora Thomas, Chair of the Family and Community Wellness Centre, shared her views on this occasion of community-based services with a reporter:

> For generations we had systems for teaching and nurturing our children. These systems allowed our people to maintain their culture and way of life. Things have come full circle. We want to teach the ways of our elders, the ways we were taught as children (Watters, *The Nickel Belt,* 2001, p.1-2).

The Empowerment of Aboriginal Women Surrounding Childbearing project, funded by the Aboriginal Healing Foundation is under the administration of the NCN Otinawasuwuk, the organization that arose out of this research. The NCN Otinawasuwuk is situated under the umbrella of the Family and Community Wellness Centre infrastructure. Shirley Anne Linklater, president of NCN Otinawasuwuk has been designated the Director of Midwifery Services by the FCWC executive. Many believe the

ultimate integration of midwifery services under the administration of the FCWC is an optimum arrangement. When asked if she believed midwifery services would benefit from being administered by the FCWC, Kim Linklater Beardy responded "for sure" (November 30, 2000). She envisioned midwifery services being holistically integrated with other childbearing and childrearing programs currently provided at the FCWC. Like the FCWC, the NCN Otinawasuwuk administration aspires to bring about community healing and wellness through community-based programs and services.

The aim of restoring childbearing practices to Nelson House, that the NCN Otinawasuwuk represents, and specifically through the Empowerment of Aboriginal Women Surrounding Childbearing project are both widely supported in the community. Chief and Councils' support of women who are seeking to have childbearing practices returned to NCN was evident initially from the resolution passed by Manitoba Keewatinowi Okimakanak tribal council designating Nelson House a midwifery pilot project site (see Appendix A), and from the letter requesting midwifery services of the Burntwood Regional Health Authority (see Appendix B). This support continued throughout the research project. For example, Chief and Council provided a letter of support to the Aboriginal Healing Foundation for the EAWSC proposal in addition to funding for two participants to undertake the midwifery field study trip. Chief and Council also provided written (see Appendix I) and verbal support of the research during meetings and interactions. In the spring of 2001, the support of Chief and Council was evident from two public meetings. At a community meeting, they asked NCN band members to support NCN Otinawasuwuk in spirit and financially. In the public meeting

of May 2001 with First Nations and Inuit Health Branch (FNIHB) executives, Councilor Agnes Spence sought support from the regional director (RD) for the return of midwifery to NCN.

Nelson House Community Mayor Bella Leonard was among those who lent her support by way of letter to the EAWSC proposal. In addition, the proposal received letters of support from many people, including the: Family and Community Wellness Centre Board Chair, Nelson House Development Corporation General Manager, Nelson House Education Authority Director, Head Start Program Director, Canadian Prenatal Nutrition Program public health nurse, NCN Indian Residential School Survivors Group Chair, Nelson House Medicine Lodge Board Chair, Building Healthier Communities Coordinator, and the Family Support/School Liaison worker. Letters of support from individuals came from elders and community members. The wide support the proposal garnered from both women and men is another demonstration of community readiness for making changes on issues surrounding childbearing.

This community readiness to restoring childbearing practices was widely evident. Kim Linklater Beardy reflected, "I think everybody is pretty adamant to try something new in the community" (November 30, 2000). In general, one pregnant woman said of her community: "They are more open to change, you know. They are more open to trying different things ("TX", October 11, 2000). Participants, like Barbara Peters, agreed that their goal was to have a birthing centre in Nelson House in the near future. "I've always dreamt about women having their babies here," she said (December 1, 2000).

Chief and Council's image of the community as progressive and "willing to try new things" reflects the wide base of support for addressing childbearing issues in NCN (Nisichawayasihk Cree Nation, 2001). The most recent example of this is the Wuskwatim dam project, a $1 billion endeavor. NCN is negotiating a partnership with Manitoba Hydro that will see them earn up to 33% of the revenue from this project (Fallding, *Winnipeg Free Press*, 2003).

12.2 Nursing Perspectives on Midwifery Services

Since northern nurses provide the majority of health care in isolated communities, it is important to consider their perspectives when exploring alternative childbearing practices. Inevitably, they exert a measure of power and control in their nursing practice, as the mainstay of health care in the isolated communities where the physician occupies a subordinate role in some respects. The question of how the midwives and nurses will collaborate and evolve a symbiotic relationship is therefore important.

Previously, when births took place in nursing stations, both trained midwives and nurses attended, the latter becoming 'nurse-midwives' by virtue of practice not education. In conversations with Bill Rutherford, FNIHB Director of Operations, Manitoba Region, (May 2002) he suggested that northern nurses are currently meeting two components (prenatal and postnatal care) of the four core competencies required to be eligible for midwifery registration with the College of Midwives of Manitoba. As well, the nurses attend births as needed and are frequently involved with women in labor prior to being evacuated. They routinely attend obstetrical emergencies.

The nurses were generally receptive to the addition of midwives as primary health care providers. It is apparent that the nurses envision themselves as being a part of a team approach in the provision of childbearing services. In the following excerpt an Aboriginal nurse places the care of childbearing women in an historical northern nurse perspective when nurses in Nelson House and other communities routinely attended births in addition to providing antenatal and postnatal care. Her concerns about not being involved in the provision of care for pregnant women is obvious: "We've always done prenatal care here. We don't want it pulled away from us we'd like to participate in everything too" ("EX"). Overall, the nurses agreed that a birthing centre in Nelson House would be a positive move:

> EX: I think, overall, the physicians in Thompson would love it if they had a birthing centre here.
> CX: Yeah.
> EX: It takes a burden off them. They would just love it; I know they would. (October 4, 2000).

In an interview with two nurses in NCN in September 2000, the Aboriginal nurse who has worked in NCN for a lengthy period of time validated the perspectives of other nurses I interviewed:

> SH: Do you see the implementation of a birthing centre here in stages? At first you might see a midwife coming out from Thompson and providing the prenatal care and gradually familiarizing people with the idea of midwifery.
> EQ: That is how I see it happening ... to have a building. To start like that right away, I can't see it working because the people still want to get used to it having a midwife deliver their babies. I think gradual will be a good thing to have a centre like that.

In the following dialogue, an Aboriginal nurse expresses the perspectives of other nurses and community members on how the birthing centre-nursing station relationship is envisioned:

SH: How do you think it would fit in with the nursing station?
EX: I don't think it should,
SH: You think it should be a separate building?
EX: Yep.
SH: Separate place, separate everything, separate people?
EX: Yes (October 4, 2000).

The FNIHB nurse administrator wondered what the role of the nurse would be if the midwife needed assistance from the nursing station: "What would be their role when this woman does deliver and the midwife wants backup?" She answers her own question in another part of the interview in reference to an obstetrical or neonatal emergency: "Who would be in-charge once they bring the baby into the nursing station or they bring the woman into the nursing station? Then, really, it's the nursing station nurses who are in charge" ("NI" August 30, 2000). Even though the birthing centre is envisioned as separate and if emergency care is sought from the Thompson General Hospital instead of the nursing station, there are obstetrical emergencies, apart from the actual birthing process that lie outside of the midwife's scope of practice. Emergencies such as urgent obstetrical and medical problems and domestic abuse would still require the care of the nurses in their role as nurse-practitioners. A close working relationship between the nurses and midwives would be necessary.

12.3 A Re-examination of Power and Practices

The support of the federal and provincial governments is needed in order to develop the required infrastructure in NCN to re-establish childbearing practices. Currently, the majority of primary health care services in NCN are provided by FNIHB-employed nurses. Visiting physician services are contracted by FNIHB from the province. On the other hand, hospital and midwifery services are provided by the province through the Burntwood Regional Health Authority. In this section, I will examine the various jurisdictional issues that need to be addressed to facilitate community-based childbearing practices. In the following discussion, I will explore the initiatives currently being put forward by the BRHA and FNIHB to address jurisdictional barriers.

This discussion centres on the belief of NCN band members that they have a right to health services from the federal government based on the Treaties and as a matter of policy. Eleanor Carriere emphasizes the significance of the Treaties as a basis for identity and a political relationship with the federal government when she describes why some people prefer to be called Indian: "Out of respect for our forefathers, some people would say that they prefer to be called Indian in honor of the Treaties" (April 27, 2001). Where it impacts health care, this political relationship with the federal government based on the Treaties was apparent from separate interviews with elders Leta McDonald and Emma Hart. They believed the federal government should fund the implementation of midwifery services in NCN (August 1, 2000). Thorough an interpreter, Leta McDonald

emphasized that "the ones that look after the Treaty are the ones that should pay for it" (August 1, 2000). Carol Prince, RN, and health director suggested in a group discussion that since the provision of midwifery services was a matter of federal policy historically, and thus by inference, it should continue: "In the past, FNIHB used to recruit nurses from England who had their midwifery training. ... Now, that we're looking into the birthing centre, they are not receptive to that idea anymore" (September 18, 2000).

Leta McDonald, an elder and former elected band councilor bitterly inferred that the Treaties were not being honored in reference to health care. Through a translator, she stated:

> The Queen did say that as long as the sun shines, the grass grows and the river flows, that they will look after the Aboriginal people. But now they've taken their word back. If I'm going to die, then I'm not going to go to the nurse, so I don't waste any money for the government (August 1, 2000)

The Treaties were frequently a topic of derision, such as in the following group meeting, where an underlying cynicism was evident regarding the federal government's lack of responsibility:

> EL: They said the government is slowly letting its responsibilities go.
> SH: Yeah? What do you think about that?
> EL: I don't like it because they broke the promise.
> SH: Yeah, the Treaty.
> EL: Yeah, the sun is still up [group laughter].
> SL: As long as the sun ... there is something there that was said I can't understand: as long as something about the grass, the grass grows?
> EL: The grass grows.
> EM: The river flows.
> SL: Well, what about the winter?
> SH: Well, the grass will always grow again, eh? Hopefully [group laughter] We'll always have another spring.
> EM: Yeah, the river will always flow [group laughter].
> ("EL" (elder), "SL" Shirley Anne Linklater, "EM" Ella Moose, "SH" Shirley Hiebert, group meeting December 4, 2000)

In these dialogues, it is apparent that participants consider the federal government responsible for health care to First Nations, and that these obligations are based on the Treaties. It is also evident that the Treaties are not being honored, generally and specifically, where health care is concerned. Many, including Leta McDonald, believe that financial imperatives underlie the federal government's approach to health services, and the well-being of First Nations people. The lack of committed federal resources creates a barrier in transferring primary health care services, and in the delivery of the current services.

The restoration of childbearing practices to NCN requires that FNIHB provide the necessary resources and infrastructure as the agency responsible for primary health services. By way of policy, the federal government continues with its policy to provide primary health care to pregnant women including the stay of the women at the YWCA until the time of birth in the Thompson General Hospital. The fact that the federal government has been providing childbearing services, as a matter of policy is a strong argument for FNIHB to expand them according to the aims of NCN. This approach is also in keeping with the position of NCN band members that the federal government should honor the Treaties where they impact health care.

The role of the province is an important consideration in the provision of midwifery services. Midwifery services are provided and funded provincially. When it comes to providing midwifery services, the Burntwood Regional Health Authority draws a fine line around First Nations living on reserve. The jurisdictional issue of who is responsible for First Nations on reserve from the perspective of the BRHA becomes

evident in the following discussion. A BRHA board member underlined the provincial-federal distinction with regards to health services and midwifery. She suggested that after midwifery services are established in Thompson, they will be expanded into rural BRHA communities:

> We would take it first to Gillam, Leaf Rapids and Lynn Lake because those are ours and from there I presume it would go on - once you get to Nelson House you're out of our territory, really. The regional health authority has the health responsibility but does not have the facilities because they are medical services (FNIHB) (December 3, 2000).

She acknowledges that the BRHA provides midwifery services. However, she points out that the federal government is responsible for the physical infrastructure on reserves. The plan of the BRHA is to establish midwifery services in Thompson and then expand them into other rural communities; however, the board member suggested NCN was out of provincial territory. Her assertion that midwifery services would first be established in Thompson was confirmed by a BRHA administrator at a group meeting in Thompson: "With the midwifery plan for this region, it was supposed to be stabilized first [in Thompson] – that was the original idea" (April 9, 2002).

The plan to expand midwifery services into the region after they are established in Thompson is stated in the *Proposal for Implementing Midwifery Services in the Burntwood Region.* The proposal does not differentiate between provincial and First Nations communities.

> Once midwifery is established in Thompson, and pending successful recruitment of midwives to the North, the BRHA will expand midwifery services in the region. (BRHA, 1999, p. 12)

The uncertainty as to the role of the BRHA regarding midwifery services in First Nations communities became evident at a meeting with Manitoba Health administration personnel at the end of April 2001. A BRHA middle manager asked Manitoba Health administrators if there were any jurisdictional issues that would be a barrier for the provision of midwifery services on reserve. The administrators replied there were no barriers, as far as, Manitoba Health was concerned.

There were several reasons given for the hesitancy that was evident among some BRHA middle management administrators to providing midwifery services in NCN.

At an April 9, 2001 group meeting in Thompson, a BRHA administrator raised the issue that if midwifery services were provided in NCN, other First Nations communities would come to expect similar services. The administrator was reminded that NCN had been designated as a midwifery pilot project site in a resolution passed in June 1999 by MKO (see Appendix A). It was believed that this designation would make NCN's position acceptable to other First Nations communities within the MKO tribal council.

The under-representation of midwives in the BRHA was also given as a reason midwifery services could not be extended to NCN. Often, only one midwife had been providing services in the BRHA. A BRHA administrator suggested that if the midwife was to provide services in Nelson House one day a week, it would require 20% of her time. Difficulty recruiting and retaining midwives in the North, was given as a reason for not being able to provide services to Nelson House. Midwives were said to have a preference for working in the south: "A lot of the ones that are from southern Manitoba

can get work in southern Manitoba and some of them aren't motivated to come here" (BRHA administrator, April 9, 2001). More recently, a registered midwife from Thompson was advised by letter that her verbal offer of employment was being rescinded because the BRHA could not fund an additional midwife (registered midwife, personal communication, April 11, 2003). At the invitation of NCN Otinawasuwuk, a midwife has been visiting the Family and Community Wellness Centre on occasional Monday afternoons, when pregnant women come to take part in services provided by the NCN Otinawasuwuk maternity workers and the Canadian Prenatal Nutrition Program.

One senior BRHA official believed a concern with liability was responsible for the perceived hesitancy of BRHA middle management in locating midwifery services in NCN. A BRHA board member also raised the issue of liability, indicating that should NCN women desire to have homebirths, a "vast insurance policy would have to be taken out" (date of interview withheld). Home-births aside, requests by the NCN Otinawasuwuk to have a midwife visit pregnant women in their homes who are interested in midwifery services have not been met. The shortage of midwifery staff in the BRHA is cited as the reason NCN cannot have more extensive midwifery services like home visits. Instead, the women are asked to make appointments with the midwife at her office in Thompson. The women would need to acquire their own transportation for appointments. This is a barrier for most women, in addition to childcare.

The midwife's position appears to reflect that of her employer, apparent in a question posed by the BRHA administrator at the April 9, 2001 group meeting: "Would the women there be interested in coming to see her (midwife) at her site here in

Thompson? It's very nicely set up." This well-intentioned invitation is reminiscent of the historical dynamics in First Nations health care where First Nations are brought to the services instead of the services to them. Midwifery activity in NCN is limited to the midwife familiarizing women with midwifery services that are available in Thompson, in addition to answering any questions the women might have.

12.4 Potential for Addressing Jurisdictional Barriers

While in practice it appears the implementation of midwifery in NCN is fraught with obstacles, from the perspective of middle management BRHA administrators and staff, there is room for cautious optimism. Senior BRHA and FNIHB management administrators have a vision for overcoming jurisdictional barriers in order to provide seamless health care.

Cal Tant, then –CEO of the BRHA emphasized at a meeting on February 12, 2001 that an approach to midwifery services in Nelson House should be carried out with the inclusion of the BRHA: "What we want to do is to bring people together that are focused on the issues. This is a wonderful opportunity for working together with all community-based groups, including First Nations people." He indicated that provincial-federal jurisdictional barriers should not impede the provision of midwifery services:

> ... 55 to 60% [of people] that use the Thompson General Hospital are from First Nations or Northern Affairs communities. First Nations representation is very important; the Board is majority First Nations. ... The best way to achieve health care is to have one system to best meet the needs and resources ... especially in Northern Manitoba, because we all have the same difficulty recruiting health professionals. It is even more difficult, the more you split up available resources

According to Peter Rogers (interview, November 5, 2002), a First Nations and Inuit Health Branch executive, initiatives are currently being made with Burntwood Regional Health Authority management to address jurisdictional issues between the federal and provincial governments that will provide a means for more optimum health services in isolated northern First Nations communities. In addition, the research questions that were submitted to a FNIHB nursing administrator were brought to the attention of the Assistant Deputy Minister in Ottawa (Appendix H) "for support in establishing a national working group to research and develop policies for the practice of midwifery in First Nations communities." The nursing administrator indicates that "our goal at FNIHB is to ensure that First Nations communities have access to the best available health care services."

12.5 Educational Barriers to Midwifery

Midwifery education opportunities for Manitoba women and specifically Aboriginal women are scarce indeed. There are no midwifery schools in Manitoba. A degree program in midwifery was approved by the Senate and Board of Governors of the University of Manitoba. The Council on Post-Secondary Education (COPSE), a provincial agency that was created by an Act of the Manitoba Legislature in 1996 has decided not to fund the program at this time. The College of Midwives of Manitoba is in the process of developing a Prior Learning and Experience Assessment (PLEA) process that will enable prospective midwives either by formal education, or informal education and experience to have their eligibility for midwifery registration determined on an individual basis (personal communication, College of Midwives of Manitoba, January,

2002). Based on meeting the four core competencies required for registration, the independent study approach enables a prospective midwife to become eligible for registration by being mentored by a registered midwife. This 'independent model of midwifery' requires that a midwife be available and accepting of having a midwifery student. The independent study approach is problematic in Manitoba for a number of reasons that are even more acute in the northern area of the province. A dearth of midwives makes this option difficult from the perspective of too few midwives to mentor prospective students.

A board member of the Kagike Danikobidan Committee, on a telephone speakerphone with the working group on November 27, 2000, outlined how an independent study course might proceed:

> To become a midwife it could take anywhere from, for example ... three years to seven or eight, depending on which route you took, how much training and how much previous experience you have. ... I don't know of any formal apprenticeship program at this point. Other options for learning midwifery are being able to buddy up to a midwife if she's willing to have you go along with her during some of the midwifery care as an observer. ... Another option is if there is a group of you that is really interested in midwifery, you can form study groups where you can look at the different aspects of midwifery care and a perhaps get individual speakers to come in and talk on different topics.

By pursuing a program of studies independently of the mentorship guidance of a registered midwife a prospective student risks not achieving the College of Midwives of Manitoba registration on completion of self-study. As well, it is exceptionally difficult for a prospective student from an isolated First Nations community to attempt to unravel a

maze of options and choose one that might meet her needs. Self-study courses that are available from the United States are prohibitively expensive. In addition, the courses might not meet the woman's learning needs. According to a Manitoba Health midwifery executive (2003) initiatives to develop an Aboriginal midwifery program are being made by provincial health, midwifery and education personnel subsequent to a meeting with representation from the NCN Otinawasuwuk, myself, Manitoba Health and the College of Midwives of Manitoba in 2002.

Midwifery education barriers identified a need for NCN women to pursue alternative midwifery education sites. The midwifery field study trip to the The Tsi Non;we Ionnakeratsha (the place they will be born) Ona:grahsta' (The Birthing Place), a maternal and child centre at Six Nations of the Grand River, near Brantford, Ontario, and the Maternidad Del Luz, in El Paso, Texas was undertaken, in part, to explore the options available at these sites.

A three-year program is becoming available for the study of midwifery at the The Tsi Non;we Ionnakeratsha Ona:grahsta.' It has not been determined if the content of this program would meet the requirements for midwifery registration with the College of Midwives of Manitoba. Shirley Anne Linkater and Lenora Spence were unsure as to whether they would be comfortable pursuing midwifery education at this birthing centre when it becomes available, but agreed that they "liked it over there." As well, they liked "meeting those midwives" because "they told us what we need to know, like what to expect as a midwife, in terms of being on-call, responsibility, and education" (June 8, 2001).

The majority of the First Nations midwives employed with The Tsi Non;we Ionnakeratsha Ona:grahsta' received their midwifery education from Maternidad Del Luz birthing centre, El Paso, Texas. On return to Six Nations, they received additional training on site before they became eligible for employment at the birthing centre. In a group discussion with the Aboriginal midwives, they spoke favorably of the maternity centre where they received their education; they believed they had received good midwifery education and a wide range of experience that assisted them in their practice.

The dearth in midwifery education sites in Canada has led prospective midwives, like women from Six Nations, to pursue midwifery in birthing centres along the Mexican-United States border. The clientele for these birthing sites is generally from adjacent Mexican border communities. Nestel (2001) criticizes the conditions that find women in a situation where they need to engage in "midwifery tourism" as a means to gain midwifery education. Midwifery tourism refers to the relatively advantaged position of North American women who journey to southern areas to pursue midwifery education.

The Maternidad Del Luz birthing centre is staffed by community midwives. A prospective midwife may develop a program of studies that suits her academic background and midwifery experience. A three-month academic session is offered that includes Spanish language studies. Distance was the greatest barrier to pursuing midwifery education in El Paso. Lenora Spence observes: "I'm not saying El Paso is not good or anything, it's just too far. I can't be in a big city. Well, I could be. I get fears that I have to watch everywhere I go, and I don't like that." Shirley Anne acknowledged, "I

wouldn't mind living there" but she indicated that the distance from her family would be a problem. The vigilance of the police in detecting illegal border crossings was also disturbing. Both women had observed the police cars on the highway and one incident where "all their clothes and all their stuff, was on the ground. Everything was left on the ground there. It looked like they emptied the car out." They liked the maternity centre and felt comfortable there. However, they felt other barriers to attending this site besides distance included not being fluent in Spanish ("I don't know the language") and the lack of financial resources to get to El Paso (June 8, 2001).

Six months later, Shirley Anne reflected (December 13, 2001) that she could accept leaving the community for education purposes if it were for a short period:

> If it's a short term, it's okay. I wouldn't mind going for training for a month or two weeks out of town. That I don't mind. I would appreciate it. But for me to go out and find a house and live there and not be here, then that's a barrier for me.

Closer to home, midwifery training by learning with a midwife was not a viable option either. Two BRHA midwives who attended the November 27, 2000 meeting were asked to come to assist the women educationally in becoming midwives:

> KLB: Would you be willing to come and do a workshop here in the evenings with prenatals?
> ND: Um, I would love to be able to say yes.
> KLB: Uh huh.
> ND: At the moment because we have a lady who is almost ready to have her baby [in Thompson].

The midwives could not make a commitment to come to NCN because a client might go into labor in Thompson. At the April 9, 2001 meeting with Burntwood Regional Health

Authority administrative officials, the midwife was again asked if she could offer some educational direction to NCN women: "I want to get a few more things organized here first before I actually start that." She suggested the meetings would need to take place in Thompson, since there were other women there who would like to learn, as well. She cautioned that "a lot of learning can take place in there, but it wouldn't necessarily be official," suggesting that such a sharing of information might not necessarily be recognized by the College of Midwives of Manitoba for registration purposes. To date, no meetings have been organized.

The NCN Otinawasuwuk women's initiatives to procure another midwife to mentor them met with failure as well. A registered nurse-midwife who was available to work in Nelson House at the nursing station and act in the capacity of a midwifery instructor found the infrastructure was missing to make this possible. FNIHB currently does not have the bureaucratic infrastructure in place that would be necessary. The provincial issues around who is responsible for midwifery services jurisdictionally would also need to be addressed. The NCN Otinawasuwuk's empowerment has been evident in this and other initiatives they have made to procure a midwifery instructor in the community.

The possibility of Six Nations midwives coming to NCN to teach midwifery was discussed. However, this route for midwifery education does not appear a feasible option if the NCN women want to register with the College of Midwives of Manitoba (CMM). The Six Nations midwives are not registered midwives with the College of Midwives of

Ontario. They would be unable to meet the CMM requirements for registration, since provincial registrations are reciprocal.

Barriers to midwifery education for nurses are restrictive. One NCN Aboriginal nurse, employed at the nursing station indicated she would like to practice as a midwife in NCN. She suggested that FNIHB should sponsor her in obtaining additional midwifery education. She compared this approach to becoming a midwife to that of the training she received to practice as a nurse practitioner.

> They can create a program to help the FNIHB nurses. We're already doing the expanded role. They provided us with a lot of education, including maternity and obstetrics ("CX" October 4, 2000).

Ironically, some of the nurses were given the opportunity to register as midwives when the invitation was put forward by the College of Midwives of Manitoba in its original intake. The Aboriginal nurse above like others working in nursing stations received information to register with the CMM. However, she did not have the necessary time to pursue registration due to the very busy schedule of the nursing station. Several of the nurses told me that they had met the criteria as outlined by the CMM to become registered midwives.

12.6 Summary

The return of childbearing practices to NCN is a complex one. Childbearing, seemingly as basic as the 'medicine chest' referred to in Treaty No. 6, has become for

First Nations people as convoluted as the larger struggle that surrounds self-determination. As Stubbing (1990), a northern physician emphasizes, there is a need for the appropriate infrastructure to be in place in order to return birth to an isolated community. There is a readiness to pursue alternative childbearing services in Nisichawayasihk Cree Nation on several fronts: 1) Chief and Council's progressive approach to self-determination in social and economic development is reflected in their support of the research, the work of the NCN Otinawasuwuk maternity workers and the aims of community members to re-establishing community-based childbearing practices; 2) Aboriginal nurse practitioners who provide the bulk of primary health care and emergency services in the community are receptive to making changes in childbearing services; 3) First Nations and Inuit Health Branch, Manitoba Region officials have demonstrated a willingness to support Nisichawayasihk Cree Nation in furthering alternative birthing practices; and 4) the Burntwood Regional Health Authority envisions a future where midwifery services will be expanded into communities like Nisichawayasihk Cree Nation.

Sizeable infrastructure barriers will need to be overcome, in order for Nisichawayasihk Cree Nation to exercise their autonomy in re-establishing community-based childbearing practices. The BRHA prioritizes midwifery services according to the needs of Manitoba residents living in urban and rural communities. An under-representation of midwives in the BRHA severely restricts the availability of midwifery services in Thompson and midwifery outreach to communities like Nisichawayasihk Cree Nation. Jurisdictional issues are evident in the manner in which the BRHA prioritizes

midwifery services and in their concerns over liability issues on reserve. First Nations and Inuit Health Branch, as the primary health care provider for on-reserve First Nations, is not taking a leading role in expanding childbearing services that reflect recent changes in midwifery legislation. Midwifery education opportunities in northern Manitoba are non-existent. A desire by the NCN Otinawasuwuk to have a midwife provide midwifery education in the community has obstacles, among them midwifery availability and the need for recognition of a community-based educational program by the College of Midwives of Manitoba.

Chapter Thirteen: How Will Autonomy Be Expressed in Childbearing?

13.0 Introduction

In this participatory action research project, I have reflexively examined how childbearing practices came to be dramatically changed from a family event that took place in the home and usually attended by women, to one that is highly medicalized in urban hospitals under the domain of physicians. I have argued for the autonomous role of women, and First Nations generally, in their pursuit of self-determination on childbearing practices that are culturally and socially reflective of their needs and aspirations. I have examined childbearing practices in an historical context to provide a means to understand power-knowledge issues that need to be addressed if First Nations are to regain control of birth. I have explored how all of these issues impact the evolution of alternative childbearing practices.

In this chapter, I will examine how the autonomy of women can be expressed around childbearing practices. Key components of this autonomy will include the ability of women to: 1) exercise their choices as to where, and how, birth takes place; 2) be able to have an egalitarian woman-midwife relationship; 3) access a combined Aboriginal/Western childbearing model; 4) seek care from midwives who are, preferably, Aboriginal – either direct-entry or nurse-midwife – and have received a community-based education. Names of individuals in this chapter are used with their consent. Where quotes are of a sensitive nature, the participant's consent for use of name is withheld.

13.1 The Autonomous NCN Woman and Childbearing Choices

While the idea of the autonomous woman, in an individualistic sense may be more of a Western philosophical notion than rooted in First Nations culture, international human rights law protects the intrinsic rights of every woman. Cook (1994), a lawyer with the World Health Organization (WHO), argues that governments should seek "the promotion and protection of women's health and should enhance the dignity of women and their capacity for self-determination" according to the Universal Declaration of the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention) (cited in Cook, 1994, p. 3). Cook (1994) maintains that women in many settings have never "enjoyed autonomy, the conviction that they can act autonomously, or the belief that they rightfully should be influential in the circumstances that affect their health" (p. 32). This applies to Nelson House women where it impacts their choices around childbearing practices. Since the colonization of childbearing practices in NCN, women have not been able to act autonomously in accordance with either their personal beliefs or cultural ways. O'Neil (1988) observation that "health has always been a priority for northern women and the relatively late emergence of political interest in health care reflects women's domination by medical institutions" (p. 44) certainly resonates with NCN women where childbearing practices are concerned.

The way Nelson House women approach the current politicization of childbearing issues is in part influenced by their orientation to the role of women in their culture. Women expressed an orientation to both traditional and career roles. Most women are homemakers. Many women who participated in the research had attained either university degrees or college diplomas, or they were in the process of pursuing them. The

women would frequently point out to me that they believed the majority of the workforce in Nelson House was made up of women. I observed during the fieldwork that the employment of women was not restricted to traditional roles. Instead, women also worked in business, building construction, and served as security guards, constables and band councilors. The women portrayed themselves generally as having an egalitarian relationship with their male counterparts. Several interview examples illustrate how the women saw themselves in their culture.

A pregnant woman with a university degree expressed her gendered perspective:

> SH: Do you think as a woman you could do anything here that a man could do?
> TX: You better believe it.
> SH: [laugh] There's no barriers?
> TX: Yeah, there is.
> SH: Yeah?
> TX: Yeah, there is. I don't know if it's just Nelson House. I don't think it is. I think it's all over the place but I'll tell you, there's more women in the workforce now than there ever has been (August 1, 2000).

She concedes that there are barriers for women in Nelson House. However, the strength of her conviction that a woman is equal to a man is apparent from her statement "you better believe it." In addition, she emphasized her belief that more than ever, women are represented in the traditional masculine realm, the workforce "there's more women in the work force now than there ever has been."

Kim Linklater Beardy has a college legal background and is currently pursuing a university degree. She reflected on our dialogue with a band councilor that illustrated her egalitarian orientation to him:

SH: I noticed that when you went in there and talked to ------ you felt quite comfortable asking him for answers.
KLB: Exactly.
SH: But that takes time, takes growth?
KLB: Oh yeah, for sure ... they're just individuals. ... I know more about them than they probably know about themselves (November 30,2000).

The strength of the equality felt by women like Bella Leonard, Mayor of the Nelson House Community, to her male counterparts is apparent from her recall of events surrounding her pursuit of the mayoral leadership, after she regained her Indian status with Bill C-31:

BL: The first time, they didn't think I belonged as a mayor because I was treaty. ... He [contender] was trying to get smart with me, and, I just told him right out what I thought. After that we got along [laughs].
SH: So, are you the first mayor that's a woman?
BL: Yeah, I don't care anymore what anybody says (December 2, 2000).

These autonomous orientations are expressed in the choices some women make in seeking care when they are pregnant. Women like Kim Linklater Beardy, who have the financial means for transportation choose to access their antenatal care from a physician in Thompson: "I always found my own doctor. I didn't go through the nursing station." (November 30, 2000).

Participants in the research strongly believed that women should be able to exercise their autonomy surrounding childbearing practices, particularly when childbirth is returned to NCN. They further agreed that women who preferred to give birth in Thompson should have their autonomy respected. Elder and midwife Emma Hart (August 1, 2000) indicated the choice as to where women wanted to access services or give birth should be left to them. A young woman, Eleanor Dumas expressed views similar to those of other pregnant women: "It's up to them. You can't force them to change. You

wouldn't force your will – we want you to have your baby in the community. It would be their right" (April 23, 2001). Mayor Bella Leonard included maternal evacuation as a choice belonging to a woman:

> SH: So you would leave it to the individual woman?
> BL: Uh huh.
> SH: Yeah. It's her decision.
> BL: Uh huh.
> SH: That would be her decision whether she wants to have her baby here or in Thompson, too?
> BL: Yeah. But they send you out so many months, weeks early...
> SH: So the women should have something to say about that too?
> BL: Oh yeah.(December 2, 2000).

The autonomy to make choices included the prospect of home-births as well. One young woman sought the advice of her grandmother about having a home-birth. Her grandmother advised that the choice was hers to make; however, the grandmother suggested that she seek her mother's opinion too. At a meeting where this situation was anonymously discussed, Ella Moose suggested "You can't force the person to go out, can you? You have to support that person" (December 4, 2000). How or whether home-births might be integrated into a holistic childbearing model met with various responses. Shirley Anne Linklater, president of NCN Otinawasuwuk and midwifery coordinator for the Family and Community Wellness Centre, indicated that the decision to include home-births in an NCN childbearing model would be a future consideration after birthing services had been reestablished in NCN.

How a woman chooses to utilize services provided at the nursing station extended to include choices about a primary health care provider, if a midwifery option was made available by the BRHA:

SL: It would be up to the mothers
NN: Yeah, it would be up to the mothers.
SH: So, if they came to the nursing station they would have an option to see a nurse or a midwife?
NN: Oh yeah [many in agreement] ("SL" Shirley Anne Linklater, "NN" [anonymous] and "SH" Shirley Hiebert, group meeting December 4, 2000).

The women in NCN see themselves as having the freedom to exercise their autonomy in a general sense, as women. Where these choices impact childbearing, they believe the autonomy of the woman should be respected. It is also apparent that they believe women should have the choices to make.

13.2 Egalitarian Woman – Midwife Relationship

The egalitarian orientation that NCN women, generally, perceive themselves as having toward their male counterparts and people overall extends to the woman-midwife relationship. An egalitarian relationship between a birthing woman and a midwife is characteristic of the midwifery model (Tyson, 2001). Jackie Walker acknowledges the naming of the organization NCN Otinawasuwuk (Receivers of Children) as:

SH: Otinawasuwuk, is that how you say it?
JW: Right.
SH: Receivers of children?
JW: Right.
SH: That's different than I did the delivery, I received the child.
JW: Right, right.
SH: It says something about the way they see it, you know?
JW: Right. Uh huh.
SH: The powers of the woman and the Creator.
JW: Right (April 27, 2001).

The power of the woman and the Creator appears to lay the foundation for an egalitarian relationship between the laboring woman and midwife that reflects balance

and synchronicity. The perceived function of midwives as receivers of children places the midwife in a more passive role than the active, life-giving roles of the woman and the Creator. This egalitarian woman-midwife orientation is consistent with Jackie Walker's perceptions of the relationship between Aboriginal people and counselors:

> Historically, Aboriginal people never used to have counselors. But they view them both as helpers and teachers. For example, when you're doing an assessment on a client, you're learning and the client is teaching you. They are teaching the counselor. They are teaching you about stories. You are learning from that process. We're always equal. You're never above them, and they are never below you. Every day you are learning things – you learn from people. At the same time we're also helping (April 27, 2001).

This illustration of an egalitarian relationship between client and service provider reflects an underlying premise of equality within the cultural group, regardless of gender or abilities. It also demonstrates the autonomy of individuals who enter into service relationships with providers. Their individuality and backgrounds are given equal weight to those of the provider – in this case, the counselor. This role for the woman is in direct contrast to the one we see in the Western approach that places her in a dependent position to the health care provider. As we have seen, such a dependent role is not favorable for taking responsibility for your own body. Others decide how you should understand and use your body to fit into the mechanics of a process beyond your control. It is a disempowering process, whereas the Aboriginal approach that creates an equal relationship between the woman and health care provider is an empowering one. Thus women are empowered through taking control of their bodies and making their own decisions when given the opportunity to make choices will do so to her benefit.

13.3. Choice of Aboriginal/Western Childbearing Model

An Aboriginal/Western childbearing model needs to take into account the previous discussions on the conceptual orientation of autonomy originating from the Creator in addition to an identity and relationship to the land. As well, that birth is sacred and a relational community event. To be culturally congruent, an Aboriginal childbearing model requires that it reflect these values and beliefs. It requires that Nisichawayasihk Cree Nation control the evolution and development of their childbearing model. Western practices will be inserted into this model in a manner that integrates the best of biomedical expertise and knowledge for the benefit of Nelson House women and children. Eleanor Carriere predicted that it will be a holistic model which will "combine the two and there will be a balance, and the benefit will be for the community and its members." She further noted that "they could incorporate technologies ... they can incorporate methods that would benefit birthing – what's best for the individual is what is good for our people" (April 27 2001).

Social-service personnel like Susan Kobliski, 'Spirit Flight Woman,' who is employed as a mental health worker like those employed with the Nelson House Medicine Lodge routinely combine traditional and Western practices in their approaches. An integrated childbearing model as envisioned by the participants could similarly combine Western and traditional beliefs and practices. Jackie Walker shared the overall anticipation that childbearing practices in Nelson House will evolve into a more traditional and empowering approach than the Western one. "Eventually, I think it could lead to more of the traditional aspect of it. And when it does ... women's instincts will play a role immediately in it" (April 27, 2001). Susan Kobliski, 'Spirit Flight Woman,'

reflected on the integration of traditional practices into an alternative childbearing model and how this can further the journey of healing:

> I've known ever since I was a child that my ancestors did things differently. ...The teachings are coming back - something so sacred and something so spiritual – it's like the long winter months and then the spring comes and you feel the warmth of the sun on your body everywhere – that's how good it feels. The teachings were of what was here at one time, a way of life (April 30, 2001).

The need to re-introduce traditional medicines and cultural practices was seen as important to the participants. How the traditional medicines might be used was not discussed. The care of the placenta for some women was seen as an important means to express their sacred orientation to birth. An Aboriginal worldview which has its basis in the sacredness of birth as a relational and empowering event requires that this orientation have a foundational place in the evolution of an Aboriginal/Western childbearing model.

The following group discussion with Cynthia Spence, Hilda Primrose, Madeleine Spence (elder) illustrates the empowerment of the women as they explore various roles, like that of the elder. They also discuss the resurgence of interest in traditional medicines:

> CS: Like I was telling my mom, I want to learn all the medicines next summer.
> HP: Yeah, I want to learn. I'll come with you
> CS: If you want to be an elder, she says to me. I said, hey, hey hold on I didn't say anything about being an elder. I just want to learn the medicines. [lots of laughter] ... But you're considered an elder, like I can be an elder by next summer, if I know all my medicines and that. I'll be considered as an elder.
> SH: Oh, okay.
> CS: So you don't have to be old to be an elder [says this softly to me].
> SH: Oh, okay.
> CS: As long as you're humble and you have something to teach.
> SH: Okay, okay.
> MS: That's what I thought, too. Even me, years ago, I didn't know what an elder was. I thought it was an old person.
> SH: Yeah?
> MS: Very old person.
> SH: Very old, okay ... but you need to have wisdom, I guess?

MS: Yeah.
SH: Uh huh.
MS: You can tell a person that's wise and a role model. ... It can be a younger person that's a role model in the community, that's a kind person.
SH: Uh huh.
MS: That's an elder...
CS: An old person is different from an elder (group meeting, December 4, 2000).

According to Eleanor Carriere, traditional healers could be involved in the development of alternative childbearing practices in Nelson House, particularly in the incorporation of traditional beliefs and values. She described a role for a traditional healer in the event of births in a hospital, or in Nelson House: "They can have a visitor, like a traditional person, so that they have a place to go. ... And I think that should happen in Thompson and here. Sometimes, they might need herbal tea, or just touch, and comfort (April 27, 2001). A holistic childbearing model with a foundation in Aboriginal beliefs and values that utilizes the best of biomedical expertise and technology is one where pregnant women have an active role in caring for themselves in a relational and egalitarian way to the midwife and community. Access to an alternative birthing model is not only a matter of choice; it is one that will provide a woman with the opportunity to realize her identity and that of her community.

13.4 Registered and Aboriginal: Direct-Entry or Nurse-midwife

The research indicated that the type of midwife the women would like to access must reflect their needs and preferences. Midwives differ in their philosophical approach to the practice and education of midwifery. The participants had no particular preference for a specific type of midwife. Instead, they demonstrated their desire for someone they could trust. In addition, they regarded registration with the College of Midwives of

Manitoba as preferential for midwives providing childbearing services in NCN. They also indicated a preference for Aboriginal midwives. However, whether the midwife had a direct-entry or nursing background was not considered important. In the context of a nursing background, it is worthwhile to consider that the participants' frame of reference was the Aboriginal nurses at the nursing station whom they have known for a long time.

By far, most women had a high degree of confidence in the nurses' ability to act in a midwifery capacity, despite a general dissatisfaction with the depth of interactions in antenatal care. The following analysis with interview excerpts and ethnographic data provides an overview of the participants' perspectives on the elements believed necessary to practice midwifery in NCN. Shirley Anne Linklater's aim to pursue midwifery as a career results from "a call." Her vision to become a midwife began 10 years ago when she visited a traditional healer in another First Nations community who informed her that she would one day be involved in bringing children into the world. At the time, she did not have this life work in mind. The healer told her she would need a drum and that she would be traveling in relation to her calling. When I arrived in Nelson House and Shirley Anne learned of the research topic, she believed her involvement in the study would be instrumental in fulfilling her calling. Several months into the research, she decided to have a drum made with an artist's depiction of her Indian spirit name on it. I suggested to her that the drum symbolized her voice, a voice she would need to return childbearing practices to NCN. In the spring of 2001, she was named the midwifery coordinator by the executive staff of the Family and Community Wellness Centre to represent their initiatives for the re-implementation of midwifery in the community. Others, like Lenora Spence have subsequently expressed their aim to become midwives.

Another perspective included having nurses in the capacity as midwives. Participants generally saw the nurses as possessing significant knowledge regarding childbearing practices, or as having the ability to become midwives. A pregnant woman said she would trust the nurses when she was in labor: "The ones that come into the nursing station when you are pregnant" ("NE" April 2, 2001). When I explained the role of a midwife at some length to a pregnant woman she responded, "Just like the nurses" ("NY" April 25, 2001). Sylvia Wood's faith in the NCN nurses was typical of responses associated with the Aboriginal nurses currently employed at the nursing station:

> SH: What kind of people would you like to see in that place [future NCN birthing centre] taking care of you that would make you feel safe?
> SW: The nurses.
> SH: The nurses?
> SW: The nurses I know (October 3, 2000).

Jackie Spence believed a nurse could qualify to take on a midwifery role: "a nurse who's experienced in delivering babies. That would be all right, too, I think" (May 7, 2001). A mother of several children said she would feel at ease with the Aboriginal nurses currently employed in NCN: "I would feel comfortable and confident in ------ and ------ in the nurses here. I've known them long enough now to be comfortable with them." She then asked: "So in order to be a midwife you have to certification of some sort?" ("TX" October 11, 2000). A pregnant woman, Leona Linklater, employed in a business office, suggested that experience is essential in addition to having accredited midwifery training, the latter being essential for "safety reasons." Like other women, she trusts the nurses as having the authoritative knowledge necessary to become qualified midwives: "I would feel comfortable if they did receive a diploma or certificate through

the college and I know that ------ is a registered nurse, so I would already have trust in her ... like, if she was to get that certificate herself" (April 23, 2001).

Overwhelmingly, the participants agreed that midwives should be registered, as Mona Hart attested:

> It would be nice if we had a registered person so that we could become registered midwives, and then in the meantime, during this process, we could also have the traditional part given to us by our own elders firsthand. We can do it in those ways also. I mean, my grandma [Susanna (Gaudin) Thomas] was not a registered nurse or a registered anything she was a human being that wanted to help bring life into this world, so she delivered ... babies (group meeting, December 13, 2001).

Regardless of the prior background of a midwifery candidate, knowledge of midwifery skills and experience practicing them were of significant importance to the participants. Lorraine Parisien summed up this sentiment with her observation that "hopefully ... this midwife has delivered babies before." She indicated other criteria she felt were crucial to the midwives who would facilitate birth in NCN: "They have had their own children already or they're nursing already." The midwife should be Aboriginal, as well as a "very calm person" (November 23, 2000). Another pregnant woman specified that midwives should be people from "our own reserve, trained and confident" ("CN" May 4, 2001). Experience, midwifery knowledge and being of Aboriginal descent were also important to Clarissa Parisien and another young pregnant woman:

> SH: What if you had a midwife?
> OX: If she knew what she was doing.
> CP: To make it safe for the mom and the baby.
> SH: What kind of midwife would you need to do this?
> CP: Someone who has done it before.
> OX: Same thing.

SH: What kind of education?
CP: Knowledge to deliver a baby and if something goes wrong.
SH: Do you think that native women would be ideal for this?
CP: Yes.
SH: Do you think they might be better in some ways
CP: Yes, they could relate to us (October 4, 2000).

The perspectives of the women illustrate their personal orientations and a concern that those who will provide midwifery care will have the expertise and knowledge to do so safely.

13.5 Midwifery Education: Aboriginal, Western and Community-Based

Differing professional approaches to midwifery are reflected in the education choices midwives pursue. However, in Nisichawayasihk Cree Nation, the choices are more pragmatic and culturally-based. The importance of a midwife being well trained was frequently verbalized as necessary to practice midwifery in NCN. Another pregnant woman, "OY," emphasized that training was important to her, but not whether the woman was Aboriginal: "It doesn't really matter, as long as they are there" (April 28, 2001). In a group meeting, Mona Hart and Hilda Primrose made obvious their preference for someone from NCN to become a midwife:

MH: It would be nice if one of our own people would be the midwife.
SH: Uh huh. So then what you're saying is if you want a midwife, you'd like to see that midwife be community-based?
HP: Well, yeah.
SH: You'd like to see someone here be educated for it, here provide the care?
MH : Absolutely (group meeting, October, 2000).

Several women in the community indicated they would like to become midwives if the training could be made available to them in either Nelson House or Thompson. The pediatrician envisioned that community-based midwives would potentially be able to offer ideal services:

> You can support some local women to become midwives. They can stay here and serve here. That would be ideal, so that you know you have access 24 hours a day, seven days a week. If you get someone from outside, there will be a problem (September 18, 2000).

The perspective of one of the Burntwood Regional Health Authority midwives who attended a group meeting was consistent with those of participants who strongly advocated for the involvement of elders and traditional practices in the evolution of alternative childbearing practices from within the community:

> One thing I wanted to make sure of is, that everybody is aware of, is that the best midwifery is midwifery that is from your own community. ... Everybody who knows about birth and looking after pregnant women needs to be valued, so the elder midwives, the elders who have knowledge – make sure they are always included in any sort of discussion, like you're doing already. That's great, the knowledge that they have is very valuable for you and for everybody, and it's important to remember that and not to think because we're registered with the College of Midwives that we don't value that as well... ("NK" group meeting, November 27, 2000).

The need to incorporate elders into midwifery education was seen as self-evident by Kim Linklater Beardy in a November 30, 2000 interview. A Kagike Danikobidan Committee board member informed me that it was the intent to have Aboriginal elders involved in the development of future Aboriginal midwifery programs in Manitoba. Participants frequently referred to the educative role of elders.

Kim Linklater Beardy reflected on the role of elders, and how she envisioned the integration of other knowledge, experientially and academically:

> As far as my culture goes, I think talking to the elders ... who were actually midwives, for instance Emma Hart. ... I would get that knowledge firsthand. I could ask any questions, like what they did when the child was breech, or what they did in extreme emergencies when the baby was in distress and so forth. ... I could get that information from the elders, the midwives that we have left in Nelson House, and the Doula training could offer something of the modern way, so to speak. I think I would like to know more anatomy ... how to be a support and how to be

> an assistant to the midwife, what you do in extreme cases (November 30, 2001).

Emma Hart, an elder and former midwife, indicated through a translator that she still has the ability and knowledge to be actively involved in birthing: "If one of my grandchildren would give birth in the house, I would do it. I would know what to do" (August 1, 2000).

An experiential approach to learning was seen as a traditional way of gaining knowledge of childbearing practices and in some situations, as a preferred method for a woman to learn the practice of midwifery. A Kagike Danikobidan Committee board member said she believed that traditional childbearing knowledge and midwifery was minimal in NCN due to assimilation and acculturation. Elder Leta McDonald concurred with this view through a translator, suggesting that there won't be many Aboriginal midwives to transmit childbearing knowledge that was previously passed down through generations of women: "There probably won't be many. ... The people always knew it, so they must have trained the women as they got older" (August 1, 2000). This orientation toward the value of experiential knowledge is evident from the following dialogue with Ella Moose, Shirley Anne Linklater and Elder Madeleine Spence in their reflections on how midwifery was practiced before the medicalization of childbirth:

> EM: Never had training. It just comes natural.
> SH: Natural?
> MS: A midwife a long time ago – they never had training
> SL: They weren't licensed; they just did it (group meeting, October, 2000).

After I summarized options available to NCN for the implementation of midwifery, the December 4 2000 group continued discussing experiential learning with another elder, "EF," Hilda Primrose, and Cynthia Spence:

EF: That's one way of learning.
SH: Uh Huh.
HP: I guess that's the best way of learning.
EM: You're actually there.
[several speak at once; laughter]
CS: Too bad I'm not pregnant; I'd teach you guys
SH: Do you also want them to learn something by books, medical things too?
[laughter]
EM: I think basically we'll have to.

The NCN Otinawasuwuk maternity workers, as well as, others including Carol Prince, RN and NCN health director, argued that midwifery education might take place in NCN under the tutelage of a registered midwife. Women in the community could "work with people who have midwifery training already ... at the birthing centre here" (November 30, 2000). Community-based training is seen as preferential to training offered outside of NCN as this statement from Mona Hart illustrates: "Sometimes, when people go out, even for a good cause, for training, they'll say, 'Well, you were out over there doing . . . why couldn't you have done it here?'" (December 13, 2001). Participants, like Shirley Anne Linklater, president of NCN Otinawasuwuk, would like to have a registered midwife educate women in NCN as their efforts indicate (section 12:6). She believed that the academic component of midwifery education could be obtained by distance education. At a January 7, 2001 meeting following the Doula workshop training, a participant, "LN," suggested: "We can have distance education for midwifery and allow Doulas to become midwives without leaving the community." In this sense, they view the experiential learning that the women are currently obtaining as birth support facilitators important to becoming qualified midwives. Potentially, the four core competencies required by the College of Midwives of Manitoba for registration could be

met in Nelson House and Thompson. Antenatal and postnatal care competencies could be attained in Nelson House and those around birth and newborn care could be acquired in Thompson where the women currently give birth. Shirley Anne said she would not be opposed to leaving NCN for midwifery education for brief periods, but that longer absences could present difficulties. "I sure wouldn't mind not having to go anywhere to be able to be a qualified midwife but I'd like to stay here and have someone teach me here" (December 13, 2001).

Another source of education was seen to come from the Aboriginal nurses in Nelson House. Mona Hart reflected the view of women participating in the November 27, 2000 group meeting who believed the nurses at the nursing station could assist in educating them to become midwives: "I'm sure they'd make some time to help; ------ is just the kind of person, and so is ------. They're always willing to help." (The nurses have availed themselves to instruct women who were employed with the Empowerment of Aboriginal Women Surrounding Childbearing project on a regular basis). On the other hand, the Aboriginal nurse who would like to become a registered midwife by building on her current academic and experiential nursing knowledge. She indicated that FNIHB, her employer, needs to provide the additional education that would be required for registration to meet the four core competencies of the College of Midwives. She argued that the education should be provided by FNIHB in the same way as the education for working in the nurse practitioner role was. "Whatever they can help us with, like we did here in expanding our role ... go through a course and expand our role in that way...." ("CX" October 4, 2000).

13.6 NCN Otinawasuwuk: An Experiential Approach to Becoming Midwives

As it has been previously discussed, the NCN Otinawasuwuk maternity workers are actively providing supportive services to women during their pregnancy and childbirth. In the process they are learning more about pregnancy and childbirth, experientially. Their knowledge is grounded in Aboriginal values and beliefs that are being re-constituted with the involvement of elders and community members. Aboriginal nurse-practitioners avail themselves to teach the maternity workers about pregnancy and childbirth at the request of the women. The maternity workers' efforts to have a Burntwood Regional Health Authority employed midwife facilitate midwifery education when she visits NCN has not been productive. Instead, a BRHA midwife provided books to the maternity workers for the women to embark on self-learning.

13.7 Summary

Study participants envision an alternative childbearing model that is community-based and grounded in Aboriginal beliefs and values. Western expertise and technology are important components to include in a holistic approach to childbearing. Within this community-based midwifery model, women's autonomy will be assured by having: 1) access to childbearing services of their choice; 2) an egalitarian relationship with the midwife; 3) midwives registered with the College of Midwives of Manitoba; 4) choices of Aboriginal midwives, either direct-entry or nurse-midwife; and 5) midwives who have gained their skills within a community-based midwifery education model. The NCN

Otinawasuwuk maternity workers, by providing supportive assistance for women during pregnancy and childbirth, are also gaining maternal care skills. This opportunity provides experiential knowledge of childbearing practices to several of the prospective midwives, with the anticipation that it will assist them in becoming registered midwives.

Chapter Fourteen: Conclusions

14.0 Introduction

In this chapter, I will summarize the dissertation by providing an overview of historical and cultural perspectives of the medicalization of birth and health services, alternative childbearing models and their success, and epidemiologic and health care issues that require consideration in view of NCN's aim to regain control of childbearing practices. In the discussion of the context and impetus of the research, the theoretical framework and research design, I will demonstrate how this research furthered the self-determination of NCN around childbearing practices. Finally, I will discuss how the three general themes of the research findings: autonomy subjugated, autonomy re-sought and the envisioning of an alternative childbearing model address the aims of the research and NCN's aspirations to re-establish childbearing practices in their community. In conclusion, I will provide thirteen potential strategies for changing childbearing practices that reflect NCN's aims and cultural beliefs.

14.1 Research Problem

The maternal evacuation policy that is implemented by the federal government reflects both the medicalization of childbearing and the colonization of First Nations people. It is representative of the long-standing issues in the complex and historically controversial interrelationship of Aboriginal communities, government and health services. This policy that requires all pregnant women to leave isolated communities

several weeks prior to giving birth in an urban centre is a hardship for those involved and violates First Nations autonomy. The literature on the subject of maternal evacuation is relatively modest. Its negative impact on women, their families and communities in addition to perceptions of culturally appropriate childbearing practices have been documented among the Inuit of northern Canada (Kaufert et al., 1985; Kaufert et al., 1988; O'Neil et al., 1988).

The de-centering of childbirth as a family and community event results in feelings of isolation and loneliness for the pregnant woman (Binns, 1990; Guse, 1982; Webber & Wilson, 1993) that are exacerbated by concerns for family left at home (England, 1996; Webber & Wilson, 1993). It is believed that the adverse stress created by maternal evacuation has a negative impact on pregnancy and labor (Binns, 1990). This is consistent with what we know generally of how stress affects women during pregnancy and labor (Klusman, 1975; Crandon, 1979; Hodnett, 1997; Newton et al., 1979; Gorsuch & Key, 1974; Rutter & Quine, 1990). While the "high level of perceived stress" which was found to be a risk factor for pre-term birth in Heaman's (2001) study cannot be determined to be due to maternal evacuation, nevertheless, it points to this possibility for some Aboriginal women (p.127).

14.2 Research Context and Approach

This participatory action research (PAR) dissertation was in response to Nisichawayasihk Cree Nation's aim to re-establish community-based midwifery in their community. Their aim is especially timely in view of the recent opportunities that have arisen for alternative primary care services around childbearing subsequent to the legislation of midwifery in Manitoba in 1997. A very important aspect of the Midwifery

and Consequential Amendments Act for Aboriginal women is the inclusion of a Mandate for a Standing Committee (Part 3:8(5) b) on Aboriginal Issues Relating to Midwifery Care, known as the Kagike Danikobidan (KD) (Always Making Grandparents) Committee. The Committee's advocacy approach to issues around childbearing is evident from the purpose and duties of the Kagike Danikobidan Committee in the Terms of Reference statement that is attached to and forms part of the Bylaw in Section 16 stated as:

> To provide the College with a perspective on midwifery that is deemed desirable and acceptable to Aboriginal women. Members of the committee will work to strengthen, enhance and advocate for their rights and interests. Consideration will be given to the unique educational, legal, clinical, cultural and political forces affecting Aboriginal women (Bylaw Terms of Reference p.9)

NCN's approach to establishing community-based childbearing services is not without precedent in Aboriginal communities in Canada. Prior to the legislation of midwifery in parts of Canada, beginning with Ontario in 1992 (Scurfield, 2002), two midwifery sites were already being established in northern Canada. The Inuulitsivik Maternity Centre, located in Povungnituk in the Ungava region of northern Quebec (referred to simply as 'POV' by community members) opened its doors in 1986 (Stonier, 1990). A birthing centre was also located in the nursing station in Rankin Inlet, NWT in 1994 so women might give birth in their community (Chamberlain, 1996; Morewood-Northrop, 1997).

The infrastructure of the Inuit birthing centres differ in several ways from that in Nisichawayasihk Cree Nation. Both Inuit centres have a physician on site. They are both isolated with access by air only to hospital services where an emergency Caesarean section or neonatal care is available. On the other hand, NCN can access these services at

the Thompson General Hospital (a level 11 facility, approximately 75 km by ambulance on an all weather road).

The Six Nations of the Grand River, Ontario is home to a First Nations birthing centre named "Tsi Non: WI Ionnakerastha" (The Place They Will Be Born). Founded in 1996, this maternal and child centre is 20 minutes by road from a hospital in Brantford, Ontario. NCN is similar to Six Nations of the Grand River, Ontario in that both communities are First Nations and are approximately the same distance by road to a hospital.

Studies support that birth takes place safely at the Inuulitsivik Maternity Centre (Chatwood, 1996) and at the Rankin Inlet birthing centre (Chamberlain, et al., 1996). The safety of out-of-hospital births is supported widely by studies such as the National Birth Center Study of 11, 814 low risk women who sought care in freestanding birthing centres in the US found that health outcomes were excellent (Rooks et al., 1989). As well, two Canadian studies were favorable for the safety of out-of-hospital births (Fraser et al., 2000; Blais, 2002).

An argument for community-based birthing in First Nations communities is put forward from several sources. Manitoba First Nations women's views were similar to those expressed in Ontario (Albert, 1996). Based on interviews carried out by the Equity Committee of Ontario, Aboriginal community members and non-Aboriginal health care providers alike maintained low-risk women would fare better to birth in the communities with community-based midwives (Schroff, 1997). In every community that members of the Equity Committee of Ontario visited, they were told low risk women could birth in

the community. This view is in keeping with the ideology of Canadian midwives who aim to provide primary care to low risk women (Rice, 1997).

Nisichawayasihk Cree Nation's aim to relocate birthing practices to their community was evident prior to the initiation of this research project in July of 2000. The Manitoba Keewatinowi Okimakanak (MKO), the political organization that represents many First Nations including NCN passed a resolution supporting their initiative to have a midwifery pilot project site located in the community (see Appendix A). This resolution was followed by NCN Chief and Council with a letter of request to the Burntwood Regional Health Authority on May 15, 2000 for midwifery services in NCN (see Appendix B). The letter refers to the anticipated research of this study. It was believed such research would assist NCN's aims for the development of alternative birthing practices. The identification of the problem to be researched by those it impacts is important if PAR research is to be community based (Coutu, 1987). Participatory research is frequently used in circumstances where there is a need to develop or evaluate policies. Aboriginal scholars (Hammersmith, 1992; Poonwassie & Charter, 2001) argue that community-based solutions to problems are more likely to reflect community values and needs, therefore ensuring a better chance of success. I anticipated that by placing research knowledge formerly under the control of experts in the hands of the participants would be an empowering experience (Gaventa, 1991). Thus, the research process itself was expected to achieve a measure of personal and community social change. Specifically, the participatory research with Nisichawayasihk Cree Nation was undertaken to pursue the community's aims of re-establishing its own childbearing practices. The objectives of the study were:

1. To examine the maternal evacuation policy from an historical and cultural context
2. To explore perceptions of current childbearing practices
3. To determine participant interest in alternative childbearing practices
4. To conceptualize an optimal childbearing model envisioned by participants
5. To identify the issues/barriers that might impact on the implementation of alternative childbearing practices

14.3 Research Framework

The 'critical postmodern gendered praxis' (see Figure 1) theoretical framework combined perspectives from critical social theory, postmodernism and a gender sensitive approach in guiding the research process. As a particularly controversial research approach with undeniably political overtones, it was imperative to continuously reflect on the dialogic nature of the relationship between the researcher and the 'researched' in the context of a changing socio-political environment. This approach to research that obtains and uses knowledge for the purpose of empowering oppressed groups may indeed be described as being political in nature (Porpora, 1999; Small, 1995), where political refers to the effect of the research process on the distribution of power and resources (Nyden et al., 1997).

From a critical social theory perspective I was able to examine the 'big picture' or the macro-politics of the concepts of domination and emancipation, and the implications for choosing the participatory action research paradigm as the predominant research methodology. In reference to domination, the Indian Act of 1876 is one source of First Nations subjugation that had particularly negative consequences for women. Emberley (1993) observes that the early domination of First Nations peoples by Europeans which was evident in the Indian Act of 1876, as being "perhaps, the most significant form of oppression to shape the lives of Native people in Canada" (p.87). The Act extended the

control of Indian affairs by the federal government to include "lands, money, personal assets, law making, services and citizenship." Women of Indian ancestry fared worse. They were denied legal Indian status and any benefits this might have provided upon marrying a non-Indian. Bill C-31 (Act to amend the Indian Act in 1985) sought to reintegrate First Nations women. Recently, Huntley and Blaney (1999) have concluded that discrimination remains similar to what Jamieson (1978) observed of the social and legal sphere of Indian women before the passage of Bill C-31:

> One thing is clear – that to be poor, an Indian and a female is to be a member of the most disadvantaged minority in Canada today, a citizen minus. It is to be victimized and utterly powerless and to be, by government decree, without legal recourse, of any kind (p. 92).

The linkage we see in the Indian Act between colonization and patriarchy is not lost on Aboriginal authors Nabigon and Couchie, who observe that "colonization is the first cousin to patriarchy" (1997, p.44). Domination as it is manifested by colonization also extends to health services in northern communities which are described by O'Neil (1988) as "one of the most powerful symbols of colonial relations between northern people and the nation state" (p.47). This colonial model of modernity in health care provision was implemented by the federal government in the 1960s with the construction of a nursing station in every Inuit community (O'Neil, 1990). By the mid-1960s, the nursing station was recognized as the core unit of medical provision among the Inuit (Waldram, Herring & Young, 1997). In keeping with a colonialist orientation, the nursing stations served as bases for sending patients south in increasing numbers due to medical reasons for extended periods of time (O'Neil, 1986). (O'Neil's observations of the Keewatin may also be seen in the context of Manitoba and northwestern Ontario since these areas were all included within what was then known as the Central Region of

Medical Services Branch, Department of National Health and Welfare). Based on the events that followed, childbirth was interpreted as a medical reason for sending women south. By as early as 1968, 97% of births in the Keewatin took place in hospitals (O'Neil & Kaufert, 1990).

Domination around the control of birthing practices by a predominantly male medical profession (Arney, 1982; RCAP, Vol.3, 1996) is indicative of the systemic subjugation of women by men as first noted in the writings of Grimke (1792-1873), an early feminist (Donovan, 1991). The medicalization of childbirth had its early beginnings in Europe. Prior to the 17th century, female and male midwives attended birth. Childbirth was viewed as a natural and normal event with a midwife (meaning to be with) in attendance. Changes took place with the simultaneous rise of science and the medical profession who ultimately came to dominate childbearing practices. The mastery of midwifery by the profession of medicine is described as a strategic success (Arney, 1982). Essential, in such a case, to the sequence of events is that the group being mastered be lacking in recognized knowledge and power. Canadian midwifery generally succumbed to the same fate as its European and American counterparts with the exception that Canada had the dubious distinction of being the only developed country in the world without any provisions for the practice of midwifery (Blais, 2002; Bourgeault, 1999). The harshest impact of the medicalization of birth can be seen in northern Canadian Aboriginal communities where pregnant women are obliged to leave their families and communities to give birth in distant urban centres several weeks prior to their due date. The tendency to medicalize the birthing practices of indigenous cultures is common the world over (Waxman, 1990). In fact, the institutionalization of birthing

practices in indigenous cultures is generally used as an index of modernity (Cosminisky, 2001). Indeed, this colonialist approach toward Aboriginal cultures is evident from the implementation and continuation of the maternal evacuation policy in northern communities. The medicalization of birthing practices that saw women disenfranchised from what was formerly the domain of women is an issue that affected all women. In the instance of Aboriginal women, Nabigon and Couchie (1997) observe that the imposition of medicalized childbearing practices worsened the effects of the oppression they already suffer on account of colonization. The experience of an Aboriginal midwife from northwestern Ontario who ended her midwifery practice when nurses and doctors began frequenting her community illustrates the fundamental character of this oppression (Terry and Calm Wind, 1994).

A critical social theory perspective also provided a context for empowerment where to be critical, research must attempt to confront an injustice in a political or social sense (Kincheloe & McLaren, 1994). A participatory action research approach was viewed as a means to achieve both social change and advance general knowledge around childbearing practices (Benson & Haravy, 1996). The critical examination of current federal childbearing policies demonstrated that the empowerment of action research is a meaningful way to challenge the dominant institutional organizations (Park, 1993). It was anticipated that an understanding of conditions or circumstances that affect NCN band members in undesirable ways around childbearing would act as a catalyst for social change (Fay, 1993; Freire, 1998). Social change is reflected by the Freirean terms 'conscientization' and 'praxis.' They explain the process that takes place when people become aware of the ways oppressive forces impact upon their lives. This leads to

'praxis,' or an informed basis for action (Freire, 1998). These terms find their origins in Marxist ideology where 'false consciousness' refers to a lack of awareness of oppressive social conditions. I made no assumptions, however, that First Nations women who would be participating in the research generally needed to be made aware of their oppression. The research project aimed simply to reach a mutual understanding of oppressive childbearing practices and other issues that were identified as problematic to the women.

From a postmodern perspective, the theoretical framework provided a closer examination of the 'micro-politics' of the women's experience around childbearing. This experience around childbearing included an understanding of the significance of language and how it engendered meaning and reality, of the interconnectedness of power relations and bodies of knowledge, of multiple representations of truth, of the insidiousness of power and resistance to it, and of subjugated knowledge. Lastly, a gender sensitive approach provided a means in which the women involved in the research were given an in-depth opportunity to speak on childbearing practices and issues related to gender in an empowering way.

The political and ideological understanding of the research topic was reflexively driven. Reflexive research embraces a questioning approach to the constitution of knowledge in a particular context with the belief that all reality is interpretively known (Alvesson & Skoldberg, 2000). The theoretical framework provided the analytical lens for understanding how cultural and social processes have arisen that came to impact NCN's life-ways and childbearing practices, and how they may be changed in view of this knowledge. Reflexivity means that in approaching cultural-social-historical information or the research findings, I engaged in purposeful reflection from the

perspective of the theoretical framework. This, then, guided how the research was understood and analyzed. The research can be reflexively understood because reality is interpretively known; that is, we interpret reality for ourselves. This approach is also based on the understanding that our behaviors are socially and culturally constituted (Giddens, 1982). The PAR approach that engages in dialectics to understand a common reality and then uses this knowledge as a means to change circumstances is how the praxis component of the research found a meaningful place within the theoretical framework.

The predominantly PAR research design that included ethnographic and gender-sensitive paradigms involved participants as co-researchers and encompassed a variety of data collection methods: participant observation, key informant interviews, semi-structured interviews, modified focus groups, quantitative prenatal retrospective chart audit, and an analysis of documents (world-wide web, historical NCN texts, NCN studies, community assessments and newspapers). One hundred and eight signed consents were obtained. The PAR principles of research, education and action provided the format for the modified focus group meetings. The group participants included all socio-economic strata of Nelson House. This approach to including a varied group is in keeping with the Frierean (1998) premise that all individuals are capable of solving problems which impact them if they are given the opportunity to engage them critically. To further their education needs the group discussions engaged information and materials related to the medicalization of childbirth, recent midwifery legislation, information around pregnancy and birth, and the Manitoba Prenatal Records which include criteria for determining risk, in addition to articles written by Aboriginal and non-Aboriginal authors that were

pertinent to the topic. As well, the participants were provided with a thematic analysis of key informant interviews, interviews with pregnant women and an analysis of the antenatal chart audit. The research settings included: Nisichawayasihk Cree Nation, the Nelson House Community, the Cities of Thompson, Winnipeg, Toronto, and El Paso Texas, as well as Six Nations near the Grand River, Ontario. The Ontario and American sites arose out of the impetus of the research itself.

Several important praxis events that furthered Nisichawayasihk Cree Nation's aims for re-establishing community-based childbearing practices arose from the research. These included the formation of the NCN Otinawasuwuk organization, the development of the Empowerment of Aboriginal Women Surrounding Childbearing proposals and a Midwifery Field Study trip to Toronto, Ontario, Six Nations near the Grand River and El Paso, Texas.

The NCN Otinawasuwuk (Receivers of Children) organization which arose after six months of the participatory action research process embodies how power and knowledge among community members can have important implications for changing the status quo to reflect the values and beliefs of Nisichawayasihk Cree Nation. Women who were involved in the core group of the research identified a need to be recognized as a non-profit organization in order to reflect their evolving identify and autonomy, provide a framework for their grassroots infrastructure, and develop the childbearing model envisioned by NCN. The organization is currently being administered within the Family and Community Wellness Centre, a band controlled public health and social services facility.

The Empowerment of Aboriginal Women Surrounding Childbearing .proposal was written in August 2001 in NCN with several of the core group of women, key informants and women involved in band administration, in addition to the support of elders, health and social services, businesses, organizations and Chief and Council. Wide community involvement was necessary for the development of the proposal. In addition, the proposal needed to demonstrate how existing health services would complement and act as a resource for this project. In itself, it proved to be an ethnographic opportunity to become more knowledgeable about the community. As well as a means to further gather, interpret and validate data. As a praxis event, it is based on all three major themes, addressing issues surrounding autonomy subjugated, autonomy re-sought and the envisioning of an alternative birthing model. The funded project was implemented within the infrastructure of the Family and Community Wellness Centre NCN: Otinawasuwuk (Receivers of Children) program. The project employed a coordinator and maternity workers to provide support to women during pregnancy and labor. A second proposal that was collaboratively written in August 2002 and funded by the Aboriginal Healing Foundation is currently being implemented for an additional two years. The total funding for the three year project is $681,000.00.

A field study trip was undertaken in June 2001 to Ontario and Texas with Shirley Anne Linklater and Lenora Spence, two study participants. The praxis and research component of the study trip had its basis in each of the three primary themes. The purpose of the study trip was to assist the women in the re-establishment of childbearing practices in NCN. This would be achieved in several ways. One aspect involved dialogue with midwives and the development of a network of midwifery resources to draw on. We

would also gain firsthand knowledge of the philosophy, infrastructure and birthing model implemented at The Tsi Non:we Ionnakeratstha (the place they will be born) Ona:grahsta' (A Birthing Place) at Six Nations near the Grand River. Finally, we would explore educational opportunities at this centre and the Maternidad Del Luz birthing centre in El Paso, Texas where several Six Nations women received their midwifery training.

14.4 The Problem with Current Childbearing Practices

The study found that the removal of mothers for childbirth was not the only aspect of colonization to negatively affect First Nations childbearing practices. The relocation of children to residential schools in distant communities also took a terrible toll. Both the maternal evacuation policy and the residential school legacy are reflective of colonization, and have separately and jointly undermined Aboriginal childbearing values and practices. The removal of both children and women from their communities compromised the transmission of cultural values and beliefs around childbearing. One outcome of the residential school legacy, known as the intergenerational impact, came to have a particularly negative effect on some childbearing women who abuse alcohol and drugs during pregnancy. Several reasons point to this conclusion. Many children returned to communities like NCN who suffered from severe emotional scars (Grand Chief Edward John, cited in Milloy, 1999). The detrimental effect of these emotional scars came to be demonstrated in dysfunctional coping mechanisms. These behaviors were transmitted to a segment of the childbearing population, where they are manifested in the use of alcohol and illicit drugs. Not only do these practices compromise optimal

childbearing practices, they serve as a means of negative role modeling and encourage a continuation of these behaviors in subsequent generations. Eleanor Carriere traditional healer and social worker, offers this explanation in the following April 27, 2001 interview excerpts:

> Those that suffered abuse never fully recovered from being institutionalized. When they came back to their communities they turned to alcohol as a crutch to lean on – that was their coping mechanism. They couldn't deal with the issue of being abused....
>
> This is what you see here in some women taking drugs, abusing alcohol - That's the effects of the boarding school system.

In addition, the Westernization of childbearing practices that resulted in the removal of pregnant women from their communities, and the realm of women had significant effects. One of these effects was the virtual destruction of supportive social networks around childbearing, which served as a means of transmitting cultural values and beliefs. As a result, women have been deprived of their former culturally-held beliefs and values in addition to social support systems that we know today can have a beneficial impact on the outcome of pregnancy (Norbeck, DeJoseph, & Smith, 1996; Nuckolls, Cassel & Kaplan, 1972). Furthermore, the meaningful role of women that included a sacred identity with childbearing was subjugated in favor of a secular Western model. Eleanor Carriere, traditional healer observes: "[Western hospital births] it's mechanical and the loving part is not there. As First Nations people we are very spiritual people. So, because it is sacred and life is a gift then birth is something special"(April 27, 2001).

The loss of the sacred significance of the role of women in bringing forth life has affected the self-worth of women in NCN. As a consequence of the imposition of Western cultural beliefs surrounding the body and childbearing, women came to assume

a passive role in their relationship with (mainly non-Aboriginal) health care providers. Inevitably, this passivity bred a colonialist dependence on the Western health care model that resulted in compromised childbearing practices. The current dependency on the Western health care model as compared to several decades past was made by an elder in a September 26, 2000 interview:

> No one bothered them [nurses] during the night except if it was a delivery – not like now when nurses are up all hours of the night with accidents because of drinking. But in those days nobody bothered the nurse except if it was a real emergency, when someone was in labor.

The research findings generally found the Western childbearing services currently provided by FNIHB as inadequate. The maternal evacuation policy that is being implemented in Nelson House is one aspect of the services which was found to be particularly lacking. Generally, women were unhappy about being evacuated. The time spent away from home and families was distressing. In addition, women were frequently concerned about the care of children left in Nelson House. Such was the case for Sylvia Wood who said she returned from Thompson after being evacuated before giving birth due to her concerns for her child: "He got depressed. He didn't eat for two days because I didn't see him for a week" (October 3, 2000). Many women resist maternal evacuation, refusing to leave the community, or return prior to giving birth like Sylvia Wood soon after they arrive in Thompson. This places the nurses in an adversarial relationship with the women, instead of in an egalitarian one where their role is one of advocacy.

Antenatal care provided by nurses (in the role of nurse-practitioners employed with First Nations and Inuit Health Branch,) was also found to be unsatisfactory. This primarily had its origins in the time they were able to spend with pregnant women who, as a result, believed they were being given inadequate attention. Optimum antenatal care

may be seen as an important component of decreasing risk around birth. A lack of antenatal care is viewed as one of the most significant risk factors predictive of an adverse outcome (Hall, 1994). According to a retrospective chart audit (1997-1999) that was carried out, using the Kessner scale, only 38 % of women utilized antenatal care optimally (initial visit at 13 weeks gestation with 8 or more visits at 34-35 weeks) (Kessner, Singer, Kalk & Schlesinger, 1973). Important in this consideration is that pre-term birth is 17% higher among Manitoba Aboriginal women (Heaman, 2001). In addition, it generally accounts for 75-85% of the perinatal mortality rate among women (Health Canada, 1999a). According to Stewart (1999), 50-75 % of pre-term births are preventable. She emphasizes a need for secondary prevention by educating women in the second trimester of signs and symptoms of pre-term labor. There is also a need to address modifiable risk factors for pre-term birth among Aboriginal women that have been identified as: high perceived stress, anemia, smoking, low weight gain and an under utilization of antenatal care (Heaman, 2001). In the antenatal retrospective chart audit that was carried out in this study it was found 85% of Nelson House women smoked and 33% used alcohol when they were pregnant in the years 1997-1999 inclusive. The potential for fetal alcohol spectrum is alarming given the high percentage of women who use alcohol when they are pregnant.

Issues around abuse that may create barriers to antenatal care also need to be addressed. Kim Linklater Beardy included issues of abuse among the reasons women may not be able to access antenatal care: "A lot of people are in situations where they have a hard time getting out. For instance, some of them are living in fear because of abuse and stuff like that" (November 30, 2000). An American study of Aboriginal

women found that the primary reasons for the under-utilization of antenatal care were due to the Westernization of childbearing practices, substance abuse and domestic violence (Long & Curry, 1998). Where the initiation of antenatal care is concerned, Berenson and colleagues concur that women who are abused during pregnancy are more likely to initiate antenatal care during the third trimester (Berenson, Wiemann, Wilkinson, Jones & Anderson, 1994). It is obvious that the current antenatal services in Nelson House are not meeting the needs of women from the perspective of the women themselves which was corroborated by the chart audit and recent studies like Heaman's (2001) involving Manitoba First Nations women referred to earlier.

Hospital policies in Thompson were critiqued by the participants. Western childbearing policies and practices were generally seen as being in the interest of the non-Aboriginal people who administer them. Institutional care at the Thompson General Hospital was seen to be unsatisfactory in several areas. Women voiced a concern over what appeared to be the practice of nurses, rather than physicians or midwives, frequently attending births at the hospital. The limitation on the number of people (usually one person) who can share the birth experience with a woman was found to be too restrictive.

14.5 An Aboriginal Childbearing Model

An Aboriginal childbearing model, like all approaches to childbearing, mirrors the cultural values and beliefs of its people. The culturally-bound influences of childbearing practices are well known. By extension, it can be said that all people are products of their culture, with "its inevitable admixture of rational and non-rational elements" (Paul, 1958, p. 234). Basic to an Aboriginal cultural childbearing model is how the autonomy of the

woman is conceptualized, as well as her relationships to others and the land. Children who grow into adults are seen to have their origins in the Creator who is sacred. Barbara Peters described the general view of NCN women around children as: "They are gifts from our Creator and they are loaned to us" (group meeting, November 20, 2000). The "loan" of children to the Cree suggests the relationship to the Creator is a sustaining one. This relationship and identity with the Creator provides a basis for autonomy that is distinct from human relationships, organizations, institutions or government.

Conceptually, this cultural orientation potentially ensures a high view of the self and an agency that finds its source ultimately in the Creator. In addition to this sustaining relationship, children who are born on the land of their Cree ancestors have an identity that is inscribed in an historical text which serves to bind them relationally as a group. The relational identity to the community that being born on the land ensures is one which reflects a generally held collective mindset. An Aboriginal childbearing model requires that birth take place in the community. Jackie Spence reflects on the association of place of birth with identity as: "I think it's got a lot to do with identity. I am really looking forward to seeing these babies that are going to be born here. They are going to be very, very strong in my mind" (May 7, 2001). A community birth affirms an identity with the land and allows for the birth event to have a community relational impact. In her master's thesis, Eva Linklater, (1997) NCN band member describes the band's relationship to the land as:

> Through many centuries of use and interaction with the land, the Nelson House Cree had transcribed their history onto it. This was our historical text, and the landscape was an affirmation that the past had really occurred. Cree culture and our worldview teaches us that we are inherent part of our land, connected to it spiritually, emotionally and physically (p. 17).

She cites Lynch for further elaboration of this relationship to the land as:

> The landscape plays a social role. The named environment, familiar to all, furnishes material for common memories and symbols which bind the group together and allow them to communicate with one another. The landscape serves as a vast mnemonic system for the retention of group history and ideals (p.18).

This relational orientation has important implications for birth since it is seen as a community event. Therefore, the birth event possesses an inherent agency for bringing about very positive changes to individual, family and community life. Relationships will be strengthened and healed, and meaningful cultural traditions – in addition to those relating to childbearing – will be enhanced, contributing to community healing. Eleanor Carriere reflects on how the return of birth to Nelson House will further decolonization:

> It would start the effect of decolonization, where people are going to use the traditional ways. It's bringing back that part that didn't exist for many years, that piece that was missing in the community. As they bring more traditions back into the community, the community will become more stabilized, more functional (April 27, 2001).

Jackie Walker emphasized how establishing community based childbearing practices will also empower women in her dialogue with me:

> JW: Doctors and nurses view pregnancy as a medical condition when the process is giving life. It will change that image alone ...because it will bring back more of the role of the woman – what women can do. You know, when they talk about women having power.
> SH: So, it will empower women?
> JW: It will empower women and they will be respected again for who they are (April 27, 2001).

An Aboriginal childbearing model requires that there be a meaningful congruency between these beliefs and childbearing practices. It requires that a woman be able to express her autonomy such as in the choices she makes around her pregnancy and birth. Bella Leonard, Mayor The Nelson House Community emphasized that a woman should

have the choice as to whether she would like to access midwifery services or submit to maternal evacuation in the following interview:

> SH: So, you would leave it to the individual woman?
> BL: Uh huh.
> SH: Yeah. It's her decision.
> BL: Uh huh.
> SH: That would be her decision whether she wants to have her baby here or in Thompson, too?
> BL: Yeah. But they send you out so many months, weeks early...
> SH: So, the women should have something to say about that too?
> BL: Oh yeah.(December 2, 2000).

The relationship between the woman and the midwife is an egalitarian one. The name the NCN Otinawasuwuk (Receivers of Children) organization gave themselves supports this perspective. It does not place the midwife in a superior role in the birth process to the woman.

An Aboriginal childbearing model was not seen to preclude the incorporation of Western expertise and practices. Rather, the incorporation of Western expertise and technology were considered important components to include for the benefit of mother and child. Risk as a considered event was examined from an epidemiological, clinician and community perspective. Risk to mother and child from a community perspective was seen could be addressed with appropriate screening to ensure that women with increased risk not birth in Nelson House, in addition to having an infrastructure in place that would address emergencies. Thompson General Hospital, a level 11 facility is within 30 minutes by ambulance from Nelson House. This is also within the recommended time frame for a physician to be available for a labor and delivery room according to the Society of Obstetricians and Gynecologists of Canada (2000).

The NCN Otinawasuwuk maternity workers have been actively engaged in re-constituting cultural childbearing practices, where the decolonization of childbearing practices is concerned in order to meet the needs of pregnant women more optimally. To aid them in this endeavor, they have extensive cultural and traditional resources in Nelson House to build on, and draw from. Several of the women who plan on becoming midwives believe their interactions with childbearing women, elders and community members around pregnancy and birth is creating a knowledge base and experience that will help them achieve their goal. The maternity workers are supporting pregnant women who suffer from alcohol abuse and other stressful situations with frequent interactions and a home visiting program. A Canadian Broadcasting Corporation television program, Manitoba North, filmed a documentary about the work of the maternity workers which aired October 7, 2002 entitled *FAS Buddy System.* As well, Senator Sharon Carstairs, based on her favorable impressions of the work of the women following a visit to Nelson House in the summer of 2002, asked the Office of the Minister of Health in Ottawa to support the maternity workers.

A comprehensive community-based childbearing model such as is envisioned by the NCN Otinawasuwuk can more optimally meet the needs of women in addition to addressing barriers to antenatal care that were identified earlier. Kim Linklater Beardy suggested that antenatal care needs to reflect and use community resources, such as the NCN Otinawasuwuk maternity workers, to be beneficial: "You'll be spending time with the prenatal, you're getting to know them, and from there you'll know their needs. You can also build on the resources we have in the community around the prenatal. ... That's the only way you can ever help a person come out of their shell is be there to provide the

services for them" (November 30, 2000). The NCN Otinawasuwuk maternity workers are integrating their services with those of the Canadian Prenatal Nutrition Program, as well as those of the public health nurses who carry out home visits to high need pregnant women and following the birth of a child. In addition, the maternity workers have received Doula training and are acting in this capacity at the Thompson General Hospital to address the lack of support for women during labor. Studies have demonstrated that support during labor for example, can result in less interventions and shorter labors (Scott, Berkowitz & Klaus, 1999; Klaus & Kennell, 1997; Gordon, Walton, McAdam, Derman, Gallitero, & Garrett, 1999).

To ensure a high standard of midwifery care and the ability for a woman to exercise her autonomy in her choice of midwife, it is believed midwives should be registered with the College of Midwives of Manitoba and be either direct-entry (without receiving prior nursing education) or nurse-midwives. As well, midwives who are Aboriginal and have received midwifery education in the community are seen to be more compatible culturally.

14.6 Infrastructure Preparedness

As Stubbing (1990) a northern physician emphasizes, there is a need to have the appropriate infrastructure in place in order to return birth to an isolated community. There is a readiness to pursue alternative childbearing services in Nisichawayasihk Cree Nation on several fronts: Chief and Council's progressive approach to self-determination in social and economic development is reflected in their support of the NCN Otinawasuwuk maternity workers and the aims of community members to re-establish community-based

childbearing practices. Preparedness is also evident in other areas: 1) Aboriginal nurse practitioners who provide the bulk of primary health care and emergency services in the community are receptive to making changes in childbearing services; indeed one of the nurse practitioners is considering becoming a registered midwife, 2) First Nations and Inuit Health Branch brought the research questions arising from this study to the attention of the Assistant Deputy Minister in Ottawa "for support in establishing a national working group to research and develop policies for the practice of midwifery in First Nations communities" (see Appendix H) and 3) the Burntwood Regional Health Authority envisions a future where midwifery services will be expanded into isolated northern communities like Nisichawayasihk Cree Nation.

However, sizeable infrastructure barriers must be overcome in order for Nisichawayasihk Cree Nation to exercise their autonomy in re-establishing community-based childbearing practices. The Burntwood Regional Health Authority prioritizes midwifery services according to the needs of Manitoba residents living in urban and rural communities. An under-representation of midwives in the BRHA restricts the availability of midwifery services to Thompson. Outreach to Nisichawayasihk Cree Nation is limited to familiarizing women to the practice of midwifery with occasional visits from a BRHA employed midwife. Jurisdictional issues are evident in the manner in which the BRHA prioritizes midwifery services and in their concerns over liability issues on reserve. First Nations and Inuit Health Branch, Manitoba region as the primary health care provider for on-reserve First Nations people, is not taking the initiative in expanding childbearing services that reflect recent changes in midwifery legislation.

Midwifery education opportunities in northern Manitoba are non-existent. There are no midwifery education programs in Manitoba. The Prior Learning and Experience Assessment (PLEA) program that enables potential direct-entry midwives to gain midwifery registration with the College of Midwives of Manitoba (CMM) is not a viable option for women in Nisichawayasihk Cree Nation at this time. The program requires that a potential midwife gain the knowledge and experience to meet the four core competencies of the CMM. Nisichawayasihk Cree Nation women cannot consider this option without a registered CMM midwife to accept them as midwifery students for mentoring; the dearth of midwives in the North makes the PLEA option unavailable to them. In addition, it would require that the women be funded in order to pursue the PLEA program. The education opportunities for the Aboriginal nurse employed with FNIHB who would like to pursue midwifery are likewise non-existent as the FNIHB does not provide for midwifery education. The PLEA program is not a tenable option for nurse-midwives for the same reasons that underlie those for potential direct-entry midwives. Out-of-province and out-of-country midwifery education opportunities were not seen as viable options primarily due to their distance from Nelson House.

14.7 Potential Strategies for Change

The broad aim of this research was to carry out a scholarly inquiry in a way that would further Nisichawayasihk Cree Nation's aims to re-establish community-based childbearing practices. The potential strategies for change being put forward include: 1) furthering Nisichawayasihk Cree Nation's self-determination around childbearing practices; 2) the establishment of a community-based birthing centre;

3) the removal of barriers that hinder the re-establishment of community-based childbearing practices; 4) support of the current NCN Otinawasuwuk infrastructure that has been established through the research; and 5) implementing interim changes to the current childbearing services. More specific strategies for change are listed below:

1. Community-based childbearing services with midwives as primary health care providers need to be established in Nelson House. This would reflect the self-determination aims of Nisichawayasihk Cree Nation around childbearing. It will provide an optimum approach to maternal and child health. As well, it will further de-colonization and facilitate community healing.

2. Nisichawayasihk Cree Nation's aims to how they would like to establish community-based childbearing practices need to be supported by First Nations and Inuit Health Branch. This is an extension of FNIHB's policy of providing primary health care services, including antenatal and postnatal services. FNIHB's support of Nisichawayasihk Cree Nation's aims of self-determination around childbearing practices is consistent with the federal government's position of furthering First Nations self-determination around health care. Furthermore, First Nations and Inuit Health Branch need to play a leadership role in establishing community-based midwifery. The federal government initiated the maternal evacuation policy that is reflective of colonization and inadequate childbearing practices. Thus, a return of community-based midwifery by the federal government can be seen as compensatory.

3. First Nations and Inuit Health Branch, together with the Burntwood Regional Health Authority, need to identify jurisdictional barriers that impede the seamless delivery of midwifery services in Nelson House. FNIHB is responsible for providing

primary health care services in isolated First Nations communities. Prior to the initiation of the maternal evacuation policy, the federal government also took responsibility for providing midwifery services. The BRHA, on the other hand, is responsible for providing provincially funded midwifery services to all Manitobans in its region. The establishment of community-based midwifery in Nisichawayasihk Cree Nation at the basic level requires the combined efforts of NCN Otinawasuwuk, Chief and Council, First Nations and Inuit Health Branch, and the Burntwood Regional Health Authority in creating a well-planned infrastructure.

4. Both direct-entry and nurse-midwives as members of the primary health care team in Nelson House need to be included in a midwifery model. First Nations and Inuit Health Branch is responsible for providing primary health care services including antenatal and postnatal services. The addition of new members into the primary health care team may be seen as an enhancement and extension of current services.

5. A funded midwifery educational opportunity to the Aboriginal nurse who would like to become a registered midwife needs to be provided by First Nations and Inuit Health Branch. FNIHB currently provides additional training for nurses to function as nurse-practitioners. Additional midwifery education can be seen as a similar responsibility.

6. Isolated communities like Nisichawayasihk Cree Nation need to be supported by the College of Midwives of Manitoba in their aim to have a distance midwifery education program in order that potential midwives do not need to leave their communities for extended periods of time. This approach to midwifery education is the

antithesis of colonization where the people - in this case, potential midwives - are brought to out-of-community education sites.

7. The NCN Otinawasuwuk needs to be supported by First Nations and Inuit Health Branch in its efforts to provide additional services around antenatal and postnatal care and labor support. One way to achieve this is for FNIHB to integrate the maternity workers into the primary health care services infrastructure.

8. The maternal evacuation policy in Nelson House needs to be discontinued. The policy has lost its relevance. It places significant stress on many women who are evacuated. In its place, additional services to women around birth preparation and support need to be provided.

9. The current antenatal and postnatal services in Nelson House and ways they may be enhanced need to be addressed. This might include additional education for nurses who are providing antenatal and postnatal care. Several nurses need to be designated as responsible for antenatal and postnatal care to enhance continuity and depth of interactions. Barriers to antenatal care such as transportation and long waiting times should be addressed.

10. The policies and practices at the Thompson General Hospital need to be reviewed by the administration regarding the number of individuals who can support a woman in labor and share the birth experience. In addition, the concerns of women about the frequency of nurses attending births needs to be addressed. Meetings with the NCN Otinawasuwuk in reviewing these issues and ways the autonomy of First Nations women can be enhanced in an institutional setting would be beneficial. *A Guide for Health Professionals Working with Aboriginal People*, a policy statement developed by the

Society of Obstetricians and Gynaecologists of Canada would be of benefit in these discussions (Smylie, 2000).

11. Nisichawayasihk Cree Nation Chief and Council need to continue to support the NCN Otinawasuwuk (Receivers of Children) in their efforts to address issues rising out of colonization affecting childbearing women and to work toward the establishment of community-based childbearing practices. The return of childbearing practices to Nelson House requires that it be a community effort with the continued support of Chief and Council. Nisichawayasihk Cree Nation Chief and Council need to support the NCN Otinawasuwuk maternity workers by identifying how the program can be further integrated into current social services and community life. The welfare of pregnant women and the unborn is a priority. Nisichawayasihk Cree Nation's future members and leadership depend on this.

12. Manitoba Keewatinowi Okimakanak needs to continue to support Nisichawayasihk Cree Nation in their efforts to re-establish community-based childbearing practices. Health services have long been contentious issues between First Nations and governments. The addressing of these issues requires a unified approach to engaging federal and provincial governments.

13. The Kagike Danikobidan Committee needs to support the efforts of the maternity workers, especially the women who would like to become midwives. Areas where the Kagike Danikobidan Committee could be of assistance include identifying education routes and networking the NCN Otinawasuwuk into wider Aboriginal and non-Aboriginal midwifery associations.

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APPENDIX A MKO RESOLUTION

Manitoba Keewatinowi Okimakanak Inc.
18th Annual General Assembly
Nisichawayasihk Cree Nation
June 23, 24 & 25, 1999

Resolution 99-06 #25

RE: MIDWIFERY PILOT PROJECT

WHEREAS, the Manitoba Legislature passed the Midwifery Act in 1997, declaring midwives to be autonomous primary health care workers; and

WHEREAS, the Manitoba Government has announced funding for the College of Midwives and has targeted the establishment of twenty midwives by the end of this year; and

WHEREAS, many First Nation women support the effort to establish the professional practice of Midwifery in Manitoba; and

WHEREAS, the Nisichawayasihk First Nation has been selected as one of the communities to participate in a Provincial Midwifery Pilot Project.

THEREFORE BE IT RESOLVED, that the MKO Chiefs in Assembly support the initiative to establish midwives in Manitoba; and

BE IT FURTHER RESOLVED, that the MKO Chiefs in Assembly support the Nisichawayasihk First Nation towards their intent to pilot this initiative in their community.

MOVED BY: Chief Ron Evans, Norway House First Nation
SECONDED BY: Chief Clarence Easter, Chemahawin First Nation
CARRIED: YES

Certified copy of a Resolution adopted at the MKO Executive Council Meeting of August 3 & 4, 1999 as deferred from the 18th Annual General Assembly of June 23, 24, 25, 1999

MKO Grand Chief Francis Flett

APPENDIX A MKO RESOLUTION

03/22/1999 12:47 2044829808 HEATHER MOOSE PAGE 02

DRAFT

RESOLUTION

WHEREAS Manitoba Health has initiated a process to regulate midwifery within the province;

WHEREAS there have been community consultations within Manitoba on Midwifery services by the Midwifery Implementation Council;

WHEREAS currently there are no regulated, insured Midwifery services available to those who desire them;

WHEREAS a Midwifery Act has been passed by the Legislative Assembly of Manitoba in June 1997 and is expected to be proclaimed July 1999;

WHEREAS many First Nation women support the effort to establish the professional practice of Midwifery in Manitoba;

THEREFORE BE IT RESOLVED that the Assembly of Manitoba Chiefs - Chiefs Health Committee support the initiative to reinstate Midwifery practice within the communities;

AND BE IT FURTHER RESOLVED that the Assembly of Manitoba Chiefs - Chiefs Health Committee support:

1. the Midwifery Act for proclamation in 1999;
2. initiatives to train First Nation Midwives and specifically, promote training opportunities within their home communities;
3. the preservation of traditional Midwifery practices and knowledge;
4. the provision of Midwifery services to all First Nation women and their families wherever they reside in Manitoba;
5. research to develop and enhance Midwifery practice and services to First Nation women.

1998-11-26
2:13 PM
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APPENDIX B NCN Letter to BRHA

Nisichawayasihk Cree Nation
NELSON HOUSE, MANITOBA, R0B 1A0
Telephone (204) 484-2332 Fax (204) 484-2392

May 15, 2000

Burntwood Regional Health Authority
867 Thompson Drive South
Thompson, Manitoba
R8N 1Z4

Dear

Nisichawayasihk Cree Nation has initiated steps towards having midwifery services provided for our First Nations membership. At the MKO Chiefs 13th Annual General Assembly, which was held June 23-25, 1999 in Nisichawayasihk Cree Nation, a formal resolution was passed to support the initiative of establishing midwives in Manitoba; and establishing a pilot project in Nisichawayasihk Cree Nation.

Secondly, on December 2, 1999, Nisichawayasihk welcomed midwives for a community visit. A meeting was held at the Nursing Station to include: Carol Couchie, Midwife -Ontario, Florence Klassen, Midwifery Consultant-Manitoba Health, Norma Charriere, Director of Health Programs-BRHA, Mary Jo Mathews, Midwifery Implementation Coordinator-BRHA, Heather McKay, Chairperson-Kagike Danikobidan, Committee of the College of Manitoba Midwives, Frances Potter, Nurse-In-Charge, Nelson House Nursing Station, Carol Prince, Health Director-Nisichawayasihk Cree Nation, and Emma Hart, Traditional Midwife-Nisichawayasihk Cree Nation.

Nisichawayasihk Cree Nation has also consented to a research project on whether it would be safe and feasible to establish a birthing centre in Nisichawayasihk Cree Nation (Nelson House). This research will be conducted by Shirley Hiebert, a Nurse Practitioner by profession. Ms. Hiebert has completed MSB relief nursing in Nelson House. She is also a Ph.D. candidate who is pursuing childbirth issues in the north through the Department of Community Health Sciences at the University of Manitoba.

Carol Prince, Health Director-Nisichawayasihk Cree Nation, and Darlene Mason, Home Care Coordinator-Nisichawayasihk Cree Nation, completed a small community survey to identify the number of midwives still present in the community. Fifteen women and three men responded. It is to my understanding that a DOULA program could be the starting point in initiating a midwifery program. We would be interested in providing a 3-5 day initial training for 10-15 interested individuals to provide support to prenatal and postnatal mothers. It is further understood that through the Burntwood Regional Health Authority, midwifery can be implemented wherein a midwife would work with our MSB nursing staff and our Family and

APPENDIX B NCN Letter to BRHA

Community Wellness Centre nurses towards establishing midwifery services and perhaps an apprenticeship program further down the road.

Therefore, this is a formal request to Burntwood Regional Health Authority to work in cooperation with Nisichawayasihk Cree Nation to implement midwifery services because we believe our community would be an ideal site based on the location from Thompson and of our history in accessing maternity services at Thompson General Hospital.

Please feel free to contact Elvis Thomas, Health Portfolio Councillor at (204) 484-2332, or Carol Prince, Health Director at (204) 484-2341 for further information.

Yours truly,

Elvis Thomas
Health Portfolio Councillor
Nisichawayasihk Cree Nation

Chief Jerry Primrose
Nisichawayasihk Cree Nation

Cc: Calvin Tant, CEO, President-BRHA Board of Directors
Neil Walker, Executive Director of Programs, Vice-President-BRHA Board of Directors
Grand Chief Francis Flett, Manitoba Keewatinowi Okimakanak Inc.
Yvonne Peters, Midwifery Implementation Coordinator-Manitoba Health
Avis Gray, Midwifery Primary Care-Manitoba Health

APPENDIX C Community Consent

MAY-23-00 TUE 10:49 AM Nisichawasihk CreeNation FAX NO. 204 484 2392 P. 02

Nisichawayasihk Cree Nation
NELSON HOUSE, MANITOBA, R0B 1A0
Telephone (204) 484-2332 Fax (204) 484-2392

May 12, 2000

Ms. Shirley Hiebert
Dept. of Community Health Sciences
University of Manitoba
750 Bannatyne St.
Winnipeg, Manitoba
R3E 0W3

Dear Shirley,

This letter is to acknowledge your research study on the establishment of a birthing center in Nelson House. We understand your research is toward your doctorate in Community Health Sciences.

Childbirth, is one of many of our traditions, an area that has in its entirety been taken from the control of the mothers. It was performed for centuries by our own mid-wives, perhaps with the same risks as we have today; and perhaps with more risks today considering the many other new diseases and genes involved.

Your proposal was reviewed with the chief, and nurses with myself. We could not foresee any problems. I need not remind of the importance of confidentiality and ethics involved in any research. As a nurse who has worked in our community, you are well familiar with the issue at hand. In accessing charts at the Nursing Station to get the medical histories of the pre-natals, perhaps this is an area for medical services to approve.

We look forward to your report. Please report to the Chief and Council upon arrival into the community.

Yours truly,

Norman Flinklater - Chief Executive Officer
Nisichawayasihk Cree Nation

APPENDIX D The Aboriginal Healing Foundation Proposal (summary)

Aboriginal Healing Foundation

FRANÇAIS

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FUNDED PROJECT DETAILS

Family and Community Wellness Centre (NCN Otinawasuwak program)

Grant ID: 3567

Title: The Empowerment of Aboriginal Women Surrounding Childbearing

Project Description:

The Empowerment of Aboriginal Women Surrounding Childbearing (EAWSC) program will employ 1 Coordinator and 6 Facilitators through the Nisichawaysihk Cree Nation (NCN) Family and Community Wellness Centre (FCWC). They will be Residential School Survivors who will provide opportunities for individuals to dialogue with each other and with the 75 to 100 pregnant women involved in the project through home or phone visits, and in structured groups designed to normalize, universalize and depathologize the negative life experiences that are symptomatic of the Residential School syndrome.

Phase 1 will address the healing and wellness needs of the Residential School Survivors employed by the FCWC, as well provide orientation to the program (which will involve but not be limited to the childbearing process and the needs of women).

Phase 2 the Coordinator and Facilitators will interact with the 75 - 100 pregnant women to develop a social network and encourage understanding and application of optimal Aboriginal childbearing practices.

Phase 3 will be a time of reflection and consolidation of knowledge gained throughout the program for future use.

Phase 4 entails apprising the communities of the final results of the program through electronic medium such as local television, radio, NCN newsletter, and through meetings with the school, Chief and Council, Mayor and Council, FCWC and the Nursing Station.

Goals
a) To initiate the mutual healing of women survivors of Residential Schools and subsequent generations by developing a social network of women surrounding childbearing practices.
b) To raise awareness of Aboriginal values and childbearing

APPENDIX D The Aboriginal Healing Foundation Proposal (summary)

practices, and provide support to childbearing women.
c) To empower women by helping them to understand the effects of the residential school legacy and offer ways of healing.

Start & End Dates:

AHF Contribution:
$227,000.00

Primary Contact:

Ms. Nora Thomas
Board Chairperson
Tel: 204-484-2341
Fax. Tel: 204-484-2341

Organization Address:

Nelson House , MB R0B 1A0

APPENDIX E Aboriginal Healing Foundation Conditional Approval

December 3, 2001

Request ID: 3567

Organization ID: 2494

Ms. Nora Thomas
Board Chairperson/Family and Community Wellness Centre
Nisichawayasihk Cree Nation
Band Office
Nelson House, MB R0B 1A0

Aboriginal Healing Foundation

Fondation autochtone de guérison

Danet'e:

On behalf of the Aboriginal Healing Foundation, I am pleased to inform you that your application entitled, "*The Empowerment of Aboriginal Women Surrounding Childbearing*" has received conditional approval from the Board of Directors to move to the next step in the funding process.

It is our practice to apply certain financial norms to all project budgets to ensure applicants are treated equally. Therefore, your budget may not necessarily be approved for the amount you requested. Please note that the *Foundation*, in its funding agreement with the Government of Canada, cannot fund existing programs, research activities, compensation, capital costs, or repair and maintenance of real property. Furthermore, the *Foundation* Board of Directors has established that it will not fund certain other project elements, for example, the purchase of spiritual items (this is done to avoid encouraging active trade in spiritual items).

We anticipate moving the project to the next stage of the process which will involve the clarification of some program issues for the purpose of strengthening your proposal. This is done to provide support to your project and to increase the likelihood of a positive outcome for your healing project. A representative will be contacting you to discuss the issues in more detail.

Please note that this is a conditional approval and is subject to the execution of a formal Contribution Agreement on terms acceptable to the Foundation, in its sole discretion. If the parties are unable to reach an agreement on the terms of the Contribution Agreement or if circumstances should change such that the Foundation, in its sole discretion, feels that the conditional approval must be withdrawn, your project will not be approved for funding.

We would ask that you kindly execute and return to us the attached Release, so as to confirm your understanding that the approval for funding is only conditional and to authorize the Foundation to release general information in relation to this conditional approval.

APPENDIX E Aboriginal Healing Foundation Conditional Approval

Please note that a project is to be considered to have received final approval only upon the signing of an agreement by an authorized representative and the Aboriginal Healing Foundation.

We look forward to receiving the Release at your earliest convenience and thereafter we will be in touch with you with regard to the next step in the funding process. Please quote your Request ID: 3567 in your correspondence to us.

Congratulations and we look forward to working with you.

Masi.

Georges Erasmus
Chair, Board of Directors
Aboriginal Healing Foundation

APPENDIX F: Question Guide: Topics for Key Informants

How could an alternative childbearing model be developed in Nisichawayasihk Cree Nation?

1. What historical, political, economic and socio-cultural factors will influence the development of a birthing centre in this community?
2. What resources are required to develop a birthing centre here?
3. What kind of infrastructure would be needed to have a birthing centre here?
4. How does reclaiming birth in NCN further self-determination?

What factors are being considered in developing a birthing centre in a First Nations community?

- identify how the community members view current birthing practices
- identify how community members view the possibility of changing birthing practices in this community
- identify the barriers/constraints to developing a birthing centre
- identify positive aspects of having a birthing centre
- identify a location for a birthing centre
- identify the technology that is considered necessary
- identify how medical backup will be provided
- identify what type of midwife is thought to be an optimum health care provider
- identify the role of the Burntwood Regional Health Authority and First Nations and Inuit Health Branch in developing alternative childbearing services

What personal choices need to be respected in birthing practices (woman/caregiver)?

How will risk be addressed?

How can cultural practices be incorporated into an alternative childbearing model?

How can alternative childbearing practices be incorporated into the existing health services in NCN?

APPENDIX G Research Group Letter/Agenda to BRHA

402-113 Market Ave.
Winnipeg, MB.
R3B 0W3
February 2, 2001

Burntwood Regional Health Authority
867 Thompson Drive South
Thompson, Manitoba
R8N 0C8

Dear _____

As I discussed with you, I am carrying out a collaborative research project with Nisichawayasihk Cree Nation (NCN) into alternative birthing practices to the current maternal evacuation policy of all pregnant women to the City of Thompson, 75 km by road from NCN. This research project is in partial fulfillment of my Doctorate of Philosophy requirements in the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

A working group of mostly women have been meeting on a regular basis in NCN to discuss alternatives to the current birthing practices. Group members include individuals from health and social service areas as well as interested band members and Metis participants from the adjacent Metis community. Persons with expertise thought significant to the research topic either dialogue with group participants at meetings or are interviewed by myself and this information is then analyzed and presented to the group. Both _____, midwife and _____midwife have participated in the research by meeting both with myself and the working group in discussing issues of relevance to the research.

It is perceived that research data from a diverse range of key informants and literature made available to the working group will enable knowledgeable decision making on birthing alternatives reflective of NCN needs, the socio-political infrastructure and the northern environment. The findings of this study will be transferable to the many other northern communities where the maternal evacuation policy is currently in place. It will assist the Kagike Danikobidan Committee and northern communities in identifying the issues most relevant to them as they explore alternative birthing practices in view of the recent changes in the Manitoban legislation of midwifery.

Given that NCN and the adjacent Metis community are within the Burntwood Regional Health Authority, it is of relevance that the working group participants have

APPENDIX G Research Group Letter/Agenda to BRHA

the perspective of the RHA itself regarding issues that may impact on their discussion of alternatives to present birthing practices.

As I mentioned to you, I am forwarding questions of a general nature for your consideration that may be seen to have the most relevance to the research topic.

Thank you for your attention to this requested participation that is of significance to NCN in their consideration of relevant issues and perspectives in bringing about optimal maternal-child care in their community. Enclosed you will find questions for consideration, and a letter requesting your participation for research from NCN and consent forms.

Sincerely,

Shirley Hiebert

Phone contact:

Email:

APPENDIX G Research Group Letter/Agenda to BRHA

Questions:

1. Midwifery was legislated in Manitoba, in June, 1997. Under the Burntwood RHA approach to midwifery services in the region:

a) Does the RHA see a role in providing midwifery services in NCN?
b) What may NCN expect at this time in lieu of the less than optimum number of registered midwives in the region?
c) Can it be anticipated that a registered midwife may provide services for maternal clients at the nursing station, the Family and Community Wellness Centre or in the homes of NCN or Metis residents?
d) Does the RHA see a role in participating in the training of midwives for NCN?
e) How does the RHA see a role in working with NCN in bringing about midwifery services in this community?
f) How might the RHA work in a First Nations and Inuit Health Branch (FNIHB) health facility (access to charts, liability, working with federally employed health care providers, etc.)?

2. Doula (birth support) training was carried out in NCN January 6, 7th, 2001. Fifteen women completed the training. NCN anticipates the role of the Doula will be expanded to include attention to antenatal and post-partum care. Antenatal care is seen as one of the most significant factors for lowering risk at birth.

a) Could the RHA see a role in collaborating with NCN and the Metis community in providing additional training of First Nations women to expand this role, as well as the possibility of funding these services?
b) How might the role of First Nations birth supporters be integrated into the policies of the Thompson General Hospital and how might the views of NCN women be heard generally at the level of policy makers in the RHA?

3. How do the goals of the RHA in providing the proposed midwifery services to the region complement First Nations goals of self-determination in the area of health care services?

4. What political, economic or human resource barriers might exist in the implementation of alternative birthing services in NCN?

5. How might these issues be addressed regarding midwifery services?

APPENDIX G Research Group Letter/Agenda to BRHA

NCN Otinawasuwuk
Family and Community Wellness Centre
Nelson House, MB.
ROB 1A0
February 27, 2001

Burntwood Regional Health Authority
Thompson Drive
Thompson, Manitoba

Dear_____

Further to our meeting with you on February 12, 2001, we, the NCN Otinawasuwuk organization would like to meet with yourself, ____and _____midwife, at your earliest convenience. We would like to discuss how the NCN Doula trained birth attendants might be integrated into hospital policy to optimally reflect the needs of First Nations women. We are enclosing a tentative agenda for the meeting for your review.

We look forward to our meeting with you.

Sincerely,

Darlene Mason
President
NCN Otinawasuwuk

cc:_____
cc:_____

APPENDIX G Research Group Letter/Agenda to BRHA

Tentative Agenda for Meeting between NCN Otinawasuwuk and Cal Tant, CEO, Burntwood Regional Health Authority,_____Director of Community Health Programs (Maternity and Midwifery) and _____, midwife.

1. To discuss having birth supporters from Nisichawayasihk Cree Nation (NCN) accompany First Nations women who give birth at the TGH.

2. To develop an 'on call' system for birth attendants.

3. To have birth supporters who are on call/or as previously arranged by the client-birth support pair be allowed to stay at the YWCA during the labor until ready for childbirth.

4. For NCN and TGH education department to coordinate an educational workshop for the staff on labor and delivery (nurses and doctors).

5. To have the views of First Nations women in reference to birthing practices formally incorporated into the TGH policy manual.

6. To have_____, midwife, provide prenatal services that may include caring for pregnant women, providing educational services and or attend women in NCN who would like to have home births or nursing station births until a birthing centre is established in our community.

7. To have_____, midwife, attend to NCN women who are staying at the YWCA during the period of their maternal evacuation.

8. That the RHA provide alternative birthing support and educational services during this interim period while full midwifery services are being established.

APPENDIX H Research Group Letter/Agenda to FNIHB/Response

402-113 Market Ave.
Winnipeg, MB.
R3B 0W3
February 2, 2001

First Nations and Inuit Health Branch
300-391 York Ave.
Winnipeg, MB.
R3C 4W1

Dear_____

I am carrying out a collaborative research project with Nisichawayasihk Cree Nation (NCN) into alternative birthing practices to the current maternal evacuation policy of all pregnant women to the City of Thompson, 75 km by road from NCN. This research project is in partial fulfillment of my Doctorate of Philosophy requirements in the Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

A working group of mostly women have been meeting on a regular basis in NCN to discuss alternatives to the current birthing practices. Group members include individuals from health and social service areas as well as interested band members and Metis participants from the adjacent Metis community. Persons with expertise thought significant to the research topic either dialogue with group participants at meetings or are interviewed by myself and this information is then analyzed and presented to the group. Several of the nurses employed by FNIHB were actively involved in the research earlier on. At this time they indicate time constraints limit further participation.

It is perceived that research data from a diverse range of key informants and literature made available to the working group will enable knowledgeable decision making on birthing alternatives reflective of NCN needs, the socio-political infrastructure and the northern environment. The findings of this study will be transferable to the many other northern communities where the maternal evacuation policy is currently in place. It will assist the Kagike Danikobidan Committee and northern communities in identifying the issues most relevant to them as they explore alternative birthing practices in view of the recent changes in the Manitoban legislation of midwifery.

As the health care provider for this community is of importance to NCN that FNIHB participate in the study to bring the FNIHB perspective to the research. I have spoken to Ms._____ ZNO regarding FNIHB participation. She expressed an interest in

APPENDIX H Research Group Letter/Agenda to FNIHB/Response

having someone participate in the research that could bring the most knowledgeable perspective to the research topic.

The questions of a general nature (enclosed) that may be seen to have the most relevance to the research topic at this time would likely be best addressed from the perspective of regional FNIHB persons in authority. The interview may take place with myself and or working group members at a time and place of convenience to FNIHB.

Thank you for your attention to this requested participation that is of significance to NCN in their consideration of relevant issues and perspectives in bringing about optimal maternal-child care in their community. Enclosed you will find questions for consideration, and a letter requesting your participation for research from NCN.

Sincerely,

Shirley Hiebert

Phone contact:
Email: :

Cc: Bill Rutherford, Director of Operations
Virginia Sanderson, Assistant Director of Operations

APPENDIX H Research Group Letter/Agenda to FNIHB/Response

Health Canada / Santé Canada

Your file / Votre référence

Our file / Notre référence

First Nations and Inuit Health Branch
Manitoba Region
300 - 391 York Avenue
Winnipeg, MB
R3C 4W1

August 31, 2001

Shirley Hiebert

, MB
R

Dear Shirley,

I am writing to provide you with a written update on the actions taken to date by the Regional Office in response to your research project. As discussed with you in past conversations, the questions that you have raised need to be addressed at a National level. I have discussed your research project with our National Nurse Practice Consultant in Ottawa. She has brought your research questions to the attention of the Assistant Deputy Minister for support in establishing a national working group to research and develop policies for the practice of midwifery in First Nations communities.

Our legal department has also been consulted for advice regarding liability issues for FNIHB nurses working with non federal employees. A committee has been established at the regional level to explore the possibility of incorporating licensed midwives into the health care delivery service available for prenatal care. During the interim of hiring a Regional Nursing Officer, Chris Egan will be the chair of this committee.

.../2

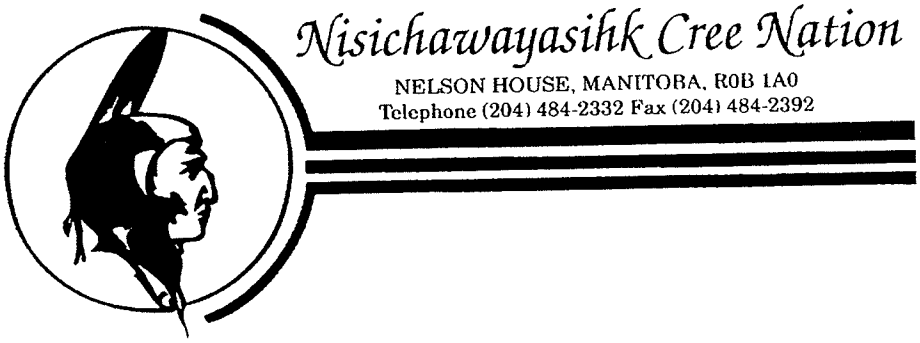
Our goal at FNIHB is to ensure that First Nations communities have access to the best available health care services. Thank you for your interest in helping First Nations communities explore new health care options for their prenatal women.

Sincerely,

A/Regional Nursing Officer
Manitoba Region

cc: Peter Rogers, Director, Professional Services Directorate
Bill Rutherford, Director of Operations
Dr. Christine Egan, Nurse Epidemiologist

APPENDIX I Band Affirmation Letter



To whom it may concern:

Shirley Hiebert* is carrying out a collaborative research project with Nisichawayasihk Cree Nation to explore birthing alternatives to the present policy that requires all pregnant women to be evacuated to Thompson several weeks prior to giving birth. On behalf of Nisichawayasihk Cree Nation a working group of women is meeting regularly with Ms.Hiebert to explore birthing practices in this community and possible alternatives.

We would appreciate your support and respect of the research process by participating in the research being carried out with Nisichawayasihk Cree Nation.

Sincerely,

Norman Linklater
Chief Executive Officer
Nisichawayasihk Cree Nation

* PhD Candidate, Dept. of Community Health Sciences, University of Manitoba

APPENDIX J Questions for pregnant women # 1

What does having a baby mean to you?
What kind of beliefs do people have about having a baby?
Would you go to an elder or traditional healer for advice?
Do you participate in traditional or religious ceremonies?
Do you eat wild meats?
Do you go for prenatal care?
What would make going to prenatal clinic help?
What makes you not want to go to prenatal clinic?
How often do you think you need to go to prenatal clinic?
Why do you think you need to go to prenatal clinic?
What do you think about being sent out two weeks ahead of time to have your baby?
What do you think of having your baby at the hospital?
What kind of people do you like to have care for you?
Do you like to have someone with you when you are in labor?
What kind of equipment do you think is needed when you have your baby?
What would you think of having your baby in Nelson House?
Have you heard of midwives?
Do you think you would like to have a midwife care for you?
If there was a birthing centre here, what would you think of that?
Do you think women would like the idea?
What would make it a good idea?
What might stop it from happening?
What would happen if something went wrong?
What does a woman need to do to look after herself well when she is pregnant?

APPENDIX K Questions for pregnant women # 2

What does having a baby mean to you?
How can you best look after yourself?
From whom do you seek advice when you are pregnant (elders, mother, sisters, friends, nurses, doctor, why)?
Do you know about women who don't take care of themselves when they are pregnant?
What could be done to help them?
When do you think you need to go to the nursing station?
How important are tests to reassure you that you and the baby are okay? (eg ultrasound, blood tests, examinations).
What do you like about prenatal clinic?
What don't you like about going to prenatal clinic?
What do you think about going to Thompson two weeks before you have your baby?
What do you think about going to the Family and Community Wellness Centre after your prenatal clinic visit?
Do you get information from the TV? (Eg satellite, Discovery Channel) Would you like to see prenatal/birth videos on the band channel?
Do you think that prenatal classes would work for you?
Would you like the CHRs to make home visits?
What do you think of having to go out ahead of time to Thompson?
Would you like to wait here instead and go out when your labor starts?
Have you heard of Doulas?
Have you heard of a Birth Plan?
Have you heard of midwives?
Would you like to know more about midwives?
Would you like to think about a midwife helping you when you have your baby?
If Nelson House had a place here where women could have their babies, what would you think of that?
What kind of people would you like to see working there (midwives, doctors or nurses).

APPENDIX L: Group Questions

What are the cultural beliefs about birthing you have heard of?
How do community members see the maternal evacuation policy?
Can you tell me what you have heard..
What do you think of when you think of natural birth?
What do you think of when you think of a medical birth?
Would you be interested in finding another way of birthing in Nelson House?
What do you think of when you think of a medical birth?
Would you be interested in finding another way of birthing in your community?
What do you think of the MKO resolution that Nelson House pilot a midwifery project?
What problems do you forsee in attempting to establish a birthing centre here?
What kind of risks do you think there might be in having a baby here?
What kind of risks do you think the community would be able to accept to have a birthing centre here?
What would make a birthing centre work well in this community?
How could this be brought about?
What would be the best kind of birthing attendants to have here?
Where do you think it should be?
What cultural beliefs do you think are important to maintain a birthing centre here?
Should there be traditional midwives included in the working at the birthing centre here?
What type of midwife training should the midwife have? (traditional midwife who is not licensed, a community apprenticeship trained midwife, a nurse-midwife, a degree trained midwife).
Where should the babies be born?
If, they are born in the nursing station what might be good or bad about that?
What other services might a birthing mother need?
What would the nurses think about babies being born here?
Would the medical backup be in place here?
How could it be?
What do you think of homebirths?
How might the community be best represented so their voices are heard on this topic?
How can the choice of women be respected? (if they choose to have a baby here, the type of midwife, the place of birth or if they choose to go to Thompson for antenatal care and birthing services).

APPENDIX M Antenatal Data Collection Guide

Name_____ID #_____

First Visit Initiated at _____weeks gestation

Number of antenatal visits:

< 5 _____ 5 – 8_____8>_____

Smokes tobacco_____

Uses alcohol _____

Uses recreational drugs_____

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APPENDIX N Information and Consent Forms

Study: **'Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation**

Investigator: Shirley Hiebert, RN, MSc. Family Nurse Practitioner

This research project is being conducted to explore the possibility of learning another way of birthing in Nisichawayasihk Cree Nation. Midwifery was legislated in April, 1997. Aboriginal women have been included in the legislation of midwifery by the formation of a special committee made up of Aboriginal women who have a voice in how midwifery will take place in your communities. The committee was named Kagike Danikobidan by elders.

This project uses a research method called participatory action research. This means participants will have a role to play in how the research is conducted, how issues are identified and how problems are dealt with. Discussion of birthing will include a wide range of topics to learn more about birthing in the North and how First Nations people think of it and how it might be changed to suit the needs of women.

Participation may involve the following activities:

As a focus group member you will be required to attend six to eight sessions with up to ten group members at a place and time that is convenient to the group. The meetings will be held every week for about a month and then less often for a period of six months. Some of you may be asked to come to the meetings for a longer period of time until all the information has been analyzed. It is expected the research will take up to six months with meetings less after that with certain interested participants.

As a key informant participant you will be interviewed either by person or telephone at a mutually convenient time or place. Several interviews may be necessary.

Thank you for your consideration of this project. The investigator will be pleased to answer any questions about the project at any time during the course of the study.

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Title of Study: **Study: "Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation**

Protocol number: E00:17

Investigator: **"Shirley Hiebert**
Department of Community Health Sciences
University of Manitoba
Bannatyne Campus
750 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3
Phone number:

Sponsor: **"Dr. John D. O'Neil**
Department of Community Health Sciences
University of Manitoba
Bannatyne Campus
750 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3"

You are being asked to participate in the study entitled: "Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation." Studies only include participants who choose to take part. Please take your time to make your decision about participating in this study. You may discuss it with your friends and family. This consent form may contain words that you do not understand. Please ask the study investigator to explain any words or information that you do not clearly understand.

Purpose of the Study:

This study is being conducted in partial fulfillment of the Doctorate of Philosophy Degree from the Department of Community Health Sciences, University of Manitoba. The project is a collaborative project with

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Study: **"Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation**

Nisichawayasihk Cree Nation to research birthing issues and possible ways to change the present maternal evacuation policy. Midwifery was legislated in April, 1997. First Nations women have been included in the legislation of midwifery by the formation of a special committee made up of First Nations women who have a voice in how midwifery will take place in your communities. The committee was named Kagike Danikobidan (Always Making Grandparents) by elders.

Study Procedures:

This project uses a research method called participatory action research. This means participants will have a role to play in how the research is conducted, how issues are identified and how problems are dealt with. Discussion of birthing will include a wide range of topics to learn more about birthing in the North and how First Nations people think of it and how it might be changed to suit the needs of women.

Participation may involve the following activities:

As a focus group member you will be required to attend six to eight sessions with up to ten group members at a place and time that is convenient to the group. The meetings will be held every week for about a month and then less often for a period of six months. Some of you may be asked to come to the meetings for a longer period of time until all the information has been analyzed. It is expected the research will take up to six months with meetings less after that with certain interested participants. As a key informant participant you will be interviewed either by person or telephone at a mutually convenient time or place. Several interviews may be necessary. You may participate in the project and influence the way it is developed as your interest, abilities and time allows you to.

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Study **'Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation**

Confidentiality

Information gathered in the research study may be published or presented in public forums, however, your name will not be used or revealed unless you expressly give your consent to this. Information regarding your identity may not have complete anonymity because of the collaborative nature of this project and the small population in Nisichawayasihk Cree Nation. The meetings will be audio-taped, and kept in a locked place. These recordings will be erased five years from now. If a secretary is used to transcribe the recordings, names of the participants will not be known. Numbers will be used to protect the names of participants.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Questions

You are free to ask any questions that you may have about the study and your rights as a research participant. If any questions come up during or after the study contact one of the following:

Shirley Hiebert
Dr. John D. O'Neil 204 789 3677
Ethics Review Board 204 789 3255

Do not sign this consent form unless you have a chance to ask questions and have received satisfactory answers to all your questions.

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Study: **'Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation**

Consent

I have read this consent form. I have had the opportunity to discuss this research study with Shirley Hiebert. I have had my questions answered in a language I understand. I understand I will be given a copy of this consent from after signing it. I understand that my participation in this study is voluntary and that I may withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity may not be guaranteed.

By signing this consent form, I have not waived any of the legal rights which I otherwise would have as a subject in a research study.

Participant signature **Date**

Participant Printed Name

Witness Signature

Witness Printed Name

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Study: 'Kagike Aniskotabidan' (Always Great Grandparents): Taking Control of Birth in Nisichawayasihk Cree Nation

I would like my name included in quotes. Circle the response and sign:

Yes **Signature**

No **Signature**

Signature of Witness **Date**

I, the undersigned have fully explained the relevant details of the research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name

Signature of person explaining the Consent **Date**

Role in the study

I, the undersigned have fully translated the relevant details of this research study to the participant named above.

Printed Name **Date**

Signature