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**ABORIGINAL MIDWIFERY AND TRADITIONAL BIRTHING SYSTEMS
REVISITED AND REVITALIZED:
INTERVIEWS WITH FIRST NATIONS ELDERS IN THE NORTHWEST REGION
OF BRITISH COLUMBIA**

by

Kimberly A. Ross Leitenberger

B.A., Trent University, 1995

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS
in
FIRST NATIONS STUDIES

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THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

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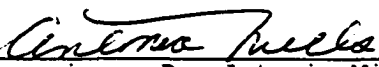
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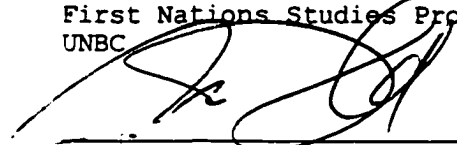
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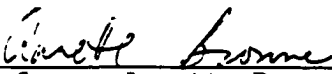
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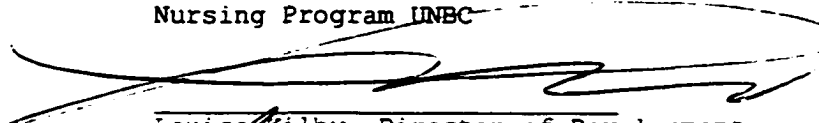
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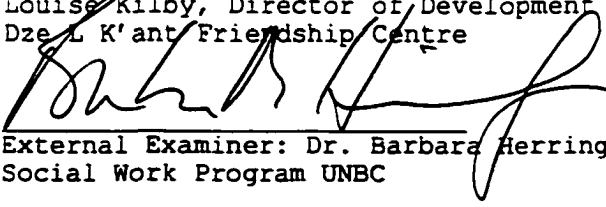

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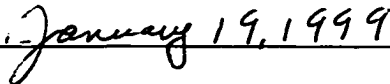

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Acknowledgments

When asked to describe myself, more often than not, I begin with the words "I am a woman". It is in this definition that I find completeness and fulfillment, it also directs my experiences and the perspectives derived from such experiences. Culturally constructed or biologically based, my self image contains elements of both, and although at times confusing and conflicting, a host of other roles both imposed and chosen fill up my life; mother-to-be, wife, daughter, sister, student, intellectual, friend.

Exploring this topic and conducting this research has added one more experience to the myriad of others influencing my existence and outlook not only in the way I define myself, but in the way I see the world.

I need to thank so many people for both helping me in this process and supporting me through this time in my life: *the Elders; Annie, Lizzie, Margaret, Antonia, Mary, Sophie, Elsie, Gloria, Kathleen, and all the Elders of the Prince Rupert Friendship House. My Committee and UNBC professors: Antonia Mills, Jim McDonald, Annette Browne, Louise Kilby and Heather Young Leslie. My support system: Janice Tollefsen, Joycelyn Carnell, Stephanie Cpyk and Dena Lehman. The professionals: UNBC, The Dze L K'ant Friendship Centre, The Prince Rupert Friendship House, The Northwest POP programs workers and coordinators, specifically Deet Rattray and her family. Finally, my family: Harvey Ross, Beverley Ross, Tracy, Cathy and Tricia, my dog Belle, the little one and my beloved husband and life partner Joshua.

* first names only have been used in the acknowledgment of the Elders for reasons of confidentiality

INTRODUCTION: THE JOURNEY

The master's degree, a long standing component of the academic ladder, is changing and evolving to suit the contemporary needs of students and the broadening world. A multitude of new ideas and ways of thinking have bloomed in the 20th century and research, academically, must accept this new direction as the millennium approaches. First Nations Studies itself is a relatively new discipline in the larger discourse of academia. Yet, it alone has changed and grown, influencing other disciplines, such as Anthropology and Sociology, and intellectuals alike. However, its greatest accomplishment today may be in its determination to include First Nations communities, the subjects of research, into the development of their own knowledge. It is this community centred approach which has led to the breaking of traditional academic boundaries and ways of both interpreting and seeing the world.

My journey, of which this thesis is only one part, has no recognizable beginning. It stems from a number of events in my life and started long before I entered the First Nations Studies Graduate Program at UNBC. Stemming from a newly discovered interest in midwifery as a traditional woman's role and method for community healing I began researching this topic while still an undergraduate at Trent University in Peterborough Ontario. My interest continued even in the year I took off between degrees to explore other aspects of life. I continued to read feverishly anything I could on what was then merely a personal passion. Something changed for me and my passion became the driving force to leave my new existence and reenter the domain of academia. So in the fall of 1996 I packed my bags and traveled to the then-unknown-to-me city of Prince George in Northern British Columbia to participate in a relatively new and innovative Masters Program being offered at the University of Northern British Columbia. After an interesting year of

making new friends, acquaintances and colleagues my dream was beginning to take shape.

The research part of this journey began in the summer of 1997 when I was completing my internship at the Dze L K'ant Friendship Centre in Smithers, B.C. The Friendship Centre serves much of the Northwest region of the province, providing programs to many remote and outlying communities. My duties included researching Fetal Alcohol Syndrome program resources which resulted in the compilation of a series of Fetal Alcohol Syndrome Resource guides that are now used throughout the region in the Pregnancy Outreach Programs and as supplements to FAS workshops. Further to this, I was involved as a research team member on the Houston Maternal Health Needs Survey conducted that summer. Working closely with employees of the Friendship Centre and Pregnancy Outreach Programs I helped administer surveys and write the final report with recommendations. All of these experiences broadened my already deep interest in maternal health issues and specifically my interest in Aboriginal midwifery. Concerns unknown to me were brought forward with this work and included the evacuation of women from their communities to birth in larger centres with hospitals. Transportation, financial aid, isolation from family and racism are just a few of the issues facing birthing women in the North. Much is being done to help ease these problems. Pregnancy Outreach Programs in B.C.'s Northwest are working with women to give mothers-to-be support and information while giving their babies the healthy start needed.

The Dze L K'ant Friendship Centre sees maternal health needs in the Northwest as a priority area for research. Over the course of the summer several small informal discussions between Friendship Centre researchers and Pregnancy Outreach employees ignited the idea of performing a Northwest Regional Maternal Health Needs Study. Being a Masters student in First Nations Studies and needing a topic for my

thesis I was invited to interview Elders from the First Nations communities in the Northwest to gather traditional knowledge and personal experiences about midwifery and birthing practices. An Elder is considered to be a person who holds special and sacred traditional knowledge about their Nation and community. I was thrilled to participate and to research a topic of great interest to me. Also, this partnership with the Friendship Centre ensured that my research was community based, allowing for direct community input and participation.

As a first step I needed to carefully decipher the intent and purpose that would form the basis of this research. The following is what I discovered and adhered to as the main objectives:

- Record and preserve traditional knowledge from First Nations communities
- Identify alternative birthing options/practices for women in the Northwest
- Create a knowledge base for new and current health programs in the Northwest
- Secure First Nations voices in the discussion on birthing options in the Northwest

My research began with a thorough review of existing literature which provided me with the historical perspective needed and expanded my understanding of contemporary issues surrounding Aboriginal midwifery and traditional birthing systems. As will be seen in *Chapter One: Literature Review*, within these larger topics, I explored the critical issues and the major theoretical arguments. By exploring midwifery's decline in Europe and almost complete disappearance in Canada, the literature suggests a subsequent rise of two official discourses of birth, a medical technology-oriented narrative and a feminist-revisionist narrative. From the literature I was able to ascertain that information on Aboriginal midwifery and traditional birthing systems had been both ignored and overshadowed by these two birthing philosophies. Further, by reviewing research on the effects of colonization on the health and well-being of First Nations peoples and Aboriginal women's

traditional roles, a picture formed as to why this data was missing. However, several recent articles on traditional Aboriginal midwifery and birthing practices along with life histories of First Nations Elders have attempted to include Aboriginal voices in the current discussion of midwifery.

The literature review gave my research direction and allowed me to develop a specific research question: what knowledge is available about traditional Aboriginal midwifery and traditional birthing systems from the First Nations communities in the Northwest region of British Columbia and how can this knowledge be applied to contemporary birthing issues in the North.

Chapter Two: Moving Towards the Contemporary outlines the general situation of Aboriginal health in Canada today. This contemporary continuation of Chapter One's discussion on the effects of colonization with regards to First Nations health and well being is followed up by a more specific look at the situation for Aboriginal infant and maternal health. This section uses statistics such as infant mortality (the number of deaths per 1000 live births up to and including the first year of life for a given population), low birth weight rate (the number of babies born in a given population weighting less than 2500 grams) and teen pregnancy (the number of babies born to mothers within the age range of 13-18 for a given population) to give further insight into the study area, Northwestern British Columbia.

One cannot forget the unique situation the North presents with regards to health care access and delivery and it is important to this topic to review the nature of birthing in the North for First Nations people both historically and in contemporary times. Lastly in *Chapter Two*, a summary of the critical issues outlined in my literature review are combined with this information to tie the research back to the research question.

Chapter Three: The Research Methodology, begins with a theoretical discussion of the issues surrounding knowledge, power, interpretation and research conducted from within an academic institution. Research with Aboriginal peoples in the past has poorly served their needs. To try and answer my questions regarding how to conduct ethical and beneficial research cooperatively with First Nations peoples I briefly examined a successful, community initiated, co-operative research project: *The Inuit Childbirth Study*. By involving the community, focusing on traditional knowledge and transferring skills to the Inuit researchers, the benefits and empowerment of this research design were obvious.

An overview of the research methodology begins with an exploration into the nature of the *Community Based Research Design* and how I incorporated its primary steps into a research design. A discussion of the community's involvement is followed by the data collection methods, the procedure, how the data was analyzed and how the results will be used.

Conducting research is a subjective process and the researcher's world view, experiences and perspectives cannot be separated from the process itself. I have attempted to place myself within this research by outlining my personal feelings and experiences, good and bad, as I followed this journey to the end. To try and account for my role as a researcher, *Chapter Three* ends with a detailed investigation of my own personal concerns and interpretations of the research process.

As will be seen in *Chapter Four: Findings*, out of the original three categories or sections of the interview questions, several patterns began to emerge. In the first section, *Personal Experience*, the Elders' stories of birth can be aligned into four categories: Women's own birth stories, Women as Midwives, Unique Instances, and stories of Infant and Maternal Deaths. Out of the questions on *Knowledge of*

Midwifery, a tremendous amount of detailed information was presented. To organize it I created several subheadings: Restrictions, Midwives Roles, Pregnancy and Labour, and Breastfeeding. Like the interviews, I ended this chapter with a brief discussion of how the women felt about *Contemporary Birthing* and the western medical system.

More came out of this chapter than the simple break down of questions into subheadings. I discovered that there were a number of base or common themes permeating all of the interviews and that these base themes were present in a general way in every single interview. Birthing was/is more than a physical or even a social event, it was/is a way of being and reflected/reflects deeper philosophical and metaphysical beliefs. It was/is treated in a holistic manner as a natural event in the course of life and was both community and family centred. Births, the knowledge surrounding birth and those who participated in the birthing scene, created an oral discourse of birthing where experiences and ideas were used as teaching methods.

Chapter Five: Moving Towards the Future; brings all these ideas together in a discussion of the possibilities for using this information in a positive way. It begins with a synthesis of the findings described in Chapter Four and how these connect to the overall themes discovered through the literature review. Key theoretical and practical contradictions are discussed along with the tensions involved in the move from midwife-centered birthing care to hospital deliveries. An exploration into the revitalization of traditional healing strategies is then followed by some examples of contemporary collaborative initiatives with regards to bringing traditional birthing practices and midwifery back to the community. Finally, a brief look at the midwifery situation in B.C. today gives us insight into the opportunities available for the Aboriginal communities in Northwestern British Columbia.

Traditional practices have survived, not always intact, through years of ridicule, denunciation, misrepresentation and punishment by law at the hands of Western society. It is important that surviving practices be protected from further loss and that they be strengthened and adapted to contemporary situations. As stated in the Royal Commission on Aboriginal Peoples (RCAP):

Traditional healing has endured major and deliberate assaults on its validity. To try and protect and preserve existing skills and knowledge, and at the same time develop and extend their application, active support - not just increased tolerance is required (Royal Commission on Aboriginal Peoples(RCAP)1996:290).

This promotion of First Nations healing practices, such as Aboriginal midwifery and traditional birthing practices, is an important and essential method of reviving Aboriginal health status and well-being in Canada. Hopefully this thesis research can help the movement towards decolonization, cultural revival and further the path of healing for First Nations peoples.

CHAPTER ONE: LITERATURE REVIEW

Everyday one quarter of a million people are born worldwide and historically midwives have been the primary caregivers of birth and the birthing process (Burtch 1994a, Oakley and Houd 1990, Northrup 1994). These women were active for thousands of years in pre-industrial Europe, Asia, Africa, Australia and North and South America providing childbirth attendance and traditional healing for pregnant women. To date, Canada remains one of only nine of the 210 countries in the World Health Organization that have no provision for midwifery (Elkins 1985:320). This is slowly changing however with the legalization of midwifery in the provinces of Ontario, Alberta and most recently British Columbia.

To begin a discussion of the literature surrounding the topic of Aboriginal midwifery and traditional birth practices, specifically in British Columbia, a wider perspective must be taken. This perspective must include a historical look at the development and decline of midwifery practice in Europe and subsequently midwifery's almost complete omission, except for traditional First Nations midwifery, immigrant groups and what Burtch (1994a) calls the *Traditional Birth Culture* that arose across the remote and outlying communities in Canada. Further, we must follow the rise of two official discourses, the medical and the natural, to come to the realization that culture has not been thoroughly considered in either narrative.

For the purpose of this literature review, the focus will return to the First Nations voices which have previously been ignored in the discussion of birthing and birthing practices. Several recent articles and studies outlined here have attempted to incorporate the Aboriginal perspective in the current discussion of midwifery. They include research on the effects of colonization on First Nations health and well-being, Aboriginal women's traditional roles and responsibilities,

Aboriginal midwifery itself, traditional birth practices surrounding pregnancy and childbirth and life stories of Aboriginal Elders from the North.

One can find controversy in almost all aspects of the midwifery movement beginning with the definition of what a midwife is. Burtch (1994a) outlines two separate definitions of midwifery with the first being a generic version, the midwife being described as any person, man or woman, who assists a woman in childbirth be they a nurse, midwife or lay midwife. Burtch's second definition is more specific in that only women can be considered midwives, with the original spelling of wife as *wyfe*, Old English for woman. However, Burtch also mentions the controversy involved in this definition as whether or not the term midwife can be applied to all the women present at a birth or simply to the woman who actually delivers the child. Oakley and Houd (1990) discuss the use of the word midwife as a reference to a long standing tradition of alliance between women giving birth and the women that attend them (1990:17).

The word midwife can be seen to have many historical base meanings such as, with woman, old wife, traditional woman healer, good woman, cunning woman, wise woman and in Quebec *sage-femme*. Benoit and Carroll (1995), found that the professional label of midwife was not necessarily a recognizable term among the First Nations of British Columbia. The Nuu-chah-nulth describe a midwife as, "she that can do anything", while the Chilcotin refer to her as "women's helper" and the Coast Salish word means to "watch and care" (1995:232). However, in terms of contemporary health care, The World Health Organization has recently coined the term *Traditional Birth Attendant* to refer to the main providers of pre, ante and post natal care to women world wide (Elkins 1985:320).

1.1 HISTORICAL PERSPECTIVE: THE DECLINE/DISAPPEARANCE OF MIDWIFERY

To give an understanding to the midwifery situation in Canada today, an historical and cross-cultural perspective must be taken. Burtch (1994a) describes the transformation of midwifery to have had three stages. The first was the redefinition of birth as a medical procedure along with the rise in technology surrounding life in general, the second was the campaigning against midwifery and the third, the complex issues surrounding the state and institutional control of midwifery, specifically the medical system, educational system and government. Burtch goes so far as to say that the "displacement of midwifery by medical and nursing personnel is set in the larger framework of technological advancements, centralization of maternity services and formal bureaucratic structures" (1994a:64).

To begin his exploration, Burtch refers to the changing patterns of state control in pre-industrial Europe and uses Bohmne's (1984, in Burtch 1994a) three stage progression of the changing status of midwifery. Bohmne's first stage, *Solitary Aid*, locates knowledge of childbirth through personal experience, such as witnessing births, and suggests that giving birth was a necessary aspect of becoming a midwife. However, in the Middle Ages midwives became licensed practitioners appointed by the church and were required to uphold church values. This is Bohmne's second stage, as the power over birth attendance left the communities' hands and entered the domain of the church and birth became not a matter of choice but a regulated affair (Burtch 1994a:64). Midwives at this time were not paid and were expected to prevent abortions, infanticide, watch for changelings, baptize and establish paternity of the newborn infants. However, in the early thirteenth century Barber surgeon guilds were established to deal with abnormal births and by the fourteenth century physicians also became licensees of

the church. These guilds significantly diminished women's roles as both midwives and licensees of the church.

Along side the previously mentioned move to church control was a period in history that many contemporary women call the Burning Times or the Women's Holocaust (Burning Times 1990). In the 16th and 17th centuries all across Europe millions of people were hanged, drowned or burned at the stake, having been accused of the practice of witchcraft. The persecution of witches grew out of a larger punitive movement, The Inquisition, an investigative body established out of the church (Marron 1989:23). With regards to witchcraft, *The Malleus Maleficarium*, or The Hammer of Witches, a treatise written by the Dominican Friars, gave the power to imprison, torture, convict and punish anyone accused of practicing witchcraft. The majority of people accused and killed were women who had some sort of power within their communities, be it as healer, land owner or midwife (Burtch 1994a, Oakley and Houd 1990). Overwhelming misogyny became the established norm as women were deemed passive and easily courted by the devil. As the organized religion of Christianity spread across the Western world, they robbed the earth and women of their respected positions, power and divinity, even into the colonies of the "New World" (Burtch 1994a:67, Marron 1989:22).

Bohmne reveals the third change to be the move to traditional professionalization, a secular position, from a church assigned position. The issue of traditional professionalism arose as medicine became organized and midwives were deemed as lacking in an acceptable knowledge base. Until the 13th century the medical profession was open to anyone, but with the establishment of medical guilds, a university-given license became a necessity. As women were barred from attending universities this became an impediment to them practicing midwifery legally. Coupled with the rise of technology in birth, specifically the development of the forceps in the 17th century, these changes allowed

the disciplines of obstetrics and gynecology to overtake the centuries of midwifery history in Europe. The big push for full obstetrical control came with the complete redefinition of birth as a pathology (Oakley and Houd 1990:31). However, up until the late 19th century there was still resistance to the male centred physician birth, as male midwives were targeted for indecency and had to practice with sheets tied over their heads or in the dark (Oakley and Houd 1990:30).

Bohmne's final stage is that of present day midwifery, a self-regulating and licensed profession in Europe, with local and international organizations who specialize in combining theoretical knowledge of medicine and practical midwifery skills (Burtch 1994a:68). To achieve this however, midwives had to continually lobby government for change and during the late 19th century many midwifery-related bills were passed in England. The first act governing midwifery was made law in 1902 following the efforts of *The Midwifery Institution*. This bill gave midwives legal recognition but the profession remained under medical control (Burtch 1994a:68). However, changes in 1936 and 1951 located the role of midwives in Britain where it stands today.

Oakley and Houd (1990) elaborate on this takeover of childbirth by the medical profession as not only a professionalization of the birth scene but also as a process that systematically excludes the issues of race, class and specifically gender (Oakley and Houd 1990:24). Oakley and Houd discuss the removal of women from the birthing scene as a "colonization" of midwifery, a formerly women-centred, controlled and regulated event:

Female midwives were part of a female controlled reproductive care system...[and] it was precisely this that posed so much of a threat to the church, the state and the emerging medical profession (Oakley and Houd 1990:26).

As with Burtch (1994a), Oakley and Houd also discuss the persecution of witches and the development of *The Malleus Maleficarium* as central to the decline in the midwifery movement in Europe. However, Oakley and Houd see the accusation of witchcraft as synonymous with hostility to women and women's real or imagined power (1990:26). *The Malleus Maleficarium* contained very real descriptions of midwives performing infanticide and the claim of women's sexual appetites that drove them to "congress with the devil and to use their work as midwives for this purpose" (Oakley and Houd 1990:27). Midwifery based knowledge such as abortifacients and herbal contraceptives as well as birthing being a woman's domain permitted women control of their own reproductive lives. This underlying attack on women and midwives through their sexual being was partly directed at this large body of knowledge.

Oakley and Houd (1990), concurrent with the description of the decline of midwifery as a misogynist issue, believe that the biggest factor in the relegation of the birthing scene to men and medical science came with the redefinition of pregnancy and childbirth as a pathology. As a pathology, childbirth and pregnancy required strict control of when, where and how the birth took place. It implied the notion that at any moment "something could go wrong" (Oakley and Houd 190:32) and therefore continuous monitoring and surveillance by an obstetrician was necessary. This was not only a medicalization of childbirth but a definition which undermined the entire rationale of a woman centred birth culture and midwife attendance (Oakley and Houd 1990:31). They argue that the triumph of obstetrics over midwifery was a strategic "success", based not only in the definition of childbirth as an illness but in the public defacing of midwives as incompetent. This propaganda, not unlike *The Malleus Maleficarium*, arose everywhere including 20th century obstetrical textbooks:

their [midwives] thinly veiled advertisements

in the newspaper show them to be willing abortionists; and since they have the right to give certificates of stillbirths, who knows whether or not an infant's death is due to natural causes or to criminal manipulation (A Textbook of the Science and Art of Obstetrics; Garrigues 1902 in Oakley and Houd 1990:27).

Oakley and Houd are firm in their representation of the care of female midwives to birthing woman as being a long standing tradition. They argue that the fundamental difference between midwifery and obstetrics lies in the intervention-oriented philosophy of medicine and that this difference is deeply rooted in the socially constructed views about women and reproduction rampant in our culture (1990:33).

Although medicalized birth has also become the norm in North America, both Oakley and Houd (1990) and Burtch (1994a) see the events surrounding the decline in midwifery in North America as taking a different path from that of their European counterparts. While in Europe the midwife never fully disappeared from the birthing scene and finally secured a legal footing as birth attendants, midwifery in Canada was almost completely wiped out with only recent acceptance of professional status.

Burtch (1994a) maintains that until recently the history of midwifery in Canada shows a lack of documentation and this is partially due to the illegal or alegal status of midwifery in Canada. Community midwives, fearful of prosecution, kept no birth or statistical records. Further adding to midwifery's lack of documentation is the fact that until recently the history books have been written from a patriarchal point of view, by men, for men and from the male perspective, which in most cases focused on the superiority of hospital births and described midwife attended births in a negative light (1994a:72). However, some brief historical accounts do describe community or neighbour midwives and it is here that we encounter references to cross-cultural and First Nations midwives for the first time. Burtch contends that midwives were

integral parts of Mennonite communities, first generation Japanese Canadians in the lower mainland of British Columbia and that:

Historical accounts indicate that Native midwives assisted settlers and one another in the colony of British Columbia (Burtch 1994a:74).

Medical and state control was established in the more eastern settlements of present day Nova Scotia and Quebec as early on as 1788 when the British government required midwives to have certification and in 1795 with the Upper Canada Medical Act. Amendments to this act in 1806 protected midwives to some extent. However, medical dominance forged its way just as it had in Europe with the entrenchment of powers over birth to the state including licensing, the system of medical registration and the necessity of medical education (Burtch 1994a:76). In these new settlements, doctors needed to develop family practice and again echoing the movements in Europe, the medical community "used campaigns of vilification, characterizing midwives as ignorant, dirty and dangerous." Thus by 1879, ninety-five percent of midwifery licenses were issued to male physicians (Burtch 1994a:77).

However, Burtch contends that in the more western colonies and less densely populated areas the nature of midwifery took a different shape. Here, the geography allowed for a more community-based, neighbourly network of midwifery to develop. Burtch following Mason (1988), describes *Traditional Birth Culture* as focused on the continuity of care of the woman, the need to stay with her throughout her entire pregnancy, the use of a variety of positions, moving around during labour, familiarity, companionship, provision for bedrest among women following birth and the use of reciprocity rather than payment for service (1994a:75).

Change for more rural areas came after the first World War as community midwifery was almost completely eradicated by physicians, the

public health movement and the growing involvement of nurses in maternity care. This came at a time when nurses were becoming more and more a part of the medical hierarchy and a period of domiciliary midwifery practiced extensively by public health nurses began in the 1920's and continued until the 1940's (Burtch 1994a:79). It has been estimated that only forty percent of Canadian mothers delivered in the hospital in 1939, and that by 1959, ninety-three percent of births were performed in hospital, suggesting that the largest change came after the second world war with the development surrounding health care plans and the generally improved conditions within hospitals including accessibility (Burtch 1994a:79).

Oakley and Houd (1990) do not lose sight of the difference between the European history of midwifery and the Canadian one, but do see the conquest of obstetrical science over midwifery in both Europe and North America as having one important similarity; that this triumph was not only of obstetricians over midwives but represented male ascendancy over women on many levels (1990:30). They believe history proves the argument for the midwifery profession being more female than male and it has been the rule and not the exception that women in childbirth have been attended by their own sex (1990:35).

1.2 THE RISE OF TWO OFFICIAL DISCOURSES OF BIRTH

What arises out of these two histories of midwifery, the European and its North American counterpart, are two official discourses of childbirth, a medical, state controlled narrative and a natural, feminist-revisionist narrative. It is necessary to explore the nature of these discourses to reveal the lack of cross-cultural input and specifically the lack of First Nations voices.

Katz-Rothman (1986) in her article "The Social Construction of Birth", describes the history of childbirth as a chronicle of political

struggle as different interest groups, namely the medical profession and its opponents, have worked to gain control over childbirth (1986:104). Katz-Rothman continues to describe this as *symbolic interactionism*, when several social meanings are attached to a single physical reality. Birthing can be seen as a physical as well as a social event and as in every social event, alternative constructions of these events can take place:

Which version is accepted and acted on is a reflection of the power of each participant. The consequences, of course, depend on the definition of the situation. Those who define, control (1986:105).

When obstetricians overtook midwives as the primary caregivers of the birth scene it was not a forced physical change but more ideologically based as the medical system gained control through redefining birth as a pathological event. Burtch (1994b) states that this redefining of birth failed to prove midwifery inferior to science and that in reality midwives were preferred by women. This ideology of medical control was reinforced by legislation which restricted other forms of birth attendance. Community control was replaced by sanctions of power by the state:

As Foucault notes of the disciplinary society, discourse and surveillance serve to produce docile bodies. Obedience becomes normal, disobedience suspect and dealt with punitively. The community of women thus became medicated through much larger structures of power and knowledge as these events became cast as medical events (Burtch 1994b:151).

Katz-Rothman (1985) and Burtch (1994b), like Oakley and Houd (1990), each argue that a second official discourse has arisen as women became unhappy with the medical version of childbirth with its rates of intervention and obstetrical rituals. Along with the definition of birth as pathology, there is also a revisionist feminist narrative of birth as

a women-centred, natural event (1986:106). Benoit and Carroll (1995) have also taken up these two definitions as the official discourses of contemporary childbirth. Their discussion of the medical narrative views the subordination and/or elimination of midwifery by obstetrical science as an issue of progress where new and more advanced technology has aided the birthing woman. They claim it is filled with images of the primitive folk healer who, inferior and undereducated, used her charms and rituals but could not compete with technology, specifically the use of forceps, as the "art and science of obstetrics conquered the ordeals that nature had placed on women" (Benoit and Carroll 1995:227). At the base of this narrative is a professional/non-professional dichotomy that does not recognize the issue of class and race but more importantly the issue of gender. The feminist narrative, according to Benoit and Carroll, takes up issue with the medical version on this very point as it tells of a male medical takeover of pregnancy and childbirth and the ensuing decline in women centred, midwifery care. On top of the professional/non-professional dichotomy outlined in the medical narrative, the feminist revisioning focuses on the inequality of power in the defining of the relationships in childbirth. Radical thinking can be seen in the following quote:

Birthing women and their newborns will continue to be victimized until obstetricians are vanquished from parturition and midwives' key role in the birthing chamber is restored (Benoit and Carroll 1995:228).

Beyond these radical descriptions of an obstetrician-free birth experience, the feminist revisioning has been important in its movement to give women alternative birthing choices and in the reorganization of maternity services (Benoit and Carroll 1996:228). Demand for health care changes coming from dissatisfied women and the quest for reform oriented around women-centred health and birthing care lead to the development of

the Natural Childbirth Movement in the mid-20th Century. Women began to realize that birth was a time of great opportunity to get in touch with their true power and that a willingness to assume responsibility and reclaim the power of birth would only occur when technology was moved where it belonged, in the service of birthing women not as their master (Northrup 1994:413).

The Natural Childbirth Movement created a discourse which emphasized the beautiful and unrestricted in birth based on the notion of the primitive woman who "goes off into the bush, gives birth painlessly and then goes right back to work" (Cossett 1994:10). Tess Cossett (1994) in her book Women Writing Childbirth: Modern Discourses of Motherhood comes at this discussion from a different angle. By analyzing literary accounts and collections of real birthing stories, Cossett believes childbirth has been dominated by a male perspective and needs to be made more visible and told from the woman's point of view.

Women must live up to this ideal of the inherent and instinctive power of birth. Cossett (1994) however, recognizes this as a cultural construct and further delegates it to be western and male in origin. Dick Read, an obstetrician, was the first to write on the possibilities of Natural Childbirth in 1933, introducing the primitive woman, the dichotomy of nature versus culture and the civilization of the primitive. According to Cossett, in Read's model, originally the woman is culture-less, and that civilization and culture have removed women from this ideal birthing state (1994:10). Read is obviously working with the nineteenth century ideals of social evolution and natural theology based on the notion that the natural is inherently good. Read's interpretation has the painlessness of childbirth as part of a woman's state of mind, that she has not yet been taught to fear childbirth. Read continues by arguing that it is only the "highly trained, charismatic obstetrician who can counter the woman's civilized fears and restore

them to their natural state" (Cossett 1994:12). Although the underlying theory of Natural Childbirth has patriarchal origins, it was women and midwives who took up this approach and used it to give power back to women in childbirth. Read wrote two other books, Revelations of Childbirth and Childbirth without Fear, both of which were largely based on women's stories of natural childbirth. This was the beginning of female appropriation of Read's theory but Kitsinger's The Experience of Childbirth: Giving Birth How it Really Feels, was the first book in the early twentieth century to be written by a woman for women (Kitsinger in Cossett 1994:23).

The Lamaze method, developed by Dr. Fernand Lamaze, can be seen as based on Read's ideas of childbirth without fear, as the woman conditions herself against pain and therefore overcomes the natural. Kitsinger is wary of the Lamaze method's "mechanistic breathing" but still tends towards Read's discussion of the primitive and spiritual nature of birth (Cossett 1994:23). Lamaze training, to Katz-Rothman (1985), was a process of distraction from the actual birth experience and women were positively reinforced for making it though a contraction without crying out. She describes Szasz and Hollender's classic article on the three basic patient/practitioner relationships developed in the hospital setting. The first, *The Active/Passive Model*, involves an anesthetized woman whose birth is completed by forceps and caesarean section. In this relationship, the doctor defines normalcy and each of the following relationships have the potential to become active/passive since in the hospital setting the doctor always has the power to render the patient unconscious (Katz-Rothman 1985:113). The second relationship, *The Guidance Co-operation Model*, forms the basis for the Natural Childbirth Movement whose goal was for the individual birthing woman to be polite, tactful and never fanatical (1985:114). The doctor guides the receptive woman through the process and with the help of her

husband is "coached" through the birth (1985:114). The third model is the most difficult to obtain in the hospital setting. The *Mutual Participation Model* is described by Szasz and Hollander as a team working towards a common goal. When it is achieved however, the woman is again separated from her birthing experience as she becomes only one of a number of people participating in the birth of her child. Further, her ability to naturally birth, even using the natural childbirth philosophy is overshadowed by the hospital procedures:

Positioning her and draping her in such a way that she cannot directly see the birth, not allowing her to touch her genitals or the forth coming baby, tells the mother that the birth is something that is happening to her, or being done to her, and not something that she is doing (Katz-Rothman 1985:116).

Staff then remove the baby and it is cleaned, processed, measured and presented to the mother. With this she becomes the receiver and not the producer. We see that the re-definition of birth as a natural event and the subsequent Natural Childbirth Movement did not challenge the medical definition of birth but simply better prepared women for the hospital experience (Katz-Rothman 1995:113). Cossett (1994) wonders if the contradictions that are found in the notion of the primitive woman giving birth painlessly and the reality of the modern woman consulting her handbook can lead one to ask if "natural childbirth is really natural or is it a cultural practice we learn from books?" (1994:23). However, we see some women appropriating the primitive woman stereotype and obscuring her male origins while others focus their energies on discrediting the patriarchal base all together. Nonetheless, Cossett argues that both dominant theories will always create four possibilities, each a success story and each a failure. She states that women will either find power or guilt in their ability or inability to perform up to each ideal. On the medical side, women can experience a

anaesthetized pain-free technology based birth while on the natural side the experience becomes an ecstatic drug-free painless birth. Failure comes to the woman who does not enjoy the medical version, unable to use her body properly but failure to not fully enjoy the natural birth can also leave women with this same feeling of failure (1994:87).

Cossett's goal is to return to the maternal subjectivity which was destroyed as women and childbirth became objectified through medicalization (1994:02). She finds maternal subjectivity an oppositional discourse and believes the Natural Childbirth Movement gives women consciousness to discuss women centred birth. However, Cossett brings up the interesting point that "Natural Childbirth rhetoric...as much as the hospital birth system itself are cultural products of particular historical moments" (1990:03). She goes further to introduce the notion that the Natural Childbirth Movement is anti-feminist in its dependence on the stereotype of the primitive woman and essential motherhood. The post-modern dilemma that Cossett presents is evident in her need to affirm women's voices as marginalized subjects while showing that these voices have also been culturally constructed by prevailing discourses and cultural practices (1994:03). We find no authentic voice or voices of women even as the shadow of the medicalized birth is lifted.

Cossett focuses on the two major narratives, the medical and the natural, but sees this dichotomy in itself as a myth as other discourses become available. She specifically mentions the oral traditions of the West, the "Old Wives Tales" (1994:05), as well as "other cultural stories of race and class which are largely omitted from the official discourses" (1994:05). It is in the hidden stories and practices where the unacceptable accounts of childbirth can be found, the oral traditions of women, usually mother to daughter, where the pain and wisdom of childbirth are revealed. Reflected in these stories are images

of the peasant crone or midwife, who has her own competing knowledge to that of the medical knowledge and who does not let the woman endure birth alone as the natural model projects:

Anthropological research has suggested that painless childbirth is by no means universal or even common among so called primitive cultures. Instead, a wide-range of different cultural beliefs and practices surround childbirth providing parallels with almost every approach, interventionist, non-interventionist, male or female centred to be found in the west (Cossett 1994:10).

Cossett sees these notions of the "other" woman, be she of a different race or simply a non-mother as important aspects of women's oral traditions and suggests that they fracture the essentialist base of both official discourses. Natural Childbirth sees every woman as a mother or potentially a mother while the medical discourse reduces the woman through the disciplines of gynecology and obstetrics to her bodily functions.

To believe in women's role as natural is to say that a woman has a specific female nature or essence. Theoretically defined, this concept is termed essentialism and is a belief in a true essence, that which is irreducible and unchanging (Fuss 1989:20). Diana Fuss (1989) describes the difficulties in negotiating around the theories of essentialism and its opponent, constructionism, when dealing with issues related to feminism. Essentialism has been used in feminist theory in a number of ways, including the claim of a female essence, of universal female oppression, and the autonomy of a female voice (1989:20). Essentialism universalizes all women and in turn ignores the fact that all cultures have a variety of myths, models, roles and symbols of women and that it is necessary to recognize the plurality of women's voices, experiences and perspectives.

As with Cossett, a dilemma arises for Fuss (1989) in her need to give voice or voices to marginalized women. Fuss states that although

this process of using identity or essence has limitations, essentialism must be acknowledged as a method for resistance as the "risking" of essence has long been used by people who base their social rights on group identity (1989:106). We must also recognize that some contemporary theories of identity negate cultural beliefs in which women's role is directly tied to their connection to nature and where this connection is not oppressive. Power and privilege come into play here: it depends upon who is using essentialism or constructionism, how they are deployed and where their effects are concentrated (Fuss 1989:106).

Burtch (1994a) sees criticisms of the medical model as ranging from the feminist standpoint of male dominance over women's bodies to criticism from within the medical institution itself over high intervention rates (1994a:05). Burtch states that the Western medical model, although reducing infant and maternal mortality rates, can do so without compromising the needs of women during pregnancy. He continues his discussion of the medical system's dominance noting it as a particular effect of "Statism" (1994a:14) where there is a growing trend for government involvement in social activities such as reproduction and reproductive technologies. He finds the medical model instrumentalist, in its exclusion of non-professionals and elitist, in its serving of only the dominant class. Although discourses such as neo-marxism and post-modernism are critical of the patriarchal ideology of the medical institution Burtch argues that a culturally based critique is also needed:

Another point is the great variation in birthing practices across cultures (and within) as set against the often monistic premises of obstetrical training including the restriction of delivery positions, length of the second stage of labour, and increases in the rate of interventions such as caesareans (1994a:30).

To recap, the history of midwifery from the Western perspective results in the rise of two official discourses or narratives, a medical and a natural or feminist. Each is formulated however, from a series of culturally constructed and historical events. Both are deficient in their exclusion of cross-cultural social realities and histories of childbirth. Recognition of alternative Western and cross-cultural oral discourses and traditional knowledge, including the voices of First Nations, is necessary to expand and include other perceptions of parturition.

1.3 SILENCED VOICES: ABORIGINAL MIDWIFERY AND TRADITIONAL BIRTHING PRACTICES

Every culture around the world has a system of management surrounding childbirth. These systems include belief structures, traditional practices during preconception, pregnancy, labour, delivery as well as in the post natal period. As previously outlined, both Cossett (1994) and Burtch (1994a&b) have acknowledged this lack of cross-cultural perspective, and, in Benoit and Carroll (1995) the silenced voices in the discussion of midwifery are recognized as those of the First Nations people. They argue:

that a deeper understanding of the interplay between medical science and gender entails the unraveling of a third history of midwifery, one that places the singular concerns of traditional Aboriginal midwives, their birthing families and their relationship to their geo-cultural community central to the chronicle (1995:226).

Benoit and Carroll situate Aboriginal midwifery within the context of the larger literature on midwifery, presented here, and incorporate data gathered from two focus groups held in British Columbia and sponsored by The Aboriginal Health Policy Branch of the Ministry of Health. This recent work with Aboriginal people suggests that a third history of midwifery is evident in Canada (1995:230). They emphasize the

need to recognize the variety of culturally rich and politically diverse First Nations both historically and in contemporary times, and that when one is exploring First Nations health it is essential to examine a multitude of factors, including political, economic, social and cultural changes through time. This narrative then, must begin with an exploration of the effects of colonization on the health and well-being of the First Nations peoples, expand to include a discussion on the changing roles of First Nations women and review briefly some of the current historical knowledge surrounding Aboriginal midwifery and traditional birthing practices in Canada.

1.4 COLONIZATION AND FIRST NATIONS HEALTH AND WELL BEING

Upon contact, a massive decline in the First Nations population occurred with the introduction of foreign disease, resulting in epidemics of small pox, measles, influenza and tuberculosis (Benoit and Carroll 1995, Graham-Cummings 1967). Hundreds of thousands sickened and died as a result of their encounters with Europeans. "Famine and warfare contributed but infectious diseases were the great killer. Influenza, measles, polio, diphtheria, small-pox and other diseases were transported from the slums of Europe to the unprotected villages of the Americas" (Royal Commission on Aboriginal Peoples (RCAP) 1996:112). The subsequent decline in the indigenous population is often described as a holocaust (RCAP 1996:112). However, the major factor in the decline of the health and well-being for the First Nations was the nature of the colonial relationship, its primary goal being the elimination of First Nations culture, physically and ideologically (Benoit and Carroll 1995, Young 1984).

With the implementation of the residential school system, young people were physically and ideologically separated from their communities and traditions when they were forced to leave their homes to

attend the schools. Abuse was rampant in these schools and pregnancy was not unheard of as young women who had been raped were often forced to abort their pregnancies either against their will or through continued physical abuse (Benoit and Carroll 1995:239, see also Miller 1996). A whole generation left the residential school system with no connection to their traditional ways and a negative view of themselves, their culture, their bodies and the reproductive process. The multigenerational effects of the residential school system have been deemed a syndrome (Medical Services Branch 1991:16, Furniss 1994:126).

The paternal attitudes of the Indian Act and the reserve system resulted in a widespread loss of culture, language, traditional roles and family units due to a variety of imposed changes such as the growing dependence on western food staples such as flour, sugar, lard and tea. The introduction of alcohol, first as a trade item, had a deep and difficult impact on First Nations communities, greatly accelerating this process. A newly formed dependence on the Western health care system arose as traditional healing methods were lost or forced underground (Benoit and Carroll 1995:237, Royal Commission on Aboriginal Peoples (RCAP) 1993:73, Graham-Cummings 1967:121).

The inability to deal with the European diseases and famine began a period of adoption of Western health and healing methods. With the colonization of the First Nations peoples and the subsequent attempt to eradicate their culture, traditional knowledge was often set aside as First Nations peoples were sometimes imprisoned for practicing traditional ways of being. Traditional healing and spiritual beliefs were condemned by the colonizers as witchcraft. Therefore, the church and state could offer relief through Western religion and medicine from the massive numbers of deaths. Although death was a natural aspect of life and both women and children were known to have died in childbirth prior to contact, Benoit and Carroll (1995) contend that recent evidence

suggests that rates of mortality and morbidity for mothers and infants in early Aboriginal societies were lower than after colonial impact (1995:235). They suggest that soaring infant mortality rates post-contact and the newly created dependance on the Western health care system gave rise to the move to hospital births as Aboriginal midwifery and Traditional birthing knowledge was lost or went underground. As with the movement from women centred births in Europe, the redefining of birth as a pathology backed by legislation made the move to obstetrician centred births in Canada both a forced physical change and an ideological one (Burtch 1994b:151).

1.5 ABORIGINAL WOMEN'S TRADITIONAL ROLES/ABORIGINAL HEALTH PRINCIPLES

Since contact, colonization has taken a great toll on Aboriginal peoples but perhaps its greatest toll may have been on Aboriginal women as their traditional roles were all but erased by the new foreign government:

One can trace the diminishing status of Native women along with the continuing process of colonization (RCAP 1993:73).

Prior to contact, Aboriginal women were respected and equal members of their Nations. Women were seen as the centre of life and being able to bring forth life was considered sacred (Malloch 1989:106). Paula Gunn-Allen (1984) states that most American Indian tribes believed the primary potential of the universe was essentially female and that this is still true today:

Pre-conquest American Indian women valued their role as vitalizers. Through their own bodies they could bring vital beings into the world - a miraculous power whose potency does not diminish with industrial sophistication or time (1984:27).

Bearing children was a transformative act, and contrary to the biological base of the medical model, the power of thought and mind were what gave rise to biological change just as it gives rise to social change (Gunn-Allen 1984:28). Gunn-Allen continues by describing woman's power as not so much in her ability to birth but in her power to make, to create and to transform. She sees the physical and cultural genocide of the First Nations peoples as being mostly about the colonizer's fear of the gynocentric societies of the New World.

Malloch (1989) in her article "Indian Medicine, Indian Health: A Study between Red and White Medicine", concurs with Gunn-Allen in that birth is a sacred event which can strengthen a family and a nation. It is a natural process, one that must be protected rather than interfered with, and it is women who are the centre of this process (1989:108). She continues by discussing the difference between the value systems of the Western medical model and Traditional First Nations healing. The principals she outlines include that good health is a gift from the creator and therefore a personal responsibility. When one neglects oneself it is disrespectful to the creator. First Nations traditional health and medicine, according to Malloch, is active and oral, and related to a whole way of life. It is also based on the principal of balance in the four areas of self: the physical, mental, emotional and spiritual. Unbalance in any one area can cause illness as the other areas are thrown off kilter (1989:106). With a focus on prevention, First Nations values of healing do not simply stop at the individual but come from past generations, to the family, community or nation and into future generations (1989:106). The promotion of this medicine wheel ideology is in part a response to the put downs of traditional healing as witchcraft historically. This positive re-interpretation of a First

Nations healing model has been adopted by many different Nations across the country.

1.6 GIVEN VOICE: ABORIGINAL MIDWIFERY AND BIRTHING PRACTICES

Malloch follows up this broad discussion of First Nations health with a more detailed discussion of First Nations traditional midwifery as an example of this philosophy of health. It must be reiterated here however, that along with these generalist principals of health and healing, the diversity and variety of First Nations beliefs surrounding health and healing are vast, with each nation and community having differing practices.

Midwives, states Malloch, are herbalist, gynecologist, obstetrician and nutritionist all rolled into one. Usually mothers themselves, Aboriginal midwives help women throughout their entire pregnancy, and at the time of their delivery "she helps them to discover and take responsibility for their female power" (1989:108). This is echoed in Terry and Calm-Wind's (1989) article "Do-Dis-Seem", an article outlining the traditional role of midwives of the Nishnawbe First Nations in Ontario.

Pre-contact Aboriginal groups in B.C. also saw birth as a natural and sacred event, part of the cycle of life and with this holistic version of the world, the midwife was an integral part of the continuation of the cycle (Benoit and Carroll 1995:234). This holistic approach required continuous care, prenatally, through labour, delivery and beyond the post-partum period extending into the child's later life. Similar to Malloch's (1989) and Terry and Calm Wind's (1989) descriptions, Benoit and Carroll (1995) discovered that a midwife had many functions and apprenticed with older more experienced women. However, it was the community who determined the level of skill and technical knowledge needed. Midwifery was a well-respected calling, and

a midwife had to be a long standing member of the society as well as have a deeper understanding of the nature of illness and other human misfortunes (Benoit and Carroll 1995:234). Young pregnant women were counselled early in life about proper and improper behaviour and later complications were often related to the failure of the mother, father or even community, to follow these do's and don'ts. An enormous energy surrounded the birthing mother and child and it was the responsibility of the midwife to pay attention to this. Delivery often occurred in kneeling or squatting positions, herbal remedies were used and abdominal massage was a common method for repositioning breech babies. The afterbirth also held cultural significance for many First Nations, with a variety of ceremonies performed (Benoit and Carroll 1995:235).

Along with the traditional responsibilities of the Aboriginal midwife, the First Nations peoples had individual systems of birthing practices and beliefs from pre-conception to child rearing. The Native Infant Education class at Malaspina College in Duncan B.C., along with Medical Services Branch, have produced a book which is a gathering together of traditional knowledge regarding childbirth reflective of the Salishian and Nuuchah-nulth Nations of Vancouver Island (see also Rattray 1997, for Traditional birthing practices for the First Nations of the Northwest of British Columbia). Teachings of The Elders (1984) uses images and traditional teachings to outline the oral information passed down generation to generation from the Elders. It begins by describing how women and their families must be prepared to have a child and continues by outlining both dietary and behavioural restrictions for pregnant women and their partners. Birth as a holistic event is echoed in these stories and the teachings continue into the post-partum period, early childhood and even into adulthood.

As an intimate part of life, birth and birthing stories are endlessly touched upon in almost any Aboriginal life history. Stoney

Creek Woman (Moran 1988), the life story of Sai'Kuz Elder Mary John, Life Lived Like a Story, (Cruikshank 1990), containing the life histories of Angela Sidney, Kitty Smith and Annie Ned, as well as Voisey, Okalik, Brown and Napayok's (1990) article "Cultural Perspectives on Pregnancy and Childbirth" are three Northern examples. In each story the women share their personal birth experiences as well as the births they attended as women's helpers. Traditional birthing practices are discussed in the context of the changing medical discourse on birth, its redefining as a medical event and the larger picture of colonization, the North and First Nations peoples.

Mary John's own mother acted as a midwife and after her death, Mary's aunties and other relatives attended her births:

There was an elderly midwife who put her hands across my back and stroked me. I can still remember how that stroking made the pain less. The labour pains did not stop but they were greatly eased (Mary John in Moran 1988:73).

Kitty Smith, a Tlingit Elder from the Yukon Territory, described one of her births as follows:

They put two sticks [upright and parallel] in the ground. I hold them. Then somebody holds my back; somebody holds my knees [in an upright position]. I had none of my babies at that doctor place (1990:246).

Okalik states in the old days women were not scared of birth because it was seen as a natural event and there were traditional systems to deal with the birth:

We Inuit look at pregnancy as natural as breathing. We don't look at it as a sickness because it is not a sickness, it is a way of life (Voisey et al 1990:39).

Napayok claims that careful monitoring by the Elders was essential and that women were assisted by women who had helped during many labours but at the same time were apprenticing with an older midwife (Voisey et al 1990:40). Positions and practices varied with each cultural group across the Northwest Territories but she agrees with Okalik that women were not afraid of the birthing process. Women were taught what it was going to be like when they were in labour and what kind of pain to expect. Marium Brown, a midwife herself, discusses how:

In the traditional way, the knowledge was passed down from generation to generation or it was passed down from one particular woman to another (Voisey et al 1990:39).

The Inuit settled in Pangniting in 1962 and even with the establishment of a hospital, Inuit midwives continued to practice and mothers were given a choice for delivery. Starting in the 1970's women began to be flown to the south while the mandatory evacuation policy of the 1980's forced all women to leave their communities to birth (Voisey et al 1990:38). Marium's last delivery as a midwife was in 1965 and she feels that the legislated takeover by hospitals slowly eroded the numbers of Inuit midwives practicing in the North.

All the Elders feel that it would be better for the mother, infant and family if women were able to birth in their communities:

We always wanted women in our communities to have their babies in the community as long as the medical people know that it will not endanger the mother (Voisey 1990:38).

Slowly, information on traditional practices through contemporary studies or the life histories of Elders is resurfacing. Traditional Aboriginal knowledge of birthing, birthing systems and midwifery is becoming an accepted part of the discourse surrounding the empowerment of birthing women and their communities.

1.7 CONCLUSION

Given the tremendous diversity of traditional practices, ceremonies and tribal beliefs associated with childbirth as well as the differential roles of Aboriginal women in traditional societies there is difficulty in arriving at a definition of midwifery that encompasses all Aboriginal peoples (Benoit and Carroll 1995:231). However, reproductive wisdom was common knowledge throughout all communities and was passed on generation to generation orally, contrary to both the medical narrative and the feminist narrative. The literature reviewed here shows us that the current medical birthing model comes from a history of both professional and masculine dominance over woman's traditional role of midwife and caretaker of the birth scene. The subsequent rise of the Natural Childbirth Movement in opposition to this, although giving more freedom and flexibility to women, did not fully challenge the ideology of the medical birth. It simply better prepared women for the hospital experience. Both narratives however exclude culture in their discussion of birth and birthing practices.

First Nations women are recovering from a time when their traditional knowledge was repudiated by the colonial powers and they are revitalizing their cultural roles by learning, and sometimes relearning, traditional beliefs. The courage to revitalize traditional birthing practices and midwifery is similar to the feminist movement against the patriarchal medical model yet the two movements are not the same. First Nations women's loyalties are oriented towards First Nations issues and communities, rather than to the feminist birthing movement which revolves around Natural Childbirth and the reimplementation of midwifery into the professional scene. The present situation allows physicians to claim a monopoly over obstetrical knowledge and for feminists to claim control over women's knowledge (Benoit and Carroll 1995:23). An understanding of the diversity of cultural systems and beliefs of the

First Nations peoples is essential to the discourse surrounding birth if true empowerment of women in reproduction is going to succeed.

CHAPTER TWO: MOVING TOWARDS THE CONTEMPORARY

It has only been in the recent past that health care providers have acknowledged that health is not simply being free from disease but that a person's or community's environment: socially, mentally, physically, culturally and economically can have an impact on the health status of the individual (Young 1994:230). Recognition of the *context of health*, largely measured by health status indicators and social determinants of health, such as socio-economic status, is key to the understanding of current Aboriginal health needs and only by addressing the base issues, such as the repercussions of colonization, is change possible.

The history of colonization and changing health status for First Nations discussed in the previous chapter is directly linked to the contemporary health situation for Aboriginal peoples in Canada today. Loss of culture, abuse at residential school as well as governmental policy aimed at assimilation, have left many First Nations with a sense of low self esteem and cultural worth. In turn, the social determinants of health, grounded in socio-economic status, are the root causes for the low life expectancy and high infant mortality for First Nations in Canada.

First Nations peoples in the North face unique challenges with regards to health care both historically and in contemporary times. Along with mandatory evacuations and limited access to appropriate services, it is important to examine health status indicators such as Infant Mortality, Low Birth Weight and Teen Pregnancy Rates, to come to an understanding of how British Columbia and the Northwest Health Region fit into this larger picture of the health of First Nations peoples and contemporary birthing.

2.1 ABORIGINAL HEALTH TODAY

It can be said that most Canadians enjoy relatively healthy lives and that Canada is widely thought to be one of the best countries in which to live. In 1994, Canada placed first when the United Nations Development Program measured the quality of life around the world:

Most Canadians enjoy adequate food and shelter, clean water, public safety, access to responsive medical and social services and the good health that results from these things (RCAP 1996:107).

However, with regards to the First Nations population in Canada, there are some very significant health status inequities in comparison to the general population and these are part of the historical legacy of the colonial relationship (RCAP 1996:96). Some of these inequalities include substandard housing and sanitation, unemployment and poverty, discrimination, racism, violence, inappropriate or absent services and the subsequent high rates of physical, social and emotional illness, injury, disability and premature death (RCAP 1996:107). These inequities are reflected in various health status indicators. Life expectancy at birth is 7-8 years less for Status First Nations and the Infant Mortality Rate (IMR) is twice as high as the national average. Infectious diseases of all kinds are more common in Aboriginal peoples and the overall rates of injury, violence and self-destructive behaviour are disturbingly high. As a result, the mortality rates in all age groups are higher than average for Aboriginal peoples. Low education levels, high unemployment, welfare dependency, conflict with the law and incarceration all contribute to a poor context of social health for Aboriginal peoples (RCAP 1996:108).

These statistics are only symptoms of a larger problem which has its roots in the past; a history of genocide and oppression:

Healing in Aboriginal terms, refers to personal and societal recovery from the lasting effects of oppression and systematic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their culture, languages, identities and self-respect (RCAP 1996:109).

The Royal Commission on Aboriginal Peoples (RCAP) Final Report

(1996) concluded that extensive involvement of Aboriginal people in their own health care is the only way to lessen the gap between the Aboriginal and Non-Aboriginal populations with regard to health and well-being. The Commission's recommended action included that Aboriginal communities be given control over the resources they need to improve the conditions that affect their health status through self-government and the settlement of land claims (1996:96). This can only be achieved when both Aboriginal and Non-Aboriginal people come together to address these root causes of the First Nations populations poor health status.

2.2 INFANT AND MATERNAL HEALTH INDICATORS

As with other health concerns for First Nations peoples, poor neonatal and infant health is largely the result of the social determinants of health and to a lesser extent, the health care options for pregnant women and new mothers. The Infant Mortality Rate (IMR) among Aboriginal People in Canada has declined steeply from as high as 200/1000 in the 1920's and 30's to approximately 14/1000 among Status First Nations and to about 20 for Inuit peoples in the 1990's (The Ministry of Health 1998:108) (Figure #2). Yet, a significant difference in the rates for Aboriginal and Non-Aboriginal people remains:

The IMR for Canadians generally is about 7/1000 live births. Thus the ratio of Aboriginal to Non-Aboriginal infant deaths is about the same today as it has been for the past 100 years - about twice as high for Indian people and three times as high for Inuit in the Northwest Territories (RCAP 1996:127).

2.2.1 Northwestern British Columbia

The Northwest of British Columbia is a unique region as the determinants of health are effected by geographical isolation, severe weather conditions and a resource dependant economy (Dze L K'ant Friendship Centre 1997:01). The Northwest Region stretches from the Yukon Border in the North, encompasses the Queen Charlotte Islands (Haida Gwaii), to the west, Hartley Bay in the south and is bounded in the east by the town of Houston (Figure #3). The local health areas include Smithers (#54), Terrace (#88), Nisga'a (#92), Prince Rupert (#52), the Queen Charlottes (#50), Kitimat (#80), Telegraph Creek (#94) and the Stikine (#87) (Figure #4).

The three major hospitals in the Northwest; Bulkley Valley Regional Hospital in Smithers, The Prince Rupert Regional Hospital in Prince Rupert and Mills Memorial Hospital in Terrace are all located in the south of the region. Other hospitals frequented for delivery include Fort St. John General Hospital in Ft. St. John, Wrinch Memorial Hospital in Hazelton and the Whitehorse General Hospital in Whitehorse, Yukon Territory (Capyk 1997 MS:190). However, all hospitals are difficult to access from some of the more Northern communities. Roads can be impassable and dangerous in the winter and sometimes even flying is impossible.

There are many barriers for health care delivery in the Northwest but there are specific obstacles for pregnant women and new mothers many of whom lack adequate and appropriate perinatal services. In the communities without hospital services women must leave 3-4 weeks ahead of their due date to deliver in the larger centres of Terrace, Prince Rupert or Smithers. Finding a new doctor, lodging, child care, financial support and transportation are customary difficulties faced by women in the North. Additionally, mental health issues such as separation from

loved ones, loneliness and stress negatively effect these women's birthing experiences.

B.C.'s Northwest has the highest percentage of First Nations people (24%) compared to any other area of the province (B.C. Ministry of Health and Ministry Responsible for Seniors 1997). As was outlined earlier in the chapter, Aboriginal populations must add issues such as racism and a legacy of colonization to an already imperfect health care system.

The context of health can be gleaned by reviewing a population's health status indicators and in the case of perinatal health needs, indicators such as Infant Mortality Rates, Low Birth Weight Rates and Teenage Pregnancy Rates are indicative of a region's health status.

2.2.1a Infant Mortality Rate

The Infant Mortality Rate of a given population can be described as the total number of infant deaths up to and including the first year of life (excluding stillborns). IMR's are measured over a specific time period and are usually outlined as a number out of one thousand live births. Infant Mortality Rates are important health status indicators because they give insight into some of the environmental and socio-economic factors effecting the health of a population (B.C. Ministry of Health 1996b):

There is no starker measure of a society's commitment to its children than the infant mortality rate." Canadian Council on Social Development (National Council of Welfare 1997:05).

Infant Mortality Rates are inclusive of the first year of life and the social determinants of health, such as an individual's or community's socio-economic status, greatly effect these rates (Young 1994). Northwestern B.C.'s IMR is noticeably higher than B.C. on average (B.C. Ministry of Health 1996b):

Total Population IMR

- NWBC: 7.8/1000 in 1995
- BC: 5.9/1000 in 1995
- Status First Nations in BC: 13.9/1000 in 1992 (Health Canada 1995:110).

As previously mentioned, IMR's for Native people have declined since the 1950's however they are still well above the national average. Status Indians in B.C. have an IMR twice that of the general population (Figure #5). Considering that NWBC has a higher percentage of First Nations peoples and a high IMR in the general and status First Nations populations, perinatal health is of grave concern for Northern British Columbia's Aboriginal population (B.C. Ministry of Health 1997). Both Young (1994) and the Canadian Council of Welfare (1997) stress that IMR's, since they include the first year of life, are indicative of a population's health status in general. Simply creating better access to services has not and will not suffice for Aboriginal communities. To change high IMRs two things need to occur. Firstly, the social determinants of health and socio-economic status of First Nations, the resulting legacy of colonization, need to be addressed. Secondly, working in conjunction with the processes of decolonization in Aboriginal communities, adequate and culturally relevant pre-natal and post-natal care for pregnant women, their babies and their families must be implemented.

2.2.1b Low Birth Weight

Low Birth Weight (LBW) has become one of the leading causes of concern affecting a child's ability to thrive and develop properly:

Low birth weight refers to babies who weigh less than 2500 grams or 5.5 pounds at birth. Approximately 75 percent of infant deaths can be explained by low birth weight. Low birth weight is also a leading underlying cause of illness in infancy and childhood (National Council of Welfare 1997:03).

LBW is the result of an array of demographic factors, medical conditions and behavioural problems all of which interact with each other often augmenting the situation. Medical complications related to LBW can include premature labour, febrile illness, high blood pressure induced by pregnancy and infection while demographic factors include the mother's socio-economic status, her level of education, the age at which she conceived, her marital status and race. In addition to these variables; smoking, stress, nutrition, alcohol use, access to prenatal care and lack of social support can further compound the outcome. Low Birth Weight has been linked to poor family support throughout pregnancy and more detrimental health issues like spousal assault and family violence (National Council of Welfare 1997:06).

Any babies born weighing less than 2500 grams are included as low birth weight babies and are usually expressed as a rate per 1000 live births. Such babies have an increased chance of morbidity and premature mortality. Although Northwestern B.C. is about average with the province as a whole, one must consider the high proportion of First Nations in the population (B.C. Ministry of Health 1996b):

Total Population LBW

- NWBC: 45.32/1000 in 1995
- BC: 45.3/1000 in 1995
- Status First Nations in BC: 58.5/1000 in 1992 (Health Canada 1995: 109).

The higher low birth weight rates for First Nations are indicative of many of the demographic and medical factors outlined previously including high levels of cigarette smoking and inadequate nutrition of mothers while pregnant. In NWBC there is a growing need for programs oriented towards First Nations mothers emphasizing healthy lifestyles during pregnancy (Health Canada 1995:107).

2.2.1c Teen Pregnancy

Pregnant teens are at risk of having Low Birth Weight babies for psychosocial and economic reasons such as single parenthood, poverty and poor education and less for biological reasons (National Council of Welfare 1997:06). Since the majority of teenage pregnancies are unintended (95%) and teen pregnancies are more likely to have poorer birth outcomes, the rate of teenage pregnancies in a particular community must be included when assessing maternal health needs (B.C. Ministry of Health 1996b).

With regards to Teen Pregnancy, the Northwest is significantly above average compared to the rest of the province and the rate is even higher among Status First Nations in B.C. (B.C. Ministry of Health 1996b):

Total Population TPR

- NWBC: 78/1000 in 1995
- BC: 49/1000 in 1995
- Status First Nations of BC: 200.2/1000 in 1992 (Health Canada 1995:109).

It is important to note that the Canadian fertility rate for Aboriginal youth ages 15-19 is four times that of the Non-Aboriginal population. Native women tend to have children earlier in life, reflecting Traditional patterns of child rearing (Health Canada 1995:107). Since the First Nations populations have generally poorer health, as outlined previously, it is essential that areas of high First Nations populations with above average teen pregnancy rates have adequate and appropriate community and culturally based prenatal and early infancy programs (B.C. Ministry of Health 1996b:134).

2.3 CONTEMPORARY BIRTHING ISSUES

Several contemporary birthing issues emerge from the discussion of Aboriginal health and well-being. These include the factors related to infant and maternal health and whether contemporary communities can improve their infant and maternal health care status through retraditionalization. Further, a review of the history of birthing and midwifery practices in the North reveals that the practice of mandatory evacuation is being reworked in an attempt by some Aboriginal Nations, such as the Inuit, to return birthing to the North.

Factors influencing Aboriginal infant and maternal health include the change in childbirth practices as traditional methods were denounced and Western medical ones adopted. Childbirth practices and policies have been the subject of extensive debate in recent years and they are seen as an important issue by Aboriginal people. By incorporating Aboriginal traditions and perspectives into perinatal health care strategies as well as addressing the base causes of poor health, such as the social conditions brought on by the history of oppression, change can occur. Many Aboriginal people argue that normal birth, where health and safety are not threatened, should once again become a non-medical, family and community event (RCAP 1996:128).

2.3.1 Birthing in the North

As was outlined in Chapter One, the two "official discourses" on birthing, the medical and the natural, have ignored the voices of First Nations peoples in the current discussion of birthing. Moreover, these "official discourses" have not only silenced the voices of Aboriginal midwifery in Canada, they also silence the North, forgetting historically and contemporarily, the people who reside here. Environmentally, culturally and ideologically, the North is unique in

its needs and development of health care and birthing systems. The reclaiming and return to traditional birthing systems, including Aboriginal midwifery and traditional beliefs has taken shape for the Inuit of the Northwest Territories. Traditionally, childbirth beliefs were constructed parallel to general understandings of illness and misfortune and pregnancy involved dietary restrictions as well as social contact restriction. A natural and communal experience, childbirth was a vital part of Inuit culture and the practices surrounding the birthing scene varied within each of the different groups of Inuit people spread across the Canadian North (O'Neil 1990b:57).

From the onset of pregnancy the young women were counselled, instructed and encouraged to attend births as a way of understanding the birthing process. Traditionally women were surrounded and supported during pregnancy and birth by their extended family and older women (Paulette 1990:45). A healthy vigorous lifestyle, a good diet as well as the squatting or kneeling positions for delivery led to few complications for women. Women recovered more quickly with the aid of supportive relatives and breastfeeding was conducted for up to three years as a healthy way to nourish the baby and as a natural child spacing method (1990:45). The role of the midwife was an honourable one and it had a spiritual dimension. The Elders regretted the intrusion of the Western medical system as it eroded strong family bonds (Paulette 1990:46).

The medicalization of childbirth in the North was a complex and dynamic issue, involving the extension of power of the south over the north, of men over women, and of the dominant society over First Nations groups (O'Neil 1990b:55). Formal Western medicine did not venture into the far North in some places until the 1950's. According to O'Neil (1990b), the first step in the medicalization of childbirth lay in the transfer of births out of the local settings and into the nursing

stations. Medical training and professional ideology were brought directly from the government and medical institutions into the communities (1990b:59). Starting in the 1960's and up until the late 1970's most Northern nursing stations were staffed by foreign trained nurse-midwives. These nurse-midwives held a pivotal role in the Canadian history of both the North and midwifery:

One could say that the irony of the history of midwifery in the North is that the new demands for midwifery services in the south emerged as this enclave of practicing midwives started to disappear from the North (1990b:63).

This decline in births in nursing stations was largely due to the federal government's official policy of the 1980's of evacuating all pregnant women in the North to Southern centres to deliver (O'Neil 1990b:61, see also Stonier 1990). This shift took place for several reasons. According to medical authorities the move to hospital births was part of an improved system of evacuation and assessment. Following the premise of the superiority of the medical model, hospital births were considered safer and equal access to the advantages of Western technology was seen as beneficial for Inuit people. Due to the influence of the medical model, traditional midwifery had few supporters except among the women and their communities (O'Neil 1990b:61). Simple access to services, although initially improving IMRs, can no longer be seen as a solution to the poor health status of Inuit communities; IMRs today remain three times the national average (RCAP 1996:127).

Seen in its historical context the demise of the Northern midwife, both the nurse midwife and the Inuit midwife, was part of a much older competition for control over childbirth between the medical profession, women and midwives similar to events in Europe and other areas of Canada (O'Neil 1990b:66).

For the Inuit communities, the continuing colonization of their culture, in this instance through childbirth control, resulted in loss of knowledge, skills and identity (O'Neil 1990b:65). The traditional teachings of the Elders were devalued and women were left with a lack of knowledge about their bodies, female health and the traditional birthing process. Women were caught between two worlds, a traditional one which was broken down by years of colonization and a medical one which forced women to leave their communities to deliver. The change from the traditional midwife attended birth had several negative effects on Northern communities including the separation of families, specifically the partners (a link has been made between this separation, and family violence), language and cultural barriers for mothers in the strange Southern hospitals as well as the lack of post natal support in the communities (O'Neil 1990b:46, see also Gallagher 1997 and Stonier 1990).

The Royal Commission on Aboriginal People's hearings in the Provincial and Territorial North found that Medical Services Branch's mandatory evacuation of all pregnant women was of special concern for First Nations Peoples. Similar to Paulette's (1990) findings, the Commission heard testimony on how these evacuations have meant an end to family-centred births, community based care and the possibility of culture-based birthing choices (RCAP 1996:134). The movement of the birthing scene out of the hands of the midwives has interfered with indigenous birthing knowledge, local midwifery skills and traditional family centred ceremonies.

The idea that midwives can provide safe, supportive and cost-effective care for pregnant women in low risk childbirth situations has become more widely accepted in Canada in the last 10-15 years with the legalization of midwifery in Ontario, Alberta and most recently British Columbia (RCAP 1996:134). However, barriers to this movement for Aboriginal communities have included ignorance of traditional ways by

the Western medical system and a history of paternal attitudes towards health care for First Nations peoples. Pressure for community-based culturally-sensitive birthing services in the North reflects the need to address the problems that have accumulated over the past 500 years as a result of imposing Western principals of healing and government protocols on Aboriginal communities. As Martha Greig of Pauktuutit states:

We seek alternatives which benefit the entire family and which do not expose women and newborn infants to unnecessary risk; alternatives which allow us to feel pride and respect in ourselves and our culture. Unfortunately, the debate we often find ourselves engaged in is premised on a disrespect for our history and for the knowledge and skills which many of our Elders still possess. Recognition of our traditional skills, knowledge, values and approaches to life is necessary, not just around the issue of childbirth but in all spheres (RCAP 1996:136).

2.4 CONCLUSION

The poor health status of the Aboriginal populations of Canada is a direct repercussion of the effects of colonization. The social conditions that contribute to a poor health status: unemployment, low education levels, poverty, inadequate diet and housing are more prevalent for First Nations communities due to their long history of oppression and colonization by the Federal Canadian Government. First Nations Peoples must add issues of racism, lack of culturally specific services and jurisdictional issues to the already long list of difficulties in receiving appropriate health care service in the North (Dze L K'ant Friendship Centre Houston 1997:01). The problems run deep and health status indicators, such as low life expectancy, high infant mortality, high accident, injury and mortality rates are compounded by the social ills facing First Nations. It is these social determinants of health which need to be recognized as the primary causes of the higher

than average infant mortality, low birth weights and high teen pregnancy rates for First Nations peoples.

The North is infamous for its needs in the area of birthing change. A review of the situation for Inuit communities gives insight into challenges faced by other Northern regions, such as B.C.'s Northwest. The Provincial Health Officer's Report for 1996 identified Aboriginal populations and Northern Regions of the province as suffering higher rates of Infant Mortality, Low Birth Weight and Teen Pregnancy. For all regions and populations of B.C. to achieve the health status of the healthiest region, programs need to be designed which address the social determinants of these health inequalities (BC Ministry of Health 1997). The move to revitalize traditional beliefs in all aspects of life for Aboriginal peoples is one way of working towards improved health and well-being. In the area of birthing, the collection and use of traditional birthing and midwifery knowledge is a growing field of interest as Elders, once again, are looked to as the holders of sacred and empowering information.

CHAPTER THREE: THE RESEARCH METHODOLOGY

3.1 RESEARCH, KNOWLEDGE AND POWER

It must always be remembered that research tools have been developed by people who see the world in a particular way. Everytime a research tool is used, the researcher must be aware of the bias of its creators (Kirby and McKenna 1989:44)

When deciding upon a research process for this thesis, it became apparent that I needed to examine the issues surrounding standard research processes, my concerns with research conducted from within an academic institution as well as my own personal interests in the research topic. I needed to account for why I wanted to do research, how my experiences would shape my research methodologies and what the goals of the research project would be. One of my foremost concerns centred upon the connection between the community's needs and my interests, which lay in the areas of women's traditional roles, midwifery, the birth-cycle and traditional healing methods, more specifically, the relation between traditional women's roles and the current health care system.

To try and answer some of my questions regarding my role as a researcher I needed to explore the ethical and methodological considerations of doing research from within an academic institution. A deeper look into issues of knowledge production was paramount in order to gain a better perspective of how I could fulfill my obligations to the university without compromising the integrity of the community input. My research needed to be completed in such a way that the voices of First Nations women, aspects of their traditional roles as well as their experience as marginalized peoples were all accounted for.

Kirby and McKenna (1989) argue that knowledge is often used within the Western world to maintain oppressive relationships and the institutionalization of knowledge has led to a monopoly on the creation

of certain kinds of knowledge. On top of the institutions themselves, ethical guidelines, research areas, research methodologies and funding help to legitimate the monopoly and maintain certain social relations (Kirby and McKenna 1989:52). In previously written material, many interactions have not been investigated and many voices have been absent from the research process:

Demystifying the research process is the first step in decoding and demythologizing the way knowledge is created (Kirby and McKenna 1989:24).

It is impossible to discuss the research process without talking about power and influence. When one engages in research, one engages in the production of revealing possible knowledges. Due to the multifaceted nature of the world, the same situation or experience can be looked upon as giving many different kinds of knowledge (Kirby and McKenna 1989:25). People experience the world in different ways and this requires a recognition of that difference within the research process. Interpretation underlies this entire process, from the beginning to the end, and must be accounted for by the researcher (Kirby and McKenna 1989:26). Methodologies carry with them assumptions which shape the way information is gathered, analyzed and the knowledge created. When doing research from the margins, reestablishing the traditional relationship between the researcher and the subjects of research is essential to ensure that the voices of the marginalized are not misinterpreted or misused (Kirby and McKenna 1989:22).

The academic perspective is based on the principle of academic freedom, the search for knowledge and the entitlement to carry out this search without interference. However, to maintain the integrity of the University community there is the obligation to use such freedom in a responsible and ethical manner. All academic institutions have ethical guidelines intended for the research that is done out of their

particular institution. UNBC is no exception, it supports and encourages the highest ethical standards in research (The University of Northern British Columbia 1998:97).

There is however, a professional responsibility by the researcher to adhere to special ethical considerations when working with First Nations communities. Recognizing that Aboriginal people have distinct perspectives is essential, and any academic research within First Nations communities must be collaborative, reflecting the needs of the community and giving respect to the traditional knowledge and value systems of each Aboriginal community. Furthermore, the multiplicity of viewpoints within communities must be presented where possible and the final product of the research must be of benefit to the community involved (RCAP 1993:05). Native communities may be wary of research and researchers, which they consider paternalistic, colonial, and ignorant of the needs of the community (Young 1994:225).

3.1.1 INUIT CHILDBIRTH STUDY

To get a better understanding of the way in which community based research worked, it was important to examine a participatory research project which had been successful in identifying the needs of the community, collaborating with the community, represented a cross section of the community and benefited the community by transferring research skills to its members. *The Inuit Childbirth Study* undertaken by the Medical Faculty at the University of Manitoba is one such research project.

In 1989, the University of Manitoba established a collaborative and participatory research program within the Keewatin region of the Northwest Territories:

This group has established a research agenda which relies on the structured participation of [Native] and Inuit representatives in development, design, implementation and analysis of research projects dealing with community-

based health policy (O'Neil 1991:216).

The program was initiated in response to concerns from both the medical and Inuit communities about the obstetric policy which forced all babies from the Keewatin region to be born in Manitoba. Inuit women were concerned that they no longer had the option to give birth in their home communities. The health care providers were interested in addressing the morbidity rates among the children left at home when the mother was evacuated to Manitoba and if the emotional stress of evacuation was related to birth complications (O'Neil 1991:223).

The community involved outlined their main concerns into three broad areas of research; the experience of women in childbirth, the stress created on the family by the mother's absence and addressing the problem of regaining traditional knowledge for empowerment. Three data collection strategies were used. Inuit researchers administered questionnaires to pregnant women at several intervals in the birthing cycle and also to the families while the mothers were gone (O'Neil 1991:225). The research staff then reviewed the obstetric records in Winnipeg for the years 1980-88 and conducted open-ended interviews with doctors, nurses, Inuit Elders, Inuit midwives and others involved in the health care field (O'Neil 1991:225).

This large research project is an example of a community-based participatory research project which involved collaboration with the community on their health care needs, acknowledged a cross section of the community and transferred research skills to Inuit people. Its use of traditional knowledge and the recognition of the distinct perspectives of the Inuit allowed this project to re-evaluate the traditional scientific approach to health care to include social, cultural and environmental variables.

By examining this previous study, as well as addressing the ethical and methodological concerns which arise from research conducted

out of an academic institution with marginalized individuals, I decided that community-based participatory research was the best method for exploring my own research interests.

3.2 METHODOLOGY

3.2.1 Community Based Research

Community Based research considers the welfare and needs of the community through promoting social change, community development and being community initiated. When research is community initiated and reflects the needs of the community, the relationship between the researcher and the community changes. Openness and close co-operation allow for a positive relationship to develop and it is essential that the research benefit the community in some way (St. Denis 1992:57). Within the area of data gathering, emphasis must be given to traditional knowledge, language and value systems, by allowing the communities to be involved in the gathering and interpretation of the data. Too often research results have been used to meet the needs of the status-quo and focused on the negative aspects of Native life, without seeking to explain the causes (Macaulay 1994:1988). Use and ownership of the knowledge has become a key concern within First Nations communities and by having the communities review results prior to publication and involving communities in the interpretation of results, this concern can be eased.

Community-based participatory research is not a fool-proof methodology and there is no standard formula for performing this type of research. It can become another method of manipulation if not carefully undertaken:

It takes careful planning, genuine and personal commitment to involvement, community acceptance, appropriate research methods and a conducive cultural and political climate (St. Denis 1992:69).

However, if appropriate research methods are used, following the ethical and methodological considerations previously mentioned, community-based participatory research is an excellent way to undertake research. If commitment to collaboration and Aboriginal perspectives is shown by the researcher, the community is likely to benefit from this approach.

3.2.2 Research Objective

The purpose of this study was to get a broad idea for the Northwest region as to what knowledge is available about past First Nations birthing practices, why these changed and how they could be incorporated into current health programs surrounding birth.

As part of the community-based research process it was necessary to decipher the intent and purpose that would form the basis of the research. The following is what was adhered to as the main objectives:

- Record and preserve traditional knowledge from First Nations communities
- Identify alternative birthing options/practices for women in the Northwest
- Create a knowledge base for new and current health programs in the Northwest
- Secure First Nations voices in the discussion on birthing options in the Northwest

3.2.3 Design

My concern regarding the research process itself was oriented around both fulfilling my obligations to the University but also producing something of value to the community with which I was working. Inclusion of First Nations perspectives and participation through out the research process as well as addressing the specific needs of the communities were integral aspects of the research. The use of a community based research design allowed me to reinvent the relationship

between the researcher and the subjects of the research and account for the role of experience in the research, for both myself and the participants. The final research design followed this format:

- outlining the intent and purpose of the research
- literature review
- background study
- findings/ethnographic descriptions
- methodology and how results will be used
- describing the nature of the relationships in the research
- discussions

3.2.4 Community Involvement

It is essential to consider the welfare and needs of the community when undertaking research. The Dze L K'ant Friendship Centre had already identified infant and maternal health as a serious research concern for the Northwest. As an invited member of their larger study and by aligning myself with other key community organizations I was able to ensure that the research would be useful and necessary within the Northwest. The Dze L K'ant Friendship Centre's use of a community based research design in previous studies influenced the methodology of this thesis.

The Friendship Centre and its affiliated community groups and organizations became an important network for the development of the research. Many relationships had already been forged through my previous work, however, some developed as the research progressed. The Prince Rupert Native Women's Group, The Prince Rupert Friendship House Elder's Group, the Dease Lake, Prince Rupert and Smithers Pregnancy Outreach Programs were some of the extended organizations I approached for assistance and guidance throughout the research.

To include the community throughout the entire research process I had the interview questions reviewed by members of the community who had lived and worked in the Northwest for many years. Further, community

members were solicited for their advice on who to interview and even participated in the interview process. I traveled to the communities myself, stayed with members of the communities when possible and had community members attend interviews with me.

Community based research emphasizes traditional knowledge and community interpretation of that knowledge. In an attempt to achieve this, I gave interviewees the questions ahead of time, allowed them to steer the interview and ensured them access to their tapes, transcripts, and the final report. They were informed that their knowledge and the data would not be used in any subsequent studies without their permission. Recognizing their right to and ownership of the knowledge presented, the Elders were given the opportunity to edit and review transcripts and were presented with regular updates on the thesis progress.

3.2.5 Methods of Data Collection: Indepth Interviews and Focus Groups

Data was collected using indepth interviews and one focus group discussion. The process for the selection of interview participants was done in co-operation with Louise Kilby, Director of Development at The Dze L K'ant Friendship Centre and key community representatives from the Northwest. The interview participants were Elders who had experience either with delivery or birthing at home and who were known to be the holders of traditional information within their respective First Nations communities. These women were suggested to me by members of the aforementioned community organizations which supported and encouraged the research. Since many of these organizations are oriented around pregnancy health in First Nations communities, they were familiar with the Elders in each community who would be able to share traditional information with me. Several other participants were previously known to me through their work at UNBC as speakers on traditional healing and

women's roles. Having attended their lectures and visited their homes, a relationship had been formed and they were happy to participate in the research.

It was established early on in the research process that longer, more personal interviews would enable me to gather the most detailed and useful information. The interviews took place in Dease Lake, Smithers, Prince Rupert, Houston, Stoney Creek and Terrace. Focus groups portray a different dynamic as participants are often more comfortable talking in groups and use one another's answers as catalysts for further discussion. At the focus group in Prince Rupert approximately eight people participated. However, indepth interviewing and focus group organization are time consuming processes and at approximately one to three hours each, I was limited to conducting seven interviews and one focus group in the four month data gathering stage.

3.2.6 Procedure

The Northwest region of British Columbia has a number of First Nations groups including: Haida, Haisla, Gitksan, Wet'suwet'en, Tahltan, Kaska, Tlingit, Nisga'a and Carrier. Each First Nations group as well as each community is unique and has distinct traditions, memories, experiences and contemporary needs. From the very beginning, the study was limited by the vastness of the region, traveling time, the remoteness of many communities as well as the extensive variety of First Nations groups. To try and overcome these limitations several centres in the region were adopted as reference points and the interviews were focused around the following areas: Dease Lake/Stikine, Smithers/Houston, Vanderhoof/Stoney Creek and Prince Rupert/Haida Gwaii. These areas were chosen with regards to their geographic location and coverage of the two major health regions in the Northwest; #13 and #15,

the Northwest Health Region and the Northern Interior Health Region respectively.

The interview questions were organized into three themes or areas of discussion. The leading section revolved around the interviewee's *Personal Experiences*, while the second section branched from this to include the interviewee's *Knowledge of Midwifery and Traditional Birthing Practices*. Finally, the interviewees were asked their opinions on the current health care system and *Contemporary Birthing* in their communities. Although preference was given to older women as interviewees, an opportunity arose for a discussion with three generations of Wet'suwet'en women on the topic of traditional birthing and their recently departed grandmother (great and great-great too) who was a well respected community midwife. This interview gave me tremendous insight into the generational transitions birthing women in the North have faced. Group interviews or focus sessions had been suggested initially by my committee as an additional method employed to gain a broader cross-section of the region and besides the Wet'suwet'en women, I was able to achieve this when I presented my research at the Prince Rupert Friendship House's Elders Group. A discussion ensued which gave me not only more relevant data but new insight from the male perspective. Some male participants gave information obtained from other female relatives but most turned the discussion quite openly over to the female participants in the group. In an interesting dynamic, it became apparent that the women were seen as the holders of this important information.

In total seven interviews were conducted between September of 1997 and December of 1997. I spent approximately 11 hours and 45 minutes interviewing 9 participants in addition to the Friendship House Focus Group where eight people participated. In an attempt to preserve valuable First Nations traditional information, audio tapes were made of

all interviews and despite complete inaudibility of one interview, all but one were transcribable. The focus session held with the Elder's Group of the Prince Rupert Friendship House was not taped however, due to the nature of the meeting. Hand written notes taken during the discussion as well as personal reflections written immediately after the meeting were used.

From these interviews I gathered 60 single-spaced pages of interview notes and transcriptions, spending approximately 45 hours and 15 minutes both transcribing the tapes, adding my personal thoughts and logging the information into computer files. Some of the more personal sections were edited out either by request of the interviewee or by my own personal decision.

3.3 DATA ANALYSIS

A qualitative approach to the research process was used and for the data interpretation *Thematic Analysis* was applied (Kellehear 1993). The transcriptions, interview notes and personal reflections of each interview, in conjunction with previous information discovered through the literature review, were searched for themes. This type of approach was subjective and interpretive and input from the participants, community members and the Friendship Centre staff broadened the perspective of the research.

The foundation of my analysis was based on the three original categories first developed in the interview questions; *Personal Experience, Knowledge of Midwifery and Traditional Birthing Systems* and *Contemporary Birthing*. However, with deeper analysis, several key patterns or topics emerged within each original heading, producing a more detailed thematic outline. These themes oriented themselves around a holistic way of being, where a midwife attended birth was treated as a natural event. A discourse of birthing stories arose from this oral

teaching method and the community played an expanded role in these birthing systems as both a support system and an educational network.

3.3.1 Use of Results

The information presented here is part of a larger study on Maternal Health Needs in B.C.'s Northwest being organized by The Dze L K'ant Friendship Centre and incorporated as supplemental material for both the proposal for funding to initiate the study and as direct data towards the regional analysis. Over the summer of 1998, a stage two funding proposal for the B.C. Health Research Foundation was completed and word on the official beginning of this project is due in the beginning of January 1999.

Although a copy of this thesis will be housed at the UNBC library and The Dze L K'ant Friendship Centre, I have decided to complete a secondary document, *A Community Summary*, for wider circulation within the communities of the Northwest. The *Community Summary* will be available to each participant, The Dze L K'ant Friendship Centre, The Prince Rupert Friendship House, the Pregnancy Outreach Programs in the Northwest and The University of Northern British Columbia.

3.3.2 Personal Interpretations of the Research

Researchers doing community-based participatory research must examine their own role in the research process and recognize their underlying assumptions and ideologies (St. Denis 1992:58). Kirby and McKenna (1989:52) refer to this as recording conceptual baggage. In recording an individual researcher's conceptual baggage, questions that must be addressed include: What do you know about this topic already? What are your certainties and uncertainties about conducting the research? The answers to these types of questions stem from an individual's world-view and by self-describing this world view a clearer

picture of how the researcher's perceptions shape the research process can be discovered. Layering ideas, by continuously rethinking and rewriting conceptual baggage, is an excellent tool to account for the individual's influence as well as the historical and political context surrounding the entire research project (Kirby and McKenna 1992:52).

Throughout my interviews and data collection process, I kept detailed personal notes in a journal. I felt it important, as Kirby and McKenna suggest, to continuously think and write out my "conceptual baggage" (Kirby and McKenna 1992:52). My journal was not restricted to my feelings regarding the interviews, but encompassed my perceptions of the participants' responses and my own mental, emotional, physical and spiritual states. Most of my journal entries fulfilled only a role to myself, giving me an opportunity to evaluate my progress, celebrate my triumphs as well as providing a forum to release tension, stress, frustration and self-doubt. However, the notes I prepared after the interviews aided in the development of the themes that emerged from my data in *Chapter Four: Findings* and in making the subsequent interviews more enjoyable, comfortable and beneficial.

I have taken these post-interview notes and subdivided them into three separate categories, each revealing something different about the research process and my experience in it. Many factors influenced my methodology and the limitations set out previously in this chapter are no exception. The very nature of longer, more personal interviews created difficulties in acquiring a level of comfort that enabled a meaningful exchange of information to take place. This was compounded by financial constraints, seasonal traveling restrictions and cultural differences. I found that the main focus of each post-interview personal reflection revolved around *The Comfort of the Interview*, *The Time and Place of the Interview* and *My Own Concerns with the Interview Process*.

3.3.2a The Comfort of the Interview

My own personal comfort in the interview process grew with time and experience. Being Non-Native had an inherent effect on how I conducted my interviews and how the participants felt in discussing their cultural heritage with me. I cannot speak on behalf of the participants, however, from my own Western academic perspective, I can safely say that I have tried to deal with the philosophical and theoretical dilemmas that accompany cross-cultural data collection and interpretation by involving the community at all levels and by aligning myself with an aboriginal organization, The Dze L K'ant Friendship Centre.

It is important to remember that no researcher works in isolation of their personal life, no matter how hard they try. Although this type of experience was part of a lifelong dream and extremely fulfilling, the physical distance between myself and my family and loved ones, not to mention the illness of my father, made conducting my research a difficult and lonely process.

Again, I cannot speak on behalf of my participants, however, their overall comfort varied according to topic, who was present at the interview and whether or not we had a previous relationship. Most of the Elders responded without reserve to my questions and offered personal stories both positive and negative. However, some issues were not easily discussed with some participants and if I sensed hesitation, I would avoid the topic. Several participants, although opening up to me, preferred that the information be edited out of the audio tape.

Of the interviews I conducted, I was the only interviewer in four; the rest included guests, both mine and the participants, while community representatives were present at two. These additional people gave insight into the discussion, helped me to expand my interview capabilities and eased the tension of first meetings. I had known

several of the Elders prior to their participating in the study, both intellectually and socially. These were by far the most rewarding and beneficial interviews.

Over the course of the research period, I found myself attending a number of conferences, including *The Community Action Program for Children's Northwestern British Columbia Pregnancy Outreach Programs Training Conference* and *The Determinants of Health: Action for Health: Working Together for Healthier Communities Conference*, both relating to the topic of my thesis and it was at these meetings that several spontaneous interviews occurred. Our common interests and the social nature of smaller conferences gave these interviews added importance as we could discuss fairly openly our opinions and insights into the topic at hand.

3.3.2b The Time and Place of the Interview

The time and place of each interview also had a great effect on its outcome. The place of each interview was decided upon by the participant and most chose their own homes. If their home was not feasible or uncomfortable for them, I gave them the opportunity to chose a neutral place instead. Besides peoples' homes, I conducted interviews in restaurants and at both The Dze L K'ant Friendship Centre and The Friendship House in Prince Rupert. Interviews held in participants homes involved distractions such as visitors. However, the interviews in the participants homes were definitely the most comfortable and visitors often added to the discussion. As was mentioned in the above section, I met some interviewees at conferences held within the region. Both the atmosphere of the conference and the timing of the interview along with our common interests in the topics changed the dynamics of the interview. We were now colleagues immersed in a discussion of issues

that effected our lives and as always the topic of birthing invited others to join in and share their experiences.

3.3.2c My Concerns with the Interview Process

I have already raised a number of concerns and most revolve around my own personal skills as a interviewer and the way in which I, as a representative of the University, must conduct my research. I tried to enable the Elders I talked with to feel comfortable enough to share stories or knowledge that they felt important before I started into a series of questions. Often, however, the participants needed the direction of the questions even with my attempts to give them control of the interview. Although all of my interviews lasted between one and three hours, my lack of interviewing experience made me feel that justice to the Elders' knowledge was not achieved. In the interviews where other people attended, this was not such an issue. Each person had their own questions and curiosities with regards to the topic of discussion. Even simply watching their interviewing methods gave me ideas to enhance my interview skills.

Further to this, from the onset of this process, I have had reservations with regards to the nature in which *informed consent* is achieved. The University requires consent for the interview to take place and proof that the participant is aware of how the information presented will be used. Although I, as a researcher, can get consent either in written or verbal form (audio taped), I had serious reservations when using either of these methods with First Nations Elders. Many people in the communities assured me that if an Elder agrees to speak with you, this is their consent and the requirement of a signature can lead to immediate mistrust of the interviewer. These concerns stem from the issues raised previously where research on First Nations historically, has been performed unethically. Although the

purpose of obtaining informed consent protects both the research and the participant, First Nations cultural differences, with regards to knowledge and the passing on of information, are not accounted for in the current academic method of achieving informed consent.

CHAPTER FOUR: FINDINGS

4.1 PERSONAL STORIES

The art of storytelling is of great importance to First Nations groups as their culture, history and knowledge is passed from generation to generation orally. The ease with which midwifery and birthing traditions were discussed by the participants in my interviews was refreshing and the willingness with which the women shared personal experiences of birth was astounding. All the Elders I talked with chose to relate personal stories and each woman felt quite comfortable in discussing their birthing experiences both negative and positive. The stories ranged from interesting, funny, deeply moving to extremely sad. Women recalled the births of their own children, the babies they helped to deliver and one woman told me the story of her own birth, a premature one, which had been told to her by her mother.

In addition to these stories, unprecedented birth stories were also part of the oral discourse of birth and many remarkable birth situations filled our conversations. In strength that is hard to find, the women also informed me of the stories of lost mothers and babies so that the real risks associated with pregnancy and childbirth would not be forgotten.

These personal experiences can be divided into four separate types of stories; the women's own birth stories, be they hospital or home, the women's stories of others' deliveries, either as midwives or participants and the women's knowledge of deliveries with special significance, such as breech births or births in unique places, which had become part of a wider knowledge base. Lastly, the Elders spoke of the sad tales of death, of mothers and children, due to pregnancy complications.

The patterns that emerge from these stories revolve around the belief in birth as a natural and normal event. As well, the narratives shared from woman to woman, specifically the unusual birth situations, are part of a larger birthing discourse where stories are used to teach and share knowledge. (see Appendix One: Interview Table).

4.1.1 Women's Own Birth Stories

Women tend to enjoy discussing the births of their children even if the experience was not pleasant. In hospital, at home, or in the bush, these stories never deviate from the base philosophy that women have an inherent ability to birth and prefer to be attended by women during this process. Socially, this becomes a method of sharing information between women and the degree to which the women in the interviews gave details on the births of their infants reflects this pattern.

Although more than one interview included stories of breech births and the complications associated with that kind of delivery, only one woman, a Carrier Elder, had had a breech birth herself:

Sometimes I had a breech birth with one of the boys...I had a really hard time....I had to lay down and one old lady, very good at it, she turned the baby right around, yeah, and then it was born..... Yeah, she just work on me and the baby come...they know they pretty good that time (Interview 3:1997).

A second Carrier Elder had an unexpected delivery while she was out in the bush drying meat for the winter. Luckily, her auntie was there to help her through the delivery:

Just my auntie. My husband was there and my uncle was there but we had two tents, like that, one tent here and one tent here and in between a big campfire.. and my husband and my uncle were, you know, just sitting by the fire.

Several times she tried to get up and get dressed to go to the train which was only an hour to the hospital but her labour was too strong and she finally decided to stay at the camp:

I'd dress up to try and get on the train, oh
I don't know why I was so crazy! What if I had
it on the train?

After finally deciding to stay, her auntie helped her through the delivery and to this day her son returns each year to the place he was born:

It was such a struggle and....when ----- was born, my aunt said " Oh!! It's a boy, it's a boy" she said. She was so happy it's a boy... We go there every summer, to do our, there's a fish camp. So he goes back, "You belong here, you were born right here." (Interview 7:1997).

In contrast, when discussing the women's personal experience of birthing, one woman in particular, who had had all her children in hospital remembers very little of the experience except the strict rules and unpleasant procedures. Not only was she denied visits from anyone but her grandmother, she had to labour alone as her husband was not permitted in the delivery room. She was severely drugged and tied down in the stirrups of the delivery bed. Her babies were locked in the nursery and she saw them only briefly each day when it was time to feed. The Catholic hospital run by nuns left her feeling helpless and looking back, she can't help but feel angry for not standing up for herself (Interview 5:1997).

Ironically, this woman's grandmother was a well known midwife in her community and had delivered her and all of her siblings. It was the great-granddaughter however, who would benefit from her great-grandmother's knowledge. During her first pregnancy, after suffering through months of constant nausea and vomiting, and being in and out of the hospital due to the resulting weight loss, it was her great-

grandmother, a Wet'suwet'en community midwife, who gave her some natural remedies to ease her sickness:

G: I was lucky to be pregnant with GD when my grandma was alive, she gave me lots of natural ways to make me feel better.

K: Oh.

G: Like for nausea and vomiting, she would say, uh, what was that stuff she used to?.. She had all kinds of different medicinal stuff but that one was.. she boiled a root and she make me drink it and she said it would make me feel better. Yeah. It was something else that she, she had it given to her and ah, it tasted gross, it didn't taste very good..... and it helped cause remember how sick I was with GD. I was in and out of the hospital cause I was losing weight cause I was so sick with my vomiting and that didn't quit until she, I was 6 months pregnant, and I was kinda complaining to gramma about it and she was like "You've got it easy these days if you were pregnant when I was delivering babies you would never make it".. She used to make me feel really bad cause I was so wimpy...(Interview 5:1997).

One of the most amazing narratives I heard was from one woman who recalled the story of her own birth. Born in 1935 in the Old Village of Masset, she was a premature baby and with no doctors to help them, her grandmother and great aunt, both midwives, placed the tiny infant into a shoebox with a hotwater bottle, simulating the warmth of the womb. They laid her arms straight by her sides and covered her underdeveloped skin with oolichan grease to try and keep it moist. She was too small and weak to feed and since at that time children were breastfed only, her mother expressed milk and carefully dripped it into her mouth from a milk-soaked piece of cloth. Later, a visiting nurse gave her mother an eyedropper to feed her with but most of her relatives felt that she would not survive (Interview 2:1997). Many infants died during that time but miraculously she lived to hear the tale of her birth and then relate it to me.

4.1.2 Women as Midwives

The birth stories women told did not stop at the birth of their own children but grew to include their own experiences of delivering other babies either as midwives or as circumstances prevailed, the only available person.

For one woman the realization that the last child she had delivered was now married with children of her own, made her laugh lightheartedly about her age. More recently however, a Tlingit Elder whose own births were attended by her mother-in-law recalled how accidentally she was able to deliver her first grandchild:

Yeah, I, ah, delivered my first grandchild because my daughter-in-law and my, my son they were with us, we were away from downtown and there was no doctor in town, so we were out in the mining camp and she got sick, right there, and when she got sick we got everything ready and we, I delivered my first grandchild (Interview 4:1997).

The line between a woman's own birth stories and those she has attended became blurred when in one Elder's narrative she was left to deliver her own baby alone while the entire community was at church:

Another time I had -----, we were living in a cabin over there and uh, everybody went to church and here I had my baby here all by myself!...All by myself. I was ready to cut the cord when my sister-in-law came back...(Interview 7:1997).

When asked whether or not this was a frightening experience, she replied using a story she had heard from other women about birthing alone:

I wasn't scared. I knew what to do with a baby. There was no choice. I would say. One elderly woman, she was my mother-in-law's sister, she went out to set her traps in the morning and she had her baby in the bush, packing her baby back (Interview 7:1997).

It is this passing on of knowledge, experience and positive reinforcement of the inherently natural process of birth and woman's ability to birth unaided if necessary which helped this woman through her delivery.

In another instance, the eldest of my participants, a Tahltan woman, told me of a birth she attended alone. Lying the woman on her side, she helped the women, who laboured for 2 days in the bush, to deliver a child. Although she spoke of only one delivery with which she helped, her age and information from her younger woman friend led me to believe she had delivered many children but that this one instance had stuck out in her mind (Interview 1:1997).

Important to recognize however, is that this was not a chosen method of birth. Women who birthed alone, did so because of uncontrollable circumstances, there being no other choice. Therefore, one unchallenged aspect of all of these stories is that women preferred to be attended in birth by women, even during the transition to hospital births. This reflects the description of Burtch's *Traditional Birth Culture* (1994a) which developed in the more rural and remote early Canadian communities of the West. The continuity of care and support systems shown in the Elders stories gives rise to the belief that women unattended in birth were considered to have had an extra ordinary experience.

4.1.3 Unique Instances

Several unique stories of childbirth arose which were not taken from the participant's direct personal experience but from the larger knowledge base of stories passed orally from women to women when the subject of birthing was discussed.

The first hospital on Haida Gwaii was located in Queen Charlotte City and for pregnant women in Masset, it was a 70 mile taxi ride to

deliver a child. Not surprisingly, a number of babies can claim the back seat of a taxi as their birth place. One Haida Elder's nephew is an example:

When my late sister was having her baby, one of her babies, she had 7 boys, anyway she, the last one, I think it was, the hospital is 70 miles away from Masset, at that time, and that was at Queen Charlotte City...you had to take a taxi, they had two taxi outfits in Masset...anyway, when a woman, when my sister started going into labour, they started, they got the cab and they started off and they're rushing, rush, rush, rush, but the baby was born anyway in the car!! (Interview 6:1997).

Although the place of birth and the lack of help during birth are two birth events that are memorable in women's minds, the breech birth must also be included in this discussion of unusual birth experiences. Breech births, as with the above story, have a way of becoming part of the wider experience of childbirth, with women using stories told to them and not taken from their own experience. Midwives usually tried to turn breech babies before the woman went into labour, and could do so easily if it was detected before the sixth or seventh month. The great-granddaughter of one Wet'suwet'en midwife recalls how her great-grandmother delivered a very difficult breech birth:

Well, she was trying to turn the baby around but the mother was in too much pain, the mother was being really rough with her, wouldn't let her, it was really hard work trying to turn the baby (Interview 5:1997).

In another story, first told to her by her mother-in-law and then to me in an interview last fall, one woman graphically described how a Tlingit midwife was able to avert major complications during a breech birth only with extreme measures:

There was one woman there, she had only one daughter and her daughter was going to have a baby and she was sitting there, she

was going to deliver the baby for her daughter and she found out that the feet started coming first.. and they said Oh!! She had an awful time, it was, she was, her daughter was in, in labour already but she still had to try to turn it around..and when the baby was going to be born, when she was turning it around, I guess, see the baby's arms are like this (elbows in), you know, but when she was turning it around, I guess it spread all over and she said trying to push this arm through she had to break one arm of the baby. But the baby was born and then they fix the arm (Interview 4:1997).

4.1.4 Maternal and Infant Deaths

Like most women, I date many of the happenings in my life from the times when my children were born and like most women, I do not forget the dates when my children were lost to me (Mary John in Moran 1988:76)

Even though the discourse surrounding childbirth and birthing systems revolves around the action, socially and physically, of bringing a new life into this world, it is not without its dangers, risks and sometimes deaths. Both mothers and newborns are victims of early mortality from childbirth-related complications and these tragic events can happen both at home or in the assumed safety of a hospital centre. The participants coupled their own personal and triumphant birthing stories with often more tragic ones, where children and/or mothers were lost.

Most women either experienced or knew of women who had lost children in birth or in early childhood. Along side of this, several of the women I talked to had lost their own mothers due to complications in childbirth. One Carrier woman lost both her mother and sibling:

M: It's just like my mother, my mother in 1934 died of childbirth....Her husband died, in February, I think and then she was very pregnant when her husband died....but anyway, my brother was 14 years old, the oldest boy and I was married already and then she, they were going to get some hay for the horses, you know, when she put on the hay rack, it was

quite heavy, on a sleigh, to hitch up a team of horses and go to the meadow and get some hay for the horses, that's what she was doing with the help of my brother who was not very big either, so that's when she hurt herself and she started bleedin, no doctor, so she uh, bled for about a month, finally her time came and then the women, all the women were helping, the baby was dead, they got the baby out and she died about 1/2 an hour later..

K: Oh no.

M: So, complications like that, you know, the women, no matter how hard they try to help still happens (interview 7:1997).

Another woman's mother also died of complications in childbirth however, she was in hospital at the time:

---. -----, that's my mom, when she had all the childbirth, and uh, she got sick, and it was her stomach, something wrong with her stomach and uh, they just kept her in the hospital and uh she got worse and then she passed away...1948, yeah, 1948 that's when ----- was born....I was 9 or 10 years old, that's why my Grandma raised us (Interview 5:1997).

The death of women in childbirth although a very tragic reality was paralleled only by the loss of infants and children. The stories of children dying due to childbirth complications and illness in early infancy were unfortunately part of the personal narratives the women shared with me. One participant recalled vividly the stories her grandmother, a Wet'suwet'en community midwife, told to her about delivering on the trapline (in camp on the trapline):

She walked for three days and uh, the woman was so strong in that way that she didn't want to be left behind on the trapline, so she'd walk go walk forever....and she didn't think she was going to deliver it and she had a premature baby, she went out on the trapline and Gramma had to walk for three days to get out there, her husband came back and grabbed Gramma and Gramma was in Moricetown or here, I can't remember if she was here or in Moricetown. But she, the father walked all the way back cause she wanted her to deliver the baby and since she walked all the way out there in the bush and for three days it took her to get there to deliver the baby. Uh, the baby had all kinds of complications, I think it even

died. Yeah, cause it was born too early and it had to be incubated and we didn't have that way in the bush in the cabin. They buried it right out there (Interview 5:1997).

The degree of loss was unimaginable to me as First Nations women, in the mid 20th century lost upwards of five children in a lifetime from a variety of complications and newly introduced European diseases. The midwife from the story above was no exception. Her granddaughter and great-granddaughter remember with sadness how their grandmother would cry whenever she spoke of her and her daughter's losses:

E: Most of the babies were born out on the trapline. Like uhummm, my other sisters and brothers they, uh were all born on the trapline. I can't remember the name but it's up towards Smithers.

G: We still have property up there and my grandmother (great)..How many babies are buried on that property? Two, three, I thought there was three?

E: There's quite a few, there's my Mom's first five kids and then, no four kids, one was buried in Hagwilgit and then four is buried out there. Then Gramma's first five that she had, they're out there and they all died out there, they're all buried out there....

G: Fever, some kind of fever....Their fever just went skyrocketing. I remember Gramma (great) talking about it and she would cry when ever she talked about her babies dying and she would cry everytime she would talk about them and many times if there was someone who was pregnant around her it would bring it up and back to her and she would start talking about deliveries and her babies, and how hard it was and how she thought she was going to go crazy everytime she lost a baby (Interview 5:1997).

The residential school experience for one participant, as well as the death of her parents early in her childhood, left her with little traditional knowledge to help her birth and raise her own children when she was a young adult:

S: Yeah. We never even seen a doctor through our pregnancy. Hazelton only hospital and then they send us to school in the 20's, 1925 I went to Lejac residential school.....

T: You never lost any babies?

S: I lost lots. I lost ----, I lost ----, ---- and ----. Four I think, eleven alive.....

S: Uh huh. I have eleven alive, I lost four. The first one I lost because I was too young and I didn't know how to look after baby, couldn't poop, if somebody told me I'd use an enema, nobody to help me. Well, I have no parents, nothing. I lost when I was a baby, 10 months old. I don't know my Mom and Dad. Gramma I know, Gramma raised us. My mother's mother (Interview 3:1997).

Fortunately, this Carrier woman relearned her cultural beliefs and practices and is now a respected Elder recognized for her unique and sacred traditional knowledge. This was the case for several of the women I talked with. One Tlingit Elder remembers having to learn everything over again after her long stay at Lejac residential school:

A: I been to school. I been to Lejac school, I was there til I was eighteen then I went home and when I got back to Atlin, I didn't even know how to ah, ah, be like an Indian, you know, because I was so much in school and I was with the sisters and what not, you know, lost my language and everything.

K: Uhhuh.

A: But it took me quite awhile, about a year, to get it back again, lost my language but I could talk again.

K: Oh good.

A: And I learned everything the Indian way, didn't take long to do it (Interview 4:1997).

Death occurred previous to contact for the First Nations, but as was outlined in Chapter's One and Two, the colonial experience, such as the residential schools, caused a generational gap in the knowledge base, a disenchantment and loss of cultural traditions and language. As well the implications of colonization on midwifery practices led to greater numbers of infant deaths and a significant rise in infant mortality rates. Therefore, together these events can be seen as contributing factors in the evolving nature of First Nations traditional birthing systems and women's personal stories.

It is in these personal stories that the silenced voices of the Aboriginal Nations and communities are found. These oral discourses shed light on First Nations parturition practices and beliefs, opening up new

possibilities for alternative and cross-cultural perspectives to broaden both the medical and feminist-revisionist models of birth.

4.2 KNOWLEDGE OF MIDWIFERY

The information given on Traditional Aboriginal midwifery knowledge located births as entire community events and as central to women's traditional roles. This becomes obvious in the descriptions of the continuity of care practiced by both midwives and women's helpers and the community at large with regards to the child's discipline. Also, birth as a natural and normal event resurfaces as the foundation of the discourse on birthing and as part of both these patterns, the teaching of the younger generation becomes paramount.

All knowledge pertaining to midwifery and birthing: the restrictions, roles of the midwife, pregnancy and labour knowledge, as well as breastfeeding can be seen as holistic in nature, connecting together all of the information presented.

The "don'ts" of pregnancy such as restrictions on diet, on activities and on things the pregnant woman can experience were coupled with the "do's", such as how pregnant women should act and take care of themselves. Along with these, a number of more culturally specific beliefs emerged from some of the interviewees and included methods to make labour easier and how to prevent conception. On top of the restrictions, the women were very detailed in their descriptions of who attended pregnant women, how many women attended, how these women learned and what roles the midwives or women's helpers held within the communities. Some of the participants had delivered children themselves and most had delivered at least some of their children at home or in the bush.

The knowledge surrounding pregnancy and labour was by far the largest area of data and included information in the following topics:

medicines for pregnancy and labour, place of birth; including the position during labour and birth and length of rest needed after birth and finally the cleaning of the baby and mother, dealing with the afterbirth and the significance of the cord. Finally, the discussion surrounding breastfeeding dealt with when breastfeeding was initiated, and for how long. A few women also discussed alternatives for women who could not breastfeed.

4.2.1 Restrictions

Although many of the participants stated very firmly that pregnancy was a natural event and that life went on as normal, further discussion revealed that restrictions to certain foods and activities were used to prevent future complications either in labour or in the child's later life.

Tahltan and Haida participants mentioned the restriction of fresh meat, either bear, salmon, oolichan or other fish (Interviews 1,2:1997). These items were deemed too "heavy", or having too much oil. Berries were also restricted, stated one Wet'suwet'en woman, both picking and eating, especially raspberries since they were believed to cause "raspberry" birthmarks, red blotches found on newborns (Preliminary Interview 5:1997).

Other foods were restricted in this same way, from fear of the resulting repercussions. Often the repercussion was caused by the way in which food was caught or killed. In the Carrier culture, rabbit snared by the waist caused women to have hard labour but any animal snared by the neck was fine (Interview 3:1997). Drowned beaver or duck could cause the unborn child to choke after they were born yet if these animals were shot first they were okay to eat (Interview 7:1997). It is important that variations geographically and culturally with regards to main food

stuffs be recognized and that the food restrictions mentioned in the interviews were part of individual Nations' beliefs.

Like the foods restricted for their potential danger to mother or child, activities were also categorized in such a way. Deemed "woman's special status" by one Haida participant, women were warned from lifting heavy objects, bending over and sweeping wooden floors as all of these actions have the potential to jeopardize the pregnancy (Interview 2:1997). Further, Nisga'a women had to turn over slowly in bed and not get up too quickly as this caused the cord to wrap itself around the baby's neck (Focus Group 8:1997). However, women could not sit around while pregnant. It was made very clear by all the participants that working normally was necessary and exercise, especially walking, was very important. If a woman was "always on the move", the child would be born "clean" stated one Carrier participant (Interview 7:1997). Otherwise, she said, the child would become mired in the "white sticky stuff in the womb and not be able to move". Another woman was told by her mother-in-law, a Tlingit midwife, that if one didn't exercise the baby would grow too big and the child would be very difficult to deliver:

A: Well, after I got married, that's how I learned and my mother-in-law tell me alot about that cause I was with my mother-in-law and then for ten years after we got married and she used to, she used to take care of me really good and she tells me what to do and everything. She always used to tell me don't sleep too much when you're pregnant because the baby grows too much. If you sleep that when the baby grows..... And she used to tell me what to eat and all that, you know, and she looks after me really good and she tells me don't sleep too much that's the main thing she used to tell me, don't sleep too much...

K: Stay active...

A: because she said the baby have a chance to grow too much if you sleep too much but if you move around, keep busy, the baby don't have a chance to grow too much (Interview 4:1997).

In addition to exercising, throughout my interviews I heard three extremely similar stories regarding ways to give birthing women a quick and easy delivery. Two involved the use of a live snake (garter), placed through a pregnant woman's dress or belt once labour had started to speed it up. One Carrier participant's aunt had this done to her by her brothers at the onset of labour:

We used to do that with snakes. Yeah, my aunt had that done to her, her brothers. She was pregnant and she had a belt on her dress and they put the snake down, down, you know, she'd be having the pain and in her first contractions and in, in, in 1/2 an hour she had that baby, just slipped out (Interview 3:1997).

Another similar story came from a woman who lived on the coast and in her story, a minnow was placed through the woman's baggy dress to encourage fast delivery (Focus Group 8:1997). It seems the belief/methods were similar and only the object used, snake or minnow, varied on geographical location.

I heard only two methods on how pregnancy was prevented and although it was discussed candidly, it was acknowledged by several interviewees that preventing a natural event, like pregnancy, was frowned upon. In the Carrier tradition, women could use a beaver's tooth to cut up the afterbirth of a previous child to stop future pregnancies or could drink Kinnikinnik tea to prevent conception:

M: They're really, like my aunt used to say, women talked sometimes I listen to them, and they used to say, they used to kinds, put down a person, a woman who doesn't, whose childless. You know, they think she's using, you know, doesn't want to have childbirth and they used to really not like that. And I heard at one time this woman she had a child and after she had no children and then they said ah.....Oh yeah, afterbirth, they do something with it. The beaver, beaver, they use a beaver tooth, they tear it up with a beaver tooth, if they don't want to have another child. These are what you call it. Taboos (Interview 7:1997).

Again as part of their special status, women were discouraged from looking at something too long as the belief was that the child would end up resembling the object. This was especially true of frogs or dogs for their not so beautiful appearance. One Haida Elder mentioned one woman who held a beautiful doll in the mirror so her child would take on its characteristics:

And I knew, my Mom used to tell me about, once in awhile she would say things like, when a woman was pregnant she wouldn't look at frogs or dogs or anything uhummm, any pictures that were ugly and uhummm, she mentioned the neighbour that was having a baby and she got a real beautiful doll and she used to hold it up to the mirror (Interview 6:1997).

In the Tahltan culture, pregnant women were also shielded from disturbing scenes such as bear kills for fear that it could pass on to the unborn fetus (Interview 1:1997).

One Haida participant was told by the Elders that tight clothes would give the child a flat nose (Interview 2:1997). Yet, due to the soft nature of baby's bones when they are born, stated a Carrier participant, you can shape their face and pull their noses out so they will not be snubbed (Interview 7:1997). Further to this, how a baby is first handled can effect its future life. One woman told me that if you grab the child by the left hand they will be left handed and vice-versa (Interview 3:1997). Similarly, parents were also known to rub an infant's hands with the hair from a beaver's paws, while saying "Let it be that he'll be just as busy as a beaver. He'll be like a busy beaver." One Tlingit participant felt this had been done to her, since she was always sewing:

That's what they do. I think they done that to me because I am a good seamstress. I do a lot of sewing... (Interview 4:1997).

Physical activities and visual objects weren't the only things that women needed to avoid, but uncontrollable noise as well. One participant recalled a story where her aunt, who was pregnant, had an older midwife say to her "Hope you don't mind noise, cause the baby will be born making that same noise", as she was exposing herself to a very loud commotion (Interview 2:1997).

I heard one very interesting belief from a Haida woman on the coast. She was told never to prepare for a child, that preparation would curse the pregnancy and the likelihood that the child would survive. Nothing was made for the baby until after its birth including all the baby's cloths (Interview 2:1997). Other participants however, described in detail how to prepare for a child.

These beliefs come from the notion that all energies, good and bad can pass through the pregnant woman to the unborn child. Avoidance of possible negative actions, sights or sounds is a protective mechanism for the child and the mother. Conversely, all that is good should be taken in, as was seen with the use of the beaver's paws to give children drive. As mentioned previously, the Native Infant Education and Care program at Malaspina College (1984) found that these energies, negative and positive, encompass both the actions of the mother and father-to-be and include more specific emotions such as anger, laziness and depression. Therefore, to have a healthy pregnancy and newborn, parents are encouraged to live in a good way. It is important to recognize however, that although the general philosophical base behind these restrictions may have been similar throughout the Northwest, variations across culture, nation and even community were noted.

4.2.2 Midwives's Roles

All the participants emphasized in some way that the elder women in a community, some referred to them as midwives, were responsible for

instructing newly pregnant women on not only the aforementioned "do's and don'ts" but on all aspects associated with pregnancy, labour and the child's early life. These women were usually older "aunties" and had gained their knowledge through the experience of their own births and by attending others. It was these "women's helpers" who attended the woman throughout the main stages of labour and delivery and stayed after to aid the woman by making her medicine, looking after the children and cleaning the house. Usually a group of as little as two to as many as four or five were involved in a birth but many participants stated that whoever wanted to help usually went, though it was always women.

Many participants mentioned that men and younger children were sent away from the birthing woman. One Tahltan woman expressed it quite firmly:

D: Yeah. Uhum. Who was usually there when the baby was born?

L: The midwives, and then the, whoever wanna be there, your sister, your aunt or your folks relatives or your friends.

D: The men were usually not allowed?

L: NO.

(Interview 1:1997).

For one Tlingit participant, separation of the birthing women, their helpers and the midwives was achieved by the physical construction of a tent outside the house (Interview 4:1997). Variations across nations and communities however, result in differing opinions on whether or not men were active participants at the birth or if their role, although still important, lay outside the birth scene itself. Other research has shown that men have been known to have delivered babies and husbands have helped their wives in labour (Rattray 1997 Unpublished Manuscript). However, these seem to be situations of special significance where no other options were available.

Although almost all women could aid a pregnant woman in labour and many could deliver children, it seems that a second group of women with

specialized knowledge would be called in either at the delivery stage or if complications arose during the birth. These women could be the "aunties" or other relatives previously mentioned, yet some were not related to the pregnant woman but known in the communities for their unique knowledge of childbirth complications such as breech births and hemorrhaging. Almost all the interviewees mentioned individuals by name as specialists of birthing, or midwives. One Carrier participant remembered one older midwife, who although having specialized knowledge, had no children of her own:

and at that time, you know, when there was complications there was an elderly woman who was just, uh, very expert, in what, in childbirth, you know, she had no children herself, but she was a midwife (Interview 7:1997).

It would seem then that two, sometimes overlapping, groups of women attended births traditionally, the pregnant woman's relatives or helpers and the community-known specialists or midwives.

All the women involved in attending women in labour and delivery gained their knowledge through experience. Birth specialists or midwives, were known to have apprenticed with the older women to learn ways to deal with complications and their education was of an oral and participatory nature where listening and watching were the main means of instruction. Midwives used methods such as massage to feel for the position of the baby and to turn a breech baby into the proper delivery position. Breech babies could be turned around if they were caught before the sixth or seventh month, claimed one Tlingit participant's mother-in-law, and whether the child was feet up or feet down could be ascertained by the way it was kicking:

and that's the way they do it and that's what my mother-in-law used to do and, ah, she always used to ask me how the baby was kick around, you know, inside (Interview 4:1997).

Massage was also used to help the placenta deliver itself right after birth and as one participant remembers, to remove some of the afterbirth that had been left inside her:

Mt: They would use herbs and stuff after to make sure nothing was left behind.

M: Yeah, that was the worst thing. With me after my first child, every evening at sunset, it's like when you have puss or something, you have this pain, Oh!! I used to just, I was so sick and then this woman came and a midwife came and she worked on me and she gave me that tea, Kinnikini tea, and after that I had no more pain.

Mt: Cause that is the worse thing if things are left behind.

M: In the, even if a little bit of the, something left behind, you know, the afterbirth.

K: And she did massage?

M: She would just massage, like you know, like you..

Mt: And she gave her the tea.

(Interview 7:1997).

As was previously outlined, the negative side of childbirth was discussed by participants and included miscarriage, infant deaths as well as maternal deaths. Miscarriages were treated similar to a birth with similar medicines made to aid the woman after delivery (Interview 3:1997). Afterbirth that was left inside a woman too long or if the afterbirth was not delivered at all were two of the most common causes for death among birthing women. One participant remembers two women dying in the arms of the midwives from hemorrhaging:

T: Did you ever run into a time when a kept on bleeding when she gave birth? Like hemorrhaging?

S: Yeah, we had quite a bit, I think 2 died from it.

T: Oh.

S: We couldn't help her. She had hard time to give birth. She died. Yeah.

K: Ohhh.

S: In the hands of the midwife.

(Interview 3:1997).

The use of traditional medicines came up a number of times in the interviews. Although many women could make medicine for women to ease the pains of childbirth, to induce the delivery of the placenta and to stop post-partum bleeding some special medicines were prepared, for example, to help women who could not have children (Interview 3:1997). The use of traditional remedies will be discussed further in the next section.

Midwives roles did not end upon delivery of the child. After the birth, when both mother and child were all right, the family would bring the child around to its relatives, the grandmothers and great-grandmothers. In the Carrier tradition those that "handled the baby", usually women of high rank, gave gifts to the infants (Interview 7:1997). In most instances it was these women, the relatives or aunties, who were responsible for the disciplining and instruction of the young children. For one Haida woman, it was the aunties who demonstrated the duties a young girl would perform while the uncles were left to teach the young men to hunt and fish:

C: And the auntie ah, her duty was to teach the baby girl what life, what her duties as a female were, that was the auntie's job, that would be the great aunt eh.

K: Oh okay. So she had a role even after the birth was over?

C: Yes, yes.

K: She would help that little girl to grow.

C: And the same for the boy, the uncle...the uncle's job was to teach the boy how to provide for like, fishing and trapping and hunting (Interview 6:1997).

This task did not fall solely on the aunties and uncles however, it was all community members, especially the Elders, mentioned one participant, who were responsible for the behaviour of the younger generation:

M: Yeah, the extended family, mostly uncles and aunts. They would be responsible like, eh, to discipline the child...They would do that right until the child was old enough to be

on their own, even then if the child's behaviour is not very good, it's still the responsibility, like uh, to discipline the... even teenagers...

K: Even teenagers?

M: Even teenagers, even if they are married, like, you know, there is no end to discipline, even if they are married and grown up and still if they see they are not doing right they have the responsibility..if they are not doing right. Which is very, very important.

J: So is that just the role of the aunties and uncles?

M: No it's for anybody. Especially if you are an Elder. If you see people not behaving it's up to you to tell them, remind them of where they came from. That is very important, they have to know that (Interview 7:1997).

It is obvious that the role of the midwives, and more generally the Elders in a community, was a strong one in terms of giving, teaching and training the younger generation. These traditional birthing systems allowed for this passing on of knowledge to occur, re-establishing generation after generation, the base philosophies of a particular Nations' way of seeing.

4.2.3 Pregnancy and Labour

4.2.3a Medicines:

The Elders revealed quite a bit of information on medicines, both herbal and cultural, spanning the entire course of pregnancy from conception into the post-partum period. Herbal remedies came from a number of participants, with one Carrier Elder in particular being known to me before hand as a traditional healer:

We just help one another, that's all, there were no doctors....we had our babies at home, we just used our own medicine, there, you know, the plants....Long ago, they were the only doctors, the women... (Interview 3:1997).

This participant is glad that the medicines have not been forgotten and that the younger generation is interested in learning them

once again. Wild raspberry coupled with wild chokecherry boiled into a tea was used to help give a woman back her strength after birth but also eased the pain of labour:

S: They make these kinds (patting her plant display). This one is Wild Raspberry, you mix it up with chokecherries, this one you put 7 only [bundles] and the other one, you use 4 bundles, like this and you boil it up on the stove in enamel pot, you don't use stainless steel because it spoils the pot, inside it turns black forever.

K: Ohhh!

S: It spoils, it leaves it black, acid or something and then the, I use enamel pots, the __ gallon size and I cook it for two hours, this one..

K: This one?

S: And boil this for 2 hours and watch the time. When I, two hours is up, I take it out, all the bundles and let it sit and then I put it in the fridge.

K: Oh okay.

S: And they take it, ah, 1/2 a cup twice a day, this one, that's what I give....

K: So would this help the woman then to uhummm...

S: To get back her strength...Yeah, she lose so much blood, her blood will get back strong (Interview 3:1997).

A coastal woman remembers pregnant women being given tea mixed with either oolichan grease or butter to ease the delivery of the placenta and to prevent women from hemorrhaging (Interview 2:1997). As well, Kinniklinik tea, which was given to women for menstrual cramps and helped keep the menstrual blood flowing, was also used to induce delivery of the placenta, help stop post-partum bleeding and as a contraceptive. One Carrier woman's grandmother used to joke with her after she had so many children to "drink that Kinniklinik tea!" (Interview 7:1997).

Although medicines could be given in smaller amounts to children, often traditional healers and midwives had to make special medicines for infants and children. As one Carrier woman stated it:

K: If a baby was sick would they have smaller, sort of special plants for babies, or do they

just make smaller doses?

S: Yeah, there some plants for babies too....
this is good medicine for babies. Black,
Wildblack Current.

K: Oh okay.

S: You use it for when they cannot poop.

K: Oh?

S: You know babies they get trouble, this is
just like a laxative for them.

K: Oh?

S: And then it's good for them, them when they
got a cold.

K: And you would make it into a tea?

S: Wild Current, you give it to them, the babies
they cannot take it in big, little bit in bottle.
(Interview 3:1997).

4.2.3b Place, Preparation, Positions of Birth:

Answers from the Elders who were interviewed varied a great degree with regards to the place, preparation and positions during delivery. It seems that differences in place, preparation and position of birth came from both cultural beliefs unique to each nation and the very nature of women's individual needs during birth.

Most women who had their children out of hospital delivered in their homes, surrounded by relatives and women's helpers. In the Tlingit culture birthing in the home was "bad luck" and in one woman's community births took place in a tent constructed outside the house, specifically for the birth:

When I am gonna have my baby they put up
a tent outside...and they branch it up,
they fix it all up and they make my bed
and have it ready and they put a fire and
a stove in there and they have it ready.
So when I am started to get, in pain, I go
in there. They don't have it inside the
house. They say it's bad luck to do that.
(Interview 4:1997).

Along with the home and a special tent, babies were born just about anyplace. In the section *Personal Stories*, we heard of births in taxi's, at fishing or hunting camps and on the trapline. Almost all the women interviewed had at least one story of an unprecedented birth. This

goes hand in hand with the Elders' strong emphasis of birth as a natural event and these stories become part of the larger knowledge of birthing and traditional birthing systems. Although woman may have birthed in odd (by today's standards) and out of the way places, the First Nations Elders were also very much aware of the risks of possible complications that are attached to any pregnancy and stories of death in childbirth, miscarriages and stillborn babies were also part of the personal narratives.

Preparation for the newly born infants was similar for those born in the home and those born in tents outside of the home. One Elder from Kincolith recalls that hot stones were often buried under the branches of the woman's bed when birth occurred outside (Focus Group 8:1997). Women birthing at home also prepared beds, clothes, sterilized the equipment needed for delivery and the cutting of the cord, sewed gowns and prepared diapers with the aid of the women's helpers. In one Carrier woman's words, everything in times past was natural, even the diapers, yet with the advent of the forest industry these things are harder to use today:

S: Natural.

K: Natural yeah.

S: And then they use, they don't use diapers, they use moss.

T: That's good. They never had diaper rash do they?

S: No baby rash at all and they use moss... and then we used to pick it in the fall, dry it and put it away. I did lots of work, lots of work to find moss.

K: For the diapers...

S: It's hard to find on account of clear-cut.

K: It is? Oh.

S: That place that they used to make moss, big field. They do away with all the moss and then after too many, field....It was the only place we used to go to make it, now we have no...I never see any. Everywhere I go I look for it and (laughs) couldn't see any!! (Interview 3:1997).

The midwives, as was outlined in the section on *Medicines*, also prepared the necessary medicines ahead of time and had them ready on the stove.

As the place of birth varied across cultures and circumstance, so did the common position for birth. A couple of standard positions were talked about but the Elders also emphasized that labouring women could chose the position most comfortable for them. Women were known to have layed on their sides, supported by a pillow, (Interview 1:1997) yet one Tlingit Elder felt that this allowed the head to fall to the hip too easily and prolonged labour (Interview 4:1997). Others kneeled down on sheets, or by a chair in which two women helpers aided the labouring woman:

and I would sit like this [sitting in chair]
and she [labouring woman] would hang onto
the chair or whatever I was sitting on and I'd
help her, she'd be turned into me and there'd be
one woman down there [behind the chair],
seeing if the baby's coming or if
the water breaks. So that's how we had a child.
(Interview 7:1997).

As one Carrier Elder graciously pointed out, women kneeled both for ease of labour and for modesty, covering themselves with a gown or skirt to prevent exposing themselves. She felt it would be very difficult for her to go to the doctor to have a baby due to the way in which women lie prone with their legs spread. She also felt this may be a concern for the young women in her community today who come from this very modest background (Interview 7:1997).

The other position mentioned was having the woman sit while another woman watched for the baby. It would seem to be similar to the above description only with the people's positions reversed (Interview 4:1997). The word "squat" was used a few times, usually in conjunction with kneeling, again a possible position for women who found it most comfortable.

Labour lasted anywhere from half an hour, as previously seen, to three days. Each labour was different and its length depended greatly on two things; how the woman helped herself and the nature of the birth, including whether there were complications or not. One midwife put it quite frankly:

Doesn't matter. When it will come, it will come. It all depends on how they help themselves. If they don't try to help themselves then the labour is long. If you try then you have it quick. If it gets worse then pretty soon it's gonna come. That's all. They don't watch time or anything. Let the baby come.
(Interview 3:1997).

4.2.3c Post-partum; Cleaning of the Infant, Mother, Afterbirth and Cord:

After the child is born a number of things must occur. For all participants, the child's eyes and mouth are either swiped clean with the finger or a small cloth. This removes the mucus which could infect the eyes or prevent the infant from breathing.

The delivery of the afterbirth was aided in many circumstances by the use of medicines, as previously outlined, or by the midwife. The midwives would slowly turn the baby and gently helped the placenta dislodge itself, while the labouring woman lay on her side. One Tlingit woman remembers how, after the cord was cut, her mother-in-law assisted the afterbirth to be expelled:

and then they wait again, you know, after they cut the cord and they look after the baby and you can feel it when the birth gonna be, is gonna come, you can feel it cause you get a slight pain, not as hard as labour pain, but a slight pain...You can feel it, right there and when you go "Oh, ah!!", like that, my mother-in-law, she says, looks like the rest is going to come. That's what she said and then she tell me if its, if you go like that again, she said and I'm going to help it to come because the cord is out there...and when I started to get the pain, slight pain, she help it. She pull the cord, slowly, she don't jerk it..she help it to come out
(Interview 4:1997).

I received a diversity of answers to the question of how the afterbirth was dealt with but they all revolved around the notion of what the women deemed "cleanliness". While some women stated that the afterbirth was "packed away", or "done away" with, others recalled the placenta being hung in a tree to dry out, another method of cleansing:

Yeah, and then what they do with the afterbirth they never just...someone would go in the bush with it and hang it under a spruce tree way up and it would get really dried up, that's how they treated it. Everything too we cleanse it, and nothing would ever bother it, or something like that, they always hang it up on the tree. That was very important, to put away the afterbirth (Interview 7:1997).

Other groups hung the dried and packed up placenta on the child so they wouldn't wander in life. However, some afterbirths were buried or as one woman Tlingit recollected, burned up:

Yeah, and when it comes out, they wrap it up and they don't throw it in the bush, they don't throw it in the garbage, they don't throw it anyplace, they make a big fire and they burn it up. They don't throw it away, it's funny, Native people, I know the white people don't understand, they the very cleanest people you ever know or what they do about their things...I never see any of the birth, I don't even know what the birth looks like, they don't even show it to me and I lay there nursing my baby (Interview 4:1997).

The cord connecting the newly born infant to their mother was also dealt with in a number of ways. Most women mentioned that scissors were used to cut the cord, but in the "old days", a sharp object or knife may have been used. One Haida woman was reminded of the times when "the cord of a baby girl was cut with a knife that belonged to the mother and naturally, the boy, the boy's cord was cut with the father's knife" (Interview 6:1997). Sterilization occurred either by boiling the scissors or pouring hot water over them. Yet, one Carrier Elder remembers an older midwife's disbelief in sterilization, claiming that

with the use of traditional medicines and as long as the women kept themselves clean no infections would occur (Interview 3:1997).

Cut about two inches above the stomach of the infant, the cord was usually tied on both ends with string, or white linen thread, braided to make it stronger (Interviews 1,3:1997). Balsam bark crushed up and burned helped stop any bleeding that occurred and after about 10 days, having dried up, the cord usually fell off the infant. Wrapped up, like the afterbirth, in cloth or a skin pouch either beaded or embroidered, the cord was sometimes kept with the child or given to the child at a later date:

What's left of it with the string tied on, it falls out in about a week or 10 days and when it falls out we take little...skin or some kind of stuff and we embroider or we bead it and then we put that cord inside and we close it up because the cord is dry, dry, dry by 10 days (Interview 4:1997).

In the Carrier tradition, recalled one woman, the cord had to be hung up outside only:

K: And what about the uhumm, cord ah, the baby's cord? Was there a special way of putting medicine on it?

S: Sometimes they clip it and then they use Indian medicine on it.

K: Yeah.

S: They tie it up and then they cut it and they put that, ah, the cord after it falls, they wrap it up and hang it anywhere they want to.

K: Ohh.

S: Yeah, they don't burn it or anything. They just hang it out.

K: In the house somewhere?

S: No, out somewhere.

K: Outside?

S: Yeah, anywhere, they hang it up.
(Interview 3:1997).

The midwives or women's helpers stayed after the birth to help the new mother who was required to rest in bed from 4 to 10 days. New mothers had to be very careful, especially with regards to their wombs, which having been stretched, could fall and the woman would either lose

her shape or be unable to have future children. Referred to as binding, several methods were used. A Carrier participant remembers the following:

So your womb doesn't fall you had to bind yourself, they made a little pillow for us about the size of between the hips, yeah, and we put that pillow in to keep our womb up eh, and then put a real wide bandage like, we make it like, our parents make it, out of a wide flannelette thing and they'd bind you while you were laying down and they'd pin it up..(Interview 7:1997).

While one Tlingit woman's description differed slightly:

and she get me up for a little while after I have the other children but she made, she sew and she made a girdle for me....yeah as soon as right after I had the baby she put that on and at the back there's skin coming down like that and there's a lace up and she put it on like that, herself, and she can tie it up as hard as she can...and that way she said, you don't go out of shape ...(Interview 4:1997).

Possibly binding began even while the women were pregnant as numerous Elders spoke of a "belt" women would wear when with child, right in the "pulse", below the mother's belly button. About eight inches across, the belt supported firstly the fetus before birth and secondly the uterus after birth. One Elder spoke of a midwife who could reposition the uterus if it had fallen after birth:

And when the womb falls, sometimes it does that, she was the one who, used to, who, uh, would put it in the right position, she knew what to do (Interview 7:1997).

4.2.4 Breastfeeding

When I initially started this research and conducted my first interview, I had not included any specific questions with regards to breastfeeding. However, it happened that a community member, Deet Rattray, a former Dease Lake Pregnancy Outreach Counselor, attended the

first interview with me and had some questions of her own to ask. After realizing that birth and traditional birthing systems do not stop upon delivery of the child and continue well into the post-partum phase, I decided to include a section on the discussion of breastfeeding in traditional First Nations communities. All of the participants agreed that breastfeeding should begin right after birth, with no waiting period. One Tlingit woman was astonished when her newly born infant latched and suckled right away:

It's surprising, as soon as the baby is born,
you put them there, their little faces and
Ah!! It's funny how they know (Interview 4:1997).

The children were breastfeed for over two years and always on demand but not all women could breastfeed. One Carrier participant stated that she tried to breastfeed as much as possible with the help of bottles but that after she got up from her 10 days of rest and started working, she "dried up" (Interview 7:1997). Another woman had an overabundance of moisture and her mother-in-law sewed her a bra fitted with cotton on the inside to prevent her from leaking. The amazing thing about this, she found, was that her mother-in-law:

never knew such thing as a bra, she didn't know
nothing about it, but it looked exactly like the
bra they have today, only it's thick with cotton
(Interview 4:1997).

A Tahltan participant remembered that women would mash up rabbit's brain and mix it with bear grease as either a breast milk substitute or as early solid food to feed to the infants (Interview 1:1997). Similar to this, when babies were first weaned all their food was masticated for them and when they were getting their first teeth, bacon rind was given to them so they would get "their teeth fast" (Interview 3:1997). Although it has been recorded in many First Nations groups in British Columbia that babies born with teeth are Elders reborn (see Mills and

Slobodin 1994), one Carrier Elder claimed that within her culture, babies born with teeth were "poison" and that their parents usually pulled them out immediately. The teeth (and all subsequent baby teeth that fell out) were thrown "to the moon or the sun and they talk to it. They tell it to have straight teeth" (Interview 3:1997).

To sum up, similar themes have surfaced throughout both the women's personal stories and from their knowledge of midwifery and traditional birthing practices. Like the woman's personal stories, birth is deemed a natural and normal event, yet the possibility of complications or even death are not forgotten. Both the community and women specifically, hold important positions with regards to traditional birthing systems outlined in the descriptions of the continuity of care practiced by the both the midwives and women's helpers at birth and the community at large with regards to the child's discipline. Also filtering through the Elders' responses was the holistic nature of traditional practices, as well as the foundation of the discourse on birthing, that the passing on of cultural knowledge to the younger generation was paramount. By reflecting and connecting to each other, these social patterns are woven together to create the basis for Traditional childbirthing systems.

4.3 CONTEMPORARY BIRTHING

When discussing the issues surrounding contemporary birthing in the Northwest all participants gave individual and quite different points of view on this controversial topic. Some women felt home birthing was better while others agreed that hospitals were safer. Nevertheless, no participant ever let go of the belief in birth as a natural and normal event:

S: Just like everyday, natural.

K: Natural...yeah.

S: If it gets worse, then they pretty soon

gonna come. That's all. They don't watch time or anything. Let the baby come....They wanted me to help at a workshop for that, I tell them, that's natural why? (Interview 3:1997).

Women's concerns were centred around both women's comfort in delivery and the safety of both mother and child. Coupled with these were the recurring dilemmas of travel and the separation of families. It seems that only by combining these two systems, the medical and traditional, can a solution be found.

All the women had lived or continue to live in communities where significant travel to hospital was necessary. For example; Dease Lake to Cassiar (~64 kms), Masset to Queen Charlotte City (~101 kms), Stoney Creek to Prince George (~98 kms) or Vanderhoof (~9kms), Atlin to White Horse (~135 kms) and Houston to Smithers (~64 kms). As has been previously discussed, the women who took part in the interviews had a variety of personal birthing experiences. Each birth story was unique and each system of birthing varied from woman to woman and nation to nation. Some participants had all of their children at home or in the bush, others had a mixture of home and hospital births while some had experienced only hospital births. This range provided insight into the traditional practices as well as into the transitional period of childbirth where women delivered both at home and in hospital. This was especially apparent in my afternoon with the three generations of Wet'suwet'en women and their discussion of their (great-great, great) grandmother.

Yet, the spectrum of answers expressed by the Elders did not create a consensus on whether home or hospital birth was preferred. One woman was firm in her belief that midwives should be used in communities without hospitals (Interview 2:1997), yet, another participant was just as certain that the Western medical system was the safest (Interview

6:1997). Two women felt that it didn't matter where you birthed, that both their home births and hospital births were similar:

A: Yeah it's all the same. The only thing is they have lots of other things too, I guess. There [hospital] they know how to look after the baby and everything, my mother-in-law she did pretty good too you know (Interview 4:1997).

It is very important to recognize the controversial nature of this topic and the host of factors influencing personal opinion on contemporary birthing. Similar to the attempts to denounce midwifery and women's healing powers in Europe as witchcraft, misinformation and ignorance of the nature of First Nations midwifery care stems directly from the centuries of public defacing of traditional knowledge and Aboriginal culture since contact by Western colonial systems of power.

Although many people are firm in their belief that women need the security of a hospital birth, others believe this can be achieved without sacrificing the comfort of the birthing woman and her family. The issue of choice came up for two participants who felt that women should be able to choose with whom, where and how they birth. These participants saw the benefits and shortcomings of both the Western and the Aboriginal systems of birth. As one Elder stated:

K: Do you think that maybe young women today should be having their babies at home?

S: If they want. Depends if they want to have their babies at home, they could, their own decision (Interview 3:1997).

Several participants noted there was "no choice" in the transition to hospital births and fears not only of the hospital itself but of repercussions from not delivering in hospital were also expressed. One woman's fear stemmed from what she described as "when the doctors do something to the women so they can't have any more children [paraphrased]" (Focus Group 8:1997). The controversy over unauthorized

sterilization of First Nations women in the mid 20th century has been recognized as both a childbirth health issue and a serious violation by the Federal Government towards the Aboriginal population. This atrocity has seen growing awareness from both Native and Non-Native groups. This same participant's mistrust continues today towards certain types of birthcontrol. Young girls, she says, get a "needle", or take a pill from the doctor which stops them from having children (Focus Group 8:1997).

The issue of birthcontrol came up as a topic for several participants and they expressed quite clearly the mistrust of interfering with the body's natural system:

One thing I always talk about is, you know, what I think now, a lot of our young people, our women are using birth controls, like I think it does something to your body and I think, what I think mostly is, you know, maybe that's why they have these cancers and stuff. Like that, like I think about it and everything has to come naturally, you have a baby and you have milk and I don't know, everything is natural and to do something like that I think is scary (Interview 7:1997).

Fear also came from a lack of knowledge of how the birthing system worked and how the law regarding birthing was changing, specifically mandatory evacuation for delivery. One woman remembers that they had no choice but to go to the hospital because several people told her that if anything happened to the babies at home the parents would have to go to court (Interview 1:1997). Ironically, many of the women had home births after the introduction of hospitals due to the inability to travel the distance to the hospital, the same reason mandatory evacuation was introduced.

Personal experience and the conception of what a hospital birth entailed varied in the responses from women. There was no simple consensus on which system to use. One Tahltan woman felt that:

Everyone live in the whiteman's way when I was brought up. I don't know, my grandmother she didn't

say how they did it. I just...it's all I know it's their new way of doing it, oh well, it's not a new way, it's just ah, using the stuff from order, from catalogue, that's all, that's the only thing different (Interview 1:1997).

Her experience of the hospital, after having many of her children at home was not an overtly negative one as the hospital where she delivered was small and births were not overly medicalized:

No, it's about the same....Oh well when I had ----- in the hospital they all ready leave the baby with you in the room. Already then, now they uh, before they used to just, leave them in the baby's room...the nursery and then they ah take the babies in whenever they want to eat (Interview 1:1997).

However, the hospital birth experience previously described in the section *Personal Stories*, where the woman was strapped down and not allowed to see her child, speaks volumes about the differences, even regionally, that women during similar time periods experienced within the hospital system.

Concern over women having to leave their communities became central to the discussion over the current system for a number of participants. One interviewee felt that the use of traditional midwives would be helpful for First Nations women, who would then be able to birth in their home communities. She felt that the distance traveled to deliver in hospital and the time spent in a strange place at such a sensitive time held the greatest threat to women having positive birthing experiences (Interview 2:1997). Another put it very concisely:

It doesn't matter where you are. You just have to go through it quick. Home, home is good. I like the home, I don't like the hospital (Interview 3:1997).

However, another participant although agreeing with the difficulties associated with waiting in a foreign community still preferred the hospital system for safety reasons:

C: I don't know, I don't think uhummm, it's such a good idea to have a midwife, I, I prefer the hospital.
 K: Okay...for the safety reasons?
 C: Uhummm..... nowadays I notice they send the mother to be over in Rupert here and they put them up in a hotel sometimes, I know this one young lady that waited for over a month, in that hotel. Uhummm. That's an awful long time (Interview 6:1997).

One woman wanted to know what we (myself and another woman who were conducting the interview) thought about the contemporary situation yet her thoughts touched upon the distance women must travel and the separation from their young children:

L: I don't know... What do you girls think?
 D: I think they have to make things easier for women who go out.
 L: Especially when they got little ones leave behind eh? And they leave them, someone got to take care of them for you....and nowadays it seems like nothing, I don't even think we noticed before, where they put the kids, I don't know where the elder ones go.
 D: I think they usually leave them with other relatives.. Some people are fortunate when they go out, they have family where they go out..
 (Interview 1:1997).

For many First Nations women in the North the extended family and larger community are still an important support system for pregnant women. Some women are lucky to be able to spend their time waiting for delivery with relatives when in urban centres.

Expanding on the concerns raised in the above discussions, one Elder brought a new light on the subject, claiming that woman should take advantage of the two different systems but always remembering that birth is a normal and natural event:

K: Do you think it's a wise move?

M: I think so. Everything is so modern now, it's like my grandchildren tell me, "it's the nineties gramma!"...I think so, I think so. Yeah.
 Mt: If we had to go back to the old ways we could, if we had too...
 M: Yeah, if we had to, if they had no hospitals, suppose they bomb the hospitals, what can we do? Wouldn't be the end of the world. Still get help (Interview 7:1997).

When all of the responses are placed together I saw that although a number of opinions and concerns are expressed with regards to both hospital births and homebirths, the issue over safety and comfort of both woman and child is a dilemma which has no easy answers. Ironically, some of the same issues which women discuss as affecting their birth experiences, like having to travel great distances and the uncertainty of weather and road conditions, are the same issues which stand in the way of safe home births from taking place in their communities. It seems that neither a radical switch to midwife attended homebirths or staying with the status quo would solve this problem. In each situation something must be sacrificed; the comfort of a birth at home with the support of relatives when women are evacuated or the reliable access to hospital safety systems if a homebirth were to have complications. Co-operation and collaboration between the Western medical system and traditional Aboriginal midwifery and its birthing practices may be the only answer. Opting for the best of both, the Indigenous system and the medical system, echoes the responses of the women interviewed.

4.4 CONCLUSION

Although First Nations women's knowledge and stories about traditional Aboriginal midwifery and birthing cultures vary across the Nations and communities of the North, similar themes arose from the data gathered. The Elders stories reiterated that women see birth as a normal and natural event. This reemerging theme cannot be disputed. The

necessity for the community to be involved, both as helpers in birth and as participants in the child's life, stem from First Nations kin based society and from traditional birthing's holistic nature and practice of continuity of care. Women want to be attended during birth by women who were traditionally the holders of sacred and important reproductive knowledge. Unique or unprecedented birthing situations were captured in a directory of birthing information and used in the passing on of knowledge orally, from generation to generation.

Birthing stories, with all of their celebrations of life also included images and instances of pain and sometimes death. Infant and maternal mortality in pre-contact times was seen, as birth itself, as a natural part of the cycle of life. First Nations beliefs in traditional healing powers included communication with animals and non-physical beings, the compelling of the will of another and the stealing and storing of souls. These beliefs were subsequently persecuted as witchcraft and this label was internalized by Aboriginal people themselves (Gunn Allen 1986:23). As stated by one participant:

S: Don't call me medicine man, I'm not, I tell them. I just use, they think I'm bad or something. ...I tell them I don't know anything about that. I just try to help people....Yeah, some medicines are good, they just don't work. They think I am bad. I tell them I can make medicine for them and try to help them out (Interview 3:1997).

Further, the colonial experience, with its introduction of European diseases, the move from traditional lifestyles to sedentary reservations, residential schooling which tore children from their families and instilled hatred of their own culture, has culminated in growing cultural loss and social dysfunction. Traditional midwifery and birthing systems were forced physically and ideologically to go underground or were abandoned altogether.

The social determinants of health greatly effect health status and with the legacy of colonization and genocide, it is no wonder that

infant mortality rates have remained twice as high for First Nations communities when compared to the general Canadian population. Until the basis for this is addressed and culture is included in program design, little change can occur.

Despite the break from tradition, women want both the benefits of a birth in one's community, the security and support of relatives, as well as the safety offered by Western hospitals. A complete return to Traditional Aboriginal midwifery and First Nations birthing systems would be difficult to implement immediately in any of the outlying communities of the Northwest. However, the philosophies or the base themes of birth as natural, that women attend women in birth, that birth is a community event and that knowledge is passed down to the younger generation orally through storytelling can all be incorporated into making the existing system more holistic for First Nations mothers and their families. As one woman stated:

They've come along way. You can have a natural, I had all of mine in the hospital naturally. You can if you so chose to do all that. I think you can have the best of both worlds now, cause you have the safety if you do have a problem but you can create your own atmosphere, you know, it's entirely up to the mother and father if they want to...
(Interview 7:1997).

CHAPTER FIVE: MOVING TOWARDS THE FUTURE

5.1 DISCUSSION OF FINDINGS AND RELATED THEMES

When the themes that the Elders revealed are tied together, their experiences and stories bring to light the inherent contradictions found between the current Western discourses on birthing, the medical and the natural, and the wants and needs of First Nations women and their families birthing in the North.

The literature review illustrated that culture, specifically First Nations voices, were absent in the current discourses surrounding birth. On the European side, the rise of the medical discourse created a vilification of midwifery based on a professional/nonprofessional dichotomy. The rise of the feminist revisionist narrative in opposition to this brought in the issue of gender, that medical science's take over of the birthing scene was an act of oppression of women as well. The colonial movement in North America continued this vilification of midwifery knowledge as witchcraft and led to the denouncing of traditional Aboriginal healing and birthing practices. Forced underground or abandoned altogether, this knowledge must be used to create a new narrative, one in which culture is seen as a relevant aspect to birthing knowledge.

The narrative themes presented by the Elders are that birth is a natural, normal, community and family event. These themes reflect the traditional perspective of holism. All things are related and birth and the knowledge surrounding birth cannot be separated from everyday experience. The stories, both personal and unique, are used as teaching tools to pass information on to the next generation.

5.1.1 Contradictions and Complexities

The contradictions that become apparent are focused on the transitional period between community based midwife attended births and hospital births. The move was forced both ideologically with the colonial vilification of traditional knowledge and physically with mandatory evacuations and government policy. When women lost the power to use their traditional birthing systems, a dependance arose on the Western medical model. As Benoit and Carroll (1995) have pointed out, recent evidence suggests that rates of mortality and morbidity for mothers and infants in pre-contact Aboriginal Nations was lower than after colonial impact (1995:235). So although the move to hospital births subsequently lowered infant mortality rates, it was the process of colonization and the introduction of disease which had caused excellerated rates initially. O'Neil (1990b) states this in the following way:

For governmental and medical authorities, a reduction in infant mortality from the "traditional" (i.e. pre-settlement) period is the justification for all the changes which have been made in obstetric care in the Keewatin [the North]. For the Inuit, the belief that "traditional" (i.e. pre-contact) birth was safe is basic to their demand for control over childbirth. The distinction between pre-contact and pre-settlement is an imposed one, for the current discourse blends both periods and reconstructs historical memory to fit ideological needs (O'Neil 1990b:56-57).

However, there is difficulty in assessing pre-contact Infant Mortality Rates, creating problems in the need to see pre-contact society as better than post-contact. To add to the complexity of the issues, even with this lowering of IMRs in both the Native and Non-native communities, First Nations IMRs continue to be twice that of the national average.

As presented in Chapter Two, the Native IMRs continue to be high due to the current status of the social determinants of health in First Nations communities. As Young (1994) describes, simply providing better access to Western services will not change the social determinants for Aboriginal peoples. The social inequities facing First Nations communities such as poverty and poor socio-economic status, are direct repercussions of colonization. Therefore, only in addressing these issues in a process of decolonization will Infant Mortality Rates, Low Birth Weight Rates and Teen Pregnancy Rates change to reflect improved health status for the Aboriginal population. At the same time, culturally specific and relevant perinatal services must be implemented. These services, in combination with the larger processes of decolonization, can help to lower Infant Mortality Rates, Low Birth Weight Rates and Teen Pregnancy Rates and subsequently improve the overall well being of First Nations peoples.

5.1.2 Contemporary Dilemmas

With much traditional knowledge gone, the move to hospital births presented in the Elders' responses reflected the need for these women to have safe and secure birthing experiences. However, the dilemma which arises is how to create a positive contemporary birthing experience where culture is not overshadowed by the medical technology-oriented narrative or the feminist-revisionist one. More specifically, we are faced with the problem of addressing how the Elders' responses and the revitalization of traditional midwifery knowledge can impact the practical health problems facing communities today.

Firstly, one must address how the revitalization of traditional knowledge can effect the social determinants of health. The Elders' experiences, stories and knowledge about traditional birthing practices

show that traditional birthing systems did exist and that they were deeply embedded in an entire way of being. For First Nations communities, recognizing their own cultural heritage and reversing the internalization of colonization can re-instill a sense of self worth, self-esteem and cultural pride. Creating positive feelings about ones self, community and nation is a first step in changing the way one reacts to their environment. Women and their families could begin a child's life in a positive way, by acknowledging and following traditional teachings, changing not only their life experiences but those of their children.

Secondly, in combination with these larger processes of decolonization, the Elders' knowledge and revitalization of traditional midwifery can be used in a practical sense by integrating it into current perinatal services for First Nations women. In the interviews, the Elders emphasized this need for women to have a choice between traditional homebirths and delivery in hospital. Seeing the benefits in both, the Elders also discussed the possibilities of combining the two systems. This revitalization as well as public acknowledgment and integration of traditional midwifery and childbirthing knowledge into the current birthing practices will create alternative options which fulfill both the need to ensure safety and the need to give women a positive birthing experience reflective of their culture, community and way of being.

The contradictions which arise from the findings are complex. Initially, First Nations voices were absent in the current discourses on birthing. This is partially due to the vilification of midwifery carried over from Europe by the colonizers and placed onto First Nations traditional birthing knowledge. As IMRs rose, the internalization of this vilification resulted in a growing dependance on the Western medical system and Aboriginal women began to choose hospital births for

safety reasons. As two sides of the same coin, the move to hospital births impacted First Nations as their cultural traditions were lost or set aside, yet benefited them by lowering alarmingly high post-contact Infant Mortality Rates.

Although initially lowering IMRs, the use of and access to Western medical technology has not evened out the disproportionate rates of infant deaths in First Nations communities as compared to the rest of Canada. Without addressing the social inequities created by colonization, IMRs, LBWs and TPRs will remain higher than average. The revitalization of traditional midwifery knowledge, expressed in the Elders' stories, can both instill a sense of self and cultural worth and be used practically in current services to change these statistics and subsequently improve First Nations health status and general well-being.

5.2 REVITALIZATION OF TRADITIONAL HEALING STRATEGIES

Re-traditionalization, in all its forms, is part of a general ferment of ideas now contributing to the renewal of Aboriginal cultures (RCAP 1996:352).

The benefits of traditional healing and the revitalization of traditional practices are multifold for First Nations peoples. They have the power to renew communities in the current process of decolonization at work in Canada. The majority of traditional healers were forced long ago to renounce their practices or to practice covertly because of persecution by Canadian governments and Christian churches and contempt on the part of bio-medical practitioners for their ceremonies, herbal treatments and other practices (RCAP 1996:212). Yet traditional practices, including Aboriginal midwifery and traditional birthing systems never faded away completely.

The reimplementation of traditional practices into or along with the current health care system must be community and culturally based with an emphasis on equity and the philosophy of holism. If such actions

are taken, the possibilities of a return to Aboriginal midwifery's birthing practices and philosophies seems feasible. By describing contemporary examples of communities who have successfully returned to traditional birthing systems and by reviewing the newly legalized status of midwifery in B.C., there is the possibility of a new combination of traditional and western practices that can enhance and positively change contemporary birthing experiences for Aboriginal people in the Northwest.

As previously outlined, in almost all areas of health Aboriginal peoples are suffering rates of illness and social dysfunction that exceed Canadian norms (RCAP 1996:223). Co-operation between traditional and mainstream practitioners has been outlined as a recommended action for change by the Royal Commission on Aboriginal Peoples for the areas of health care and general well-being. Its investigations have shown that any new, revitalized or co-operative Aboriginal health and healing system should embody four essential characteristics: the pursuit of equity, the inclusion of holism, the movement towards autonomy and be both culturally and community based.

The pursuit of equity in access to health and healing services and in health status outcomes is paramount as an initial intervention method. Along with raising life expectancy rates and lowering infant mortality rates, new health strategies must also work at evening out inequalities within the Aboriginal population itself by reaching out to Non-Status, Off Reserve and Metis populations (RCAP 1996:203). The inclusion of holism in approaches to health and well-being is reflected by acknowledging the interconnectedness between the four areas of self, the mind, body, heart and spirit as well as the individual, family, community, nation and future generations (RCAP 1996:205).

Although Aboriginal authority and control over health systems has begun to take place with Health Transfer agreements in many Aboriginal

communities, the transfers continue to work within the original design and world view of the Western model and need to be reorganized to reflect new community priorities (RCAP 1996:208). With this in mind, the need for culturally based programs must also reflect a diversity in the design of systems and services that accommodates not only the differences in culture across Canada but also of community realities. Examples of culturally based healing initiatives involve direct collective community participation in ceremonies, one to one client consultation with Elders and other healers and the participation of traditional Elders and healers in new program designs (RCAP 1996:350):

It is often pointed out that much of the content of Aboriginal cultures has been lost and that the dominant Non-Aboriginal culture has been absorbed by Aboriginal people. This is true, but to exaggerate this point is to miss one of the central facts of Aboriginal existence: Inuit, First Nations and Metis peoples of Canada are unique peoples and they are determined to remain so. Traditional norms and values, though changed and constantly changing, retain much of their power (RCAP 1996:209).

By enlisting the support of the mainstream system, more effective responses to health care for Aboriginal peoples will be achieved by bridging the cultural gaps through cross-cultural awareness, cross cultural input and by renewing the balance of power between our two worlds.

5.3 COLLABORATION/COOPERATION: CONTEMPORARY EXAMPLES

Several contemporary communities can be seen as excellent examples of women reclaiming their positions as the caretakers of the birth process through the integration of traditional midwifery practices in their health systems. The Sioux Lookout Zone Hospital in Northwestern Ontario, the newly opened Birthing Centre on the Six Nations Reserve in Ontario and the long standing Inuulitsivik Maternity Centre in Puvirnituk are three such organizations.

In the Sioux Lookout Hospital, although no actual labour coaching or home birthing is allowed, traditional midwives are able to help the expectant mother through much of her pregnancy term. The hospital has set up a self-help program aimed at collaboration between Native women and the professional medical community. The goal of this program is to make the existing health care system more responsive to community members and create better liaisons between the community and health care workers (Malloch 1989:112).

Traditional healers may practice in the hospital if it is requested by the patient and the midwife can give prenatal and post-natal counseling to the mothers. This mutual co-operation of existing health care and traditional health methods reflects the belief that Native people deserve the right to practice their own medicine with their own people.

This has also recently taken shape for the First Nations of the Six Nations Reserve in Ontario. The newly opened centre officially called *Tsi Non:we Lonnakeratstha* (The Place They Will Be Born) is the first Native-only birthing centre in Ontario:

The goal is to provide a space where women with normal low-risk, pregnancies can prepare, labour and deliver combining elements of traditional rites and ceremonies with modern medical procedures and know-how (Nolan 1996:July 3).

With a friendly, homey atmosphere, traditional ceremonies such as smudging and sweetgrass purification are used. Women and their families can also bring gifts of tobacco to the sacred fire burning outside the centre. *Tsi Non:we Lonnakeratstha* was built in response to a community health survey which indicated that Native women wanted to incorporate these traditional elements into their birth plans and to have their babies on Native Land. As Katsy Cook, a registered midwife from Akwesasne Reserve near Cornwall states:

The medical profession doesn't have to believe the way we believe, but our belief systems are an integral part of our culture and to think that we can have children without them is absurd (Nolan 1996:July 3).

Funded by the province until 1999 the centre is staffed by several Six Nations women who have been trained as Traditional Birthing Assistants, two additional First Nations midwives from Hamilton, and one from the Akwesasne Reserve near Cornwall Ontario. There are classrooms for prenatal activities and a kitchen for nutrition teachings. Breastfeeding is encouraged and mothers-to-be can birth in one of three birthing rooms, in hospital or in their homes.

The movement to bring birthing back to the Inuit communities in the Eastern portion of the Northwest Territories and Northern Quebec began in 1982 with the opening of The Inuulitsivik Health Centre in Puvirnituk (Tuluguk 1993:239). Initiated at the same time, *The Maternity Project*, brought together the efforts of the Native Women's Association and the seven surrounding villages. Public meetings, consultations with local organizations, surveys, questionnaires and interviews with Elders were used to get an understanding of the maternal needs in the Nunavik region. The goal of this project was to promote quality health care at the community level, to revitalize community knowledge including all aspects relevant to women and reproductive health, bring deliveries back to the North and to give the Inuit people control over their own health (Tuluguk 1993:239, Stonier 1990:63, see also O'Neil 1991 and 1990a&b for similar studies conducted in the Keewatin district of the NWT).

The Inuulitsivik Maternity opened in 1986 as an annex to the Health Centre with four maternity beds. Inuit midwife apprentices were nominated by the community and have been trained locally on the job as they work towards becoming the women's primary caregivers. One third of all deliveries are conducted with local staff and most communication

occurs in the Inuituk language (Stonier 1990:65, Tuluguk 1993:240). A perinatal committee chaired by a midwife meets weekly to review prenatal files and, along with risk grading, determines the place of birth and perinatal careplan for the pregnant women in these communities (Tuluguk 1993:239). Seven hundred and seventy-five in-community deliveries have occurred from 1986-93 and one Inuit midwife has completed the required training to achieve full privileges at the health centre (Tuluguk 1993:240, Gallagher 1997).

Stonier (1990), in her article "The Inuulitisivik Maternity", discusses the positive aspects of the maternity as allowing women care in her own language and culture by her own people. Although women in the surrounding communities must travel to Puvirnituq, the stay is shorter than traveling south, they can stay with relatives and their partners and families can be present. Stonier sums up her discussion by stating that "it is from within the culture and community that real positive changes in the health of a people begins" (1990:77). The Inuulitisivik Maternity is now 11 years strong and presently 80% of all births from the surrounding areas are performed at the maternity. Birthing has once again become an important part of the Inuit identity as a family and community event (Gallagher 1997:52).

As we have seen in these innovative examples, both the movement to include traditional midwifery knowledge and birthing practices into the current system and the move to bring births back into remote communities, are part of a larger process of decolonization for First Nations peoples. By returning birth to the hands of the midwives and communities, First Nations groups are taking control over their lives; socially, mentally, emotionally and spiritually with the inclusion of traditional birthing's holistic perspective in the contest of the best western medical assistance to decrease the high IMRs.

5.4 ABORIGINAL MIDWIFERY IN BRITISH COLUMBIA TODAY

Midwifery's growing acceptance in Canada has lead to its legalization in Alberta and Ontario in the early 1990's and more recently in the province of British Columbia. The benefits of midwifery and alternative birthing movements include lower hospital and medical costs, lower rates of caesarean sections and other medical interventions achieved thorough the reduced use of technology and pharmaceuticals as well as with the implementation of low cost birthing centres and home deliveries.

The B.C. provincial government's recognition of midwifery as a self-regulating profession was the result of lobbying from The Midwifery Association of British Columbia (MABC) and B.C. Midwifery Taskforce as well as consumer concern and the Royal Commission on Health Care and Costs recommendation to legalize midwifery (Benoit and Carroll 1995:226).

The British Columbia College of Midwives was formally acknowledged in 1995 and is comprised of nine people; three public and six professional and these members set the standards of practice, the code of ethics and review public complaints (Author Unknown 1995:02). Although the Midwives Association of B.C. took the first step by applying to the Health Professions Council to have midwifery recognized as a legitimate, self-governing profession, the government still plays a role as it appoints the public members of the College, requires the submission of annual reports and has final approval of College bylaws (Author Unknown 1995:01).

The professionalization of midwifery can be seen as a major part of the midwifery movement in Canada as medicalized birth has reached a near hegemonic state with 99% of births taking place in hospitals (Burtch 1994a:05). Previous to this legislation, midwifery was not only marginalized but illegal and Section 72 of the Medical Practitioner's

Act restricted the performance of midwifery to members of the College of Physicians and Surgeons. However, independant, community and Aboriginal midwives have been practicing in the province for a long time and up to the present when evacuation to hospitals was not possible (Benoit and Carroll 1995:225).

Although historically Aboriginal midwifery has been ignored in the official discourses of birth, it is making itself heard in the new movements to legalize midwifery in Canada. In B.C., the Committee on Aboriginal Midwifery was established to determine the specific place that Aboriginal midwifery will hold in the larger scheme of legalized midwifery and to ensure that, ideologically and legislatively, it will not become overshadowed in the process of professionalization and entrenchment into the Western medical system.

This Committee will guide the development of additional registration requirements and standards of practice for the First Nations populations. These additions will include the honouring of Native cultural and spiritual customs as well as the use of traditional herbal remedies and healing practices (Author Unknown 1995:03). The recognition of and rejuvenation of Aboriginal midwifery is part of a larger health promotion and illness prevention movement taking place in First Nations communities across British Columbia. Focus on perinatal care and traditional ties will help address issues such as infant mortality, low birth weight, malnutrition, Fetal Alcohol Syndrome, parenting skills and community support by ensuring that the knowledge of the Elders is retained (Author Unknown 1995:03).

Some see traditional healing as an adjunct treatment service; others insist on it remaining an alternative service, completely separate from Western style medicine and social services. However, the possibility for real healing to take place revolves around the notion of collaboration and full partnership with Western medical science. Having

community Elders provide personal birth stories, knowledge of midwifery and traditional birthing practices as well as information on traditional health and the traditional roles of men during the prenatal period could enhance existing programs. The revitalization of cultural beliefs, even within the context of the Western health care system, is a method of empowerment for First Nations women and their families. Further, the exploration of existing alternative birthing options and the use of traditional midwifery knowledge in birthing centres, a reality for other Northern areas, could lead future research initiatives.

As previously mentioned, several Aboriginal communities have already begun this process with culturally based community birthing centres and Aboriginal midwives. With the recent acceptance of midwifery as a profession in British Columbia and the recognition of a separate committee on Aboriginal Midwifery, British Columbia has begun to empower Aboriginal women birthing in the North.

5.5 CONCLUSION

Traditional healing methods and therapies can make two sorts of contributions; they are valuable in their own right for their direct efficacy in treatment and they contain ideas that can be adapted to solve difficult problems in restoring whole health to Aboriginal people (RCAP 1996:211).

Midwifery in Europe originally was a community based activity. Its move to church and then state control led to the denunciation of the traditional women healers who were the caretakers of the birthing scene. From this decline of midwifery in Europe one can trace the rise of two culturally constructed official discourses of birth, the medical-technology based narrative and the feminist-revisionist narrative. However, neither gives voice to cultural difference in their discussions and they have silenced alternative birthing systems, including First Nations traditional midwifery knowledge and birthing practices.

Although centuries of colonization, denunciation of culture, abuse, genocide and oppression have obscured Aboriginal voices in the discussion of both healing and birthing, traditional practices have survived. Upon contact the introduction of European diseases, warfare and assimilatory government policies caused a cultural lapse, where ideologically and physically, First Nations peoples were forced to renounce their traditional and cultural beliefs. This movement is similar to the European movement to vilify midwifery, women healers and their power in the birthing scene. Accused of witchcraft, European and Aboriginal midwives were cast out of their traditional spheres of healing with the threat of damnation. After centuries of suppression in Europe, midwifery and women's healing knowledge eventually gained a secure footing. In the "New World", this same suppression of traditional healing practices has caused them largely to go underground. Yet the depth of the knowledge the Elders gave shows that it had not completely disappeared despite the growing dependance on Western society, its governments, educational and health care systems.

Colonization has left a legacy of social illness within the First Nations populations of Canada. Centuries of persecution have resulted in loss of cultural knowledge, generational gaps, low self-esteem and lack of self worth and nations, communities and individuals continue to suffer today from these effects. The social determinants of health, such as socio-economic status, low levels of education attainment and political marginalization, have resulted in an extremely poor health status for Canada's Aboriginal peoples. As the health care system fails to improve First Nations well being to the national standard, we see alarming discrepancy in health status indicators.

The North has a unique history as First Nations peoples' birthing cultures not only survived but were practiced up until relatively recently. Obstetrical policy and misrepresentation of traditional

birthing practices led to the mandatory evacuation policies which First Nations across the North are seeking to change. Northwestern B.C. is no exception. With higher than average regional rates of infant mortality, low birth weight and teen pregnancy, coupled with the highest percentage of First Nations population in B.C., health care access and delivery for Aboriginal peoples must be challenged. Only by addressing the history of oppression, genocide and assimilation, and the subsequent effects on the social determinants of health, will change occur. Promoting the revitalization and use of traditional healing practices as well as including Indigenous philosophies in the current health care system are ways to encourage positive health status change in Aboriginal communities.

Traditional knowledge must be protected and promoted. When I asked the question, What traditional knowledge is available about midwifery and birthing practices in the Northwest?, it was the Elders who answered with enormous amounts of information about their personal experiences, specific healing knowledge and feelings on the contemporary birthing scene. Again and again the same thoughts were expressed, that birth is normal and natural, to be celebrated as a holistic, family and community centred event. The Elders see these aspects of traditional birthing as essential to conducting healthy births today, be they in hospital or at home. By incorporating the base philosophies of Aboriginal midwifery and traditional birthing practices into the contemporary birthing system, women may be able to attain the best of both worlds.

Since prenatal education and care is a right of all prospective parents in Canada, making prenatal care for First Nations peoples not only accessible but culturally sensitive is paramount (Aboriginal Nurses Association of Canada (ANAC) 1996:14). The socio-economic barriers which hinder specifically First Nations women must be considered in any program and should include one on one counseling, possibly in the home,

as well as culturally appropriate resource materials for Aboriginal peoples.

One method for instituting change could be to provide information and establish awareness throughout First Nations communities about the practice and benefits of traditional midwifery. Emphasizing that normal birth is not a medical risk and that traditional childbirth was an entire community event, deliveries could occur in communities by trained and certified licensed midwives. However, there must remain a choice of practitioner (ANAC 1996:31). In addition to these ideas, the possibility of establishing child birthing centres, where identified by First Nations communities as a useful community resource, is also a viable mode of action. With regards to community involvement; raising awareness of community midwifery as a profession, providing information on midwifery training and encouraging youth to consider midwifery as a profession are other planning methods (ANAC 1996:31).

Other ideas for change include culturally based programs for First Nations women and their families, reflective of the holistic and community centred nature of traditional practices. These could be established either in the southern centres where women must evacuate to for delivery or in newly developed birthing centres in the North. Cultural awareness in hospitals must be a priority and simple steps like providing language interpreters, cultural foods, medicines and recognition of spiritual practices can make women birthing out of the community more comfortable. Funding to allow partners to accompany birthing women, and to cover transportation, accommodations and childcare as well as the establishment of birthing group homes, where women and their families can stay and interact with others in similar situations, are two other methods to enhance birthing experiences for Northern women.

Reimplementing the oral discourse of birth by having Elders teach workshops or participate in these programs is essential. Further, all communities should be well informed on alternative birthing options and successful First Nations attempts to bring traditional practices into the birthing scene such as the Inuulitsivik Maternity and *Tsi Non:we Lonnakeratstha*.

As with the Commission's finding on the general health and well-being of the Aboriginal population, the goal for change in Aboriginal prenatal and pregnancy health will not come from a complete replacement of traditional birthing practices over the medical model but will involve the combination of these two worlds for the optimal health of First Nations mothers and their families to be met (RCAP 1996:137).

Along with ensuring the safety of Aboriginal mothers, infants and their families, any alternative must recognize the diversity of First Nations traditional beliefs by being community initiated and community based. The revitalization and reimplementation of Aboriginal midwifery knowledge and traditional birthing systems must instill pride and self worth into First Nations cultures and be part of the larger movement towards decolonization at work in Canada today.

I have not always felt empowered by my role as a woman or by my connection to the earth. Western society has made me feel ashamed of my body, its cycles and gifts. This research has given me one very important gift, the knowledge that being a woman is the most important part of my life and it shapes my outlook and my experiences.

Like the beginning of this journey, the end will also be lost in a host of memories, new endeavors, academic relationships and most importantly friendships sown over the two year period of this process. Now a new experience has entered my life, I have become pregnant with my first child. Every moment has been joyous and I wonder if this thesis was in preparation for this pregnancy and new role of motherhood.

Women are the givers and caretakers of life. They are the centre of life and have an intimate connection to the Earth and all of creation. Their gifts sustain the people on this earth and must be honoured, celebrated and respected.

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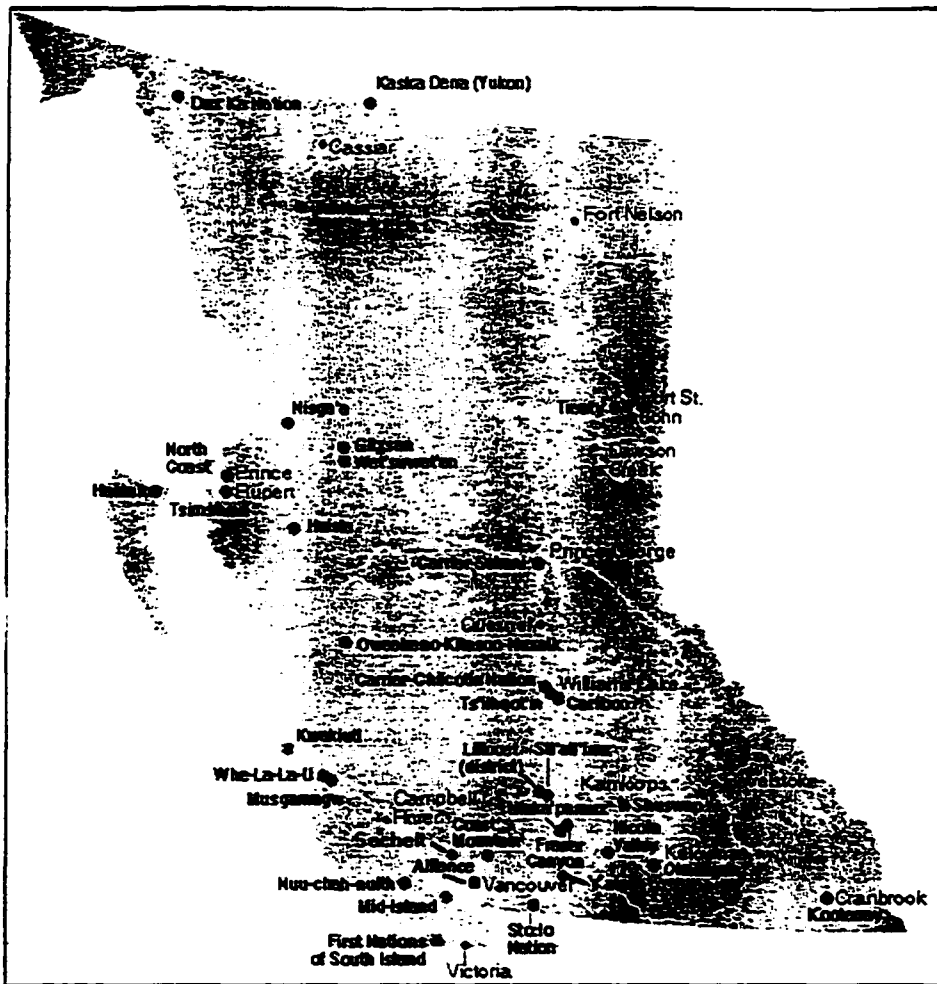
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Figure #1
Map of First Nations of British Columbia
 (source: <http://www.aaf.gov.bc.ca/aaf/fn/fn.html>)

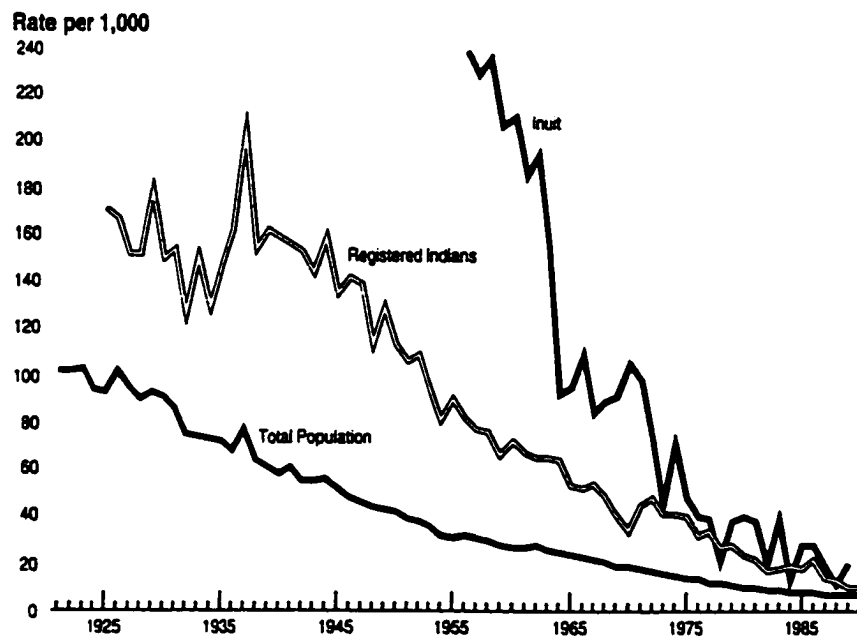


- B.C. First Nations Community Descriptions and Affiliated Tribal Councils
- B.C. First Nations Tribal Councils and Affiliated Communities

All information provided courtesy of the Government of Canada, Department of Indian Affairs and Northern Development.

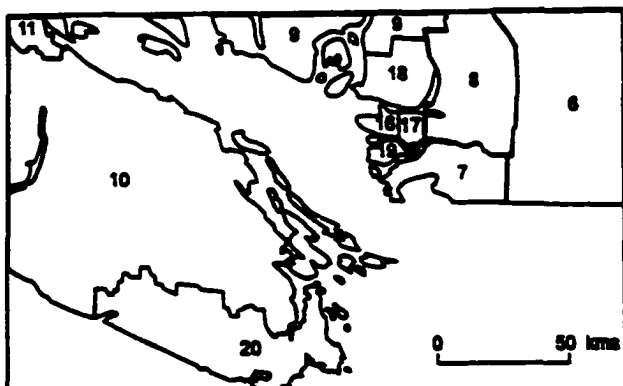
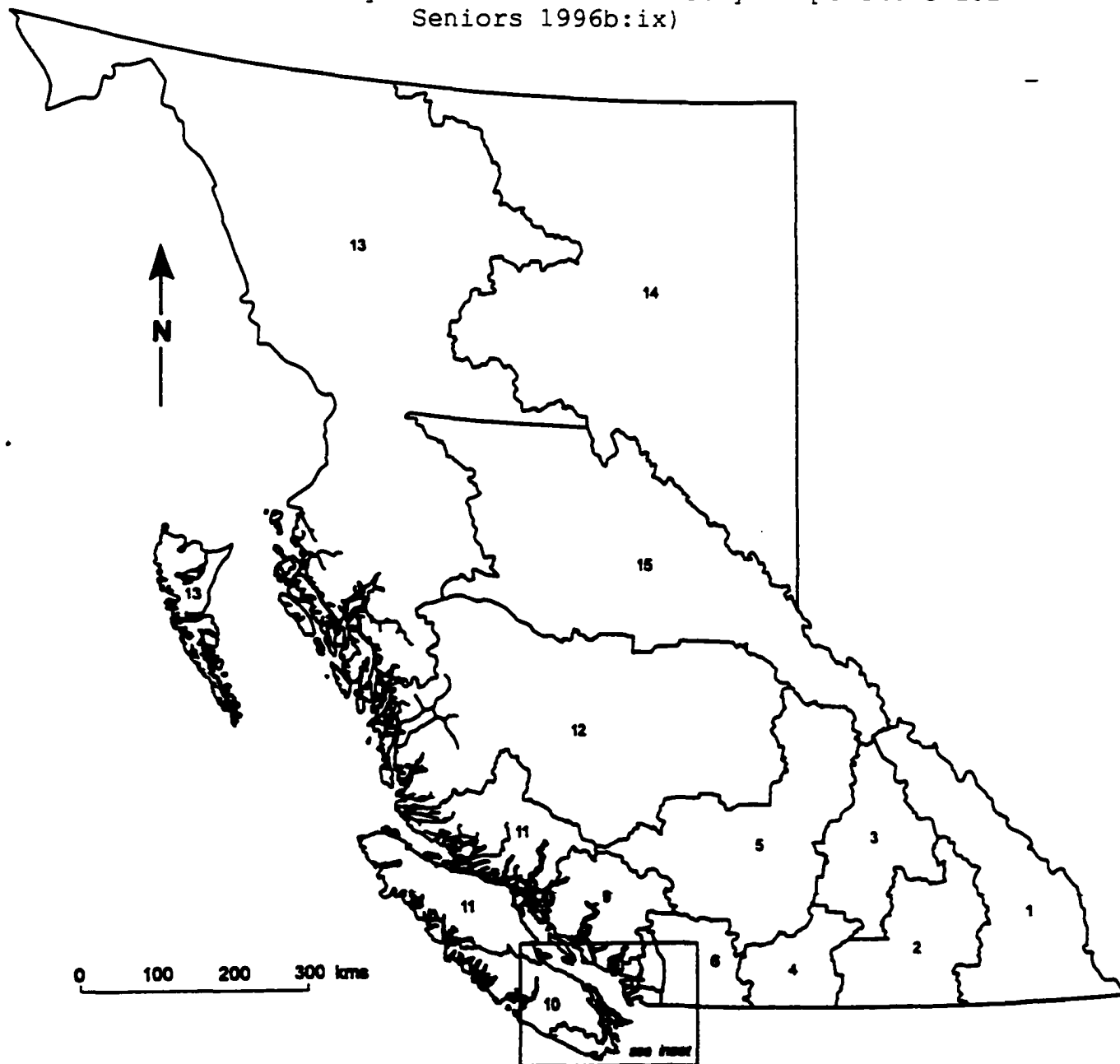
Figure #2
Infant Mortality Rates (IMR's) for Registered Indians, Inuit
and Total Population

(source: Royal Commission on Aboriginal Peoples 1996:128)



Source: Kue Young, "Measuring the Health Status of Canada's Aboriginal Population: a statistical review and methodological commentary", research study prepared for RCAP (1994).

Figure #3
Map of British Columbia Health Regions
 (source: Ministry of Health and Ministry Responsible for Seniors 1996b:ix)



- | | |
|----------------------------------|-----------------------------------|
| 01 East Kootenay RHB | 11 Upper Island/Central Coast RHB |
| 02 West Kootenay-Boundary RHB | 12 Cariboo RHB |
| 03 North Okanagan RHB | 13 North West RHB |
| 04 South Okanagan Similkameen HB | 14 Peace Land RHB |
| 05 Thompson RHB | 15 Northern Interior RHB |
| 06 Fraser Valley RHB | 16 Vancouver HB |
| 07 South Fraser Valley RHB | 17 Burnaby HB |
| 08 Simon Fraser HB | 18 North Shore HB |
| 09 Coast Garibaldi RHB | 19 Richmond HB |
| 10 Central Vancouver Island RHB | 20 Capital HB |

Note: Prepared by: British Columbia Vital Statistics Agency (10/96).
 Map Boundary Source: Central Statistics Branch.

Figure #4
Map of British Columbia Local Health Areas
 (source: Ministry of Health and Ministry Responsible for Seniors 1996b:viii)

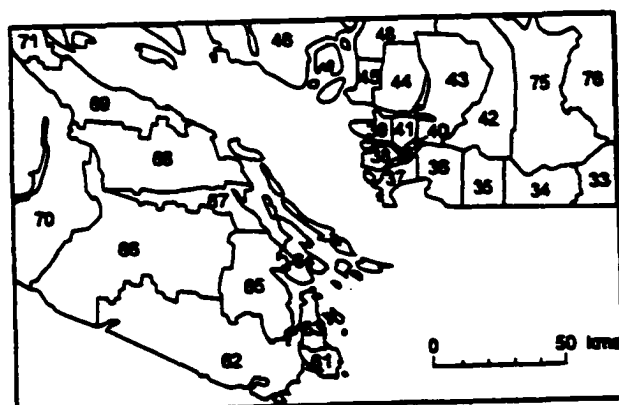
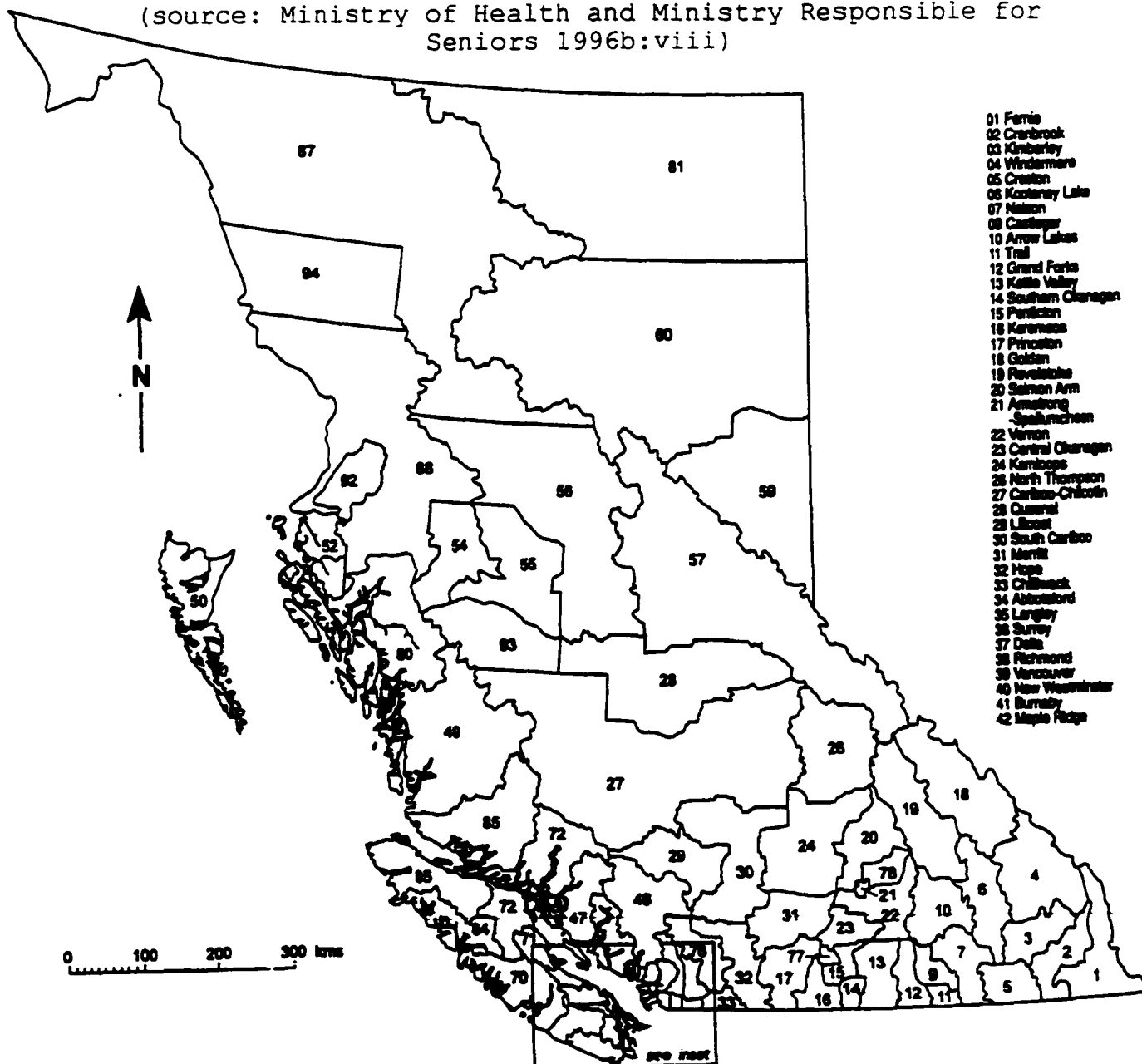
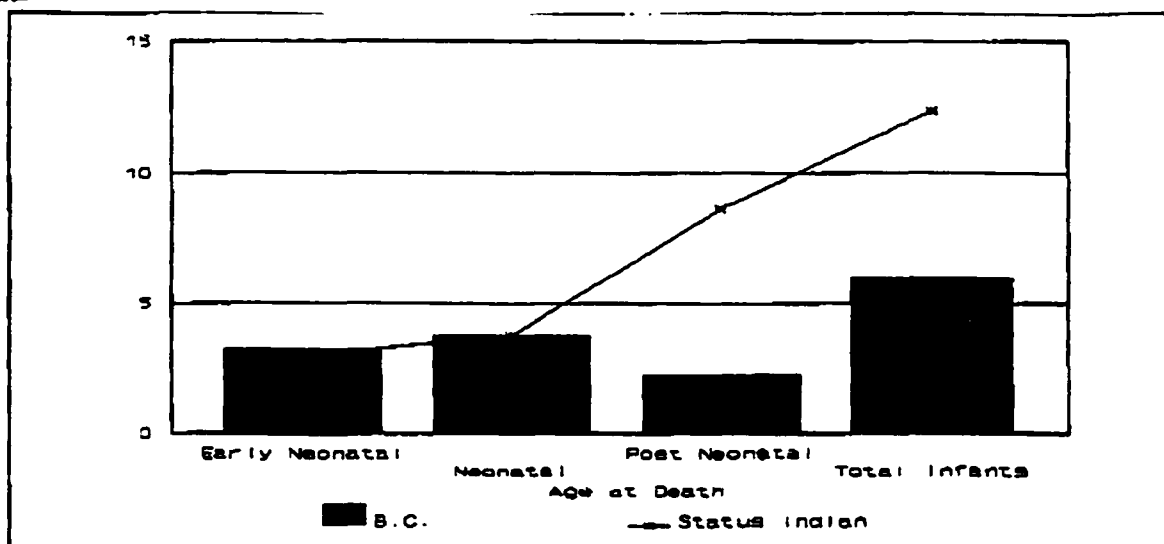


Figure #5
Infant Mortality
Status Indian vs. B.C., Both Genders
British Columbia, 1992
 (source: Health Canada 1995:110)

Rate



Rate per 1000 Live Births
 Source: Vital Statistics

INFANT MORTALITY
STATUS INDIANS VS BRITISH COLUMBIA POPULATION, 1987-1992¹

Sex	Indian/ B.C.	Age at Death							
		Early Neonatal		Neonatal		Post Neonatal		Total Infants	
		No.	Rate	No.	Rate	No.	Rate	No.	Rate
Male	Indian	27	3.26	36	4.35	95	11.48	157	15.83
	B.C.	581	6.29	686	5.07	445	3.43	1 151	6.50
Female	Indian	27	3.54	32	4.19	58	7.60	90	11.79
	B.C.	422	3.27	493	3.82	302	2.34	795	6.16
Total	Indian	54	3.39	68	4.27	153	9.62	227	13.89
	B.C.	1 003	3.79	1 179	4.46	767	2.90	1 946	7.36

Total number of live births in B.C. 1987-1992
 Status Indian: 15 908
 Provincial: 264 502
 Source: Vital Statistics

¹ For additional detailed statistics by year (1987-1992),
 see Appendix C: Pages 5, 6 and 7

Note: Early Neonatal: Age at death less than 7 days.
 Neonatal: Age at death less than 28 days.
 Post Neonatal: Age at death greater than 28 days to
 under one year.
 Infant: Age at death less than one year.
 Rate per 1000 live births.

Appendix I

INTERVIEW TABLE

<u>Title</u>	<u>Participants</u>	<u>Nation</u>	<u>Date/Place</u>
Interview #1	2	Tahltan	Sept. 24 1997, Dease Lake, B.C.
Interview #2	1	Haida	Preliminary: Oct. 8 1997, Prince Rupert, B.C. Secondary: Oct. 9 1997, Terrace, B.C.
Interview #3	1	Carrier	Oct. 28 1997, Stoney Creek, B.C.
Interview #4	1	Tlingit	Nov. 8 1997, Smithers, B.C.
Interview #5	2	Wet'suwet'en	Preliminary: Oct. 9 1997, Terrace, B.C. Secondary: Nov. 10 1997, Houston, B.C.
Interview #6	1	Haida	Nov. 12 1997, Prince Rupert, B.C.
Interview #7	1	Carrier	Dec. 4 1997, Stoney Creek, B.C.
Focus Group #8	~8	Nisga'a Gitxsan Haida	Nov. 13 1997, Prince Rupert, B.C.

Letter of Intent:

Aboriginal Midwifery and Traditional Birthing Systems Revisited and Revitalized: Interviews with First Nations Elders in the Northwest Region of British Columbia

This research will be conducted as part of the requirements for the First Nations Studies Masters Program at the University of Northern British Columbia in Prince George, B.C. I will be collaborating with the The Dze L K'ant Friendship Centre in Smithers, B.C. which is initiating a similar study in the spring of 1999. As a separate but complimentary part of it the Friendship Centre's study, I have been asked to interview Elders from the First Nations communities of Northwestern British Columbia. This gathering of traditional knowledge, personal experiences and perceptions on birthing practices in combination with Dze L K'ant's research project would serve the following purposes:

- 1) Record and preserve traditional knowledge from First Nations communities
- 2) Identify alternative birthing options and practices for women in the Northwest.
- 3) Create a knowledge base for new and current health programs in the Northwest
- 4) Secure First Nations voices in the discussion on birthing options in the Northwest
- 5) Ensure that my thesis research is both community based and recognized as a priority area of research in the Northwest.

The process for the selection of interview participants will be done in co-operation with Louise Kilby, Director of Development at Dze L K'ant and key community representatives from the Northwest region which the Friendship Centre serves. The number of First Nations Groups in this region is extensive and each Nation as well as each community are unique in their traditions, memories, experiences and needs. I hope to conduct nine interviews at approximately 1-3 hours each. Again, this is only part of a larger study being undertaken by The Dze L K'ant Friendship Centre and additional information and interviews may be used to expand the data I gather for the Centre's final report.

Some or all of these questions will be asked and some questions may be altered to accommodate for the unique ancestry/nation of the interviewee, i.e. Aboriginal midwife to Haida midwife and depending upon if the interviewee was a midwife or a relative of a midwife, i.e. granddaughter. Audio and video taping of each interview would be ideal and upon permission of each participant these recording techniques will be used.

Thank-you for your time and help,

Kimberly Ross

Interview Questions

Three themes:

- 1) Interviewee's experience
- 2) Traditional Aboriginal Midwifery/Birthing Practices
- 3) Contemporary Birthing

Section #1

1a) I am interested in hearing about your knowledge and experience in the area of childbirth, traditional midwifery and birthing practices.

1b) How many babies have you delivered? How many births have you assisted?

1c) When were you delivering babies, what years? Was there a hospital/clinic or a nursing station in or near your community then? When did births begin taking place in hospitals in your community? What was this transition like? Was your community aware of other birthing options before hospital births began?

1d) Do you have any specific experiences/stories you would like to tell?

1e) Do you have children?

1f) Were any of your children born at home? What were your experiences? Were any born in the hospital? Which did you prefer?

Section #2

2a) What is your traditional word/term for a midwife? What does it mean?

2b) What were some of the traditional practices, ceremonies, beliefs surrounding childbirth and the practice of midwifery?

2c) What was the role of the midwife leading up to the birth? (prenatal care)

2d) (supplementals) What did/does the arrival of a newborn baby mean in your community?

What things did a woman do differently when she became pregnant? Was she looked upon differently in the community? How did the woman prepare for having a baby?

2e) How did/does someone become a midwife?

2f) What were/are some of the responsibilities of a midwife in the community? What types of skills did/does a midwife possess? How did/does a midwife pass on her skills?

2g) (supplementals) How was/is a new midwife chosen? Were/are they always women? Could/can a man be a midwife? How long was/is the training period for a new midwife? What was/is involved in this training? Have you trained anyone?

2h) What was a traditional homebirth like? Who participated and Why?

2i) (supplementals) What traditions were followed when the woman went into labour? Where was the woman during labour? What was prepared? What were the positions for birth?

2j) What was the role of the midwife after the baby was born?

2k) (supplementals) What was done right after birth? (tying of the cord etc.) What ceremonies were performed regarding the afterbirth? When did the mother begin breastfeeding?

Section #3

3a) How do you feel about birthing today in your community? How do you view the Health Care System and hospital births?

3b) What do you see as some of the problems for women who must leave their communities to give birth? What solutions do you suggest?

3c) What are your feelings on the use of traditional Aboriginal midwives or registered midwives today, either for homebirths or in a hospital setting?

3d) Do you want to add anything else?

Appendix 3

Informed Consent**Aboriginal Midwifery and Traditional Birthing Systems Revisited and Revitalized:
Interviews with First Nations Elders in the Northwest Region of British Columbia**

The purpose of this study is to gather and record traditional aboriginal knowledge on midwifery and birthing needs through interviews with First Nations Elders from communities in Northwestern British Columbia. This study will benefit First Nations communities by:

- 1) Preserving cultural knowledge.
- 2) Ensuring First Nations perspectives in the establishment of birthing options for women in this region and when creating a knowledge base for new and current health programs.

Agreement to Participate

I agree to participate in the interview and possible return visit for this study and I have been properly informed of the following things:

- ~ that I will be asked questions about my personal experience and knowledge
- ~ that the information I give will be used in Kim Ross' Masters Thesis for the Department of First Nations Studies at UNBC and The Dze L K'ant Friendship Centre's Regional Study of Birthing Needs and Midwifery.
- ~ that I will remain anonymous in the study
- ~ that my participation is voluntary and that I may withdraw at any time
- ~ of how I may access the data and results of this study
- ~ that the audio and video tapes of my interview will be confidentially stored

I have agreed to have this interview:

Audio taped _____ Video taped _____

If you have any questions feel free to contact Kim Ross, The Dze L'Kant Friendship Centre or The Department of First Nations Studies at The University of Northern British Columbia.

Signature of Participant

Date _____

{ I have received a copy of this letter }

Signature of Principal Researcher

Date _____

Appendix 4

COMMUNITY ACCESS TO DATA/RESULTS

Each participant will be asked if they would like copies of the audio tapes, video tapes and transcriptions of their interviews. Each participant will be offered a *Community Summary* of the final thesis project and will have access to a complete copy of the final thesis project to be housed at the Dze L K'ant Friendship Centre in Smithers, British Columbia.

STATEMENT OF CONFIDENTIALITY

All participants in the study *Aboriginal Midwifery and Traditional Birthing Systems Revisited and Revitalized: Interviews with First Nations Elders in the Northwest Region of British Columbia* will remain anonymous. The only persons who will listen to or view the audio or video tapes will be myself and Dr. Antonia Mills at the University of Northern British Columbia, supervisor to the thesis project. Community members participating in the interviews, with permission of the interviewee, may use the information for other community purposes. All audio and video tapes will be stored in a personal locked filing cabinet at the home of Kimberly A. Ross Leitenberger, primary researcher.