

## **Native Childbirth in the Canadian North: Are Midwives the Answer?**

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**ABSTRACT:** Native women residing in the Subarctic and Arctic are currently struggling for the right to decide whether they will be hospitalized or have a midwife present for the birth of their children. The argument presented in this review paper outlines the cultural and clinical factors in favour of recognizing and legalizing traditional midwifery in the North and critically examines the statistical and safety concerns raised by those arguing against giving Northern Native women an alternative to evacuation from their home communities.

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### **INTRODUCTION**

Canadian government policy regarding Native health in the North was developed in the 1950s as an attempt to control alarming mortality and morbidity rates. Public health programs, nursing stations and systems of referral and evacuation to secondary and tertiary care facilities were the major components of this policy (Paulette 1990a). Maternity care was provided primarily at nursing stations and attempts were made to familiarize traditional birth attendants with modern medical techniques. Unfortunately, the nurses imported to the North as instructors of classes of Native midwives, true to a Western tradition which devalues indigenous knowledge and skills, were soon undertaking the job of maternal care themselves (Young 1988). By the mid-1970s the reluctance of non-Native nurse-midwives to remain in the North resulted in the practice of evacuating mothers near their delivery date.

The present situation in the North can be viewed as a continuation of, and colonization by, the allopathic medical philosophy developed in nineteenth century Europe. Allopathic medicine was male-dominated, elitist and prided itself on courageous interventionist strategies. Childbirth was seen as dangerous, a crisis controlled and remedied only through the art of medicine; the knowledge of midwives was considered inadequate and their traditional role replaced and de-valued (Catano 1985).

Native midwives in the Arctic and Subarctic suffered the same erosion of their cultural role in the 1960s and 70s. Believing hospitals to be the only place to give birth because of the risks to infant and maternal health that inhere in home births, physicians and government health officials have advocated a birth

environment unsuited to, and therefore rarely found in, the isolated and sparsely populated North. Women from small communities must be flown, sometimes thousands of miles, to the few large centres in the North offering hospital care. And midwives, once an integral part of Native culture, are now rarely found. Their traditions are being lost because few women are aware of alternatives to evacuation, and because a stigma is attached to non-Western, non-heroic health care.

This paper focuses on the desire of Northern Native women to give birth in their own communities, a desire which escalates into a fight for the legitimacy of traditional systems and for the right of Native groups to determine their own futures. In order to give voice to the opposition, however, the beliefs of physicians and policy makers that run counter to Native desires will also be examined. It is apparent that there is a strong opposition to the women's proposals, for they are still fighting. What is surprising is the lack of material published by those refusing to grant the women's wishes. Perhaps this indicates a lack of professional interest in alternatives, or the tacit assumption that these women cannot pose a threat to the medical establishment. The challenge of this paper — which endeavours to tell both sides — was to access the meager information written by those against midwifery in the North.

## TRADITIONAL PRACTICE

### *Birth as Component of a Larger Cultural Framework*

For Northern Natives, childbirth was intimately tied to one's identity as a woman and to the maintenance of a healthy, respectful bond between the generations. Elders possessed important knowledge regarding birth, and this was traditionally passed from generation to generation, often through apprenticeship (Preston 1982b; Voisey et al. 1990). Hospital births have devalued the knowledge held by elders whose experience does not apply to the sterile, secretive world of labour and delivery rooms. As a result, elders are powerless to prepare the inexperienced for childbirth. What was once an occasion for joy and sharing is now intensely private and often embarrassing, and elders lament that the days when women helped one another are gone (Paulette 1990a, 1990b).

Acting as a midwife was traditionally seen as seizing one's female power and helping others to realize their potential as women (Malloch 1989). Birth attendants subscribed to a holistic vision of health. They considered it a spiritual as well as a physical activity and saw their role as supplying emotional support as well as offering technical assistance. Hospital procedures, in comparison, tend to reduce childbirth to a sickness with physicians dividing the physical from the spiritual and emotional and assuming responsibility only for the former (Robinson 1990).

Birth was traditionally a much-celebrated life-cycle event that often involved

the entire community (Paulette 1990a). It was the central occasion from which many important rituals extended, some of these decreeing the future relationship of the newborn to particular members of the family or community. The naming ceremony, tied intimately to Inuit belief in reincarnation, often occurred during the final moments of delivery. The women attending the birth would call out the names of departed friends and relatives, and the baby would decide to enter the world at the moment the women called the correct name, thus naming itself (Putt 1990). Traditionally, there was an important bond between the child and the midwife who assisted at his or her birth. The first animal killed, if the child was a boy, or first item sewn, if a girl, was to be given to her (Putt 1990). Attending the birth of a child in the days of home births was the Senajik — the one who cut the cord and dressed the child. This person was responsible for the child's moral development (Stonier 1990). These Inuit traditions have been threatened or, in the case of the midwife-child relationship, completely destroyed because of the evacuation policy.

#### *Self-sufficiency and Autonomy*

Traditional childbirth practices of Native women in the Subarctic and Arctic, though differing somewhat by region, were generally founded on a belief in self-care and control over the proceedings. An Inuit woman could decide who would be present at the birth of her child; those wishing to attend had to obtain her consent (Freeman 1978). In both Inuit and James Bay Cree tradition, the pregnant woman was responsible for birth preparation — be this the gathering of materials to make a mattress, the preparation of a stick-and-rope contraption which would support her weight during contractions, or the collection of moss for diapers (; Flannery 1990; French 1977; Paulette 1990a).

At the onset of labour, the woman would continue her normal work. For the Cree, this was due to the value placed on autonomy and non-interference; the pregnant woman was not willing to defer control to another or cause unnecessary interference until it was inescapable (Preston 1982a, 1982b). In the case of an Inuk woman this was due less to reticence, as the midwife and other women would often arrive early to gossip and drink tea (French 1977), and more to a belief that remaining active would ease delivery (Paulette 1990a). The midwife was very conscious of her role as helper, and did not usurp control of the birthing process. She did not offer aid but rather gave it when requested (Preston 1982b). This is in stark contrast to the philosophy behind hospital births, and for this reason many Native women are critical of obstetrical intervention, regarding it as an unnecessary and unwanted intrusion into a natural process (Malloch 1989; Robinson 1990). Actual control over decision-making has been denied Native women by the medical system since the 1970s. Prior to this time they could decide whether they wished to deliver with a midwife or be flown to a hospital (Stonier 1990; Voisey et al. 1990).

Traditionally, Native women possessed an intimate knowledge of their bodies and of childbirth, having witnessed several births before having a child

themselves. This awareness, necessary if one is to feel comfortable and in control of labour and delivery, has been compromised due to the absence of home births in contemporary communities (Paulette 1990b). Those who attended births provided on-going and informative care. Women in labour were prepared beforehand but were also told what was happening during the birth — a situation which promoted feelings of security and confidence instead of fear and surprise (Ford et al. 1992).

## CONTEMPORARY ISSUES

### *Quality of Care*

For Native women flying to an alien community to give birth, the quality of care they receive is very important, and goes beyond the hospital itself. As Jennifer Stonier states:

so often we look at the quality of the experience as something sort of nice that you can add onto the end after the technology and all the hard stuff is in place...The quality of the experience is not something aside; it is inherent to the health status of the people.(in Robinson 1990:16)

What follows is an examination of the Northern Native woman's experience of hospital birth. It is important that the succeeding comments and criticisms be placed in the context of the statement made by Bernard Binns — an obstetrician who makes two or three trips to Rankin Inlet each year to assist in training staff and to see patients — that childbirth is only a relatively short period of a woman's life and therefore safety should be the first priority (1990:81).

Native women are uncomfortable at being separated from their families. Childbirth has devolved from an important, bond-strengthening family event to a "trial of separation" (Stubbing 1990:75). By concentrating on improving the health of the mother, the experiences and in many cases the health of families left at home without their usual care-giver have been sacrificed. Women worry about their children left at home and the children, missing their mother, become ill, unmotivated, and suffer from insomnia (Enerk 1990). Fathers feel frustrated at being the primary care-givers for a period of time which can extend up to two months. There is a fear that the absence of the mother from the home during the final stages of her pregnancy and for the birth impedes bonding between father, older children and the new baby (Paulette 1990a; Stonier 1990). The stresses associated with evacuation have also been blamed for the perpetuation of domestic violence (Ford et al. 1992). Because Native women often perform double duty as care-giver and breadwinner, the family may experience financial difficulty (Putt 1990).

The hospital experience can be very traumatic. The environment is felt to be hostile, and the women often do not respond well to health care providers who lack empathy and meaningful communication skills and who remain culturally and

physically distant from patients (Willms et al. 1992). Language differences prevent communication between Natives and Euro-Canadian health professionals (Enerk 1990). Seen as patients in a total institution, hospitalized Natives lose their cultural context and become consumers of a system which may have no cultural relevance for them. A clinical perspective pervades encounters between Western health care workers and Native women. They are seen as patients and are provided with medical care, when what is perhaps needed is psychological or social support (O'Neil 1985). Hence the fear expressed by elders who believe that drugs have taken the place of traditional support systems in hospital births (Paulette 1990a).

Women have expressed their discomfort with the presence of interns and a resulting lack of privacy. They feel that they are "guinea pigs" for new doctors and nurses (Voisey 1990). In fact, a nurse at Moose Factory General suspects that women are flown to the hospital at Queen's University as "teaching material" (Ford et al. 1992). Unlike traditional midwives, who are permanent, integrated members of Native communities, staff turnover in hospitals and nursing stations in the North is enormous (Stonier 1990; Voisey et al. 1990). This may prevent a pregnant woman from developing an on-going relationship with the doctor who will assist in the birth. These situations cannot help but exaggerate the already-unfamiliar environment and procedures of Western medical institutions servicing Inuit and Indian women.

Though they may be completely healthy, Native women from isolated Northern areas are often forced to spend the last weeks of their pregnancy as patients in a hospital. Moose Factory General serves women who live in communities along the Western coast of James Bay and although there are medical facilities in each of the communities, pregnant women are flown to Moose Factory at 38 weeks. Upon arrival, they move into the infamous Ward 5. This ward "has become a symbol of everything that is wrong with the experience of evacuation: disruption, dislocation, alienation, lack of privacy, boredom, loneliness, anxiety about being away from home and family" and there are even complaints that "hospital staff use the ward as a smoking lounge" (Ford et al. 1992:8). Some hospitals do not offer boarding facilities and in these cases Native women must await the onset of labour billeted out to an unfamiliar, often Euro-Canadian home (Enerk 1990; Robinson 1990).

Women who boycott educational and preparatory classes and who lie about their due date or conceal their pregnancy in order that they may give birth at home are offering a passive resistance to this poor-quality care (Ford et al. 1992; Paulette 1990a; Stonier 1990). Unfortunately, communities lack the obstetrical infrastructure of the recent past — the nurse-midwives who staffed the nursing stations and the traditional birth attendants who were active in the villages — and thus are incapable of dealing effectively with home births. And childbirth classes, although culturally inappropriate, do prepare a Native woman somewhat for her hospital ordeal. By refusing to attend these classes, women are complicating and adding stress to their birth experience because they have not been prepared for what they will encounter.

*Safety*

Many medical professionals maintain that evacuation is necessary for the safety of the mother and child. As Binns (1990:81) states:

It has been shown statistically by several studies in different countries, that the most important factor in reducing maternal and perinatal mortality is rapid access i.e. within minutes, to a centre that can handle both obstetrical and neonatal problems rapidly and efficiently.

It has been suggested by Binns that midwives be used as a supplement to pre- and postnatal care, but that for the Canadian North, given its formidable distance from most tertiary care institutions, a policy of evacuation for birth be continued. An alternative to the home birth experience proposed by Binns (1990), is to create a family environment within the hospital. However, given the absence of family at most Native births which occur in hospitals, this would be rather difficult and costly to achieve.

The Federal and Territorial departments of health are concerned that the use of midwives or nurses will "decrease the status of maternal and infant health" (Paulette 1990a). They do not trust traditional birth attendants and see a lack of fully trained midwives in Canada. It will be interesting to determine whether this government policy will change, now that midwives have been legally recognized and licensed in Ontario. Many of the sources used in this paper were written before the November 1991 Midwifery Act became law.

The philosophical basis for medical and government concern lies in the belief that childbirth is a series of risks, not a natural process (Putt 1990). Obstetrical risk — defined using quantitative and qualitative terms like age of mother, number of children previously born, previous complications and suspected complications — has been and continues to be conservatively defined. Putt (1990) believes the recent increase in patient evacuations has been prompted by a more strict subjective analysis of the mother's risk. Because Native communities are viewed as "sick" by contemporary Northern medical ideology (O'Neil 1985), the risk assessment of these pregnant women is particularly conservative. Yet childbirth risk categories should be assigned in a culturally sensitive way. While Euro-Canadians see pregnant teens as a high risk population, requiring evacuation to southern hospitals, the Inuit, with their emphasis on family support, see evacuated teens as being placed in a higher risk situation (Putt 1990). Risk should also be seen as resulting in part from social forces which can be shaped. The low compliance with pre- and postnatal programs in many Northern communities could be alleviated by the continuous, preventative, and educational nature of midwife-assistance. Women who are involved as key decision-makers in all stages of their own care are likely to experience enhanced autonomy and responsibility for outcomes — an attitude change and awareness that could decrease risk (Fooks 1986).

Hospital births are certainly not without their own set of risks. Evacuation itself is inherently dangerous. Because women conceal pregnancy and lie about their dates, many are flown out during labour or shortly after giving birth. Besides

increasing a woman's experience of stress, complications that arise en route to the hospital in such a situation will present more of a challenge (Ford 1992). Air travel in the North can be risky because of weather conditions and isolation in the event of a crash. Even given a safe arrival at a hospital, it is not true that one will always encounter better qualified staff, as most Northern doctors are recent graduates of medical school (Putt 1990).

Hospitals practice an interventionist approach to birth, and this routine monitoring and interference "may cause significant added risks to both mother and infant in the majority of low-risk, normal births" (Fooks 1986:3). For example, fetal heart monitors are used regularly in hospitals and may increase the likelihood of unnecessary intervention because they are not accurate predictors of fetal stress (Baker 1989). The stress experienced by the woman in labour, often associated with the forced relinquishing of autonomy to a male physician during birth, increases a woman's experience of pain and has been correlated with abnormalities and worse birth outcomes (Putt 1990; Stonier 1990). A woman's health, and the health of her fetus, are at further risk because of increased access to drugs and alcohol in an urban centre, and because the stress of the hospital situation often increases drug use, particularly tobacco.

The desire expressed by Northern Native women is not to have access exclusively to home birth. They realize the value of the emergency care that can be provided in hospital settings and believe they should have the power to make informed decisions regarding their personal risk and treatment (Voisey et al. 1990). They are also aware of the increased risk in the present situation: community-based nurses lack the practice to deal with emergency situations and thus are ineffective when an emergency arises prior to evacuation (Stonier 1990).

#### *Statistics*

Physicians and administrators in favour of evacuation usually rely on statistics regarding perinatal and maternal death rates to support their argument. However, one must regard this information critically. A simple causal relationship cannot be assumed between hospital births and decreasing mortality rate. Instead, this historical trend must be seen in a wider social context. Social and economic conditions, prenatal care, public health and general medical techniques and facilities have improved over time. All these factors have contributed to the decreased infant and maternal mortality rate (Fooks 1986).

Statistics can be misleading, especially when they are collected in isolated Northern communities. Kaufert et al. (1990) list three areas in which statistics can skew data: numbers, accuracy and interpretation. Numbers present a problem because in order to find a numerical difference statistically significant, a large sample is necessary. Because of the small size of communities in the Canadian North (and even the area as a whole), statistical results are vulnerable to skewing. Caution must be exercised when comparing perinatal and maternal mortality rates recorded in different years, and in different populations.

Recording errors affect the accuracy of results. Conditions such as still-birth and

miscarriage do not fall easily into statistical categories and their recording becomes a matter of personal judgement. This problem is compounded by the fact that the populations being dealt with in the North are small — a single error could provide the basis for an entire argument for or against home births.

Interpretation, or rather misinterpretation, involves the tendency for statistical correlations to be taken as causal relationships between two factors. Because nursing stations have higher perinatal mortality rates than hospitals, it is assumed that nursing stations are inadequate places to give birth. Instead of making connections of this kind, one must examine the number of preventable deaths versus those that would have occurred regardless of the birthing environment, and take into consideration the fact that many preventable deaths would have required immediate tertiary care hospitalization — something impossible in the Canadian North. And because of current evacuation policy, nurses located in isolated communities lack experience with childbirth. Were nursing stations staffed with teams of traditional birth attendants and nurse-midwives, the statistics might look quite different.

Robinson (1990) warns that comparison of populations can be misleading because different populations have different levels of biological, environmental and lifestyle risk factors which cannot be adequately controlled for in statistical analyses. She also states that perinatal mortality rates do not have a universal definition — yet another caution against taking for granted statistical statements which compare different groups and were conducted by different agencies.

Although statistics point to an improvement in maternal and infant outcomes in the neonatal period with a shift to hospital births, the highest risk period for Northern Native infants is when they return to the poor living conditions of the community (Paulette 1990a). When put into perspective, it seems ridiculous to emphasize hospitalization, given the incredibly high cost of flight to, and board in, distant communities, when the real problem lies in the standard of living in Native communities and the lack of funding available to implement community development programs.

### *The Fight for Cultural Legitimacy*

The health care system in the North is still functioning under the precept of colonialism and the revival of midwife traditions is part of a larger concern for legitimizing cultural patterns and alleviating dependence on perceived authorities (Putt 1990). Native women in Northern Ontario lament that there is money available for maternal health care but that it is being spent by agencies on behalf of Native people, and not by the Natives themselves (New Democratic Party 1989:14). The involvement of these women in midwifery and other health issues is a result of their desire to see control of programs and purse-strings put in Native hands. And their fight for recognition is not only against physicians and hospitals. A commonly-voiced concern at Northern community meetings held by the Interim Regulatory Council on Midwifery has been that advocacy, research and policy



development by groups in the South ignore Northern Native women and their particular needs. Such research must be done jointly with women's groups in the North (Ford 1991). Direct participation is necessary because it is obvious that simply writing Native women into legislation and regulation does not guarantee Native awareness and agreement. As an example, the 1991 Ontario Midwifery Act contains an aboriginal exemption clause which enables a Native person to practice midwifery without having undertaken provincially regulated training. Ford et al. (1992) noted that the women of James Bay were largely unaware of this clause.

Colonial systems foster an unquestioning dependence upon the services and authority offered by those in power. O'Neil (1985) sees the colonial aspect of health care as a powerful converting device despite its merit for Native people. Indians and Inuit, often plagued by the low self esteem that is a symptom of life in a world where others are always doing what you should be doing for yourself, find it difficult to fight the health care system. Unfamiliar with modern medicine — which isolates itself from those who use its services with complicated jargon and a policy of personal distance from patients — Native women tend to accept the authority of doctors and nurses (Putt 1990). Perceived dependence on the existing system and the lack of traditional midwives has convinced women that there is no alternative to birth outside of the community, even though no one can force a woman onto a plane (Voisey et al. 1990). Some younger women even prefer the thought of birth in a hospital, being convinced that it is the safer method, or fearing the consequences of angering Western health professionals averse to home birth (Ernerk 1990; Preston 1982b; Putt 1990; Young 1988).

The importance many Northern Native women attach to home births, and the right to a medical system that provides them with culturally appropriate alternatives, is part of a much larger negotiation for self determination and the recognition that traditional practices have an inherent social and medical value. Inuit women believe that Native midwives have disappeared because they do not possess a legitimacy beyond Inuit culture — they do not possess Western qualifications symbolized by a certificate or diploma (Voisey et al. 1990). Yet these same women are aware of the importance of midwifery in a culture that has maintained an intricate balance with nature and they do not want to relinquish this important source of cultural knowledge and tradition (Grieg 1990; Voisey et al. 1990).

## CONCLUSIONS

Those advocating a return to midwife-assisted birth practices welcome the participation of, and training in, Western medicine. They understand that modern practices can increase the safety of home births and believe that a collaboration between health care professionals and midwives, a sharing of expertise, would be a positive cultural interaction provided the natural or sacred essence of the birth event was not compromised (Malloch 1989; Voisey et al. 1990). An important step

is the re-examination of traditions in a modern context. Women need to look to the past and revive those elements considered applicable and necessary in the present. Realizing the value of traditional midwives would present the medical profession with alternatives to hospitalization and could result in a non-interventionist policy in Northern childbirth practice, drastically reducing the number of women requiring evacuation.

Midwifery, as it is taught in Europe and North America, shares much of its philosophy with traditional Native birth practices. A holistic, preventative, non-interventionist, socially and culturally sensitive approach is advocated, and respect for the autonomy of the pregnant woman is emphasized. This correspondence is fortunate, because Native women understand that without training and certification from Western medical institutions, little faith will be placed in the skills of a Native midwife (Ford et al. 1992). The challenge will be to make this training available to women in the North, and to innovate on Western midwifery practice by blending it with traditional methods.

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